UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF TEXAS
LUFKIN DIVISION

THE ESTATE OF GLENN EARL SMALLWOOD JR., by and through its Administrator, **JOHN SMALLWOOD**,	§	
Plaintiff,	§	
v.	§	Civil Action No.
	§	**(JURY TRIAL DEMAND)**
SOUTHERN HEALTH PARTNERS, INC.; ANGELINA COUNTY, TEXAS; ALECIA LEWIS, LVN, individually; and **DAYTON RODRIGUEZ**, individually,	§	
Defendants.	§	

PLAINTIFF'S ORIGINAL COMPLAINT

I. INTRODUCTION

1. This case involves the wrongful death of Glenn Earl Smallwood Jr., a 33-year-old Black man, father of three minor children, and United States Army Veteran. On the night of June 16, 2023, Mr. Smallwood was in a medical and mental health crisis when the police arrested him on a misdemeanor public intoxication charge and brought him to the Angelina County Jail in Lufkin, Texas.

2. Mr. Smallwood's medical and mental health needs were readily apparent to the guards who met him in the jail sallyport after his arrest. He was paranoid, confused, sweating, shaking, unsteady, and bleeding from his mouth. Although Mr. Smallwood was not threatening, violent, or aggressive, jail guards made the perfunctory decision to strap him tightly into a restraint chair before taking him inside the facility. They did so pursuant to a blanket policy or practice of securing intoxicated detainees in restraint chairs while they detoxified.

3. Shortly after the guards started strapping him in the restraint chair, Mr. Smallwood became noticeably listless and began vomiting. Despite the plain dangers of aspiration, choking, and/or asphyxiation, and despite his underlying medical needs, they continued strapping him into the restraint chair, immobilizing his body, forcing him into a semi-reclined position that impaired his ability to clear his airways and restricted his breathing.

4. As jail guards fastened and tightened the straps around Mr. Smallwood's limbs and torso, he began to fade in and out of consciousness while continuing to retch and vomit. Whatever conceivable justification guards may have once had to put him in the restraint chair was long gone. After they finished strapping him into the chair, the guards wheeled Mr. Smallwood into the jail's intake and booking station—where newly arriving detainees normally undergo a required medical screening process. However, because his condition rendered him unable to answer basic questions, they skipped the requisite medical screening and wheeled him straight into a detox holding cell. Before shutting the door, guards heard him retching and moaning and saw him lose consciousness.

5. Minutes later, a licensed vocational nurse (LVN) working for a private, for-profit correctional healthcare company, Southern Health Partners, Inc., entered the detox cell and found Mr. Smallwood strapped into the restraint chair, limp and unconscious. She tried to elicit a reaction from him by performing a sternum rub—a pain stimulus technique used in emergency medicine to assess a patient's responsiveness—but he did not react.

6. Although the Southern Health Partners LVN should have immediately summoned emergency medical care for her unresponsive patient, she did not do so. Instead, she used "smelling salts" to momentarily rouse Mr. Smallwood. She then left her subdued and seriously ill patient alone in the detox cell, still strapped in a restraint chair, for about an hour before coming back and taking his vitals, which were abnormal, and then leaving him again.

7. Despite being an entry-level nurse with a limited scope of license, which prevented her from diagnosing patients or independently practicing medicine, the Southern Health Partners

LVN failed to call an ambulance, arrange for hospital transport, or seek guidance from a qualified medical professional. Her failure to summon a higher level of medical care was the byproduct of a profit-driven corporate practice that put unsupervised LVNs in charge of making critical medical decisions that they were neither qualified nor licensed to make.

8. Pursuant to this dangerous business practice, the Southern Health Partners LVN repeatedly assured concerned guards that Mr. Smallwood was fine and then left the jail for the night—leaving her dying patient alone in a detox cell, senselessly strapped in a restraint chair, with no on-site medical provider at the jail. When jail guards entered the detox cell about 15 minutes later, he was dead.

9. Mr. Smallwood's estate brings this federal civil rights case under 42 U.S.C. § 1983 to redress the egregious violations of his constitutional rights and to seek justice and accountability against those responsible for his pain and suffering and his wrongful death.

II. JURISDICTION AND VENUE

10. This Court has original subject matter jurisdiction over Plaintiff's civil rights claims under 42 U.S.C. § 1983, per 28 U.S.C. § 1331 (federal question jurisdiction) and 28 U.S.C. § 1343 (civil rights jurisdiction).

11. The Court has personal jurisdiction over each of the named defendants because they either (1) reside in this judicial district, and/or (2) have sufficient minimum contacts in the State of Texas to warrant jurisdiction over them.

12. Venue is proper under 28 U.S.C. § 1391(b) because a substantial part of the events or omissions giving rise to Plaintiff's claims occurred in this judicial district.

III. PARTIES

13. Plaintiff is the Estate of Glenn Smallwood Jr., duly formed under Texas law and acting through its court-appointed Administrator, John Smallwood. John Smallwood is Glenn Smallwood Jr.'s surviving brother. He is a citizen of the United States and a resident of Lufkin. As

Administrator of his brother's estate, he is pursuing this civil rights action for the benefit of all eligible statutory beneficiaries, including the decedent's three surviving children.

14. Defendant Southern Health Partners, Inc. ("SHP") is a Delaware correctional healthcare corporation headquartered in Tennessee and doing business in this judicial district for the purpose of making a profit. SHP is a "person" under 42 U.S.C. § 1983. At all relevant times, SHP acted under color of state law and pursuant to a contract with Angelina County to provide necessary medical care to people in the Angelina County Jail. SHP was responsible for ensuring that the care it provided met minimum constitutional standards and for training and supervising its jail healthcare staff to meet those standards. SHP's registered agent for receiving service is Corporation Service Company d/b/a CSC-Lawyers Incorporating Service Company, located at 211 E. 7th Street, Suite 620, Austin, TX 78701.

15. Defendant Angelina County is a governmental entity, a Texas political subdivision, and a "person" for the purposes of 42 U.S.C. § 1983. Angelina County is responsible for operating the Angelina County Jail. Everyone detained in the jail is entitled to the federal constitutional promises of adequate medical care and freedom from excessive force. Angelina County's duty to ensure that all people detained in its jail receive constitutionally adequate medical care is nondelegable, and it remains liable for any unconstitutional customs and practices committed by SHP that result in harm to any detainees.

16. Defendant Alecia Lewis is a licensed vocational nurse (LVN) who, on information and belief, resides in Texas. Defendant LVN Lewis was an employee or agent of SHP who was responsible for providing medical care at the Angelina County Jail during Glenn Smallwood's detention. At all material times, she was acting under color of state law. The allegations against her arise from her actions in Texas and in this judicial district.

17. Defendant Dayton Rodriguez is a lieutenant with the Angelina County Sheriff's Office who, on information and belief, resides in Texas. Defendant Lt. Rodriguez approved,

authorized, and participated in putting and keeping Mr. Smallwood in a restraint chair on June 16, 2023. At all material times, he was acting under color of state law. The allegations against him arise from his actions in the State of Texas and in this judicial district. Plaintiff is suing Defendant Lt. Rodriguez based on his own unconstitutional actions and based on the unconstitutional actions of his sheriff's office subordinates.

IV. FACTUAL ALLEGATIONS

A. Background

18. Glenn Earl Smallwood Jr. was born in Galveston and spent his childhood living in various parts of East and West Texas. He lived in Utah as a young man, while serving in the Army National Guard, before moving back to Texas where his family resided. Mr. Smallwood had three children, one son and two daughters. In early June of 2023, he was living with his two youngest children and their mother in Huntington, Texas, a small city in Angelina County located about ten miles east of Lufkin.

19. Like millions of Americans, Mr. Smallwood lived with a mental illness. For much of his adult life, he suffered from schizoaffective disorder, a psychiatric condition that combines symptoms of schizophrenia with mood disorder symptoms. His schizophrenic symptoms included paranoid thoughts and delusions, as well as auditory and visual hallucinations. His mood disorder symptoms manifested in bouts of major depression. Mr. Smallwood took prescription medication to help manage his illness. He also self-medicated with stimulant drugs and alcohol, particularly when he was out of his psychiatric medication.

20. On the morning of June 16, 2023, Mr. Smallwood walked into the Burke Center, a mental health facility in Lufkin, seeking prescription medication. The Burke Center was familiar with Mr. Smallwood, having previously treated him for his psychiatric needs. When he showed up at the facility that morning, he was in a state of active psychosis: hallucinating, seeing people who weren't there and hearing voices telling him to harm himself. He was unmedicated and suicidal.

