CIVIL ACTION COVER SHEET	DOCKET NUMBER	Trial Court of Massachusetts The Superior Court

PLAINTIFF(S): Laurie Arria, Administratrix Estate of Michael J. Ramey

ADDRESS: 225 Abbot Street

North Andover, MA 01845

COUNTY: Suffolk

DEFENDANT(S): Commonwealth of Massachusetts, et al..

ATTORNEY: Hector E. Pineiro

ADDRESS: 807 Main Street

Worcester, MA 01610

ADDRESS: Boston, Massachusetts

BBO: 555315

TYPE OF ACTION AND TRACK DESIGNATION (see reverse side)

CODE NO.	TYPE OF ACTION (specify)	TRACK	HAS A JURY CLAIM BEEN MADE?
AA1	Contract Action involving Commonwealth, etc.	A	☒ YES ☐ NO

***If "Other" please describe:**

STATEMENT OF DAMAGES PURSUANT TO G.L. c. 212, § 3A

The following is a full, itemized and detailed statement of the facts on which the undersigned plaintiff or plaintiff counsel relies to determine money damages. For this form, disregard double or treble damage claims; indicate single damages only.

SUFFOLK SUPERIOR COURT CIVIL CLERK'S OFFICE
2019 SEP 10 A 11:34
MICHAEL JOSEPH DONOVAN CLERK / MAGISTRATE

TORT CLAIMS
(attach additional sheets as necessary)

A. Documented medical expenses to date:
1. Total hospital expenses ..... $
2. Total doctor expenses ..... $
3. Total chiropractic expenses ..... $
4. Total physical therapy expenses ..... $
5. Total other expenses (describe below) ..... $

Subtotal (A): $

B. Documented lost wages and compensation to date ..... $
C. Documented property damages to dated ..... $
D. Reasonably anticipated future medical and hospital expenses ..... $
E. Reasonably anticipated lost wages ..... $
F. Other documented items of damages (describe below) ..... $

G. Briefly describe plaintiff's injury, including the nature and extent of injury:
Wrongful death to negligent, grossly negligent, reckless misconduct in medical care of an incarcerated person

Damages in excess of: $100,000.00
TOTAL (A-F):$

CONTRACT CLAIMS
(attach additional sheets as necessary)

Provide a detailed description of claims(s):

TOTAL: $

Signature of Attorney/Pro Se Plaintiff: X Hector E. Pineiro **Date:** Sep 9, 2019

RELATED ACTIONS: Please provide the case number, case name, and county of any related actions pending in the Superior Court.

CERTIFICATION PURSUANT TO SJC RULE 1:18

I hereby certify that I have complied with requirements of Rule 5 of the Supreme Judicial Court Uniform Rules on Dispute Resolution (SJC Rule 1:18) requiring that I provide my clients with information about court-connected dispute resolution services and discuss with them the advantages and disadvantages of the various methods of dispute resolution.

Signature of Attorney of Record: X Hector E. Pineiro **Date:** Sep 9, 2019

Suffolk

COMMONWEALTH OF MASSACHUSETTS

~~WORCESTER~~, ss

SUFFOLK SUPERIOR COURT
CIVIL ACTION NO.: 1984CV02843C

LAURIE ARRIA, ADMINISTRATRIX ESTATE OF MICHAEL J. RAMEY

Plaintiff

v.

CORRECT CARE SOLUTIONS, LLC, its successor company WELLPATH, LLC., COMMONWEALTH OF MASSACHUSETTS, DAVID A. ANDREWES, M.D., KATHERINE VAN ZANDT, NP., VENKATESWARA RAO DAVULURI, MD. VHS ACQUISITION SUBSIDIARY NUMBER 7, dba ST. VINCENT'S HOSPITAL, MARTHA FEHR, M.D., PRAVEEN DEVINENI, M.D., VENABABU KANDIMALLA, M.D., CORRECTIONAL OFFICERS JOHN DOE 1-5,

Defendants

COMPLAINT AND REQUEST FOR JURY TRIAL

INTRODUCTION

1. This is an action by the estate of Michael J. Ramey for state and federal claims arising from deliberate medical indifference and reckless, negligent and/or grossly negligent practice by medical providers at the Worcester County Jail and House of Correction ("the jail") and at Saint Vincent Hospital, which caused Mr. Ramey to suffer horribly and, on September 16, 2016, to die at the age of 36.

