ADANTÉ D. POINTER, ESQ., SBN 236229
PATRICK M. BUELNA, ESQ., SBN 317043
TY CLARKE, ESQ., SBN 339198
MATTHEW T. NORMAN, ESQ., SBN 351413
POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert St., Suite 208
Oakland, CA 94607
Tel: 510-929-5400
Website: www.LawyersFTP.com
Email: APointer@LawyersFTP.com
Email: PBuelna@LawyersFTP.com
Email: TClarke@LawyersFTP.com
Email: MNorman@LawyersFTP.com

Attorneys for Plaintiffs

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

LESLEY OVERFIELD, an individual; A.O., a minor, by and through his Guardian ad Litem, SYMBRIA OVERFIELD; B.O., a minor, by and through his Guardian ad Litem, SYMBRIA OVERFIELD,

Plaintiffs,

v.

WELLPATH COMMUNITY CARE, LLC, a corporation; COUNTY OF EL DORADO, a municipal corporation; and DOES 1-50, inclusive.

Defendants.

Case No.:

COMPLAINT FOR DAMAGES
(42 U.S.C. § 1983)

JURY TRIAL DEMANDED

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

INTRODUCTION

1. In February 2022, Decedent Nicholas Overfield ("Nick") was arrested and detained at El Dorado County Jail (sometimes, the "Jail") for a failure to appear in court. During the course of this arrest, Nick informed the arresting officers that he was HIV[1] positive and would need his prescribed antiretroviral medication during his detention to ensure his HIV remained in check. Nick's mother, Plaintiff Lesley Overfield, then handed the arresting officers the HIV medication prescribed to her son, which the arresting officers took with them.

2. Nick was detained at El Dorado County Jail for the next two months. Medical records show that he was denied his prescribed HIV medication for the **entire two months** he was redatined. Defendant Wellpath Community Care, LLC ("Wellpath") contracts with the Defendant County of El Dorado to provide medical services in El Dorado County Jail. Wellpath has a well-documented history of providing shockingly inadequate medical "care" in jails and prisons across the country.[2]

3. On April 22, 2022, Plaintiff Lesley Overfield went to visit her son at the Jail. Upon Lesley's arrival, Nick was wheeled into the visiting area in a wheelchair because he could not walk. Nick was so unwell and so diminished that he could not even speak to his mother. The next day, Lesley spoke with a Wellpath Jail nurse regarding her observations of her son from the previous day and to demand that the Jail provide Nick with the medical care he clearly needed. That same evening, Nick was rushed to the hospital for sorely needed emergency medical care. Defendants were either unaware of or, worse, ignoring the severity of Nick's general health and medical

[1] HIV (human immunodeficiency virus) is a virus that attacks the body's immune system. If HIV is not treated, it can lead to AIDS (acquired immunodeficiency syndrome). There is currently no effective cure.
[2] https://www.sfchronicle.com/california/article/wellpath-health-care-jails-17917489.php

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

condition until they were forced to confront those things by his mother. After being hospitalized, Nick was soon transferred to hospice care. Tragically, Nick died several months later on June 21, 2022.

4. In a tragic and inevitable turn of events, Nick's health had deteriorated at an alarming rate during and as a result of his detention at El Dorado County Jail. Despite having Nick's prescribed HIV medication, and despite having been told Nick upon his arrest that he needed his HIV medication to keep his HIV in check, Defendants failed to provide Nick with his HIV medication. As a direct and proximate result, Nick's HIV devolved into AIDS.[3] Nick's death certificate identified encephalitis varicella zoster virus as the immediate cause of death and indicated that Nick contracted this virus two months prior to his death.[4] Thus, at the time Nick contracted the encephalitis varicella zoster virus, he was already a pre-trial detainee of County and under the care of Wellpath.

JURISDICTION

5. This action arises under Title 42 of the United States Code, Section 1983. Jurisdiction is conferred upon this Court by Title 28 of the United States Code, Sections 1331 and 1343. The unlawful acts and practices alleged herein occurred in South Lake Tahoe, California in El Dorado County, which is within this judicial district.

PARTIES

6. Decedent NICHOLAS OVERFIELD (hereinafter "Decedent") was an adult, and died intestate, unmarried, and was the biological father of Plaintiffs A.O. and B.O. who are minors.

[3] AIDS is the late stage of HIV infection that occurs when the body's immune system is badly damaged because of the virus. In the U.S., most people with HIV do not develop AIDS because taking HIV medicine as prescribed stops the progression of the disease.

[4] Most people who die from HIV/AIDS do not die from the virus itself but rather from these so-called "opportunistic infections," which take advantage of a weak immune system.

Decedent was the biological son of Plaintiff LESLEY OVERFIELD.

7. Plaintiff LESLEY OVERFIELD is a competent adult, a resident of California, and a citizen of the United States. Plaintiff LESLEY OVERFIELD is the biological mother of Decedent. Plaintiff LESLEY OVERFIELD brings these claims individually on the basis of 42 U.S.C. §§ 1983 and 1988, the United States Constitution, and federal civil rights law.

8. Plaintiff A.O. (hereinafter "A.O.") is a minor and brings this suit by and through his Guardian ad Litem, SYMBRIA OVERFIELD. A.O. is the biological son of SYMBRIA OVERFIELD and Decedent. Plaintiff A.O. brings suit individually and as co-successor-in-interest to Decedent.

9. Plaintiff B.O. (hereinafter "B.O.") is a minor and brings this suit by and through his Guardian ad Litem, SYMBRIA OVERFIELD. B.O. is the biological son of SYMBRIA OVERFIELD and Decedent. Plaintiff B.O. brings suit individually and as co-successor-in-interest to Decedent.

10. Defendant COUNTY OF EL DORADO (hereinafter "Defendant COUNTY") is and at all times herein mentioned is a municipal entity duly organized and existing under the laws of the State of California that manages and operates the EL DORADO COUNTY SHERIFF'S OFFICE and EL DORADO COUNTY JAIL.