Based on Mr. Smallwood's alarming presentation, Burke Center personnel quickly realized that he needed a higher level of care and decided to have him involuntarily transferred to an inpatient hospital that could stabilize him and care for his serious psychiatric needs. But before they finished processing the paperwork to secure a mental health warrant, Mr. Smallwood left the facility.

21. At some point after leaving the Burke Center that morning, Mr. Smallwood likely self-medicated with methamphetamine, a synthetic stimulant commonly referred to as crystal meth or meth. Meth is an addictive and dangerous drug that can exacerbate the psychotic symptoms of a person's psychiatric disorder. It can also cause death from its toxic effects if a person who's overdosing does not receive timely medical treatment. The warning signs of a life-threatening meth overdose include difficulty walking, shaking, sweating, confusion, nausea, vomiting, lethargy, drowsiness, shallow breathing, and unconsciousness.

22. Because of the outstanding mental health warrant issued by the Burke Center that morning, local Lufkin authorities were looking for Mr. Smallwood. They were trying to find him to bring him to a hospital or in-patient mental health facility—where he could get the psychiatric help he desperately needed. In Texas, psychiatric "holds" (also known as emergency detentions) can last up to 48 hours. Once the person is evaluated, medicated, and stabilized, the facility releases them to either a family member or trusted friend, or a court orders them to undergo further treatment.

B. Mr. Smallwood's Arrest, Detention, and Death

23. That evening, two Lufkin police officers respond to a call that Mr. Smallwood is behaving bizarrely in a residential neighborhood. Upon their arrival, they find him on his hands and knees, crawling around on a public sidewalk, shirtless, speaking incoherently, hallucinating, and bleeding from his mouth. Mr. Smallwood tells the officers that he's a "psych patient." Instead of taking him to a nearby hospital or psychiatric facility for an evaluation (or heeding the mental

health warrant), they arrest Mr. Smallwood for public intoxication without incident, and an officer drives him to the Angelina County Jail.[1]

24. Defendant Lt. Rodriguez and three of his subordinate jail guards (Sergeant Sean Matthews, Officer Blane Wilson, and Officer Christian Epperly) are awaiting Mr. Smallwood's arrival. Shortly after the patrol car pulls into the jail's sallyport and parks, they approach the car and remove Mr. Smallwood, whose medical and mental health needs are readily apparent. He requires assistance to walk from the patrol car to the jail's entrance, shuffling slowly between two guards, unsteady on his feet. He's lethargic, sweating, shaking, and bleeding from his mouth. He's confused, paranoid, and delusional. He speaks nonsensically and shows signs of psychosis (hallucinations), talking to people who are not there. Given his plainly noticeable symptoms, Mr. Smallwood is unfit for confinement without clearance from a qualified medical provider. He needs help, not jail.

25. During his escort from the patrol car to the jail's entrance, Mr. Smallwood does not make any threatening motion or gesture towards any of the officers or engage in self-harm. Though he's paranoid, irrationally worried that someone might shoot him, he doesn't exhibit any behavior that a reasonable law enforcement officer would consider hostile, menacing, or aggressive.

26. Nevertheless, as they approach the jail entry door, an officer grabs the emergency restraint chair that's sitting a few feet away and brings it next to Mr. Smallwood. A restraint chair is a metal-framed, high-backed chair with straps, buckles, and cuffs used to immobilize a person's shoulders, arms, wrists, legs, ankles, and torso, forcing them into a fixed, semi-reclined position.

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[1] Video footage from the arresting officer's body-worn camera shows Mr. Smallwood's arrest, transport, restraint, and initial detention at the Angelina County Jail. The portion of that footage that begins with Mr. Smallwood's arrival at the Angelina County Jail is available in the following link: Body Worn Camera Footage. Citing a completed in-custody death investigation that it intends to keep open "indefinitely," Defendant Angelina County refused to produce jail surveillance footage, which captures the critical two hours leading up to Mr. Smallwood's death. As soon as the federal discovery rules permit, Plaintiff will request the footage and amend this complaint accordingly. For now, Plaintiff incorporates the withheld footage herein by reference.

The constitution permits officers to use restraint chairs on violent, aggressive, or uncontrollable people who present an immediate threat to the safety of themselves or others.

27. There's no discussion about putting Mr. Smallwood in the restraint chair. It's done as a matter of routine practice. Just before the officers put him in the restraint chair, Mr. Smallwood says, "I'm good. I'm good" (suggesting it's unnecessary to place him in the chair). The tone of his voice is neither raised nor belligerent. In response, an officer states, "We don't want you falling down, bro," as the apparent justification for the restraint, and tells him to "have a seat" in the chair. Mr. Smallwood then compliantly sits in the restraint chair without any physical resistance.

28. At this point, another sheriff's department officer, Tyrone Porter, arrives at the scene. The five detention officers then briefly talk about the blood coming from Mr. Smallwood's mouth, which is visibly dripping onto his bare chest. But they don't talk about Mr. Smallwood's other medical symptoms or whether it's safe, appropriate, or reasonable to secure him in a restraint chair in his condition.

29. As the senior supervising officer at the scene, Defendant Lt. Rodriguez personally authorizes the chair restraint of Mr. Smallwood. At the time he exercises this authority, he knows that Mr. Smallwood suffers from mental illness and had previously received treatment at "more than one" psychiatric facility. He knows that Mr. Smallwood is hallucinating—in the lieutenant's own words: "speaking to entities that [are] not physically there." He knows that Mr. Smallwood is unsteady on his feet, sluggish, confused, sweating, shaking, and bleeding from his mouth. And he knows that Mr. Smallwood is neither uncontrollable nor behaving in a violent, combative, or aggressive manner.

30. Despite this knowledge, he decides to have Mr. Smallwood put in the restraint chair because of his apparent intoxication. Defendant Lt. Rodriguez, along with his four subordinates, then start to strap Mr. Smallwood into the restraint chair, beginning with his legs. As Defendant Lt. Rogriguez is strapping Mr. Smallwood's ankles to the restraint chair, he becomes drowsy and

listless, and his eyes start to roll back in his head—as shown in the following image taken from the arresting officer's body camera footage:

31. Shortly after that, Mr. Smallwood begins to retch, loudly and repeatedly, and then vomits in the direction of Defendant Lt. Rodriguez, causing him to quickly move out of the way, and prompting smiles and laughter from the officers as depicted in this image:

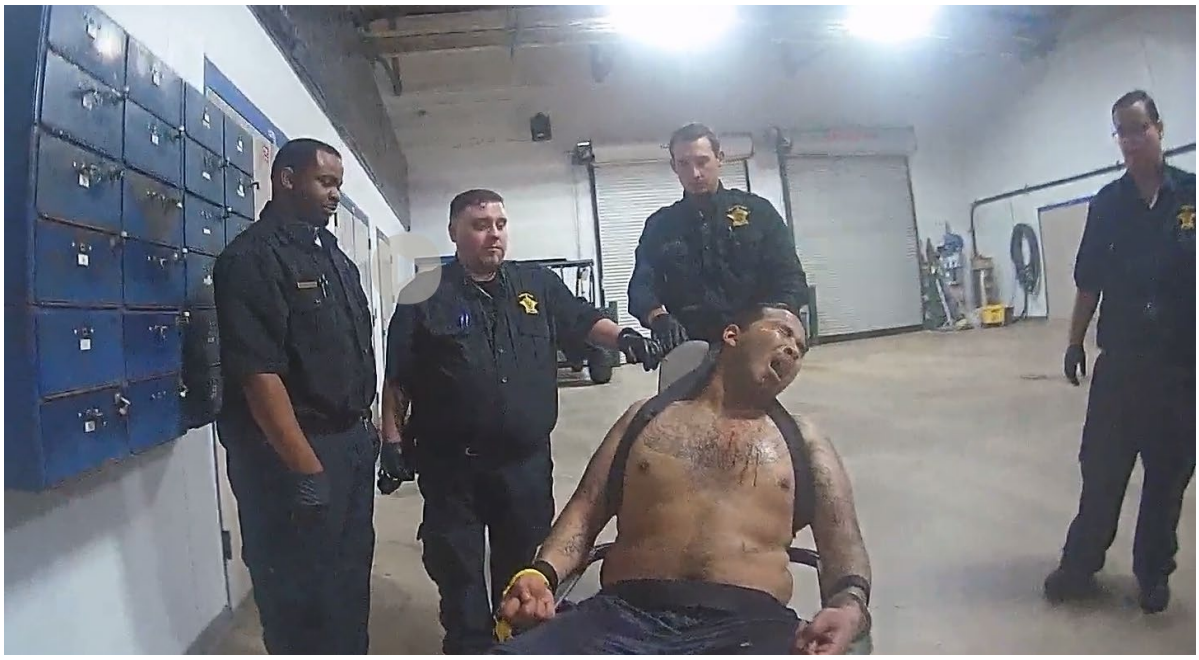
32. Mr. Smallwood's vomiting is no laughing matter. It is obvious that keeping him in the restraint chair in his condition will put him at risk of harm or death. Whatever conceivable

justification Defendant Lt. Rodriguez may have once had for authorizing the chair restraint is long gone. Despite the dangers of aspiration, choking, or asphyxiation, and despite Mr. Smallwood's underlying medical needs, Defendant Lt. Rodriguez and his subordinates continue cuffing and strapping him into the restraint chair.

