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U.S. DISTRICT COURT
N.D. OF ALABAMA

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF ALABAMA SOUTHERN DIVISION

MELANIE DAUGHTRY, AS COURT APPOINTED GUARDIAN FOR JOSHUA CALEB HOUSE,	)	
PLAINTIFF,	)	**CIVIL ACTION NO.:**
v.	)	
SGT. CODY DAVIS, HEALTH CARE PROVIDERS, and QCHC, INC.,	)	**JURY DEMAND**
DEFENDANTS.	)	

COMPLAINT

I. Introduction

1. The plaintiff, Melanie Daughtry, in her capacity as the court appointed guardian for Joshua "Caleb" House, brings this action on Mr. House's behalf seeking redress for injuries he suffered while incarcerated at the Calhoun County Jail ("Jail") from around November 4, 2024 until his hospitalization on December 2, 2024.

2. Plaintiff brings this action pursuant to 42 USC §1983 to enforce Mr. House's rights under the Fourteenth Amendment to the United States Constitution. On Mr. House's behalf, Plaintiff seeks compensatory and punitive damages for the permanent injuries Mr. House suffered as a result of Defendants' deliberate indifference to his serious medical needs.

II. Jurisdiction and Venue

3. This action arises under the Fourteenth Amendment to the United States Constitution and under federal law, including 28 USC §2201 and 42 USC §§1983 and 1988.

4. This Court has subject matter jurisdiction pursuant to 28 U.S.C. §§1331 and 1343. Venue is proper in the Northern District of Alabama, Southern Division, because Defendant QCHC, Inc. resides in this district, consistent with 28 U.S.C. §1391(a).

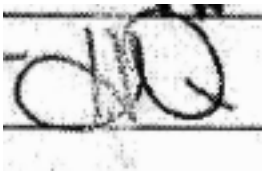
III. Parties

5. Plaintiff Melanie Daughtry is a resident of the State of Alabama and a citizen of the United States. She is the court-appointed guardian of Caleb House. She brings this action solely in her representative capacity as the guardian of Mr. House.

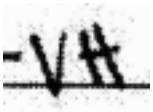
6. Defendant Cody Davis is a Sergeant at the Calhoun County Sheriff's Office. Sergeant Davis was responsible for the denial of medical care to Caleb House for eleven hours on December 2, 2024, resulting in serious and permanent injuries to Mr. House. At all times relevant to this action, Defendant Davis was acting under color of state law. Defendant Davis is sued in his individual capacity.

7. HQ is a medical practitioner employed by QCHC, Inc. ("QCHC"). At all times relevant to this action, HQ was acting under color of state law. HQ is a person who

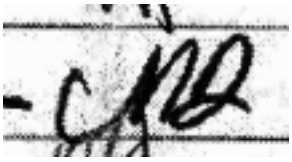
would be named as a Defendant in this action except that his or her identity, beyond the initials in the medical records pasted below, is not presently known to Plaintiff.



8. VH is a medical practitioner employed by QCHC, Inc. ("QCHC"). At all times relevant to this action, VH was acting under color of state law. VH is a person who would be named as a Defendant in this action except that his or her identity, beyond the initials in the medical records pasted below, is not presently known to Plaintiff.



9. MD is a medical practitioner employed by QCHC, Inc. ("QCHC"). At all times relevant to this action, MD was acting under color of state law. MD is a person who would be named as a Defendant in this action except that his or her identity, beyond the initials in the medical records pasted below, is not presently known to Plaintiff.



10. Defendant QCHC, Inc. ("QCHC") was the medical provider at the jail at the time Caleb suffered his injuries. Although Defendant QCHC is a private entity, it performs a traditional state function in providing health care to incarcerated

individuals and is therefore subject to suit as a state actor pursuant to 42 USC §1983. At all times relevant to this action, Defendant QCHC acted under color of state law and pursuant to official policy.