11. Defendant WELLPATH COMMUNITY CARE, LLC (hereinafter "Defendant WELLPATH") was at all times herein mentioned a Delaware corporation licensed to do business in California. Defendant WELLPATH provided medical, psychiatric, nursing, medication and health care to prisoners and detainees in Defendant COUNTY jails, pursuant to contract with the Defendant COUNTY. On information and belief, WELLPATH and its employees and agents are responsible for making and enforcing policies, procedures, and training related to the medical care of prisoners and detainees in Defendant COUNTY OF EL DORADO's jails.

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

12. Plaintiffs are ignorant of the true name and/or capacities of defendants sued herein as DOES 1 through 50, inclusive, and therefore sues said defendants by such fictious names. Defendants DOES 1 through 50 are employees of Defendants WELLPATH and/or COUNTY. Plaintiffs will amend this complaint to allege the true names and capacities of Defendants DOES 1 through 50 when ascertained. Plaintiffs believe and allege that each of the Defendant DOES 1-50 are legally responsible and liable for the incident, injuries, and damages hereinafter set forth. Each Defendant DOE 1 through 50 proximately caused injuries and damages because of their negligence, breach of duty, negligent supervision, management or control, violation of public policy, and failure to provide constitutionally-adequate medical care. Each Defendant DOE 1 through 50 is liable for his/her personal conduct, vicarious or imputed negligence, fault, or breach of duty, whether severally or jointly, or whether based upon agency, employment ownership, entrustment, custody, care or control or upon any other act or omission. Plaintiffs will seek leave to amend this complaint in order to name Defendants DOES 1 through 50 when ascertained.

13. Plaintiffs are ignorant to the true name and/or capacities of defendants sued herein as Defendant DOES 51 through 75, inclusive, and therefore sues said defendants by such fictious names. Defendants DOES 51 through 75 are employees of the South Lake Tahoe Police Department who initially arrested Plaintiffs' Decedent in February 2022. Plaintiffs will amend this complaint to allege the true names and capacities of Defendants DOES 51 through 75 when ascertained. Plaintiffs believe and allege that each of the Defendant DOES 51-75 are legally responsible and liable for the incident, injuries, and damages hereinafter set forth. Each Defendant DOES 51 through 75 proximately caused injuries and damages because of their negligence, breach of duty, negligent supervision, management or control, violation of public policy, and failure to provide constitutionally-adequate medical care. Each Defendant DOE 1 through 50 is liable for his/her personal conduct, vicarious or imputed negligence, fault, or breach of duty, whether severally or

jointly, or whether based upon agency, employment ownership, entrustment, custody, care or control or upon any other act or omission. Plaintiffs will seek leave to amend this complaint in order to name Defendants DOES 1 through 50 when ascertained.

14. In doing the acts and/or omissions alleged herein, Defendants DOES 1 through 50 acted within the course and scope of their employment for Defendant WELLPATH and/or COUNTY.

15. In doing the acts and/or omissions alleged herein, Defendants DOES 1 through 50 acted under color of authority and/or under color of law.

16. Due to the acts and/or omissions alleged herein, Defendants, and each of them, acted as the agent, servant, and employee and/or in concert with each of said other Defendants herein.

FACTUAL ALLEGATIONS

17. In February 2022, Plaintiffs' Decedent Nicholas Overfield (hereinafter "Nick") was arrested at his home without incident for a failure to appear in court and was detained at El Dorado County Jail as a pre-trial detainee. Nick was 38-years-old at the time of his detention and was HIV positive.

18. As an individual living with HIV, Nick was prescribed antiretroviral medication. Antiretroviral medications are crucial to protecting HIV positive patients from infection and other health-risks that are inherent to being immunocompromised. According to the National Institutes of Health and the U.S. Department of Health and Human Services, antiretroviral treatment is recommended for all HIV positive individuals. Antiretroviral treatments protect the immune systems of HIV positive patients and prevent HIV infections from developing into AIDS, which is the late stage of HIV infection that occurs when the body's immune system is badly damaged because of the virus. In the U.S., most people with HIV do not develop AIDS because taking HIV

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

medicine as prescribed stops the progression of the disease.[5]

19. On the night of his arrest, while still at home, Nick told the arresting officers that he was HIV positive and would need his prescribed antiretroviral medication. Nick's mother—Plaintiff Lesley Overfield—handed the arresting officers Nick's HIV medication so that he would have it while in jail.

20. On information and belief, the officers who arrested Nick and received his HIV medication from Lesley were South Lake Tahoe Police Department Officers. These yet-to-be-identified officers are named in this lawsuit as Defendants DOES 51-75.

21. On information and belief, yet-to-be-identified employees of the Defendants County of El Dorado and Wellpath, identified in this Complaint as Defendants DOES 1-50, were aware that Nick was HIV positive at the time that he was initially brought into the jail and that he was prescribed antiretroviral medication.

22. Over the next two months, Nick remained a pre-trial detainee at the El Dorado County Jail. During that time, Plaintiff Lesley Overfield (hereinafter "Lesley") was in frequent contact with El Dorado County Jail as she attempted to make sure that Nick was provided with his antiretroviral medication.

23. Medical records indicate that Nick was **never** provided his prescribed antiretroviral medication during his two-month detention at El Dorado County Jail. This is a shocking failure to provide even the bare minimum of medical care to a pre-trial detainee who was HIV positive.