33. Once Defendant Lt. Rodriguez finishes with the leg restraints, other officers remove the handcuffs behind Mr. Smallwood's back and tightly strap his waist, shoulders, arms, and wrists to the chair, immobilizing his limbs and torso, forcing him into a semi-reclined position that restricts his breathing and impairs his ability to clear his airways. As they do this, Mr. Smallwood mumbles something about needing to throw up again and loudly retches, prompting an officer to state, "Don't throw up on me." As the officers proceed to strap his shoulders and his wrists to the restraint chair, Mr. Smallwood again appears to drift off to sleep or fade into unconsciousness as depicted in this image:

34. After the officers secure Mr. Smallwood in the restraint chair, he awakens from his stupor and begins to retch again. One of the officers then jokes with Defendant Lt. Rodriguez about him having Mr. Smallwood's vomit on his arm. Defendant Lt. Rodriguez responds, "Just my luck." Before wheeling Mr. Smallwood through the jail's entryway door, which the arresting officer

opens, the sheriff's department officers casually stand and watch Mr. Smallwood retch again, loudly and repeatedly, as depicted here:



35. As they wheel Mr. Smallwood through jail's entrance and down a long narrow corridor, he continues to make loud retching and vomiting sounds, prompting an officer to remark in jest, "I might throw up if I see that again, man, I can't." While following the others down the corridor, the same officer makes a joke about needing some bleach.

36. After passing through the long corridor, the officers wheel Mr. Smallwood through the jail's intake and booking station—where newly arriving detainees normally undergo a vital medical screening process. The purpose of an intake medical screening is to identify and address any urgent or emergent medical or mental health needs—to ensure the safety and wellbeing of the detainee. Ironically, however, because Mr. Smallwood's medical and mental health condition renders him incapable of answering basic questions, no medical screening takes place. He's too sick to screen.

37. Instead, the officers wheel Mr. Smallwood through the intake and booking station, without pausing, and into a "detox" holding cell. When another officer who wasn't involved in the

chair restraint sees Mr. Smallwood for the first time, he asks the restraining officers, "What the fuck [is] up with all this blood?" One of the officers responds, "I think someone beat him up."

38. For the next 30 seconds, Defendant Lt. Rodriguez and several other officers stand either inside the detox cell with Mr. Smallwood or a few feet away. Because the cell door remains open during that time, they can all hear Mr. Smallwood violently retching, moaning, and making choking-like sounds before becoming silent and still. No one suggests removing Mr. Smallwood from the restraint chair. Defendant Lt. Rodriguez takes one long look at Mr. Smallwood before shutting the detox cell door and sighing.

39. Minutes later, at approximately 9:52 p.m., Defendant Alicia Lewis, an LVN employed by Defendant Southern Health Partners, enters Mr. Smallwood's cell (along with Sgt. Matthews) to assess him. She sees her patient strapped to a restraint chair, limp and unconscious. She performs a sternum rub, and he doesn't respond. When an unconscious patient doesn't respond to a sternum rub—a painful stimulus meant to assess responsiveness and brain function—it's a medical emergency. At this point, Defendant LVN Lewis should immediately summon emergency medical care. Had she done so, Mr. Smallwood would be alive today. But she doesn't.

40. Instead, Defendant LVN Lewis leaves the cell to get an ammonia pack (colloquially called "smelling salts") and reenters Mr. Smallwood's cell at about 9:54 p.m., again accompanied by Sgt. Matthews. Smelling salts, a folk remedy widely used on fainting ladies in the 1800s, release ammonia gas that irritates a person's nose and lungs, triggering an inhalation reflex that may be involuntary. Defendant LVN Lewis puts the ammonia pack under her patient's nose to try to revive him. Mr. Smallwood reacts but then quickly fades back into unconsciousness, prompting her to reapply the smelling salts, which produces a similarly ephemeral reaction.

41. Defendant LVN Lewis informs Sgt. Matthews that Mr. Smallwood is simply "very intoxicated." Ignoring her patient's life-threatening medical needs, she then leaves him alone in the cell, unconscious, strapped in the restraint chair. She documents nothing and neither summons

emergency medical care nor alerts a supervising medical provider. Though she understands and appreciates her patient's serious medical needs, she consciously disregards them and leaves.

42. Over the next hour, Defendant Lt. Rodriguez is both aware of and concerned about Mr. Smallwood's ongoing and extremely serious medical needs. He wonders at one point if Mr. Smallwood will be "okay," noting that he had been "throwing up and shaking." He later asks another detention officer whether Mr. Smallwood is breathing. He has the authority to remove Mr. Smallwood from the restraint chair and summon emergency medical care. Instead, despite his concerns, he leaves Mr. Smallwood strapped in the restraint chair.

43. At approximately 10:52 p.m., Defendant Lt. Rodriguez enters the detox cell to check on Mr. Smallwood. He notices that Mr. Smallwood is taking "short breaths" and leaves to find the nurse.

44. At approximately 10:54 p.m., Defendant Lt. Rodriguez returns to Mr. Smallwood's cell with Defendant LVN Lewis. She sees that her patient is pale and unconscious and that his breathing is shallow and labored. After cleaning some dried blood off Mr. Smallwood's face and chest, she purportedly takes his vitals. She documents a few elevated vital signs, including a blood pressure of 150/90 and a heart rate of 115 beats per minute.[2] But she doesn't check her unconscious patient's respiratory rate, take his body temperature, listen to his lungs, or conduct a basic physical examination. Nor does she ask Defendant Lt. Rodriguez to remove him from the restraint chair.

45. After she supposedly takes Mr. Smallwood's vitals, Defendant Lt. Rodriguez asks her if they need to send Mr. Smallwood to the hospital. Defendant LVN Lewis responds by saying that although his vital signs are "slightly elevated," it's a "normal reading for someone who's intoxicated," and that he "just needs to detox." Apparently not convinced, Defendant Lt. Rodriguez

[2] Though Defendant LVN Lewis documented these moderately abnormal vital signs, it is reasonable to infer that she fabricated this documentation. When she purportedly took Mr. Smallwood's vitals, he was in the process of dying.

asks her again if they should transport Mr. Smallwood to the hospital, and she responds, "No," a response that costs Mr. Smallwood his life. She and Defendant Lt. Rodriguez then leave the cell at about 10:59 p.m. Mr. Smallwood remains strapped in the restraint chair, pale, unconscious, breathing in short gasps—dying.

46. Just over twenty minutes later, at 11:22 p.m., Defendant LVN Lewis looks through the detox cell window. She sees her patient, Mr. Smallwood, who remains strapped in the restraint chair. He's unresponsive: pale, limp, lifeless. He's not breathing. His heart is no longer beating. There may still be a chance to save him, with immediate resuscitation efforts, but that window is closing fast. Every second counts. Incredibly, Defendant LVN Lewis does not enter the detox cell, summon emergency medical attention, or alert a supervising medical provider. Instead, she callously leaves the facility for the night, erasing any remaining hope of Mr. Smallwood's survival.

47. Fourteen minutes later, at approximately 11:36 p.m., Sgt. Mathews notices that Mr. Smallwood is unresponsive, and he and Officer Porter quickly enter the detox cell. Sgt. Mathews begins chest compressions on Mr. Smallwood, who is still in the restraint chair, while Officer Porter begins to remove the straps from the chair. Additional officers enter the cell and help move Mr. Smallwood from the restraint chair to the floor, where they continue chest compressions until Lufkin Fire Department medics take over.