2. For more than three weeks before his death Mr. Ramey, a pretrial detainee at the jail, manifested increasingly disturbing signs of a painful and deadly neurological infection, cryptoccocal meningitis. First at the jail and then at the hospital, providers baselessly attributed the variable and progressing symptoms of the disease to malingering or drug seeking behavior, and to all intents and purposes they figuratively sat on their hands. During his final week of life, while hospitalized at Saint Vincent, Mr. Ramey's treating doctors speculated about malingering, dithered, and delayed or dispensed with vital diagnostic and treatment measures – notwithstanding that they knew the symptoms were consistent with meningeal infection, that their patient reversed his initial refusal to have a painful lumbar puncture procedure, and that they had readily available means to obtain authorization for that procedure regardless of whether or not he consented to it.

3. On September 10, as he continued to deteriorate, Mr. Ramey wept as he pleaded with a doctor to "please help me." Finally, after a tragically belated diagnosis a last minute attempt to intervene on September 14 was unavailing at best. Shortly after midnight on the 15th, Mr. Ramey went into cardiac arrest. He was resuscitated and moved to intensive care, where diagnostic scans shortly revealed herniation and diffuse hypoxia of the brain. When his parents and siblings received their first notice of his hospitalization and rushed to his bedside, Mr. Ramey was brain dead.

4. For deliberate medical indifference, and for wanton, negligent and grossly negligent disregard for Mr. Ramey's urgent medical needs, his estate brings claims in civil rights and wrongful death against the entities and the individuals responsible for denying him essential medicall. For the reckless, grossly negligent or negligent conduct by the Commonwealth, its employees, agents, servants, or others for whose negligent conduct it is liable under the law, the estate brings claims under the Massachusetts Tort Claims Act M.G.L. c. 258 ("MTCA").

JURISDICTION AND VENUE

5. This action is brought pursuant to 42 U.S.C. §§ 1983 and 1988, the Eighth and Fourteenth Amendments to the United States Constitution, and the common law, Constitution and statutes of the Commonwealth of Massachusetts. In particular as to state law, plaintiff brings claims against the Commonwealth as well as against individuals and private entities under the statutory and common of tort and malpractice, including the Massachusetts Tort Claim Act, M.G.L. c. 258.

6. There is no reasonable likelihood that plaintiff's recovery will be less than or equal to $25,000.

7. This Honorable Court has original jurisdiction of the action generally pursuant to M.G.L. c. 212, §§ 3 & 4, and it has exclusive jurisdiction of claims against the Commonwealth per the 11th Amendment to the U.S. Constitution and the MTCA, § 3.

8. Venue in the Suffolk County Division of this Court is proper under MGL, c. 223 § 1 and 258 § 3.

PARTIES

9. The Plaintiff Laurie Arria resides in North Andover, Essex County, Massachusetts, and is the Administratix of the Estate of her late brother, Michael J. Ramey.

10. The defendant Commonwealth of Massachusetts ("The Commonwealth") is a sovereign with a usual place of business at the City of Boston, Suffolk County, Massachusetts, and is sued for the conduct of its agency, the Worcester County Sheriff's Office ("WCSO") in the operation of the jail and for the negligence of its employees, agents, servants, and contracted employees and entities under it's the direction of the WCSO.

11. Defendant Correct Care Solutions, LLC, ("Correct Care") was at all pertinent times a foreign corporation with its principal office at 1283 Murfreesboro Pike, Suite 500, Nashville, Tennessee, and its resident agent in the Commonwealth is Corporate Creations Network, Inc., of 225 Cedar Hill Street, # 200, Marlborough, Worcester County, Massachusetts.

12. Defendant WellPath, LLC ("WellPath"), was at all pertinent times a foreign limited liability company with its principal place of business located at 1283 Murfreesboro Pike, Suite 500, Nashville, TN, 37217. The firm has a resident agent located at Business Filing Inc. 155 Federal Street Suite, 700, Boston, MA 02110.

10. Defendant David Andrewes, M.D., ("Dr. Andrewes") of 16 Prouty Road, West Brookfield, Worcester County, Massachusetts, was at all times pertinent hereto a duly licensed physician in Massachusetts and, as the Medical Director of the jail, was the plaintiff's primary care physician. He was employed by Correct Care and/or WellPath at all times material to this complaint.