24. As a direct and proximate result of not being given his HIV medication by Wellpath, the County, and their employees, Nick's health rapidly deteriorated to a life-threatening condition

25. On or about April 22, 2022, Lesley visited her son at El Dorado County Jail. This

[5] https://hivinfo.nih.gov/understanding-hiv/fact-sheets/hiv-treatment-basics

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

was not out of the ordinary, as Lesley visited Nick approximately every two weeks while he was detained. However, on this visit, it was clear just how badly Nick's health had spiraled. A deputy brought Nick into the visiting room in a wheelchair because he was too weak to walk. He was visibly disoriented and could not speak to his mother. Lesley was so concerned that she rushed out of the visiting room to ask the deputy what had happened to her son but was not provided any information. Instead, the deputy told her that she would have to ask her son—an especially cruel response given that he could not speak—and then left the building.

26. On or about April 23, 2022, Lesley reached out to a nurse at El Dorado County Jail to express her concerns regarding the condition she observed Nick to be in on the day prior. She was informed that Nick was in the infirmary because he had lost control of his bowels.

27. On or about the evening of April 23, 2022, Nick was rushed from El Dorado County Jail to Barton Memorial Hospital in South Lake Tahoe, California. Hospital records indicate that Nick was brought to the hospital because of "progressive weakness" and an altered mental state. Jail staff informed the hospital medical staff that Nick had been falling frequently and had been unable to move for the previous few days.

28. In one medical record from Barton Memorial Hospital dated April 24, 2022, a nurse writes that she spoke with a jail nurse from El Dorado County Jail who reported that Nick "has not had access to his HIV medications since taken (sic) into custody in February".

29. Given the severity of his medical condition, Nick was transferred to a hospital in San Francisco for further treatment. Tragically (because this was all preventable), he was placed into hospice care soon after and died on June 21, 2022.

30. Plaintiffs are in possession of Nick's death certificate from the Defendant COUNTY. On this certificate, the immediate cause of death is identified as encephalitis varicella zoster virus. The death certificate indicates that there were two months between the onset of this condition and

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

Nick's death, meaning that Nick contracted this ultimately deadly condition while he was a pre-trial detainee at El Dorado County Jail.

31. AIDS is the most advanced stage of HIV. The Center for Disease Control has developed a list of AIDS-defining conditions—any HIV positive individual who has one of these conditions listed has a diagnosis of AIDS. HIV-related encephalopathy is an AIDS-defining condition.[6]

32. Given that encephalitis related to HIV is an AIDS-defining condition, Nick's death certificate indicates that he contracted the condition while in the custody and care of the Defendants COUNTY and WELLPATH, and Nick contracted the condition while being deprived of his prescribed HIV medication that protected his immune systems, Plaintiffs allege that the Defendants' inadequate medical care caused Nick to develop AIDS and die.

MONELL **ALLEGATIONS AGAINST DEFENDANT COUNTY**

33. Plaintiffs are informed, believe, and believe, and therein allege that Defendant COUNTY exhibits a pattern and practice of exposing pre-trial detainees and inmates to unconstitutional detention conditions and procedures at El Dorado County Jail and despite these incidents, none of the Sheriff's Deputies and/or other jail staff are ever found in violation of department policy or disciplined, even under the most questionable of circumstances. Defendant COUNTY's failure to discipline or retrain El Dorado County Jail staff is evidence of an official policy, entrenched culture, and posture of deliberate indifference toward protecting citizen's rights and the resulting death and injuries is a proximate result of the Defendant COUNTY's failure to properly supervise its Deputies and/or other jail staff and ratify their unconstitutional conduct. Plaintiff is informed, believe, and therein allege that the following instances are examples of the Defendant COUNTY's pattern and practice of condoning misconduct by failure to discipline and/or

[6] https://www.thewellproject.org/hiv-information/aids-defining-conditions

train:

a. On July 28, 2022, Dustin Heier, a man with a seizure condition, died at a nearby hospital shortly after being booked at El Dorado County Jail. He was taken to the hospital twice on or about the day of his death and it is unclear why jail staff did not leave him in the care of the hospital on the day of his death.[7]

b. In March 2022, Ronald S. Miller sustained multiple skull fractures after being assaulted and began suffering from blackouts, nose bleeds, and headaches. Mr. Miller informed the jail medical staff of his recurring injuries but was denied medical attention because there was no record in his medical file of skull fractures. In May 2023, Mr. Miller suffered a blackout that resulted in him further injuring his head. He was taken to the hospital and diagnosed with multiple skull fractures, but after returning to jail Mr. Miller was denied further medical treatment and was told he must wait until he is out of jail for additional care. *Miller v. El Dorado County Jail*, (E.D. 2023) Case 2:23-cv-00666-DAD-EFB.

c. In March 2021, detainee Jeffrey Ellsworth informed jail staff upon booking that he needed to see a psychologist for his preexisting mental health issues and prescribed medication. Mr. Ellsworth was told to file a medical request slip and promptly did so the same day. After waiting several weeks, Mr. Ellsworth was told that he was "on the list to be seen" but had not yet received any medical care nor his prescription. Mr. Ellsworth filed another medical request but was again denied care and his prescription, simply being told to "hang in there." As of filing his complaint, Mr. Ellsworth had not received medical care nor his prescription for over two

[7] https://www.davisvanguard.org/2022/08/questions-arise-about-in-custody-death-at-el-dorado-county-jail/

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

months. *Ellsworth v. El Dorado County Nursing Staff, et al.*, (E.D. 2021) Case 2:21-cv-01070-TLN-EFB.

d. In December 2020, detainee Colin Bowers experienced sharp pains in his upper stomach while being booked into El Dorado County Jail. Mr. Bowers was told that his oxygen levels were normal and despite further attempts to have correctional and medical staff assist him, was denied any further medical treatment. After being released the next day, Mr. Bowers called for an ambulance and was taken to Marchall Hospital, where he was rushed into emergency surgery to remove his gallbladder. *Bowers v. El Dorado County Jail*, (E.D. 2021) Case 2:21-cv-00520-KJM-DB.

e. In September 2020, a week after being incarcerated, two of Jeremy Bonderer's temporary fillings fell out, causing him severe pain. The jail medical dentist saw Mr. Bonderer twice, but Mr. Bonderer was told that only dental emergencies would be treated. Despite his teeth causing him severe pain, Mr. Bonderer had still not received any treatment at the time of filing his amended complaint, over a year and a half later. *Bonderer v. El Dorado Count Jail, et al.*, (E.D. 2021) Case 2:21-cv-01335-WBS-AC.

f. In September 2019, after two of Ryan Shropshire's fillings fell out while in custody, he was seen by a dental care provider and was told that there was no sign of infection and that his teeth were restorable, but he would not be eligible for an annual dental exam until he had been in custody for a year. Mr. Shropshire was not examined again until September 2020, at which point one of his teeth was no longer restorable and he required an X-ray follow-up. Mr. Shropshire submitted medical requests but was simply told by jail & medical staff that his concerns were "noted." Mr.

