UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF GEORGIA
BRUNSWICK DIVISION

DINETHA L. RAYNER, INDIVIDUALLY, AND AS ADMINSITRATRIX OF THE ESTATE OF KELSEY JEROME RAYNER, SR.	)	
PLAINTIFF,	)	
v.	)	Civil Action Number: 2:19-CV-00048
SHERIFF MARK MELTON, APPLING COUNTY CORRECTIONS OFFICERS ADAM BELL, ANTHONY BARWICK, JEFFERY HAMILTON, NADIA WATTS, ELAINE DOWDNEY, ERNESTINA MERCED, BRANDON GRIFFIS, AND WILTON EDWARDS, INDIVIDUALLY AND IN THEIR OFFICIAL CAPACITIES, SOUTHEAST CORRECTIONAL MEDICAL GROUP, LLC, KACEY NEWBERRY, LPN, CHRISTI TURNER, LPN, LYNN MARSH, LPN, KNICOLE LEE, FNP, JOHN DOE, ADVANCED PRACTICE NURSE, AND JOHN ROE, M.D.,	)	
DEFENDANTS.	)	

AMENDED COMPLAINT

COMES NOW Dinetha L. Rayner, the surviving spouse of Kelsey Jerome Rayner, Sr., individually and as the Administrator of the Estate of Kelsey Jerome Rayner, Sr. and pursuant to Rule 15(a)(1)(B) makes this her amended complaint for damages in the above captioned matter, and shows the court as follows:

I. JURISDICTION AND VENUE

1. This is an action for damages pursuant to 42 U.S.C. § 1983 based upon the violations of Plaintiffs' rights under the Fourth, Fifth, and Fourteenth Amendments to the United States Constitution. Jurisdiction exists pursuant to 28 U.S.C. § 1331 and 1343 based on 42 U.S.C.

§1983 and questions of federal constitutional law. Supplemental jurisdiction over Plaintiffs' state law claims is pursuant to 28 U.S.C. §1367.

2. Venue is proper in this District under 28 U.S.C. § 1391(b)(1) because at least one Defendant resides in this judicial district. This District also is an appropriate venue for this action under 28 U.S.C. § 1391(b)(2) because all or at least a substantial part of the events or omissions giving rise to the claims asserted herein occurred in this judicial district.

II. PARTIES

3. Plaintiff DINETHA L. RAYNER is an individual who is the duly appointed administratrix of the estate of the late Kelsey Jerome Rayner, Sr. (hereinafter "Mr. Rayner"). Plaintiff submits herself to the jurisdiction of this court.

4. Defendant SHERIFF MARK MELTON, IN HIS OFFICIAL CAPACITY, (hereinafter also referred to as the Appling County Sheriff's Department) is and at all relevant times was the Sheriff of Appling County, and a law enforcement officer for Appling County and had supervisory and managerial authority over the Appling County Sheriff's Department. In his capacity as Sheriff of Appling County, said Defendant is responsible for the management and operation of the Appling County Sheriff's Department and specifically responsible for ensuring that the sheriff's deputies and corrections officers of the Appling County Sheriff's Department complied with the color and pretense of the federal and state laws as well as the ordinances, regulations, customs, and usages of the State of Georgia and the Appling County Sheriff's Department. Furthermore, said Defendant is responsible for the policies, practices, customs and regulations of the Appling County Sheriff's Department; and for the hiring, training, supervision and discipline of agents, employees and deputies of the Appling County Sheriff's Department. Said Defendant is sued both in his official and individual capacities. Said Defendant is a resident and citizen of the State of Georgia and may be served with process at his place of employment, 560 Barnes Street, Baxley, GA.

5. Defendants ADAM BELL, ANTHONY BARWICK, JEFFERY HAMILTON, NADIA

WATTS, ELAINE DOWDNEY, ERNESTINA MERCED, BRANDON GRIFFIS, and WILTON EDWARDS were, at all times relevant to this matter, employees of the Appling County Sheriff's Office, and responsible for Mr. Rayner's safety and security. At all times relevant to this matter, said Defendants were acting under color and pretense of the federal and state laws as well as the ordinances, regulations, customs, and usages of the State of Georgia and the Appling County Sheriff's Department. Said Defendants are sued both in their official and individual capacities. Said Defendants are residents and citizens of the State of Georgia and may be served with process at their place of employment, 560 Barnes Street, Baxley, GA.