IV. Statement of Facts

11. Caleb has been diagnosed with schizoaffective disorder and bipolar disorder.

12. Caleb was booked into Calhoun County Jail on or around November 4, 2024, after a two-night stay in the locked psychiatric unit at Gadsden Regional Medical Center from November 2 to November 4.

13. Throughout his incarceration at the Calhoun County Jail, Caleb's psychiatric condition constituted a serious medical need.

14. Defendant QCHC's records reflect that Caleb was placed on "suicide watch" on November 13, 2024.

15. Caleb was placed on suicide watch because he required medical observation for his psychiatric condition, a serious medical need.

16. While on suicide watch, Caleb was housed in a suicide watch cell by himself. He relied on deputies and medical staff, including Defendants, for his basic needs.

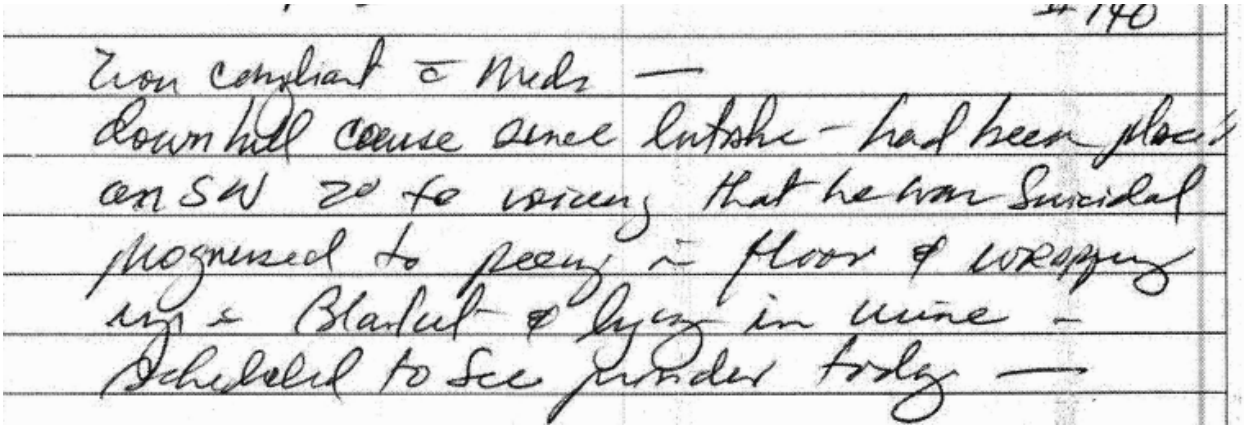
17. Pursuant to the suicide watch protocol, Caleb was to be assessed every four hours, with observations noted in the Medical Observation Record contained in his medical records from Defendant QCHC.

18. Caleb was also to be seen at regular intervals by a mental health therapist.

19. The Medical Observation Record for December 1, 2024 at 20:30 states that Caleb was "laying under bunk" and that he "took meds" and had "0 needs" followed by the initials VH.

20. VH is a health care provider employed by Defendant QCHC.

21. The jail medical records also contain a physician's note from December 2, 2024 stating, in pertinent part, "downhill course since intake – had been placed on SW 2d to voicing that he was suicidal … progressed to peeing on floor and wrapping … in blanket & lying in urine – scheduled to see provider today…"


Non compliant c Meds —
Downhill course since intake - had been placed
on SW 2d to voicing that he was Suicidal
progressed to peeing on floor & wrapping
up in Blanket & lying in urine —
Scheduled to see provider today —

22. The December 1, 20:30 Medical Observation Record referring to Caleb "laying under bunk" appears to correspond to the reference in the above December 2, 2024 physician's note to Caleb "peeing on floor" and "lying in urine," as such observations are not otherwise reflected in the Medical Observation Record.

23. It was obvious to Defendants that Caleb's ability to regulate his own body temperature on suicide watch was limited. His clothes had been taken away. He was

issued only a "turtle suit," made of a thick fabric that cannot be rolled or folded. Otherwise, Caleb was naked in the suicide watch cell.