11. Defendant Katherine L.Van Zandt, NP, ("NP Van Zandt") of 17Wheelock Road, Shrewsbury, Worcester County, Massachusetts, was at all time pertinent hereto a duly licensed nurse practitioner in Massachusetts and was employed by Correct Care and/or WellPath.

12. Defendant Marth A. Fehr, M.D. ("Dr. Fehr") is a duly licensed physician in the Commonwealth who has a medical specialty in Neurology. She resides at 18 Ed. Clark Road, Hubbardston, Worcester County, Massachusetts. Dr. Fehr was employed at St. Vincent's at all times material to this complaint.

13. Defendant Venkateswara Rao Davuluri, MD ("Dr. Davuluri") is a duly licensed physician in the Commonwealth who has a specialty in internal medicine. He resides at 15 Aspen Road, Shrewsbury, Worcester County, Massachusetts. He was employed as an internist/hospitalist at St. Vincent's at all times material to this complaint.

14. Defendant Praveen Devineni, MD., ("Dr. Devineni") is a duly licensed physician in the Commonwealth who has a specialty in internal medicine. He resides at 5 Laurel Ridge Lane, Shrewsbury, Worcester County, Massachusetts. He was employed as an internist/hospitalist at St. Vincent's at all times material to this complaint.

15. Defendant Venababu Kandimalla, MD., ("Dr. Kandimalla") is a duly licensed physician in the Commonwealth who has a specialty in internal medicine. He resides at 8 Hickory Bend Road, Shrewsbury, Worcester County, Massachusetts. He was employed as an internist/hospitalist at St. Vincent's at all times material to this complaint.

16. Defendant VHS Acquisition Subsidiary Number 7, dba St. Vincent's is a duly organized corporation under the laws of Massachusetts with a usual place of business at 123 Summer Street, Worcester, Massachusetts.

17. Defendants John Doe 1, John Doe 2, John Doe 3, John Doe 4, and John Doe 5, are individuals, whose identities are at present unknown to the plaintiff, who at all pertinent times were employed by the Commonwealth as correctional officers at the jail.

18. Each individual defendant is sued in his or her individual capacity.

FACTS

19. Each preceding paragraph is incorporated in this section as if fully set for herein.

20. At all times material, Defendant Commonwealth's agency the Worcester County Sheriff's Office was responsible for maintaining and operating the Worcester County Jail and House of Corrections where it exercised custody of sentenced and pretrial inmates.

21. At all times material, Defendant Commonwealth acted through its employees, agents, or independent contractors.

22. At all times material to this complaint the WCSO executed contracts with private providers to provide medical and mental health services to inmates at the jail.

23. Correct Care was founded in 2003 and is currently owned by a private equity firm, H.I.G. Capital, a Miami based in Miami, Florida, an alternative assets investments firm with over $34 billion in equity capital under management.

24. Correct Care was at all times material to this complaint a healthcare company that provided healthcare services to US prisons, including immigrant-only prisons run by the GEO Group.

25. Correct Care entered into a healthcare contract to deliver medical and mental health services to Worcester County Jail inmates after the Worcester Jail terminated its health care contract with Naphcare, a private company based in Alabama that provided services to the Worcester County Jail.

26. Beginning July 2016, each medical provider defendant at the jail was employed by Correct Care, including Dr. Andrewes and NP Van Zandt.

27. As medical director of the WCSO and of Correct Care, Dr. Andrewes was responsible for establishing medical policies and treatment protocols for the treatment of incarcerated inmates.

28. At all pertinent times both Dr. Andrewes and NP Van Zandt were responsible for providing medical care to inmates in accordance with acceptable standards of nursing and medical care.

29. At all pertinent times WCSO medical policy 932.08, provided that inmates had the right to unimpeded access to health care. Under this policy inmates were entitled to receive medical care by making a written or verbal request.

30. At all pertinent times WCSO medical policy 932.09, entitled "Sick Call," it provided that "[a]cess to daily sick call is an inmate's right, not a privilege."

31. Policy 932.09 provided it was the jail's policy to give inmates "the opportunity to report medical illness or other health problems and to receive diagnosis or treatment ...on a daily basis."