6. Defendant SOUTHEAST CORRECTIONAL MEDICAL GROUP LLC (hereinafter "SECMG") is a limited liability company contracted by Defendant Appling County or Appling County Sheriff's Office or was acting as Defendant Appling County or Appling County Sheriff's Office's agent. Defendant was acting under color of state law at the indicated times.

7. Defendant KACEY NEWBERRY, LPN (hereinafter "Newberry"), is a licensed nurse practitioner employed by Defendant SECMG or was acting as Defendant SECMG's agent at all times material to this matter. Defendant was acting under color of state law at the indicated times.

8. Defendant CHRISTI TURNER, LPN (hereinafter "Turner"), is a licensed nurse practitioner employed by Defendant SECMG or was acting as Defendant SECMG's agent at all times material to this matter. She is the head nurse at the Appling County Jail and the Clinical Site Coordinator. Defendant was acting under color of state law at the indicated times.

9. Defendant KNICOLE LEE, FNP (hereinafter "Lee"), is a Family Nurse Practitioner employed by Defendant SECMG or was acting as Defendant SECMG's agent at all times material to this matter. Defendant was acting under color of state law at the indicated times.

10. Defendant LYNN MARSH, LPN (hereinafter "Marsh"), is a licensed nurse practitioner employed by Defendant SECMG or was acting as Defendant SECMG's agent at all times material to this matter. Defendant was acting under color of state law at the indicated times.

11. Defendant JOHN DOE, upon information and belief, is an Advanced Practice Nurse employed by Defendant SECMG or acting as Defendant SECMG's agent at all times material to this matter, and who was acting under color of state law at all the indicated times.

12. Defendant JOHN ROE, upon information and belief, is a Medical Doctor employed by Defendant SECMG or acting as Defendant SECMG's agent at all times material to this matter, and who was acting under color of state law at all the indicated times.

13. Plaintiff pleads and states that Defendants and their agents and employees, acted willfully and wantonly toward Mr. Rayner, proximately causing his death. Therefore, no immunity applies in this matter. Moreover, Defendants have exhibited a pattern and practice of ignoring and violating the rights of the citizens of Georgia, including the decedent, which proximately caused the death of Mr. Rayner and, furthermore, negligently supervised and trained their employees despite their knowledge of the need to do so.

III. FACTS

14. On or about October 1, 2016, Sheriff Melton and SECMG entered into a Correctional Health Services Agreement. Per its terms the agreement continued in force through September 30, 2017. Said contract provided that: *SECMG will provide emergency medical treatment to inmates as necessary and appropriate on site. With the assistance of the Sheriff's officers and 911 services, SECMG will arrange for emergency service to be provided at local hospitals. Appling County Sheriff's Office will be responsible for the cost of emergency transportation and treatment.*

15. On April 16, 2017 at about 1:40 P.M., Mr. Rayner was arrested for Theft by Taking by officers of the Baxley Police Department. He was subsequently booked into the Appling County Jail.

16. On April 17, 2017, at about 10:45 A.M. employees of SECMG did Mr. Rayner's Medical intake and triage/receiving screening.

17. The medical history taken from Mr. Rayner showed he had suffered a nervous breakdown in

2008, that he had a history of prescribed use of Risperdal and Prozac, and that he had been diagnosed with manic depression and schizophrenia.

18. On April 18, 2017 at 4:53 P.M. Mr. Rayner bonded out of the Appling County Jail.

19. On June 28, 2017 at 6:55 P.M. Mr. Rayner was arrested for theft of services and no business license at Fred's Store on South Main Street.

20. On June 30, 2017 at about 9:30 A.M. employees of SECMG did Mr. Rayner's Medical intake and triage/receiving screening.

21. The medical history taken from Mr. Rayner at that time revealed a history of bipolar depression, prior use of medications for his psychological health including Vistaril and Clonidine. He had also been hospitalized in 2012 for a nervous breakdown.

22. At the time of Mr. Rayner's medical evaluation, he was showing signs of depression including crying and rapid speech.

23. On Thursday, June 29, 2017 Mr. Rayner complains of chest pains and is taken to the local ER for tests. Test results are normal and he is returned to the Jail.