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

Shropshire was still waiting for an appointment as of the filing of his complaint in March 2021. *Shropshire v. D'Agostini, et al.*, (E.D. 2021) Case 2:21-cv-00466-WBS-DB.

g. In July 2016, Brian Spears was transferred to El Dorado County Jail with a 30 day supply of heart medications and specific medical instructions to give Mr. Spears a bi-weekly dose of Humira in order for him to walk. After several weeks, Mr. Spears had not received any dose of Humira and made several medical requests to see a doctor about his prescription, but his requests went unanswered. Several weeks later, Mr. Spears finally saw the jail's doctor, but was told that Mr. Spears's Humira prescription was too expensive, and the jail would not pay for it. Despite being informed by a rheumatologist that Mr. Spears's Humira prescription was necessary, the jail's doctor refused, and Mr. Spears was never given his medication. *Spears v. Bianchi, et al.*, (E.D. 2016) 2:16-cv-02177-DAD-JDP.

h. In 2016, detainee John Mizerak, Jr. suffered severe dental pain resulting from medical issues preexisting his incarceration. After being seen by the jail's dentist he was diagnosed with needing a root canal but was informed that the jail would not perform the procedure. Mr. Mizerak requested to have the surgery conducted by his own dentist outside of jail at his own expense, but he was denied. Mr. Mizerak was also denied pre-prescribed medication for the pain he suffered due to his condition. As a result, Mr. Mizerak suffered immense pain and three of his teeth deteriorated to the point where they became unsalvageable. *Mizerak v. Eslick, et al.*, (E.D. 2016) Case 2:16-cv-00323-MCE-CKD.

i. In 2015, Lawrence Spies, Jr. died in El Dorado County Jail less than 24 hours after being booked for misdemeanor charges. Despite both the sheriff's and medical staff

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

having actual knowledge that Mr. Spies was in immediate danger of committing suicide, he had not been placed on any suicide precautions, was not assessed for his risk of suicide, and no protective measures were recommended by the medical staff. After failing to perform a single cell check once placed in his cell the night before, Mr. Spies was found dead the next evening when food was being brought into his cell. *Spies, Sr. v. El Dorado County*, (E.D. 2016) Case 2:16-cv-02232-WBS-GGH.

j. In April 2014, Richard Anderson fractured his hand, yet despite submitting several medical requests for treatment Mr. Anderson was never treated for his injury. Shortly after, another inmate, Robert Gay, fell as he was climbing out of his top bunk and hit his chest against the sink in his cell. Despite having heavy bruising and difficulty breathing, Mr. Gay was not given an X-ray or any treatment. The Jail's medical staff refused to treat Mr. Gay because he was scheduled to be transferred to prison the following week, and the medical staff decided to shift the responsibility of caring for his injury to the future prison staff. *Anderson v. El Dorado County Sheriff's Department, et al.*, (E.D. 2015) Case 2:15-cv-00773-AC.

34. Plaintiffs are informed, believe, and therein allege that Defendant COUNTY knew, had reason to know by way of actual or constructive notice of the aforementioned policy, culture, pattern and/or practice and the complained of conduct and resultant injuries/violations.

***MONELL* ALLEGATIONS AGAINST DEFENDANT WELLPATH**

35. Plaintiffs are informed, believe, and therein allege that Defendant WELLPATH exhibits a pattern and practice of exposing pre-trial detainees and inmates to unconstitutional detention conditions and procedures across California and the United States, and despite these incidents, none of the WELLPATH medical staff are ever found in violation of policy or disciplined, even under the most questionable of circumstances. Defendant WELLPATH's failure

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

to implement constitutionally sufficient medical standards and procedures, and failure to discipline or retrain WELLPATH medical staff is evidence of an official policy, entrenched culture, and posture of deliberate indifference toward protecting citizen's rights and the resulting death and injuries is a proximate result of the Defendant WELLPATH's failure to properly supervise or train its employees and ratify their unconstitutional conduct. Plaintiffs are informed, believe, and therein allege that the following are examples of WELLPATH's sweeping pattern and practice of providing constitutionally deficient medical care and conditions, failing to improve blatantly deficient care and conditions, and condoning misconduct by failure to discipline and/or train:

a. In 2021, the United States Department of Justice released the findings of its investigation into the shocking quality of healthcare that Wellpath provided to the San Lois Obispo County Jail.[8] The investigation found conditions that "violate the Eighth and Fourteenth Amendments" due to Wellpath's "failure to provide constitutionally adequate medical care to prisoners." Specifically, the DOJ found that "the Jail fails to provide adequate care for prisoners with HIV" and "[m]edications for prisoners with HIV are frequently delayed or not provided during the entirety of a prisoner's incarceration." Examples of Wellpath's unconscionable practice of depriving adequate HIV treatment to inmates include:

   i. On April 30, 2019, inmate E.E. tested positive for HIV while in custody. Labs and tests were ordered, but initially no appointment was ordered with an infectious disease specialist. E.E. submitted sick call slips on June 3, 2019, June 24, 2019, and July 2, 2019 requesting treatment for his HIV infection, including medication and an appointment with an infectious disease