32. Policy 932.10 entitled "General Health Care Services" provided that a "treatment plan shall be developed for each inmate house in the unit [the jail medical unit], and "the frequency of nursing and physician rounds shall be indicated on each inmate's treatment plan, but at a minimum of every 4 hours by qualified health care staff."

33. Under policy 932.10 the medical department under the direction of Andrewes was responsible to establish guidelines and procedures for continuity of health care and for special medical programs to include chronic care, medical preventative maintenance, management and care of communicable or infectious disease, detoxification of inmates, policies and procedures regarding informed consent and treatment.

34. Under policy 932.10 (G) Andrewes was required and responsible for developing a written plan for each individual inmate who is diagnosed with a communicable or infectious disease. According to policy the "treatment plan shall outline specific course of therapy for the individual management and care of the affected inmate.

35. Jail policy 932.20A (entitled AIDs Supervision, education and testing, hepatitis and communicable disease) was enacted for control of communicable diseases and supervision of inmates who carried or were reasonably suspected of carrying the AIDS virus (HIV) education and training of staff and inmates and confidential voluntary testing of inmates.

36. Mr. Ramey was incarcerated at the jail July 14, 2016, awaiting trial on charges of unarmed robbery and drug larceny.

37. Even though Correct Care, the Commonwealth, and defendants they employed knew Ramey suffered from chronic hepatitis C, no treatment plan was developed for him.

38. There is no indication in the medical record that during his incarceration of 2016 Mr. Ramey was offered any AIDS/HIV education as policy 932.20A required, nor any discussion with him about possible testing.

39. At all times material to this complaint Correct Care set the hours of work for NP Van Zandt and Dr. Andrewes and exercised control over their work and details of their employment.

40. The WCSO maintained a health care contract with Correct Care up until January 25, 2019.

41. Documents filed with the Massachusetts Secretary of State, Corporations Division, show that Correct Care Solutions, LLC changed its name to WellPath.

42. Correct Care Solutions now uses the name Wellpath. https://wellpathcare.com/

43. WellPath and Correct Care are names being used interchangeably.

44. All of the medical and nursing staff employed by Correct Care at the Worcester County Jail began receiving compensation through Defendant WellPath beginning January 25, 2019.

45. The change of corporate name from Correct Care to WellPath, was due in large part to an unsealed federal indictment of May 2017 in which federal prosecutors accused Texas State Senator Carlos Uresti of accepting substantial bribes from a company, Physicians Network Associates ("PNA"), acquired by Correctional Health Care Companies, which then merged with Correct Care Solutions in 2014.

46. According to the federal indictment in Texas, Senator Carlos Uresti received payments of $10,000 per month from PNA to ensure it kept its lucrative contract to provide medical care to prisoners at the Reeves County Detention Center (RCDC) in West Texas, *See, e.g.*, United States v. Uresti, U.S.D.CT (W.D. Tex.), Case No. 5:17-cr-00381-DAE.

47. Also indicted was PNA former President, Vernon C. Farthing, III, who stayed on the payroll of Correct Care, which claimed it was fully cooperating with the investigation.[1]

48. Defendants Dr. Andrewes and NP Van Zandt are sued in both their individual and official capacities as Medical Director and Nurse Practitioner at the WCSO on behalf of WellPath.

49. At all pertinent times Dr. Andrewes and nurse Van Zandt were under a contract with the Defendant Commonwealth to provide medical care, treatment and services to inmates at the WCSO including the Plaintiff.

50. At all times material, Dr. Andrewes was Mr. Ramey's primary care physician and such health care services as were provided to Mr. Ramey at the jail were provided by Dr. Andrewes personally or by others under his direction, supervision, and control.

51. At all times material, Dr. Andrewes and NP Van Zandt acted within the scope of their employment by Correct Care at the WCSO.

52. At all times material, Dr. Andrewes and NP Van Zandt acted under color of state law.

53. On or about July 14, 2016, a Correct Care employee conducted an intake physical of Mr. Ramey and learned he had complaints of headaches and a history of chronic hepatitis C without coma, epilepsy and mental disorders.

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[1] In February 2018, Uresti and a codefendant were found guilty. Uresti was sentenced to 12 years in prison in June 2018.