24. The floor in the suicide watch cell is bare concrete.

25. The temperature in the jail is such that most of the health care providers, who are able to be active throughout their shifts, wear long sleeves and/or sweaters to be comfortable.

26. All health care providers employed by Defendant QCHC are aware of the substantial risk of harm that inmates may become hypothermic while lying naked on bare concrete. QCHC was the medical care provider involved in the death of Tony Mitchell, who died of hypothermia while on suicide watch in a concrete-floored cell in January 2023 in Walker County, Alabama.

27. QCHC has a policy of deliberate indifference toward inmates becoming hypothermic.

28. It is obvious that inmates on suicide watch deprived of clothes face a substantial risk of becoming hypothermic, and Defendant QCHC has had numerous patients on suicide watch become hypothermic; however, Defendant QCHC has failed to train its personnel to check for hypothermia and/or to treat such patients for hypothermia, leading to Plaintiff's injury in question here.

29. The failure of health care providers employed by Defendant QCHC to record important facts such as "peeing on floor" and "lying in urine" in the Medical

Observation Record evidences their deliberate indifference to Caleb's serious medical needs, including his serious medical needs relating to the substantial risk that he would become hypothermic while he was on suicide watch, deprived of clothes, in a cold environment and lying on a bare concrete floor in his own urine.

30. Health care providers also failed to record vital signs, including body temperature, in the Medical Observation Record, which states that "A complete set of vital signs must be documented at a minimum of every 8 hours." However, no vital signs documentation was contained in Caleb's medical records from QCHC.

31. It was obvious to VH that Caleb was experiencing a serious medical need when she found him lying on the floor in his own urine at 20:30 on December 1, 2024, and that he faced a substantial risk of becoming hypothermic.

32. The Medical Observation Record for December 2 at 01:17 states that Caleb "appears to be sleeping, 0 needs per Sgt Smith" followed by the initials of VH.

33. The Medical Observation Record for December 2 at 0543 states "ate breakfast, 0 needs per Sgt Smith" followed by the initials VH.

34. The Medical Observation Record for December 2 at 0930 states "took meds, no needs voiced" followed by the initials HQ.

35. Like VH, HQ is a health care provider employed by Defendant QCHC.

DATE	TIME	
12-1-24	0900	Meds admin. Ø complaints voiced —— TK
12-1-24	1300	Awake. Ø complaints voiced —— TK
12-1-24	1732	NO C/O voiced per Sgt. Davis —— MD
12-1	2030	laying under bunk, took meds, Ø needs —— VH
12-2	0117	appears to be sleeping, Ø needs per Sgt Smith —— VH
12-2	0543	ate breakfast, Ø needs per Sgt Smith —— VH
12-2	0930	took meds. NO needs voiced —— DW
12-2	1830	Being Seen by Dr. Turkey, Inmate will be Sent to ER. —— MD ATW

36. Despite the note in the Medical Observation Record for December 2 at 0930 of "no needs voiced," it was obvious to HQ that Caleb, after lying in his urine on the bare concrete floor of his cell, either was hypothermic or faced a substantial risk of becoming hypothermic and thus was experiencing a serious medical need.

37. There are no entries in the Medical Observation Record for December 2 between 0930 and 1830.

38. The health care providers employed by Defendant QCHC, including HQ, failed to check on Plaintiff for over 11 hours on December 2, 2024, even though it was obvious to HQ that Plaintiff was in medical distress from hypothermia and that he needed medical treatment and warming.

39. The Regional Medical Center records from that evening contain the following information:

> Per ED documentation, nurse from Calhoun County Jail reported that patient had his morning medications at approximately 900 this morning and was 'normal' but was found to be lethargic and altered when being taken to see the Jail MD at approximately 1800. I spoke to the nurse at Calhoun County Jail (Michelle) was [sic] endorses events prior to patient's arrival in the ED. She reports that patient has been 'housed' at Calhoun County Jail since 11/4/2024 for Gadsden City Jail and has been on suicide watch; she cannot account for his activity from 0900-1800 but states that he 'has been alone'. Nurse additionally reports that patient was 'alert but not responsive' when being taken for his regularly scheduled time to see the Jail MD.