48. By then, it is too late to save Mr. Smallwood. His jaw is stiff and clenched—rigor mortis has begun to set in. Medics transport him to CHI St. Luke's Health-Memorial Hospital, in Lufkin, where ER personnel pronounce him dead at 12:05 a.m. on June 17, 2023.[3]

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[3] The forensic pathologist who performed Mr. Smallwood's autopsy concluded that he died from the "toxic effects of methamphetamine." If this is indeed the cause of Mr. Smallwood's death, it was preventable. With timely medical intervention, he would have survived. Significantly, however, Angelina County failed to provide the forensic pathologist with critically important video footage showing what happened in the hours and minutes leading up to Mr. Smallwood's death. The footage shows him vomiting while strapped in a reclined restraint chair, putting him at risk of aspiration, choking, or asphyxia. Whether Mr. Smallwood's death was caused by methamphetamine, impaired respiration, or a combination of both, it was avoidable. It is also possible that when he entered the jail, Mr. Smallwood was suffering from life-threatening alcohol withdrawal, which is easily treatable with proper medical care.

49. Glenn Smallwood's wrongful death resulted from the violation of two fundamental constitutional rights: his right to be free from excessive force; and his right to receive adequate medical care during his pretrial detention. Defendants Lt. Rodriguez and Angelina County are liable for the constitutionally excessive force used against Mr. Smallwood, and Defendants LVN Lewis and Southern Health Partners are liable for the constitutionally inadequate medical care he received. Additional material factual allegations in support of these constitutional claims are set forth below.

C. Additional Material Facts Supporting Plaintiff's Constitutional Claims for Improper Use of the Restraint Chair

50. The United States Constitution entitles arrestees and pretrial detainees to be free from excessive force.[4] An officer's use of force is constitutionally excessive if it is objectively unreasonable in light of the facts and circumstances, without regard to the officer's underlying intent or motive. Simply put, law enforcement officers cannot use more force than is reasonably necessary to accomplish a legitimate governmental purpose. Municipalities are liable for excessive force used by their officers if they have policies, customs, or practices in place that result in their officers using the force. They are also liable for harm to pretrial detainees caused by municipal policies or pervasive practices that serve no legitimate purpose and amount to punishment.

1. Defendant Lt. Rodriguez and his subordinates

51. Defendant Lt. Rodriguez and his subordinates violated Mr. Smallwood's right to be free from excessive force by unreasonably putting and keeping him in a restraint chair for no legitimate purpose. At the time Defendant Lt. Rodriguez authorized the use of the restraint chair,

[4] The Fourth Amendment applies to arrestees, and the Fourteenth Amendment applies to pretrial detainees. Because Mr. Smallwood may have been an arrestee during some of the events described herein and a pretrial detainee during others, Plaintiff is alleging claims under both the Fourth and Fourteenth Amendments. The legal standard under these amendments is the same.

Mr. Smallwood was not engaging in violent, aggressive, or combative behavior, and he did not pose a threat of harm to himself or others. Indeed, the opposite is true: Mr. Smallwood was lethargic, unsteady on his feet, and subdued. And although he was paranoid and delusional, he was neither out of control nor resistant; he was under control and compliant and even sat in the restraint chair when asked to do so.

52. Video footage shows officers telling Mr. Smallwood that they didn't want him "falling down," as the justification for using the restraint chair. While this rationale might've justified transporting him in a wheelchair, it certainly didn't justify tightly securing his limbs, shoulders, and waist to a metal-framed restraint chair, causing multiple abrasions and bruises, and restricting his breathing.

53. To the extent that the officers perceived Mr. Smallwood's paranoia as threatening, the purported "threat" quickly evaporated once they began securing his legs to the restraint chair. At that point, Mr. Smallwood became visibly drowsy and listless. He appeared to have fallen asleep or passed out, and his eyes rolled back into his head. No reasonable officer could have conceivably construed his behavior as threatening at that point.

54. Continuing to strap him into the restraint chair *after* he began vomiting was objectively unreasonable and put him at substantial risk of serious harm or death from choking, aspiration, or asphyxia. This is because the reclined angle of the chair compromised his ability to clear his airways. Video footage showing the officers smiling, laughing, and joking in reaction to Mr. Smallwood's sickness belies any claim that they felt threatened by his behavior or had any legitimate concern for his wellbeing.

55. While Mr. Smallwood was in the detox cell, still strapped in the restraint chair, he lost consciousness. He was so unresponsive that a sternum rub did not awaken him, and it took two doses of "smelling salts" to produce a temporary (likely involuntary) reaction—before he slipped back into unconsciousness. There was no conceivable lawful basis to keep Mr. Smallwood

strapped in a restraint chair during that nearly two-hour period. Doing so was objectively unreasonable.

56. While Mr. Smallwood was locked in the detox cell, officers could see that his breathing had become labored. Keeping him in the restraint chair exacerbated his respiratory distress, as the tightly secured straps over his shoulders, torso, and waist interfered with his ability to fully inhale and exhale and otherwise impaired his respiratory function. This was objectively unreasonable.

57. Near the end of Mr. Smallwood's time in the detox cell, Defendant Lt. Rodriguez became concerned enough about his shallow breathing ("short breaths") that he tracked down the nurse. After entering the cell with her, he learned that Mr. Smallwood had abnormal vitals and felt the need to repeatedly ask the nurse if they should transport Mr. Smallwood to the hospital. Yet, even then, he failed to exercise his authority to remove Mr. Smallwood from the restraint chair. This was objectively unreasonable.

58. Defendant Lt. Rodriguez is not only liable for his own unconstitutional conduct. As the highest-ranked officer at the jail, he had supervisory authority over Sgt. Matthews and Officers Wilson, Epperly, and Porter. He had a duty to oversee these four subordinate officers and ensure their compliance with constitutional standards. He actively participated in the unconstitutional conduct committed by these officers by personally directing it, tacitly authorizing it, or otherwise failing to supervise them—thereby giving rise to his individual supervisory liability for their constitutionally offensive conduct.

59. The actions of Defendant Lt. Rodriguez were carried out with intent, malice, and/or reckless disregard for Mr. Smallwood's civil rights. It was foreseeable that using a restraint chair to immobilize Mr. Smallwood would cause him serious harm or death. This was foreseeable before the lieutenant and his subordinates began restraining him in the chair—when he was noticeably confused, paranoid, lethargic, sweating, unsteady, and bleeding from his mouth. Keeping him in

the restraint chair after he began vomiting, losing consciousness, and/or experiencing respiratory distress was unreasonable. It was excessive. It put him at risk of asphyxia, choking, or aspiration. It impaired his respiratory function, exacerbated his underlying medical condition, prevented the nurse from adequately assessing him, and played a direct role in his death.

2. Defendant Angelina County

60. Angelina County is liable for the misconduct of Defendant Lt. Rodriguez and his sheriff's office subordinates because they each acted pursuant to a constitutionally impermissible policy, custom, or practice of using restraint chairs on intoxicated detainees, including in situations where, as here, the restraint is unjustified by the person's threat level and/or puts them at substantial risk of harm. This policy, custom, or practice was the moving force behind the violation of Mr. Smallwood's rights and caused his unnecessary suffering and death.

61. Following Mr. Smallwood's death, his surviving brother, John Smallwood, spoke with Angelina County Sheriff Tom Selman, at the Angelina County Sheriff's Office. During the conversation, John Smallwood asked Sheriff Selman why his brother was put in the restraint chair when he was not being violent. The sheriff responded by stating that it is common practice for jail guards to secure intoxicated detainees in restraint chairs while they detoxify. He added that they use restraint chairs whenever intoxicated detainees are put in detox cells. Separately, another sheriff's office official confirmed to Glenn Smallwood's surviving sister, Veronica Smallwood, that it was jail policy to keep intoxicated people in restraint chairs.

62. These statements from sheriff's department officials confirm that Angelina County had an overbroad, constitutionally impermissible policy, custom, or practice of using restraint chairs on intoxicated detainees while they undergo detoxification. While it may be reasonable to use restraint chairs on *some* intoxicated individuals, it is not reasonable to do so in situations where, as here, the restraint is unjustified by the person's threat level and/or puts them at risk of serious harm due to an underlying medical or mental health condition.

63. In addition to these direct statements, there is ample circumstantial evidence of a widespread practice or custom of putting and keeping intoxicated detainees in restraint chairs to detoxify—regardless of any safety risk they may (or may not) pose. For example, despite video footage of their plainly unjustified use of the restraint chair on Mr. Smallwood, none of the officers involved received any discipline or corrective counseling after Mr. Smallwood's death. Likewise, Sheriff Selman told the decedent's family that his officers acted in accordance with department policy in their use of the restraint chair and that their actions were appropriate in all respects.