24. On Friday, June 30, 2017 Mr. Rayner bonds out and is released.

25. On Friday, July 14, 2017 Mr. Rayner's bonding company came off their bond on the misdemeanor charges at the request of an employee of Sheriff Melton. However, the bond remained in force as to the pending felony charge according to the Appling County District Attorney.

26. On Saturday, July 15, 2017, Mr. Rayner was arrested for making harassing phone calls and disorderly conduct by deputies of the Appling County Sheriff's Department.

27. On Sunday, July 16, 2017 at about 9:15 A.M., Lee and Marsh performed medical intake and triage/receiving screening of Mr. Rayner.

28. The medical history taken at that time was consistent with his prior history given on his prior intakes.

29. Medical intake revealed an abnormality in that Mr. Rayner had a fever of 99.9 degrees at the time of intake on 10:37 AM.

30. On July 16, 2017 during his intake by SECMG employees, new orders were given for the administration of Claritin and Vistaril by Lee and Marsh.

31. On July 16, 2017 as a result of conflicts with other inmates Mr. Rayner was placed in administrative segregation, in Segregation Cell #8, and on July 22, 2017 he was moved to Segregation Cell #4.

32. On Thursday, July 20, 2017, Turner examined Mr. Rayner and performed a urinalysis. Turner noted that Mr. Rayner had complaints of low back and stomach pains. The urinalysis indicated a high bilirubin." According to Newberry, they were aware at this point that “Something was going on with the liver.” From this date until his death, Mr. Rayner continued to exhibit signs of intense stomach pain, but neither the Appling County Sheriff’s Department nor the medical staff of SECMG made any effort to address his continued pain or complaints.

33. On Friday, July 21, 2017 at 10:19 A.M., Newberry noted in Mr. Rayner’s chart that, “Rayner complains of stomach pain, seen by the nurse and blood work ordered for Saturday, June 22, 2017. Bowel sounds and vitals check out normal.”

34. Turner ordered a blood test and ordered that it be done on July 22, 2017.

35. No vital signs were recorded in the notes of the visit during which Mr. Rayner had complained of stomach and back pain.

36. Lee noted in Mr. Rayner’s Chart that, “Physician orders CBC, CMP, INR, and FE.” The samples for the lab tests were to be taken on Saturday, July 22, 2017.

37. At the time of the events giving rise to Plaintiff’s complaint, Newberry, who had been assigned to the Appling County Jail since May 2017, was being trained as a correctional nurse.

38. On July 22, 2017, Newberry was present at the Appling County Jail for the purpose of taking samples from the inmates for lab work. Marsh was also scheduled to be present for the same

purpose but did not show up at the jail. Marsh was also scheduled to be present for the same purpose but did not show up at the jail.

39. Newberry was therefore working by herself at the Appling County Jail taking samples from the inmates for lab work. Newberry did not know how to do Mr. Rayner's lab so she called Turner. Turner told her to "wait until I get back." As a result, Newberry did not take any blood sample for lab analysis from Mr. Rayner as ordered.

40. At no time subsequent to Saturday, July 22, 2017, was any blood sample taken from Mr. Rayner.

41. On Friday, July 28, 2017, Turner noted in Mr. Rayner's Chart that, "Full time nurse unavailable on 7-22-17, so part-time nurse attempted to get blood work, but was not able."

42. The Sheriff's Office, through SECMG, did not have the appropriate staff at the facility to meet its' constitutional obligations of providing adequate medical treatment to detainees.

43. On Monday, July 24, 207, at 9:07 A.M., a nurse employed by SECMG came to Mr. Rayner's cell and gave him his morning doses of Claritin and Vistaril.

44. Later on Monday, July 24, 2017, Mr. Rayner was taken to the State Court of Appling County in reference to his misdemeanor charges. Mr. Rayner was in obvious physical distress and in extreme pain, which was noticed by other inmates at the courthouse. He kept his arms folded over his stomach and was bent over. When his case was called he had to have the help of the deputy to approach the Judge.

45. Mr. Rayner pled guilty to all of the misdemeanor charges that were pending in Appling County. During his plea, Mr. Rayner told the State Court the following:

> *"And I been using the bathroom, passing blood and all that, too. They supposed to took me to the hospital after that, but they didn't. I really need my body checked out, Mr. Pres. Whatever you can do to help me get out I'd appreciate it."*

46. Mr. Rayner was sentenced to 12 months to serve, which was to be suspended on satisfactory completion of probation.

47. Despite his felony bond remaining in place, Mr. Rayner was returned to custody at the Appling County Jail and he was not released.