54. Correct Care staff also obtained medical records of Mr. Ramey showing he had a history of heroin abuse.

55. On July 15th Ramey was placed in a medical unit for inmates detoxifying from narcotics, benzodiazepines, or alcohol.

56. Beginning July 16 Ramey began to complain to nursing staff of headache; on July 19 he requested to see a doctor regarding "breakthrough seizures" and requested administration of an anti-epileptic drug, Gabapentin, an anti-epileptic drug; Dr. Andrewes and NP Van Zandt decided to taper him off this medication..

57. On August 9th Mr. Ramey was seen by Correct Care staff he complained of chronic headaches from multiple skull fractures.

Ramey's cryptococcal infection

58. Cryptococcosis is an important infectious disease globally, particularly among patients with defective cell-mediated immunity.

59. Human immunodeficiency virus (HIV) infection is the most significant risk factor.

60. The most common clinical presentation is cryptococcal meningitis (CM) with over 1 million cases and 600,000 death per year globally.

61. HIV infected patients are mainly at risk of cryptococcosis when they become highly immunosuppressed and their CD4 count – a measure of HIV-related damage – drops.

62. Immunocompetent patients are also susceptible to CM.

63. Patients who survive CM may have long-term sequelea related to the infection, such as local neurological deficits, blindness, deafness, cranial nerve palsies and memory deficits.

64. The initial clinical presentation manifestations of CM infection are highly variable.

65. Subacute headaches and confusion are common smptoms.

66. CM also presents with signs and symptoms typical of meningitis including fever, headache and neck stiffness.

67. Intracranial pressure is often elevated in CM victims and can cause cranial nerve palsies or seizures.

68. Classical features of meningism (e.g. stiff neck) occur in less than 20% of patients.

69. Altered mental status in CM patients is associated with higher mortality.

70. Ocular involvement occurs in almost 40% of cases of cryptococcosis and usually occurs as a result of intracranial involvement, e.g. raised intracranial pressure and or direct infiltration of the optic nerve.

71. Cranial neuropathies and opthalmoplegia are common complications in CM patients.
72. Forty percent of patients with CM have ocular involvement, including papilledema and chroioretinitis.

73. Immune optic nerve dysfunction and blindness have been reported as well.

74. Treatment and survival of CM consists of three phases: induction, consolidation and maintenance.

75. In the induction phase it is important to recognize the symptoms start the patient on potent fungicidal drugs because the rate of fungal clearance from the cerebrospinal fluid (CSF) during the first few weeks of treatment predicts survival and long term prognosis.

76. Infection from CM is usually lethal without treatment; prompt diagnosis and therapy improve a patient's chances.

77. On August 13th Mr. Ramey reported to nurse Heughins "I just don't feel right, I have been slurring my speech." Ramey also complained he was experiencing neurological symptoms including headaches for five (5) days and dizziness, and he also complained of left side paralysis, inability to move the left side of his face or to feel his face.

78. After being examined by Dr. Andrewes he was appropriately referred and transported to St. Vincent's by ambulance.

79. He was admitted to St. Vincent's from August 13 through August 16 after being seen and examined by Dr. Devineni.

80. A neurologist examined him and concluded he had chest pain, had not experienced a stroke and prescribed Gabapentin for him given his history of seizures. He was also diagnosed with atypical headaches.

81. His discharge note from St. Vincent's stated a diagnosis of atypical headaches and improved left sided numbness, and called for an outpatient follow-up examination with a neurologist by August 23, 2016.

82. Neither Dr. Andrewes nor NP Van Zandt scheduled a follow up appointment for Ramey as ordered by St. Vincent's physicians.

83. On August 16th Ramey was seen by Correct Care staff and by NP Van Zandt after complaining of 8/10 headache pain.

84. Mr. Ramey was examined by Dr. Andrewes on August 17th and was diagnosed with migraine headaches. He released Ramey from a medical unit to return to general population.

85. On August 17th Dr. Andrewes identified a neurological problem: "Flaccid hemiplegia affecting left nondominant side."

86. But the August 23 deadline for Mr. Ramey's follow-up examination by a neurological specialist came and went without the exam – nor, despite increasing indications of the need for it, was a neurological exam ordered subsequently.

Ramey's 1st fall

87. On August 23rd a nurse was called to examine Ramey regarding a fall – Ramey was sitting on his cell bed had an injury in his left eye area and stated he did not remember what happened except that he spilled coffee all over himself.