[8] https://www.justice.gov/crt/case-document/file/1429036/download

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

specialist. A specialist did not see him until July 8, 2019, and E.E. did not begin receiving medication until July 20, 2019—nearly three months after his diagnosis.[9]

ii. J.J., a prisoner with HIV, received double the recommended dosage of his HIV medications for over two months in 2019, and was not provided appropriate HIV laboratory studies. The jail did not schedule regular provider appointments for him as mandated by both the jail policy and professional standards for prisoners with chronic conditions.[10]

iii. K.K. reported he was HIV positive to medical staff at intake in February, 2019. Over the next sixteen months, the Jail provided HIV medications to K.K., but discontinued one of his medications in June 2019, and replaced it for nine months with an ineffective drug that can cause drug resistant trains of HIV. Wellpath ordered laboratory studies to monitor the new medication's efficacy but never sent them to the lab. K.K. submitted a sick call slip asking to discuss his HIV status in July 2019, but a doctor did not see him until six weeks later. Medical staff saw K.K. for just one chronic care appointment during his entire incarceration, and it occurred in March 2020, over a year after his admission.[11]

iv. L.L., who was admitted to the Jail in April 2019, received no HIV medications during her first week in custody. Then the Jail began providing her only one of the three medications she had been taking to manages her HIV. This was the only drug she received for the next week before her

[9] https://www.justice.gov/crt/case-document/file/1429036/download (at 8.)
[10] *Id.* at 11.
[11] *Id.*

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

release, and during that week she did not receive even that drug for three consecutive days. Receiving just one of three HIV medications creates a high likelihood of developing resistance to that medication, which is extremely dangerous.[12]

v. M.M., admitted in July 2019, reported two weeks after admission that she had been HIV positive for 20 years and provided information about her medication and treatment in the community. The Jail did not begin providing medication until 11 days after she reported her HIV infection. She remained in the Jail for 10 months, during which time the Jail never ordered any tests to measure her viral load.[13]

b. In a 2020 probe into the Massachusetts Department of Corrections, the United States Department of Justice found that Wellpath's mental health care was so abysmal that it may constitute "cruel and unusual punishment," with "vague" policies that increased the risk of self-harm and suicide among mentally ill prisoners.[14] A follow-up report in 2023 revealed that Wellpath had low staffing levels and high rates of unlicensed mental health providers.[15]

c. A 2019 probe by the United States Department of Justice into the Federal Correctional Complex in Coleman, Florida revealed that Wellpath failed to develop a mandatory quality-control surveillance plan to monitor healthcare services provided to inmates.[16]

---

[12] https://www.justice.gov/crt/case-document/file/1429036/download (at 11.)
[13] *Id.*
[14] https://www.justice.gov/opa/press-release/file/1338071/download
[15] https://www.justice.gov/crt/case-document/file/1581466/download
[16] https://oig.justice.gov/news/doj-oig-releases-report-bops-contract-correct-care-solutions-llc-federal-correctional-complex

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

d. A 2020 Reuters investigation found that large jails using Wellpath have higher death rates than jails with publicly run health care. The investigation found that from 2016 to 2018, for every 10,000 inmates in Wellpath's care, 16 died; in publicly run jails, that rate was 13 per 10,000.[17]

e. Wellpath has allegedly performed procedures and administered medications without patients' informed consent and without following the company's protocol for involuntary treatment.[18] For example, at one South Carolina jail, incarcerated individuals were reportedly injected with an opioid treatment drug without their consent.[19] At another, monitors found that Wellpath staff forcibly administered psychotropic medications without following the established protocol for the involuntary administration of medication.[20]

f. Numerous investigations have found that Wellpath has repeatedly and systematically failed to meet contractually required staffing levels and hires under-qualified medical professionals. For example:

i. In the aforementioned 2021 DOJ investigation into San Lois Obispo County Jail found that Wellpath staffed an inadequate number of medical professionals, putting incarcerated individuals at "substantial risk of serious harm."[21]

ii. A 2018 DOJ investigation into Wellpath's predecessor found that

---

[17] https://reuters.com/article/idUSL1N2HG0MD/
[18] *See, e.g.*, Order Granting Plaintiffs' Motion to Enforce Settlement Agreement and Wellpath Implementation Plan at 23, *Hernandez v. County of Monterey*, No. 13-cv-02354 (N.D. Cal. Sept. 26, 2023).
[19] https://www.postandcourier.com/news/charleston-county-continued-to-pay-jails-medical-provider-millions-despite-pattern-of-neglect/article_d5680a6e-d93a-11ed-bcd7-f3f08cf76ef0.html
[20] Declaration of Cara E. Trapani in Support of Plaintiffs' Motion to Enforce the Settlement Agreement and Wellpath Implementation Plan at 37, Hernandez v. County of Monterey, No. 13-cv-02354 (N.D. Cal. Aug. 10, 2023)
[21] https://www.justice.gov/crt/case-document/file/1429036/download (at pp. 14-16).

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

incarcerated individuals were simply not sent to outside medical providers due to medical and security staffing shortages.[22]

iii. A 2015 investigation by DOJ's Office of the Inspector General (OIG) found that a Federal Bureau of Prisons (BOP) facility in Texas that contracted with Wellpath's predecessor CCS "had significant issues staffing its health services unit."[23]

iv. An audit at Monterey County Jail found that Wellpath provided no dental care for months because it lacked adequate dental staff and stopped conducting intake screenings due to a shortage of nursing staff.[24]

v. A CNN investigation even found that Wellpath staff shredded and hid medical requests at some facilities due to a lack of available medical staff.[25]

vi. A 2022 report by the National Union of Healthcare Workers, a group that represents many Wellpath nurses in California, found that the Sonoma County Jail staffed less than two-thirds of the nurse hours that were required by their contract. The staffing levels in the jail were so low that for every 500 prisoners in the Sonoma system, just one registered nurse was on duty at any given time.[26]

vii. There are also reports of Wellpath employing licensed vocational nurses in roles that require registered nurses with more advanced training.[27] [28]