48. Upon information and belief, Officer Bell, was present in court when Mr. Rayner spoke to the judge during his plea colloquy. Officer Bell had an opportunity to see Mr. Rayner before, during, and after his court appearance. Officer Bell returned Mr. Rayner to the jail and neither arranged for his release nor did he make any attempt to secure much needed medical attention for Mr. Rayner

49. After returning from court on July 24, 2017, Mr. Rayner used the intercom system in his cell to call the guards at least five different times before his death on July 26, 2017.

50. Several days after Rayner was moved into Segregation Cell #4, Turner was told that Mr. Rayner was getting worse. Turner replied that if he would not take his medication then there was "Nothing they could do."

51. On the morning of Tuesday, July 25, 2017 Mr. Rayner began to experience increased distress from the infection which would eventually kill him. Video taken of his cell that morning show that he ate nothing that morning, and that he was in so much pain that he kneeled down and put his head and elbows on the floor.

52. On July 25, 2017, Mr. Rayner did not see John Doe Advance Practice Nurse or the John Roe, M.D., at the jail when John Doe Advance Practice Nurse or John Roe, M.D. made a periodic visit that day because the ordered labs were not complete.

53. Mr. Rayner did not eat any food on the evening of July 25, 2017.

54. Mr. Rayner had to use the toilet numerous times during the night of July 25-26, 2017, and eventually pulled his bedding off his bed and moved it to the toilet area of his Segregation Cell #4.

55. Mr. Rayner began vomiting repeatedly on the morning of Wednesday, July 26, 2017.

56. Georgia Department of Corrections Standard Operating Procedures 209.06 (which should have been applied by Appling County Sheriff's Office), requires a health care provider to visit each offender in segregation daily, with the presence of the provider announced, and recorded. No such visits were recorded by any health provider employed by SECMG.

57. On July 26, 2017, at 9:46 A.M. Mr. Rayner received a morning dose of Vistaril and his daily dose of Claritin, from Turner.

58. On the afternoon of July 26, 2017, Mr. Rayner did not get his afternoon dose of Vistaril. There is no record as to why his medications were not administered to him that afternoon.

59. Newberry attempted to have Mr. Rayner take his medications, but he allegedly refused them. Newberry did not request to examine Mr. Rayner.

60. Mr. Rayner spent the remainder of his life either writhing in pain (which could have been seen on the monitor) or completely still in a pain pose. Mr. Rayner was moaning and crying out in pain starting at about 3:00 P.M. on July 26, 2017.

61. Thereafter, the guards were told by another inmate that Mr. Rayner needed medical attention – the guards told the inmate not to worry about it.

62. Newberry was administering medicine to the other inmates while Mr. Rayner was moaning in pain.

63. On July 26, 2017, at 5:08 P.M. Hamilton came to Segregation Cell #4 and checked on Mr. Rayner.

64. On July 26, 2017, at 5:10 P.M. Mr. Rayner's supper tray was delivered to his cell by other inmates. Mr. Rayner was not able to get up to take his supper tray, and did not eat any of his supper.

65. At 5:20 P.M. Mr. Rayner fell to the floor face down in the fetal position.

66. At 5:24 P.M., a white male inmate came to take away Mr. Rayner's supper tray.

67. The policy of the Appling County Sheriff's Department is that inmates who are mentally/emotionally disordered shall receive in-person surveillance of at least every 15 minutes, per Policy Number 3.8 of the Appling County Sheriff's Office's Jail Operations Manual.

68. The policy of the Appling County Sheriff's Department is that if, during a surveillance check a detention officer notes any circumstances that may adversely affect the safety of an inmate he is to institute the steps necessary to correct the problem, notify the Shift Supervisor of the problem, the corrective action taken, and the results of his actions and to record that information in the daily log, per Policy Number 3.8 of the Appling County Sheriff's Office's Jail Operations Manual.

69. Mr. Rayner's rapid respirations (heavy panting) are evident on the video monitor.

70. At 5:52 P.M. Officer Watts came to Segregation Cell #4 and checked on Mr. Rayner, but offered him no assistance whatsoever, despite his obvious distress.

71. At 6:29 P.M. Officer Griffis came to Segregation Cell #4 and checked on Mr. Rayner, but offered him no assistance whatsoever, despite his obvious distress.