40. Consistent with the statement that Caleb "has been alone" all day, the Mental Health care provider was not permitted to see Caleb on December 2, 2024.

41. The Mental Health General note for December 2 states "Made attempt to see inmate due to him being on suicide watch. There was no officer available to escort therapist to inmate's cell; therefore, therapist was unable to lay eyes on the inmate."

42. This note was made at 4:24 PM on December 2, 2024.

43. Defendant Davis was the corrections sergeant on duty this day.

44. Defendant Davis prevented health care practitioners, including HQ and the mental health provider, from accessing Caleb, in deliberate indifference to Caleb's serious medical needs that led to him being placed on suicide watch with a requirement of being assessed every four hours.

45. In the absence of an officer to escort health care practitioners, Defendant Davis had the ability to check on Caleb himself. On other dates in the log, for instance, the Medical Observation Record for December 2 at 05:43 stating "ate

breakfast, 0 needs per Sgt Smith", the log indicates that corrections officers perform checks when sufficient staffing is not available to escort health care practitioners.

46. Defendant Davis knew that it was his responsibility to check on Caleb if no escort for health care practitioners was available. However, he did not do so, in deliberate indifference to Caleb's serious medical needs, with the result that no one checked on Caleb for over 11 hours.

47. The next entry in the Medical Observation Record, from 1830, states, "Being seen by Dr. Gurley. Inmate will be sent to ER." This is followed by the initials of MD.

48. During the 11 hours between 0930 and 1830, Caleb's medical condition deteriorated even further. He became more and more hypothermic.

49. When the jail physician, Dr. Hurley, who is employed by Defendant QCHC, finally arrived to examine Caleb at 1830, he determined that Caleb should be "sent to ER."

50. Caleb arrived at Regional Medical Center and was admitted at 19:32 with an initial diagnosis of "severe hypothermia, hypotension and bradycardia possibly related to sepsis."

51. The Regional Medical Center records state "He reportedly has been on suicide watch and was alone from 0900-1800 … He was transferred to the ER and found to be unresponsive and bradycardic with a temperature of 72.7 degrees. His heart rate

was in the 30's on arrival with agonal respirations and no cough or gag reflex requiring intubation…"

52. Caleb was "critically sick" according to the hospitalist notes and remained so for several days, including several days spent on a respirator.

53. Caleb was discharged to the psychiatric unit on December 11, 2024.

54. Plaintiff's discharge diagnoses included "Severe sepsis with septic shock, present on admission"; "Bibasilar pneumonitis"; "Severe hypothermia, hypotension and bradycardia possibly related to sepsis"; "Lactic Acidosis"; "Metabolic encephalopathy"; Transaminitis; and Thrombocytopenia.

55. As a result of Defendants' deliberate indifference to his serious medical needs, Caleb suffered permanent physical and emotional injuries.

56. Defendants acted with malice to Caleb's federally protected rights.

V. First Cause of Action: Deliberate Indifference to Serious Medical Needs in Violation of the Fourteenth Amendment to the United States Constitution via 42 USC §1983.

57. Plaintiff brings this claim pursuant to the Fourteenth Amendment to the United States Constitution against each Defendant.

58. Defendant QCHC, through its employees and agents, performs a traditional state function in providing health care to incarcerated individuals and is therefore subject to suit as a state actor pursuant to 42 USC §1983. Defendant QCHC is liable

because its policy or custom amounting to deliberate indifference to Plaintiff's serious medical needs caused Plaintiff's injury.

59. Defendants, acting separately and/or in concert and under color of state law, deliberately, purposefully, and knowingly deprived Caleb of treatment for his serious medical needs, including hypothermia, for over 11 hours on December 2, 2024, resulting in serious and permanent injuries.

60. Defendants were subjectively aware of, and knowingly disregarded, a substantial risk that Caleb would experience life-threatening hypothermia if denied medical treatment after being found lying in his own urine on a bare concrete floor.