---

[22] https://s3.documentcloud.org/documents/5978540/Hampton-Roads-DOJ-report.pdf (at p. 14).
[23] https://www.oversight.gov/sites/default/files/oig-reports/a1515.pdf (at p. iii).
[24] Declaration of Cara E. Trapani in Support of Plaintiffs' Motion to Enforce the Settlement Agreement and Wellpath Implementation Plan at 6-7, 45, *Hernandez v. County of Monterey*, No. 13-cv-02354 (N.D. Cal. Aug. 10, 2023).
[25] https://www.cnn.com/interactive/2019/06/us/jail-health-care-ccs-invs/
[26] https://drive.google.com/file/d/1D5JCXjq6vsGBr9agirhZ4-c80MVhCsNM/view
[27] https://thelensnola.org/2023/05/16/orleans-jail-monitors-find-falsified-records-understaffing-at-facility/
[28] https://www.globenewswire.com/news-release/2023/08/24/2731561/0/en/Haddad-Sherwin-LLP-Reaches-12-75-Million-Settlement-for-Death-of-Shasta-County-Jail-Inmate-Under-the-Care-of-Wellpath.html

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

g. Further, there are reports of Wellpath staff not following the company's own protocols. For example:

i. Wellpath staff have reportedly failed to perform mortality reviews, notify a physician when patients showed abnormal vital signs, develop individual treatment plans for patients with mental illnesses, and assign different staff members to review an initial grievance and an appeal.[29]

ii. Some staff have failed to monitor for attempts at self-harm or suicide, and some have even falsified logs by stating that they performed welfare checks.[30]

iii. Wellpath has also reportedly failed to abide by its own plan for implementing a court-approved settlement agreement, including failing to timely respond to sick call requests, refer incarcerated patients to outside providers as needed, or even schedule internal quality improvement meetings.[31]

h. Wellpath's payment structure incentivizes cutting costs by minimizing the number of healthcare services provided and opting to provide less resource-intensive services.[32] In its state and local contracts, Wellpath is typically paid a set rate based on the average daily population at the facilities where it provides care, with caps on the total amount that it can be compensated.[33] But some Wellpath contracts appear to

---

[29] Declaration of Cara E. Trapani in Support of Plaintiffs' Motion to Enforce the Settlement Agreement and Wellpath Implementation Plan at 7, 19, 27, *Hernandez v. County of Monterey*, No. 13-cv-02354 (N.D. Cal. Aug. 10, 2023); https://www.justice.gov/opa/press-release/file/1429076/download? (at p. 8).

[30] *Id.*; https://www.nola.com/news/crime_police/care-from-orleans-jail-health-provider-causes-serious-harm/article_9a3b7dca-f36d-11ed-aaa9-f7c0e64a05be.html

[31] Order Granting Plaintiffs' Motion to Enforce Settlement Agreement and Wellpath Implementation Plan at 10-11, *Hernandez v. County of Monterey*, No. 13-cv-02354 (N.D. Cal. Sept. 26, 2023).

[32] https://www.nyulawreview.org/wp-content/uploads/2020/11/NYULawReview-Volume-95-Issue-5-Gelman.pdf

[33] https://wellpathcare.com/wp-content/uploads/2022/09/2022-09-09-Wellpath-2021-Corporate-Responsibility-Report.pdf (at p.6).

incentivize the company to reduce the number of transfers to hospitals[34] or to employ fewer staff members.[35] Meanwhile, in at least one contract that did permit reimbursement for specific services provided, the DOJ found that Wellpath's predecessor CCS was overcharging the Bureau of Prisons by inflating its billing rates in invoices.[36]

36. Plaintiffs are informed, believe, and therein allege that Defendant WELLPATH knew, had reason to know by way of actual or constructive notice of the aforementioned policy, culture, pattern and/or practice and the complained of conduct and resultant injuries/violations.

DAMAGES

37. As a direct and proximate result of each of the Defendant's deliberate indifference to Decedent's obvious and serious medical needs and distress, Decedent and Plaintiff suffered injuries, emotional distress, fear, terror, anxiety, and a loss of sense of security, dignity, and pride as United States Citizens.

38. As a direct and proximate result of each Defendant's act and/or omission as set forth above, Plaintiffs sustained the following injuries and damages, past and future, among others:

a. Wrongful death of NICHOLAS OVERFIELD;

b. Hospital and medical expenses;

c. Coroner's fees, funeral and burial expenses;

d. Loss of familial relationships, including loss of love, companionship, comfort, affection, society, services, solace, and moral support and loss of familial association;

[34] https://www.newyorker.com/magazine/2019/03/04/the-jail-health-care-crisis
[35] https://oig.justice.gov/reports/2015/a1515.pdf (at p.8).
[36] https://www.oversight.gov/sites/default/files/oig-reports/a1937_0.pdf (pp. 6-8).

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

e. Pain and Suffering, including emotional distress;

f. NICHOLAS OVERFIELD's conscious pain and suffering, pursuant to federal civil rights law (Survival claims);

g. NICHOLAS OVERFIELD's loss of life, pursuant to federal civil rights law;

h. Violation of constitutional rights; and

i. All damages, penalties, and attorneys' fees and costs recoverable under 42 U.S.C. §§ 1983, 1988; and as otherwise allowed under California and United States statutes, codes, and common law.

39. The conduct of Defendant Jail Staff was malicious, wanton, oppressive, and in reckless disregard of the rights and safety of NICHOLAS OVERFIELD, Plaintiffs, and the public. Plaintiffs are therefore entitled to an award of punitive damages against Defendant DOES 1-50.