72. At 7:13 P.M. Officer Griffis came to Segregation Cell #4 and checked on Mr. Rayner, but offered him no assistance whatsoever, despite his obvious distress.

73. At 8:02 P.M. Officer Dowdney came to Segregation Cell #4 and checked on Mr. Rayner, but offered him no assistance whatsoever, despite his obvious distress.

74. At 8:20 P.M. Officer Merced came to Segregation Cell #4 opened the door, entered the Segregation Cell #4, covered her nose and mouth with her collar, because of the smell in the cell, and touched and spoke to Mr. Rayner.

75. Officer Merced was accompanied by Officer Griffis. But neither officer offered him any assistance whatsoever, despite the fact that he was obviously profoundly ill and in distress.

76. During Mr. Rayner's last few hours, his cries for help, moans of pain, and obvious distress led

the inmate in the segregation cell across the hallway, Latasha Denise Smith, to repeatedly use the intercom in her own cell to call the corrections officers in the tower for assistance to him.

77. Smith repeatedly told the officers in the control tower that Mr. Rayner was dying and that they needed to take him to a hospital.

78. Her complaints were so frequent and bothersome to the officers in the control tower that they disabled her intercom button and prevented her from making any further verbal complaints.

79. After her intercom button was disabled, she employed other methods to try and get the attention of the officers in the control tower, at one point taking off her bra and waving it in front of the camera in her segregation cell to get the attention of the corrections officers in the control tower. When the correction officer buzzed her to see what she wanted and she again begged the officer to get Mr. Rayner to the hospital, she was told to shut up and get back in bed.

80. Despite the complaints of Ms. Latasha Denise Smith, the corrections officers in the tower made no effort to provide medical assistance to Mr. Rayner.

81. According to Joshua Brewton, an inmate who was in Segregation Cell #5, Mr. Rayner did not respond to other inmates who called out to him on July 26th, 2017.

82. Mr. Rayner's stomach was visibly massively distended on the evening of July 26, 2017.

83. Mr. Rayner remained on the floor of his cell unable to move for hours. According to the video recording of his cell, at 9:21 P.M. Mr. Rayner tried several times to push himself up off the floor without success.

84. At 9:31 P.M. Officer Merced came to Segregation Cell #4 and checked on Mr. Rayner, but offered him no assistance whatsoever, despite his obvious distress.

85. At 9:32 P.M. video of his cell shows that Mr. Rayner tried to push himself up again without success. He rolled onto his back and stayed there.

86. A few minutes later at 9:46 P.M. Mr. Rayner stopped moving.

87. At about 9:57 P.M. Mr. Rayner died of the perforation of the descending colon brought on by

peritonitis caused by sepsis

88. At 9:57 P.M. Officer Edwards, who was monitoring Mr. Rayner's cell via video and audio from the control room, could no longer hear Mr. Rayner breathing. Accordingly, Officer Edwards called to the cell on the intercom to check on him.

89. At 10:00 P.M. the corrections officer in the Control Tower called on the intercom to Segregation Cell #4 to check on Mr. Rayner, since he was not moving. There was no response from Mr. Rayner. Officer Merced advised Officer Griffis to go and check on him. Officer Griffis went to Segregation Cell #4 and found that Mr. Rayner was dead. Officer Griffis radioed that Rayner was not breathing. Officer Griffis was ordered to start CPR on Mr. Rayner.

90. Proper CPR was not conducted upon Mr. Rayner.

91. At 10:02 P.M. the Sheriff's Department notified Appling Co EMS that assistance was needed at the jail.

92. Appling Co EMS arrived at the jail at 10:04 P.M, and at Mr. Rayner's cell at 10:05 P.M.

93. At 10:22 P.M. a cardiac monitor showed no heart function. Mr. Rayner was declared dead.

94. At all times relevant to this matter, the Appling County Sheriff's Department has operated the Appling County Jail through its Detention Operations Division.

95. Among other things, the Detention Operations Division of the Appling County Sheriff's Department is responsible for maintaining inmates physical and mental health.

96. Sheriff Melton had statutory duties to provide medical care to inmates confined under his supervision pursuant to O.C.G.A. §§ 42-5-2(a), 42-4-4(a)(2), 42-4-32(d), and 42-4-51(b).