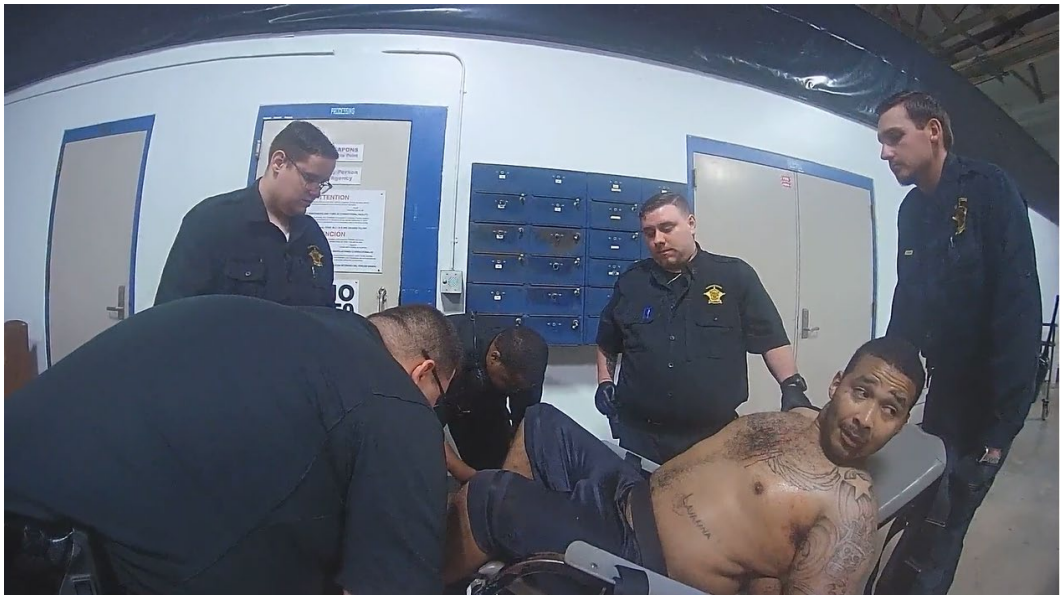
64. Moreover, based on the behavior of Defendant Lt. Rodriguez and his sheriff's office subordinates in putting and keeping Mr. Smallwood in the restraint chair, it is reasonable to infer that Angelina County had a widespread practice of using restraint chairs on intoxicated people, even if they are not violent, aggressive, or combative. The fact that five members of the detention staff, including a lieutenant and a sergeant, participated in the chair restraint and made no effort to remove Mr. Smallwood, even after he began vomiting and lost consciousness, strongly indicates that they were acting pursuant to a widely accepted practice.

65. Video footage of Mr. Smallwood's arrival at the jail shows the restraint chair positioned for immediate access in the sallyport—near the doorway into the jail—as seen here:

66. The decision to use the restraint chair took mere seconds. The speed of the decision, which the guards made with no discussion or deliberation, suggests an ordinariness to their use of

the restraint chair in these conditions, rather than a sense of exigency or unusual circumstances warranting the restraint. No one voiced objections or questioned the reasonableness of the chair restraint. They did it automatically, by rote, without thought or consideration.

67. The demeanor of the jail guards, as captured on video, further undercuts any suggestion that they thought Mr. Smallwood posed an imminent threat to their safety. Throughout the process of securing him in the restraint chair, their body language was calm, cool, and relaxed as depicted in these images:



68. At other times, body-worn camera footage shows the sheriff's department officers intermittently laughing, smiling, or joking around:

69. At no point prior to the chair restraint did Mr. Smallwood exhibit any violent, aggressive, or combative behavior. He did not make any threatening motions or gestures towards any of the officers. He was neither resistive nor out of control. At most, he expressed some paranoid fear that one of the officers (or someone else) was going to shoot him. But he did not express this fear in a belligerent or hostile manner.

70. Indeed, the only action or behavior by Mr. Smallwood that seems to have influenced their decision to use the restraint chair was his unsteadiness on his feet, which prompted an officer to say, "We don't want you falling down, bro," immediately before instructing him to "have a seat" in the chair. If their primary concern was Mr. Smallwood falling down and injuring himself, they could have used less restrictive alternatives, such as a wheelchair, to take him into the facility.

71. These facts—the location of the restraint chair by the jail's entrance, the speed and ordinariness of initiating the chair restraint, the absence of discussion amongst the officers about whether to secure Mr. Smallwood in the restraint chair, the lack of any objections to the restraint

chair's use, the casual nature of the officers' demeanor and body language during the encounter, and their failure to explore less restrictive alternatives—suggest that chair restraint was a common occurrence in similar situations. Collectively, these facts support a reasonable inference that Angelina County had a widespread custom or practice of using restraint chairs on all intoxicated people, even if not warranted by the circumstances.

72. The practice of using restraint chairs on people merely because they are intoxicated is constitutionally overbroad and dangerous. The complete immobilization of a person in a restraint chair carries significant risks, including exacerbating any preexisting medical conditions, causing respiratory distress, producing additional injuries, and preventing healthcare staff from performing thorough medical assessments. Here, the immediate use of a restraint chair, without considering less restrictive interventions, exposed Mr. Smallwood to a substantial risk of serious harm or death. These risks increased dramatically when he began vomiting, losing consciousness, turning pale, and exhibiting signs of respiratory distress. Mr. Smallwood lost his life as a result of this cavalier practice.

73. Angelina County policymakers knew or should have known that their blanket policy, practice, or custom of securing intoxicated detainees in restraint chairs would put detainees, like Mr. Smallwood, at substantial risk of serious harm. Even though this risk was foreseeable, county policymakers failed to take reasonable steps to prevent it.

74. Angelina County's policy, practice, or custom of putting and keeping intoxicated people in restraint chairs while they detoxify worsened Mr. Smallwood's underlying medical condition, led to his gratuitous suffering, caused his death, and was the moving force behind the constitutional deprivations alleged herein.

75. In addition, Angelina County failed to train its jail detention staff on (1) the limited, permissible use of restraint chairs, (2) the dangers of using restraint chairs on people with certain medical symptoms, including vomiting, loss of consciousness, or respiratory distress, (3) the need

to remove people from restraint chairs when they no longer exhibit the behavior that supposedly justified the restraint in the first place, and (4) how to monitor people in restraint chairs.

76. The need for this basic restraint chair training was obvious, and it was foreseeable that the failure to provide it would cause harm to people detained in the Angelina County Jail. Despite the obvious need for this training and the predictable consequences of not providing it, Angelina County officials made a conscious and deliberate choice not to train their detention staff on the appropriate use and limitations of restraint chairs.

77. The lack of training is apparent from the actions and inactions of the detention staff, including their inappropriate initial decision to put Mr. Smallwood in the restraint chair and their egregious decision to keep him restrained even after he began vomiting, lost consciousness, turned pale, and exhibited signs of respiratory distress.

78. The County's training failure resulted in the frequent, knee-jerk use of restraint chairs where it was unwarranted, led to people being kept in restraint chairs longer than reasonably necessary, and subjected people to unreasonable risks of harm and actual harm.

79. Angelina County's failure to provide adequate training resulted in Mr. Smallwood's gratuitous suffering, caused his physical injuries and death, and was the moving force behind the constitutional deprivations alleged herein.

80. Finally, Angelina County's restraint chair policy and widespread practice served no legitimate governmental aim, subjected detainees to unconstitutional conditions of confinement, and caused Mr. Smallwood's unnecessary suffering and death.

D. Additional Material Facts Supporting Plaintiff's Constitutional Claim for Inadequate Medical Care

81. The Fourteenth Amendment to the United States Constitution entitles pretrial detainees to adequate medical care during their detention. Jail healthcare personnel, such as LVNs, cannot act with deliberate indifference to the serious medical needs of their patients. Correctional

healthcare corporations are liable for constitutionally inadequate medical care if they have policies, customs, or practices in place that result in their employees providing inadequate medical care and causing harm. They are also liable for harm to pretrial detainees caused by corporate policies or pervasive practices that serve no legitimate purpose and amount to punishment.

1. Defendant LVN Lewis

82. Defendant Alecia Lewis was an LVN, an entry-level nurse with a limited scope of license. Under Texas nursing rules and regulations, LVNs must be guided and supervised by more qualified health professionals. They are not allowed to diagnose patients, prescribe medications, perform independent medical assessments, come up with their own treatment plans, or act without supervision. According to the Texas Board of Nursing, LVNs are best suited to serve assigned patients with predictable healthcare needs.