61. Defendant QCHC and its employees and agents abdicated their responsibility to provide Constitutionally adequate care when they failed to check on Caleb December 2 between 0930 and 1830 and failed to treat him for hypothermia.

62. Defendant QCHC has a policy of deliberate indifference toward inmates becoming hypothermic.

63. It is obvious that inmates on suicide watch deprived of clothes face a substantial risk of becoming hypothermic, and Defendant QCHC has had numerous patients on suicide watch become hypothermic; however, Defendant QCHC has failed to train its personnel to check for hypothermia and/or to treat such patients for hypothermia, leading to Plaintiff's injury in question here.

64. The failure of health care providers employed by Defendant QCHC to record important facts such as "peeing on floor" and "lying in urine" in the Medical Observation Record evidences their deliberate indifference to Caleb's serious medical needs, including his serious medical needs relating to his psychiatric condition as well as the substantial risk that he would become hypothermic while he was on suicide watch, deprived of clothes, in a cold environment and lying on a bare concrete floor in his own urine

65. Defendant Cody Davis is a Sergeant at the Calhoun County Sheriff's Office. Sergeant Davis was responsible for the denial of medical care to Caleb House for eleven hours on December 2, 2024, resulting in serious and permanent injuries to Caleb. Defendant Davis prevented health care practitioners, including HQ and the mental health provider, from accessing Caleb, and otherwise failed to check on Caleb himself, in deliberate indifference to Caleb's serious medical needs that led to him being placed on suicide watch.

66. Defendants' conscious disregard of a substantial risk of harm to Caleb amounts to deliberate indifference to a serious medical need in violation of the Fourteenth Amendment.

67. Defendants' deliberate indifference was the proximate cause of the pain, suffering, and damages that Caleb suffered.

68. Defendants' actions in violating Caleb's Fourteenth Amendment rights were malicious and taken with reckless disregard for Caleb's Constitutionally protected rights.

VI. Damages

69. Plaintiff is now suffering, and will continue to suffer, irreparable injury from Defendants' unlawful conduct as set forth herein unless enjoined by this Court.

70. Caleb experienced extreme emotional distress, severe emotional and physical pain and anguish, embarrassment, humiliation, shame, damage to reputation, damage to his personal and family relationships, loss of income, legal fees, medical expenses, lost earning potential, and other pecuniary losses as a consequence of Defendants' unlawful conduct.

71. Plaintiff and Caleb have no plain, adequate or complete remedy at law to redress the wrongs alleged herein and this suit for declaratory judgment, injunctive relief, compensatory, and punitive damages is his only means of securing adequate relief.

VII. Request for Relief

Plaintiff seeks the following relief:

72. Award a judgment in his favor against Defendants in an amount in excess of the jurisdictional limits of this court for compensatory damages, including damages for severe emotional and physical pain and anguish, embarrassment, humiliation,

shame, damage to reputation, damage to his personal and family relationships, loss of income, legal fees, medical expenses, lost earning potential, future rehabilitation expenses, future medical costs, future counseling, and other pecuniary losses as a consequence of Defendants' unlawful conduct;

73. Award punitive damages against the Defendants to punish and deter further wrongdoing;

74. Grant injunctive relief as necessary to affect this Court's judgment and prevent the recurrence of the harms alleged herein;

75. Award Plaintiff reasonable attorney's fees pursuant to 42 U.S.C. § 1988, including a reasonable attorney's fee for work preliminary to and necessary to the institution of this action;

76. Award Plaintiff all litigation expenses, cost, prejudgment and post judgment interest as provided by law, and;

Such other and further relief as the Court deems just and proper.

THE PLAINTIFF DEMANDS A TRIAL BY JURY ON ALL ISSUES SO TRIABLE

Respectfully submitted,

/s/ L. William Smith
Jon C. Goldfarb asb-5401-f58j
L. William Smith asb-8660-a61s
Christina M. Malmat asb-1214-y44q
Counsel for Plaintiff

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