97. No corrective actions were taken in response to Mr. Rayner's obvious physical distress, rapid panting, cries for help, warnings that he was dying, distended abdomen, as required by the Appling County Sheriff's Office Jail Operations Manual Policy 3.8.

98. Sheriff Melton's officers were not properly trained on how to handle a medical emergency, as the standard was apparently if the detainee is breathing, that was all that was required.

99. Sheriff Melton's detention officers failed to render medical aid to Mr. Rayner as required by Rules and Regulations numbered (C)(64) (Policy Statement #4 p. 37), or make a detailed report of the incident.

100. Nowhere in 100 pages of policies for the Appling County Sheriff's Department is there any indication as to the circumstances setting forth when a prisoner/detainee should be transported to a medical facility.

101. The policy of the Appling County Sheriff's Department is to release inmates whose bond has been posted per Policy Number 1.18 of the Appling County Sheriff's Office's Jail Operations Manual.

IV. CAUSES OF ACTION
COUNT I
42 U.S.C. § 1983

DELIBERATE INDIFFERENCE TO SERIOUS MEDICAL NEED AND FAILURE TO RENDER MEDICAL AID

102. Plaintiff re-alleges and incorporates herein by reference the allegations of Paragraphs 1 through 101, above, as if fully set out herein.

103. Defendants jointly, or severally, or both, deprived Mr. Rayner of his Fourteenth Amendment rights, privileges, or immunities as a citizen of the United States.

104. Defendant Melton, as Sheriff of Appling County, had statutory duties to provide medical care and aid to inmates confined under his supervision pursuant to O.C.G.A. §§ 42-4-4(a)(2), 42-4-32(d), 42-4-51(b), and 42-5-2(a). The corrections officers named above were responsible for making sure that inmates confined to the Appling County Jail were provided with adequate medical care.

105. Defendant SECMG and its employees identified above, as contractors of the Defendant Sheriff of Appling County, had a duty to provide adequate medical care to inmates of the Appling County Jail.

106. Mr. Rayner had a serious medical need, that was so obvious that even a lay person would

easily recognize the need for medical care.

107. Even one of the inmates told the Sheriff's correctional officers that Mr. Rayner was dying, and so recognized the need for medical care that she took off and waved her bra to get their attention after the staff had disabled her intercom button because she requested help for Mr. Rayner so often.

108. Mr. Rayner had a serious medical need, which had been communicated to the Corrections Officers of the Appling County Jail, the medical staff of SECMG, the State Court of Appling County, and at least one Appling County Sheriff's Deputy, who was present in the courtroom for his misdemeanor plea on July 24, 2017.

109. Mr. Rayner's serious medical need obviously posed a substantial risk of serious harm to him if left unattended. He was breathing rapidly, his stomach was distended, he was writhing in pain, and he was moaning and crying out in pain.

110. Corrections Officers Bell, Barwick, Hamilton, Watts, Griffis, Dowdney, Merced, and Edwards individually, and in their capacity as employees of the Sheriff of Appling County, knew, based on their personal observation of him, that Mr. Rayner had a serious medical need that posed a substantial risk of serious medical harm.

111. The defendants named above provided medical care that was so cursory as to amount to a failure to provide care, or failed altogether to provide or get necessary medical care for decedent's serious medical need in disregard or indifference to the risk of serious harm to Mr. Rayner.

112. The defendants named above were acting under color of law when they failed to provide or get necessary medical care for Mr. Rayner.

113. The Defendants conduct caused Mr. Rayner's death.

114. Accordingly, Plaintiff is entitled to damages in an amount sufficient to provide full and reasonable compensation for the physical, mental, and emotional pain and suffering sustained

by Mr. Rayner, medical expenses incurred to treat Mr. Rayner, and lost future wages of Mr. Rayner.

COUNT II
42 U.S.C. § 1983
FAILURE TO RELEASE

115. Plaintiff re-alleges and incorporates herein by reference the allegations of Paragraphs 1 through 101 above, as if fully set out herein.

116. Defendants jointly, or severally, or both, deprived Mr. Rayner of his Eighth Amendment and Fourteenth Amendment rights, privileges, or immunities as a citizen of the United States.

117. Sheriff Melton failed to release Mr. Rayner on bond on Monday July 24, 2017, after the resolution of his misdemeanor criminal cases in the State Court of Appling County.