CAUSES OF ACTION

FIRST CAUSE OF ACTION
(Fourteenth Amendment – Deliberate Indifference under 42 U.S.C. Section 1983)
(Plaintiffs A.O. and B.O. as co-successors-in-interest to DECEDENT against Defendants DOES 1-75)

40. Plaintiffs hereby re-allege and incorporate by reference each and every paragraph of this Complaint.

41. By the actions and omissions described above, Defendants DOES 1-75 violated 42 U.S.C. §1983, depriving Decedent of the following clearly established and well-settled constitutional rights protected by the Fourteenth Amendment to the United States Constitution:

a. The right to be free from deliberate indifference to Decedent's serious medical needs while in custody as secured by the Fourteenth Amendment.

42. Defendants DOES 1-75 subjected Decedent to their wrongful conduct, depriving Decedent of rights described herein with reckless disregard for whether the rights and safety of

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

Decedent would be violated by their acts and/or omissions.

43. As a result of their misconduct, Defendants DOES 1-75 are liable for Decedent's injuries and/or damages. Defendant DOES 1-75's conduct was egregious, outrageous and shock the conscience; and/or were committed with oppression and/or malice; and/or were despicable and perpetrated with a willful and conscious disregard for Plaintiff's safety, health and wellbeing. As such, Plaintiff to punitive damages and penalties allowable under 42 U.S.C. §1983.

WHEREFORE, Plaintiffs pray for relief as hereinafter set forth.

SECOND CAUSE OF ACTION
(Fourteenth Amendment – Familial Loss under 42 U.S.C. Section 1983)
(Plaintiffs LESLEY OVERFIELD, A.O., and B.O. individually against DEFENDANTS DOES 1-75)

44. Plaintiffs hereby re-allege and incorporate by reference each and every paragraph of this Complaint.

45. By the actions and omissions described, Defendants DOES 1-50 violated 42 U.S.C. § 1983, depriving Plaintiffs LESEY OVERFIELD, A.O., and B.O. of the following clearly established and well-settled constitutional rights protected by the Fourteenth Amendment of the United States Constitution including:

a. Right to familial association.

46. Defendant DOES 1-50 subjected Decedent to their wrongful conduct, thereby depriving Decedent and Plaintiffs of the rights described herein with reckless disregard for whether the rights and safety of Decedent, Plaintiffs, and others would be violated by their acts and/or omissions. Defendant DOES 1-50 were deliberately indifferent to Decedent's serious medical needs, thereby depriving Plaintiffs of their familial relationship with their father and son.

47. As a direct and proximate result of Defendant DOES 1-50's acts and/or omissions as set forth above, Plaintiff sustained injuries and damages as set forth herein.

48. Defendant DOES 1-50's conduct was egregious, outrageous and shock the

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

conscience; and/or were committed with oppression and/or malice; and/or were despicable and perpetrated with a willful and conscious disregard for Plaintiff's safety, health and wellbeing. As such, Plaintiff to punitive damages and penalties allowable under 42 U.S.C. §1983.

WHEREFORE, Plaintiff prays for relief as hereinafter set forth.

THIRD CAUSE OF ACTION
(Supervisory and Municipal Liability for Unconstitutional Custom or Police Practice – 42 U.S.C. section 1983 (*Monell*))
(Plaintiffs LESLEY OVERFIELD, A.O., and B.O. individually and as co-successors-in-interest to DECDENT against Defendants COUNTY, WELLPATH and DOES 1-50)

49. Plaintiffs hereby re-allege and incorporate by reference each and every paragraph of this Complaint.

50. Plaintiffs are informed and believe and therein allege that the Defendant COUNTY and WELLPATH high-ranking officials, including DOES 1-50, knew and/or reasonably should have known that El Dorado County Jail staff, including El Dorado County Sheriff's Deputies and Wellpath jail medical staff, exhibits a pattern and practice of improper and inadequate medical treatment for detainees, including depriving them of necessary medical treatment and medications, and despite these incidents, none of the El Dorado County Jail medical staff or employees of the El Dorado County Jail are found to be in violation of jail policy or disciplined or retrained, even under the most questionable of circumstances. Defendant COUNTY and WELLPATH's failure to discipline or retrain medical staff is evidence of an official policy, entrenched in a deliberate indifference for the safety, health, and wellbeing of detainees, and the resulting deaths and injuries are a proximate result of the DEFENDANT COUNTY and WELLPATH's failure to properly supervise its medical staff and ratify their unconstitutional conduct. Plaintiffs are informed, believe, and therein allege that the instances previously discussed in the *Monell Allegations* section are examples of the Defendant COUNTY and WELLPATH's pattern and practice of condoning constitutionally inadequate medical care by failure to discipline, retrain, and supervise.

51. Despite having such notice, Plaintiffs are informed and believe and thereon allege

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

that Defendants DOES 1-50, and/or each of them, approved, ratified, condoned, encouraged and/or tacitly authorized the continuing pattern and practice of misconduct and/or civil rights violations by said El Dorado County Jail and WELLPATH medical staff and/or employees.

52. Plaintiffs are further informed and believe and thereon allege that as a result of the deliberate indifference, recklessness, and/or conscious disregard of the misconduct by Defendants COUNTY, WELLPATH and DOES 1-50, and/or each of them, encouraged these medical staff and/or employees to continue their course of misconduct, resulting in the violation of Decedent's and Plaintiffs' rights as alleged herein.