83. Notwithstanding the limited scope of her nursing license, Defendant LVN Lewis acted as Mr. Smallwood's sole and exclusive medical caregiver when he was detained on the night of June 16, 2023. She was subjectively aware of Mr. Smallwood's extremely serious medical needs. Yet, she (1) unilaterally decided that he did not require hospitalization or even a higher-level of medical care after her sternum rub produced no response, (2) applied smelling salts to her nonresponsive patient and then ignored him for an hour, (3) failed to document either her sternum rub or her use of smelling salts, (4) did not take a complete set of vitals or perform a basic physical assessment, (5) inappropriately diagnosed her patient's elevated heart rate and blood pressure as being "normal" for an intoxicated person, (6) repeatedly assured concerned jail detention staff that he was fine when he wasn't, (7) neglected to initiate any steps to remove him from the chair restraint even when he was unconscious, (8) failed to consider whether he was suffering from life-threatening intoxication or withdrawal, and (9) left the jail for the night without calling a supervisor or the jail's designated medical provider. Her limited-scope license did not authorize her to diagnose patients or independently set treatment plans, yet she did both. She acted with deliberate

indifference to her patient's serious medical needs and in violation of the rules and regulations governing her practice.

84. Although Defendant LVN Lewis was acting pursuant to the widespread company practices of her employer, Southern Health Partners, she maintained an independent responsibility to ensure she was not exceeding the scope of her medical authority. According to the Texas Board of Nursing, it is "the LVN's responsibility to ensure he or she has access to an appropriate clinical supervisor and that the policies, procedures, and guidelines for that particular setting are established to guide LVN practice." The state nursing board stresses that LVNs must personally exercise caution "not to overstep the legal parameters of [their] nursing practice when an employer may not understand the limits of the LVN scope of practice" (though, here, SHP knew the limits of the LVN scope of practice).

85. Defendant LVN Lewis was a medical gatekeeper at the jail. It was her job to ensure that any detainee who needed emergency, acute, or specialty care received it. She was not a medical doctor, a physician assistant, or a registered nurse. She knew Mr. Smallwood needed a higher level of care than she could provide and prevented him from receiving it. She knowingly exposed him to a substantial risk of serious harm and consciously disregarded that risk.

86. Defendant LVN Lewis was subjectively aware of Mr. Smallwood's serious medical needs. When she first saw him, he was strapped tightly to a restraint chair, unconscious. A sternum rub provoked no reaction. She knew that he was unresponsive, sweating, shaking, and bleeding from his mouth. She also knew that he had been vomiting. It was the type of medical emergency that anyone would recognize. Yet she disregarded it.

87. Defendant LVN Lewis's decision not to send Mr. Smallwood to the hospital after her unsuccessful sternum rub put her patient at substantial risk of serious harm or death. Rather than summoning emergency medical care or even consulting with a higher-level medical provider, Defendant LVN Lewis instead decided to retrieve ammonia inhalants ("smelling salts") and to

administer them twice in an effort to rouse her unresponsive patient. Though smelling salts can trigger an involuntary reaction, she determined that her patient was okay (just intoxicated) and left him alone, in a restraint chair, for approximately one hour.

88. As an LVN, she was not authorized to make this type of independent diagnostic determination, which closed Mr. Smallwood off from any meaningful medical care. Her actions presented a clear disregard for the substantial risk that her intoxicated patient would die of an overdose or another medical condition. She did not notify a supervising medical provider that she had decided to use smelling salts on an unresponsive patient and unilaterally determined that no further intervention was necessary. She did not even document her actions.

89. Ammonia inhalants are not a substitute for a medical assessment and should never be the sole intervention on an unresponsive patient suffering from an unknown medical emergency. Using smelling salts instead of conducting a real medical assessment is dangerous because the reaction elicited by the ammonia inhalation might falsely suggest the patient is responsive and brings medical professionals no closer to determining the cause of the patient's unconsciousness. Deploying smelling salts in lieu of summoning medics, calling a medical doctor, or alerting the jail's designated provider prevented Mr. Smallwood from receiving a true assessment and resulted in the denial of life-saving medical intervention.

90. As stated above, Defendant LVN Lewis was aware that Mr. Smallwood had been vomiting. Though patients at risk of acute intoxication or overdose require, first and foremost, clear airways, she did nothing to ensure that her patient's airways were unobstructed. Instead, after administering smelling salts, *which can induce vomiting*, she left Mr. Smallwood restrained to a chair in a semi-reclined position that made it nearly impossible for him to clear his airways. This put her patient at substantial risk of choking, aspirating, asphyxiating, or succumbing to an avoidable death from overdose or withdrawal.

91. Defendant LVN Lewis's decision to leave Mr. Smallwood without any medical monitoring for an hour was deliberately indifferent. Patients placed in full restraints are rendered vulnerable and require regular medical observation. Mr. Smallwood had additional risk factors due to his intoxication, vomiting, loss of consciousness, and other serious signs and symptoms. Instead of monitoring him closely and frequently, however, she ignored him for the next 60 minutes.

92. When Defendant LVN Lewis came back to Mr. Smallwood's cell one hour later, it was not because she decided to check on her patient. It was because the lieutenant on duty was concerned about Mr. Smallwood's respiratory distress and tracked her down.

93. When Defendant LVN Lewis returned to the cell shortly before 11:00 p.m., she could see that her patient was unconscious and pale and that his breathing was labored. Once again, she decided not to summon emergency medical care or consult with a higher-level medical provider. Nor did she measure her patient's rate of respiration, take his temperature, listen to his lungs, check his reflexes, conduct a basic physical assessment, consider other possible causes of his symptoms, or ask the guards to remove him from the restraint chair.

94. Instead, Defendant LVN Lewis purportedly took her dying patient's heart rate and blood pressure, both of which were elevated, and interpreted them as being "normal" for an intoxicated person. She then repeatedly assured concerned jail staff that Mr. Smallwood did not need to go to the hospital and just needed to detox. Here, again, she was making diagnostic decisions and acting well outside the scope of her limited nursing license. She was deliberately indifferent to the serious medical needs of her patient and deprived him of life-saving medical care.

95. At a bare minimum, Defendant LVN Lewis should have notified the jail's medical provider/director about her restrained patient's abnormal vital signs and deteriorating medical condition. In fact, she should have done this an hour earlier when she first noticed Mr. Smallwood unconscious in the restraint chair. This was required by basic correctional healthcare standards. The same standards obligated her to alert the custody staff that the chair restraint was jeopardizing

Mr. Smallwood's health, impairing his respiration, and interfering with her ability to conduct a basic medical assessment.

96. Finally, Defendant LVN Lewis's departure from the facility at 11:22 p.m., when she knew there would be no medical staff on-site to observe or treat Mr. Smallwood, was deliberately indifferent. Just before leaving, she could see that her patient, who remained strapped in a restraint chair, was unresponsive, pale, and showing no observable signs of life. In all likelihood, he was in cardiac arrest. With immediate resuscitation efforts, there was still a chance to save him. But instead of entering the cell, she left the facility. Detention officers found Mr. Smallwood dead less than fifteen minutes later.

97. The actions of Defendant LVN Lewis were carried out with intent, malice, and/or reckless disregard for Mr. Smallwood's civil rights. It was foreseeable that her failure to summon emergency medical care when she first noticed Mr. Smallwood's unconsciousness—when her sternum rub failed to provoke a response—would cause him serious harm or death. It was foreseeable that relying exclusively on smelling salts to "treat" her nonresponsive (or unconscious) patient would cause him serious harm or death. It was foreseeable that ignoring him over the next hour would cause him serious harm or death. And it was foreseeable that her subsequent failures to summon emergency medical care would cause him serious harm or death. Her actions played a direct role in Mr. Smallwood's death.

2. Defendant Southern Health Partners

98. Defendant Southern Health Partners is liable for the misconduct of Defendant LVN Lewis because she acted pursuant to an unconstitutional, profit-driven corporate policy, custom, or practice that put untrained and unsupervised LVNs in charge of making diagnostic medical decisions that they were neither qualified nor licensed to make. This policy, custom, or practice did not advance any legitimate government interests; to the contrary, it required routine and

systemic violations of Texas's nursing protocols. This policy, custom, or practice was the moving force behind the violation of Mr. Smallwood's rights and caused his senseless suffering and death.

99. Southern Health Partners is a private, for-profit correctional healthcare corporation, incorporated in Delaware and headquartered in Tennessee. SHP holds hundreds of contracts to provide medical care in jails throughout numerous states, including Texas.

100. Beginning on January 1, 2018, Angelina County contracted with SHP to provide "reasonably necessary medical care" at the Angelina County Jail. Thereafter, the parties annually renewed the contract. The County paid SHP $340,307 for jail healthcare services in 2023, the year of Mr. Smallwood's death.

101. In its contract with Angelina County, SHP expressly agreed to "provide for the delivery of all medical, dental, and mental health services" to "individuals under the custody and control of the County at the Jail." SHP's responsibility included providing "nursing care," "regular physician care," "emergency medical care," and "emergency ambulance services when medically necessary."