118. Mr. Rayner remained on bond for his outstanding felony criminal case, and as a result should have been released.

119. The failure of the Appling County Sheriff's Department to release Mr. Rayner was a violation of his rights under the Eighth and Fourteenth Amendments to the U.S. Constitution.

COUNT III
FALSE IMPRISONMENT

120. Plaintiff re-alleges and incorporates herein by reference the allegations of Paragraphs 1 through 101 above, as if fully set out herein.

121. On July 24, 2017, Sheriff Melton failed to release Mr. Rayner from custody after he was sentenced to probation on that date.

122. Further detention of Mr. Rayner was unlawful.

123. The said Sheriff's failure to release Mr. Rayne was in bad faith.

124. Mr. Rayner was deprived of his personal liberty until July 26, 2017, the date of his death in the custody of the Appling County Sheriff.

125. Because of his false imprisonment Mr. Rayner was made to suffer great physical, mental, and emotional pain.

126. As a result, Sheriff Melton is liable in damages to Plaintiff for an amount to be proven at trial.

COUNT IV
NEGLIGENCE PER SE
MEDICAL MALPRACTICE

127. Plaintiff re-alleges and incorporates herein by reference the allegations of Paragraphs 1 through 101 above, as if fully set out herein.

128. Defendant SECMG, in its capacity as a contractor of the Appling County Sheriff's Office, and its employees Turner, Lee, Newberry and Lynn had statutory duties to provide medical care to inmates confined under the supervision of the Appling County Sheriff pursuant to O.C.G.A. §§ 42-5-2(a), 42-4-4(a)(2), 42-4-32(d), and 42-4-51(b).

129. At all times relevant to this, matter Mr. Rayner was a pretrial detainee, in the custody of the Appling County Sheriff, and confined at the Appling County Jail.

130. SECMG and its employees/agents Turner, Lee, Newberry, Marsh, John Doe, Advanced Practice Nurse, and John Roe, M.D. negligently failed to provide reasonably adequate medical care to Mr. Rayner.

131. SECMG and its employees/agents Lee and Marsh failed to follow up once it was determined at intake into the Appling County Jail on that Mr. Rayner was febrile.

132. SECMG and its employee/agent Newberry failed to adequately investigate Mr. Rayner's complaints of low back pain and stomach pain on July 20, 2017. SECMG and its employee/agent Newberry failed to adequately investigate Mr. Rayner's refusal to take medicine and moaning on July 26, 2017 (and earlier).

133. SECMG and its employee/agent Turner failed to collect samples for lab tests as ordered at any time during Mr. Rayner's incarceration.

134. SECMG failed to allow Mr. Rayner to see John Doe Advanced Practice Nurse or John Roe, M.D., or both, because its employees/agents had failed to collect lab samples as ordered.

135. As a result of the negligent failure of SECMG to provide reasonably adequate medical care to Mr. Rayner, he died in the Appling County Jail on July 26, 2017.

136. In compliance with the law of the State of Georgia, attached to this complaint is the affidavit of Dr. Lori E. Roscoe, setting forth the negligence of the Defendants and specifying therein the standard of care.

COUNT V
NEGLIGENCE MEDICAL MALPRACTICE

137. Plaintiff re-alleges and incorporates herein by reference the allegations of Paragraphs 1 through 101 above, as if fully set out herein.

138. SECMG and its employees/agents Turner, Lee, Newberry, and Marsh negligently failed to provide reasonably adequate medical care to Mr. Rayner.

139. SECMG and its employees/agents Lee and Marsh failed to follow up once it was determined at intake into the Appling County Jail that Mr. Rayner was febrile.

140. SECMG and its employee/agent Newberry failed to adequately investigate Mr. Rayner's complaints of low back pain and stomach pain on July 20, 2017. SECMG and its employee/agent Newberry failed to adequately investigate Mr. Rayner's refusal to take medicine and moaning on July 26, 2017 (and earlier).

141. SECMG and its employees/agents Turner, Newberry and Marsh failed to collect samples for lab tests as ordered at any time during Mr. Rayner's incarceration.

142. SECMG failed to allow Mr. Rayner to see John Doe Advanced Practice Nurse or John Roe, M.D. on July 25, 2016, because its employees/agents had failed to collect lab samples as ordered.

143. As a result of the negligent failure of SECMG to provide reasonably adequate medical care to Mr. Rayner, he died in the Appling County Jail on July 26, 2017.