53. The unconstitutional actions and/or omissions of Defendants DOES 1-50, as well as other medical staff employed by or acting on behalf of Defendants COUNTY and/or WELLPATH, on information and belief, were pursuant to the following customs, policies, practices, and/or procedures of the El Dorado County Jail. Stated in the alternative, these unconstitutional actions and/or omissions were directed, encouraged, allowed, and/or ratified by policy making-officials for the Defendant COUNTY and WELLPATH:

a. To cover-up violations of constitutional rights by any or all of the following:

   i. by failing to properly investigate and/or evaluate complaints or incidents of improper or inadequate medical treatment;

   ii. by ignoring and/or failing to properly and adequately investigate and discipline unconstitutional or unlawful activity; and

   iii. by allowing, tolerating, and/or encouraging medical staff to make false statements, file false reports, and/or withhold or conceal material information.

b. To allow, tolerate, and/or encourage a code of silence among El Dorado County Jail medical staff and employees whereby medical staff and/or employees do not provide

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

adverse information against fellow employees;

c. To use or tolerate inadequate, deficient, and improper procedures for handling, investigating, and reviewing complaints of misconduct by medical staff and employees;

d. To fail to have and enforce necessary, appropriate, and lawful policies, procedures, and training programs to prevent or correct the unconstitutional conduct, customs, and procedures described in this Complaint, with deliberate indifference to the rights and safety of Plaintiff and other detainees, and in the face of an obvious need for such policies, procedures, and training programs to prevent reoccurring and foreseeable violations of rights of the type described herein;

e. To have in place trainings, policies and procedures that deprive inmates & detainees of prescribed medications despite knowledge of their necessity and the risks of injury/death involved with depriving and/or delaying the administration of medications.

54. Defendants COUNTY, WELLPATH and DOES 1-50 failed to properly train, instruct, monitor, supervise, evaluate, investigate, and discipline DOES 1-50, and other El Dorado County Jail personnel, with deliberate indifference to Plaintiffs' and Decedent's constitutional rights, where were thereby violated as described above.

55. The aforementioned customs, policies, practices, and procedures, the failures to properly and adequately train, instruct, monitor, supervise, evaluate, investigate, and discipline, as well as the unconstitutional orders, approvals, ratification and toleration of wrongful conduct of Defendants COUNTY, WELLPATH and DOES 1-50, were a moving force and/or a proximate cause of the deprivations of Plaintiffs' and Decedent's clearly-established and well-settled constitutional rights in violation of 42 U.S.C. §1983, as more fully set forth in Cause of Action 1-3,

above.

56. Defendants subjected Plaintiffs and Decedent to their wrongful conduct, depriving Plaintiffs and Decedent of rights described herein, knowingly, maliciously, and with conscious and reckless disregard for whether the rights and safety of Plaintiffs and Decedent and others would be violated by their acts and/or omissions.

57. As a direct and proximate result of the unconstitutional actions, omissions, customs, policies, practices and procedures of Defendants COUNTY, WELLPATH and DOES 1-50 as described above, Plaintiffs sustained serious and permanent injuries and are entitled to damages, penalties, costs and attorneys' fees as set forth in this Complaint.

WHEREFORE, Plaintiffs pray for relief as hereinafter set forth.

FOURTH CAUSE OF ACTION
(Title II of American with Disabilities Act)
(Plaintiffs A.O. and B.O. as co-successors-in-interest to DECEDENT against Defendants COUNTY, WELLPATH, and DOES 1-50)

58. Plaintiffs hereby re-allege and incorporate by reference each and every paragraph of this Complaint.

59. At the time of Plaintiffs' Decedent's detention at El Dorado County Jail, he was HIV positive. Persons with HIV are protected by the Americans with Disabilities Act.[37]

60. As against Defendants COUNTY and/or DOES 1-50, the Defendants failed to reasonably accommodate Decedent's HIV positive status under Title II of the Americans with Disabilities Act and from excluding qualified individuals from participating in or denying benefits and services provided by Defendant COUNTY; or from otherwise discriminating against such qualified individuals with symptoms of disability recognized under Title II of the Americans with Disabilities Act, resulting in refusal to adequately accommodate Decedent's disability during the

[37] https://archive.ada.gov/hiv/ada_qa_hiv.htm

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

course of the subject-incident. Defendants COUNTY and DOES 1-50 were informed of Decedent's HIV positive status at the time of his detention and were even physically given his medication at the time of his arrest. Defendants COUNTY and DOES 1-50 knew or should have known that by depriving Decedent of his prescribe antiretroviral medications that were prescribed by to him for HIV treatment would foreseeably cause significantly more injury because of Decedent's disability than would be suffered by other members of the public. As a result of Defendants COUNTY and DOES 1-50 refusing to reasonably accommodate Decedent's disability, Decedent died while in the custody of Defendant COUNTY.

61. As against Defendant COUNTY and DOES 1-50, the Defendants knew and/or had reason to know of Decedent's disability and the severe risks faced by HIV positive individuals if they are not provided with their antiretroviral treatments.

62. The aforementioned conduct of Defendants COUNTY and DOES 1-50, in failing to reasonably accommodate Plaintiff's disability, discriminated against Plaintiff by reason of his recognized disability.

WHEREFORE, Plaintiffs pray for relief as hereinafter set forth.

JURY DEMAND

63. Plaintiffs hereby demand a jury trial in this action.

PRAYER

WHEREFORE, Plaintiffs pray for relief as follows:

1. For general damages in a sum to be proven at trial;

2. For special damages, including but not limited to, past, present, and/or future wage loss, income and support, medical expenses and other special damages in a sum to be determined according to proof;

3. For punitive damages against WELLPATH and DOES 1-75 in a sum according to proof;

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607

4. For reasonable attorney's fees pursuant to 42 U.S.C. § 1988 and § 794 (a); and as otherwise may be allowed by California and/or federal law;

5. Any and all permissible statutory damages;

6. For injunctive relief, including but not limited to, changing the medical response procedures, policies and guidelines for attending to HIV positive inmates;

7. For the cost of suit herein incurred; and

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

Dated: January 10, 2024

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE

/s/ TY CLARKE
ADANTÉ POINTER
PATRICK BUELNA
TY CLARKE
Attorney for PLAINTIFFS

POINTER & BUELNA, LLP
LAWYERS FOR THE PEOPLE
155 Filbert Street, Ste 208, Oakland, CA 94607