102. Under its contract with Angelina County, SHP was "financially responsible for all physician and nurse staffing" and required to provide all "medical and support personnel reasonably necessary for the rendering of health care services" at the jail.

103. Despite agreeing to provide all "reasonably necessary" medical personnel, SHP staffed the Angelina County Jail with only one person per shift—for a total of 16 hours a day, with allowances for vacations, sick time, and holidays. Put differently, the Angelina County Jail was without *any* medical personnel for *at least* eight hours each night. SHP knew this was an insufficient staffing level to provide all "reasonably necessary medical personnel" at a jail that had an average daily population of more than 250 people.

104. Further, rather than hiring an on-site medical doctor, physician assistant, nurse practitioner, or registered nurse, SHP elected to staff the Angelina County Jail with a less-costly

licensed vocational nurse with a limited and directed scope of license. The LVN's supervision was to be achieved solely through a remote "professional provider" to be made available "for resource, consultation, and direction." Although the contract allowed SHP to fill this role with either a physician or a mid-level provider, the company elected to go with a less-costly mid-level provider: a nurse practitioner.

105. SHP did not commit to the provider being on-site for any set amount of time, if at all, and placed no restrictions whatsoever on the provider's other professional commitments, such as maintaining a private patient caseload or working at other SHP jails. In fact, most SHP providers (also called "medical directors") manage a large private patient caseload and work at multiple other jails.

106. The provider's duties under SHP's contract include direct patient care, reviewing the nursing care, administrative tasks (e.g., formulary reviews, protocols, quality assurance, education, and training), and "phone consults" with the LVNs. Yet, SHP only committed to *four hours per week* for all these combined services, leaving virtually no time to supervise or consult with the on-site LVNs.

107. As discussed above, LVNs have a limited scope of license. They are not allowed to diagnose patients, prescribe medications, perform independent medical assessments, or act without supervision. They are "information gatherers" who are supposed to pass that information on to a higher-level practitioner to make diagnostic and treatment decisions. However, it does not work this way at the Angelina County Jail. Instead, the nurse practitioner, who serves as the jail's provider-medical director, does next to nothing to supervise the LVNs and leaves it up to them to make important patient-care decisions.

108. This profit-driven system of medical care and supervision was predictably risky. Leaving Defendant LVN Lewis with no supervision explains why she failed to summon emergency medical care when finding her unconscious patient, used a sternum rub in an unsuccessful effort

to rouse him, administered ammonia inhalants in subsequent attempts to rouse him, misdiagnosed him as being merely intoxicated, determined his abnormal vitals were "normal for an intoxicated person," failed to alert the provider that he was unconscious, pale, and suffering from impaired respiration, and left the jail after telling concerned guards that he didn't need to go the hospital and just needed to detox.

109. Indeed, SHP routinely staffs its jails under this same arrangement: on-site nurses with limited-scope licenses and remote medical directors who are supposedly available to consult with them but who rarely, if ever, visit in person or provide any actual supervision. These entry-level nurses do not maintain regular communication with the designated providers and frequently make patient-care decisions independently.

110. This staffing scheme has the practical effect of having unqualified nurses make diagnostic medical decisions that are outside the scope of their license. This has a predictable and detrimental impact on patient care, particularly in situations where emergency medical care is necessary but is either misdiagnosed or ignored by an unqualified LVN.

111. This practice by SHP is well-documented and widespread, and SHP officials have had ample notice of its dangers. Two other lawsuits involving people who died while in SHP's care at the Angelina County Jail have noted the problems with SHP's staffing model: leaving the on-site nurse totally unsupervised and relying on a remote provider to act as medical director "in name only." *See Cabrera v. S. Health Partners*, Case No. 9:23-cv-80 (E.D. Tex.) and *Lambert v. Angelina County*, Case No. 20-cv-0097 (E.D. Texas).

112. SHP's practice also extends beyond Angelina County. In Leon County, Texas, for example, SHP relied on a single LVN working 15 hours per week to constitute the on-site jail medical care. *See Belknap v. Leon County*, Case No. 6:22-cv-1029-ADA_JCM, 2023 U.S. Dist. LEXIS 90851, at *3 (W.D. Tex. Apr. 3, 2023), *report and recommendation adopted,* 2023 U.S. Dist. LEXIS 89597. The Western District of Texas found plausible allegations of an SHP custom

of inadequate staffing, failing to provide treatment for jail emergencies, and allowing unqualified LVNs to make medical determinations. *Id.* at *25.

113. Likewise, in Hopkins County, Kentucky, a single LPN was working alone at a jail where SHP provided patient care. *Shadrick v. Hopkins Cty.*, 805 F.3d 724, 729 (6th Cir. 2015). After a 25-year-old died of a MRSA infection, the Sixth Circuit acknowledged that SHP relied too heavily on limited-scope-of-practice nurses and further failed to provide adequate supervision to the nursing staff in the jail. *Id.* at 733–34, 739–41.

114. Similarly, in Kenton County, Kentucky, SHP staffed a jail with a single LPN who in at least one case bizarrely also used smelling salts on a patient (this one suffering a seizure) and acted out of the scope of her authority by (mis)diagnosing an acute patient's level of medical need. *Grote v. Kenton County*, 85 F.4th 397, 402–03, 408 (6th Cir. 2023). The Sixth Circuit later found that the nurse's conduct, particularly given her limited license and authority, was "so cursory as to amount to a conscious disregard" of the patient's "clear medical needs." *Id.* at 409.

115. SHP also relied on an on-site nurse and a remote medical director to provide care at the Montgomery County Jail in Kentucky. *Rice v. Montgomery County*, Case No. 5:14-cv-181-KKC, 2016 U.S. Dist. LEXIS 59605, at *3–4, *41–42 (E.D. Ky. May 5, 2016). The remote medical director testified that he physically visited the jail only once every three months. *Id.* at *34. He also testified in a deposition that he had his own full-time, private practice (where he saw 20–24 patients a day) and served as the medical director at 21–23 other jails at which SHP provided health care services. The Eastern District of Kentucky found the evidence sufficient to establish SHP's liability for constitutionally inadequate supervision. *Id.* at *41–43.

116. SHP endorses these insufficient staffing models at the highest level of the company. In a deposition, SHP CEO Jennifer Hairsine acknowledged that medical directors act in a remote capacity and are not scheduled for regular hours on-site at the jails in which they oversee patient care. CEO Hairsine further indicated that, so long as off-site medical directors "can perform their

duties," the company is "fine with" having them juggle numerous contracts and carry a full-time, private practice caseload. CEO Hairsine further testified that there is no individual within SHP specifically charged with ensuring that jail medical directors adhere to their contractual obligations.

117. SHP relies extensively on LVNs and LPNs because they are cheaper to pay, and this reliance preserves the company's profit margin. This pervasive SHP business practice of relying chiefly or exclusively on limited-scope nurses to attend to the various medical needs of jail patients had a predictable yet dire outcome in Mr. Smallwood's case.

118. Baked into SHP's widespread insufficient staffing model—through which limited-scope-of-practice nurses were left alone in jails with only a remote, on-call medical director—was an inherent failure to supervise its nursing staff.

119. Indeed, SHP enabled a supervision structure for nurses so diffuse as to render it meaningless. Its CEO testified that supervision of on-the-ground nursing staff is a "team effort," from "senior management" within the company's corporate office "to our VP of operations out in the field, regional directors, regional representatives." CEO Hairsine added that the logistics of supervision "can be done in a variety of ways." In other words, there was no set structure for supervision, no standard methods, and in many instances, an express practice of LVNs or LPNs acting outside the scope of their medical licenses.

120. This staffing practice did not result in simple communication breakdowns or misunderstandings: it had the result of leaving entry-level nurses alone to field a variety of complex patient needs well beyond the scope of their authority, without clarity on who is responsible for their supervision.

121. Defendant LVN Lewis, left by her employer without oversight or support, acted unilaterally in mis-assessing the severity of Mr. Smallwood's condition, relying on antiquated smelling salts to "treat" him, allowing him to remain restrained without adequate observation, and

determining that he did not require hospitalization. Each of those decisions exposed Mr. Smallwood to substantial risk of serious harm, exacerbated his medical condition, and ultimately killed him.

122. Defendant SHP knowingly set the table for all of Defendant LVN Lewis's failures, omissions, and deliberately indifferent actions through its widespread and explicit corporate practices. SHP elected to staff the Angelina County Jail with a single unsupervised LVN despite warnings from courts that doing so exposes patients to "obvious" risks of harm and indicates a "conscious disregard" of patient medical needs.