144. In compliance with the law of the State of Georgia, attached to this complaint is the affidavit of Dr. Lori E. Roscoe setting forth the negligence of the Defendants and specifying therein the standard of care.

COUNT VI
WRONGFUL DEATH

145. Plaintiff re-alleges and incorporates herein by reference the allegations of Paragraphs 1 through 101 above, as if fully set out herein.

146. All Defendants had statutory duties to provide medical care to inmates confined under the supervision of the Appling County Sheriff pursuant to O.C.G.A. §§ 42-5-2(a), 42-4-4(a)(2), 42-4-32(d), and 42-4-51(b).

147. SECMG and its employees/agents Turner, Lee, Newberry and Marsh negligently failed to provide reasonably adequate medical care to Mr. Rayner. All Defendants failed to provide reasonably adequate medical care to Mr. Rayner.

148. SECMG and its employees/agents Lee and Marsh, failed to follow up once it was determined at intake into the Appling County Jail that Mr. Rayner was febrile.

149. SECMG and its employee/agent Newberry failed to adequately investigate Mr. Rayner's complaints of low back pain and stomach pain on July 20, 2017. SECMG and its employee/agent Newberry failed to adequately investigate Mr. Rayner's refusal to take medicine and moaning on July 26, 2017 (and earlier).

150. SECMG and its employees/agents Turner, Newberry and Marsh failed to collect samples for lab tests as ordered at any time during Mr. Rayner's incarceration.

151. SECMG failed to allow Mr. Rayner to see John Doe Advanced Practice Nurse or John Roe, M.D. on July 25, 2016, because its employees/agents had failed to collect lab samples as ordered.

152. As a result of the negligent failure of all Defendants to provide reasonably adequate medical care to Mr. Rayner, he died in the Appling County Jail on July 26, 2017.

153. Plaintiff Dinetha L. Rayner was the lawful spouse of Mr. Rayner.

154. Plaintiff is entitled to bring this action. On the date of his death, Mr. Rayner was 42 years of age and had a reasonable life expectancy of 33 years.

155. Plaintiff is entitled to recover the full value of the life of Mr. Rayner, from all Defendants in

an amount to be proven at trial.

COUNT VII
FAILURE TO TRAIN

156. Plaintiff re-alleges and incorporates herein by reference the allegations of Paragraphs 1 through 101 above, as if fully set out herein.

157. Appling County Sheriff's Policy Manual does not address the circumstances in which detention officers must render medical aid or see that medical aid is rendered to inmates.

158. The Appling County Sheriff's Office and Sheriff Mark Melton failed to properly train the Correction/Detention Officers on when and how to render medical aid to the detainees as required by law.

COUNT VIII
PUNITIVE DAMAGES

159. Plaintiff re-alleges and incorporates herein by reference the allegations of Paragraphs 1 through 101 above, as if fully set out herein.

160. Plaintiff contends that Defendants, jointly, severally, or jointly and severally, acted with malice or with reckless indifference to Mr. Rayner's federally protected rights.

161. Defendants' conduct showed a callous disregard for whether the conduct violated Mr. Rayner's protected federal rights.

162. Accordingly, Plaintiff is entitled to recover punitive damages from all Defendants, except Sheriff Mark Melton.

COUNT IX
ATTORNEYS FEES AND EXPENSES OF LITIGATION

163. Plaintiff re-alleges and incorporates herein by reference the allegations of Paragraphs 1 through 101 above, as if fully set out herein.

164. Defendants have acted in bad faith, have been stubbornly litigious, or have caused Plaintiff unnecessary trouble and expense and Plaintiff is entitled to recover from Defendants all expenses of litigation, including attorney fees.

WHEREFORE, Plaintiff prays for the issuance and service of process as provided by law, for trial by jury, and that they recover damages for pain and suffering, medical expenses past and future, punitive damages, and attorney's fees and expenses of litigation, and court costs, and such other damages as are just and proper.

This 13th day of May, 2019.

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CERTIFICATE OF SERVICE

I hereby certify that on this date, I electronically filed the foregoing ***Amended Complaint*** with the Clerk of Court using the CM/ECF system, which will automatically send email notification of such filing to all parties of record through the electronic system of the Southern District of Georgia, Brunswick Division.

This 15th day of May, 2019.

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