123. SHP knew that relying on limited-scope-of-practice nurses to provide all the direct patient care in jails presented an extreme risk that patients' medical needs would go inadequately treated, particularly in emergency situations. Yet, to maintain its profit margins, SHP has continued to do so despite over a decade of warnings. These decisions were willful, malicious, and carried out with reckless disregard for the civil rights of SHP patients, including Mr. Smallwood. It was foreseeable that these practices would put patients at substantial risk of harm or death. The practices in fact caused Mr. Smallwood's senseless suffering and preventable death.

124. Compounding the dangers created by its understaffing and inadequate supervision was SHP's failure to train the LVNs at the Angelina County Jail on (1) the permissible scope of their nursing practice, (2) the obligation to notify the jail's designated provider about patient care needs and developments, (3) how to recognize and respond to emergencies, (4) the dangers and signs of acute intoxication and withdrawal, (5) when to summon emergency medical care, (6) how to monitor and assess restrained patients and communicate with custody staff and the provider about them, and (7) the need to follow the policies and protocols governing their work.

125. The need for this basic training was obvious, and it was foreseeable that the failure to provide it would cause harm to people detained in the Angelina County Jail. Despite the obvious need for this training and the predictable consequences of not providing it, SHP officials made a conscious and deliberate choice not to equip its LVNs with basic training on these important job

responsibilities. This decision left SHP patients without personnel who knew how to identify their medical needs and/or respond to those needs, putting them at substantial risk of serious harm.

126. Federal courts have taken note of training deficiencies at other SHP jails. For example, the Sixth Circuit discussed SHP's inadequate training to LPNs "who lack the essential knowledge, tools, preparation, and authority to respond to the recurring medical needs of prisoners" at the Hopkins County Jail. *Shadrick,* 805 F.3d at 739. And the Eastern District of Kentucky found "no evidence that SHP's administrators took responsibility to train its medical staff" in the Montgomery County Jail and indeed, SHP did not claim to have "any training program at all." *Rice*, 2016 U.S. Dist. LEXIS 59605, at *41–42.

127. In this case, an untrained LVN evidently failed to understand the limited scope of her nursing license, failed to notify the jail's medical director about Mr. Smallwood's serious medical needs, failed to recognize that he was experiencing a medical emergency, failed to summon emergency medical care, failed to appropriately monitor and assess her restrained patient, failed to communicate with the custody staff about monitoring him and removing him from the chair restraint, and failed to follow the standards governing her work.

128. The lack of training can be inferred from the actions and inactions of Defendant LVN Lewis. While it's plausible that all of her inexplicably bad decisions were born out of a callous disregard for Mr. Smallwood wellbeing, it's also plausible that some of her actions were the result of SHP's deliberate choice not to adequately train its LVNs.

129. SHP's failure to train was carried out with intent, malice, and/or reckless disregard for Mr. Smallwood's civil rights and resulted in the worsening of his medical condition, led to his gratuitous suffering, caused his death, and was the moving force behind the constitutional deficiencies alleged in this complaint.

130. Finally, SHP's understaffing and inadequate training practices described above were widespread and pervasive, served no legitimate governmental objective, subjected detainees

to unconstitutional conditions of confinement, and caused Mr. Smallwood's unnecessary suffering and death.

V. CAUSES OF ACTION

A. Defendant Angelina County: 42 U.S.C. § 1983

131. Based on the allegations in this complaint, Defendant Angelina County is liable under 42 U.S.C. § 1983 for violating Glenn Smallwood's rights under the Fourth and Fourteenth Amendments to the United States Constitution.

132. Defendant Angelina County is liable because its policies, customs, and practices described in this complaint, including its standard practice to restrain intoxicated individuals and its failure to provide obviously needed training on the permissible uses and limitations of restraint chairs, were the moving force behind the constitutionally excessive force that caused Mr. Smallwood's senseless suffering and death.

133. Alternatively, Defendant Angelina County is liable for the unconstitutional conditions of Mr. Smallwood's confinement because the cruel and inhumane manner in which he was restrained resulted from an intended practice that was not reasonably related to a legitimate governmental objective. While there are legitimate government interests in the short-term use of restraint chairs for acutely dangerous or out-of-control people, Angelina County's broader policy of restraining intoxicated individuals irrespective of their threat level was not reasonably related to this interest. This constitutionally overbroad and punitive restraint chair practice led to the violation of Mr. Smallwood's constitutional rights and proximately caused his unnecessary suffering and death.

134. Pursuant to the nondelegable duty doctrine, Defendant Angelina County is also liable for the unconstitutional policies, practices, and customs of Defendant Southern Health Partners that were the moving force behind the deprivation of Mr. Smallwood's constitutional right to adequate medical care and that caused his unnecessary suffering and wrongful death.

B. Defendant Lt. Rodriguez: 42 U.S.C. § 1983

135. Based on the allegations in this complaint, Defendant Lt. Rodriguez is liable under 42 U.S.C. § 1983 for violating Glenn Smallwood's right under the Fourth and Fourteenth Amendments to be free from excessive force.

136. Defendant Lt. Rodriguez is liable because it was objectively unreasonable for him to put and keep Mr. Smallwood in the restraint chair in the circumstances described in this complaint. It was foreseeable that this unreasonable and excessive restraint would cause harm to Mr. Smallwood, and it in fact caused his unnecessary suffering, injuries, and death.

137. Defendant Lt. Rodriguez is liable for his own constitutional violations and for those of his subordinates, including Sgt. Matthews and Officers Wilson, Epperly, and Porter, which caused Mr. Smallwood's unnecessary suffering and wrongful death.

C. Defendant Southern Health Partners: 42 U.S.C. § 1983

138. Based on the allegations in this complaint, Defendant Southern Health Partners is liable under 42 U.S.C. § 1983 for violating Glenn Smallwood's rights under the Fourteenth Amendment to the United States Constitution.

139. Defendant Southern Health Partners maintained unconstitutional policies, customs, and/or practices. This includes its profit-driven policy, practice, or custom of staffing the Angelina County Jail with untrained and unsupervised licensed vocational nurses and putting them in charge of medical care that they were neither qualified nor licensed to provide. It also includes the failure of Southern Health Partners to provide its LVNs with the obviously needed training described in this complaint. Southern Health Partners is liable because these corporate policies, practices, and customs were the moving force behind the episodic acts or omissions that resulted in the violations of Mr. Smallwood's constitutional right to adequate medical care, and they predictably caused his unnecessary suffering and wrongful death.

140. Alternatively, Defendant Southern Health Partners is liable for the unconstitutional conditions of Mr. Smallwood's confinement because its intended and systemic staffing practices were not reasonably related to a legitimate governmental objective. There was no legitimate interest in demanding that LVNs act outside the scope of their nursing license, in leaving jail detainees without other medical care, or in failing to supervise and train entry-level jail nurses. These widespread practices led to the violation of Mr. Smallwood's constitutional rights, amounted to punishment, and proximately caused his senseless suffering and death.

D. Defendant LVN Lewis: 42 U.S.C. § 1983

141. Based on the allegations in this complaint, Defendant LVN Lewis is liable to under 42 U.S.C. § 1983 for violating Glenn Smallwood's right under the Fourteenth Amendment to adequate medical care.

142. As described in this complaint, Mr. Smallwood had objectively serious medical needs. He obviously needed a higher level of care than Defendant LVN Lewis could provide. She was aware that failing to secure that care would put her patient, Mr. Smallwood, at substantial risk of serious harm. Notwithstanding her awareness, she deliberately chose not to summon emergency medical care or even call a qualified medical professional.

143. Defendant LVN Lewis is liable because she acted with deliberate indifference to Mr. Smallwood's serious medical needs, and her deliberate indifference caused his unnecessary suffering and death.

VI. JURY DEMAND

144. Plaintiff demands a trial by jury.

VII. REQUEST FOR RELIEF

145. Plaintiff asks the Court for the following relief:

146. Compensatory damages against all defendants named in this complaint for Glenn Smallwood's mental and physical pain and suffering leading up to his in-custody death, the loss of

his of life, the loss of the value of his life, and all other compensatory damages available under federal law;

147. Compensatory damages against all defendants to Glenn Smallwood's eligible beneficiaries for their loss of society and companionship, their loss of love and affection, and their loss of care, comfort, and guidance, as well as all other compensatory damages available to them under federal law.

148. Punitive damages against Defendants Southern Health Partners, LVN Alecia Lewis, and Lt. Dayton Rodriguez;

149. Attorneys' fees and all recoverable litigation costs under 42 U.S.C. § 1988; and

150. Any such other relief that the Court deems just and proper.

DATED this 29th day of April, 2025.

Respectfully submitted,

BUDGE & HEIPT, PLLC

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