88. Ramey's ambulated unsteadily and was diagnosed in consultation with Van Zandt as "Ineffective health maintenance r/t Med watch d/x migraine.

89. Ramey was returned back to the medical unit to be placed under "close observation."

90. Van Zandt examined Ramey on August 23rd. She told Ramey that Gabapentin was not approved by the jail for migraine headaches.

91. Ramey told Van Zandt when he woke up from the floor he felt "like my head was about to explode" and was having left sided weakness, numbness and difficulties walking.

92. Although her motor testing of Ramey's extremities was abnormal, Van Zandt wrote-off and concluded Ramey was did not appear to use "full effort."

93. Van Zandt diagnosed Ramey with migraines and a fall but also concluded without any medical basis that Ramey was engaged in an "apparent medication seeking behavior. No diagnostic intervention needed at this time."

94. Ramey was told to notify nursing staff if he had any worsening symptoms (e.g. headaches, dizziness, focal neuro deficits, rashes, etc.)

Ramey's 2nd fall

95. On August 24d a nurse found Ramey crying loudly while on laying on his side stating "Please help me." Ramey said after reporting he had fallen and broken a tooth.

96. Ramey reported to the nurse neurological symptoms, staing:"I can't feel my legs."

97. Nurse Tedstone reviewed a WCSO surveillance tape and concluded as he walked he stumbled backwards slowly sliding down and lightly fell to the floor.

98. Ramey was "medically cleared" by a verbal order by Dr. Andrewes who spent some time with Ramey during the exam discussing whether he would prescribe him Gabapentin (Neurontin).

99. Although Gabapentin had been prescribed to Mr. Ramey by St. Vincent's doctors, Dr. Andrewes concluded the following: "Falls med seeking behavior."

Ramey's 3rd fall

100. On August 30th Mr. Ramey was examined by Nurse LeClair who noted he had trouble grabbing a medical cup in his right hand, poured medication into his mouth and then took a cup of Gatorade in the right hand and poured it down the front of his shirt. He told her "I don't know what I am doing with this hand."

101. The nurse attributed this lack of coordination to "infective health maintenance r/t falls and dehydration."

102. On that date Mr. Ramey also told a nurse practitioner he had left sided headaches, dizziness and left sided chest pain. Ramey told the nurse he fell in the morning, hit his head but did not tell anyone about it.

103. Mr. Ramey was moved to medical watch by order of NP Van Zandt and was given Tylenol 650 mg., Motrin 800 mg and Meclizine, an antihistamine prescribed to prevent nausea, vomiting and dizziness.

Ramey's 4th Fall

104. That night at approximately 11:19 pm, after being admitted to the Correct Care's medical unit, Mr. Ramey was sitting on an exam table and when he tried to stand fell to the floor, landing on his face. He was noted to be disoriented with slurred his speech and told staff he did not know what was happening to him and could not control his arm or hands.

105. After placed in a bed Mr. Ramey to cry stating: "I don't know what's wrong with me, I can't explain it."

106. Mr. Ramey was seen by Dr. Andrewes on August 31st. Despite plaint signs of neurological deterioration Dr. Andrewes wrote an assessment of "Falls and med seeking behavior."

107. An registered nurse concluded there was a problem with "ineffective health maintenance medical watch r/t falls and dehydration."

121. At that time Mr. Ramey described his pain in the range of 9/10.

122. On September 4th, frustrated with the lack of care and repeated his nonsensical reference to diabetes, telling a nurse, "I am all set, I am not even a diabetic."

123. On September 5th he again refused to have his vitals taken and told nursing staff "no I just want my meds."

124. No vitals were obtained on September 6th for the same reason.

125. On afternoon of September 6thNP Van Zandt saw Mr. Ramey, who remained on medical watch for observation due to falls and dehydration.

126. He told NP Van Zandt he could not hear, that everything was ringing, complained of dizziness and said, according to her note, "What. I can't hear you, what did you say."

127. NP Van Zandt wrote that as she entered his cell Mr. Ramey "immediately crosses his eyes and state the same that he is dizzy and cannot hear me. Per officers pat[ient] was able to ambulate to shower w/o difficulty also seen earlier crossing his eyes when spoken to. Pt activity moving all extremities no obvious deficits noted. Does not allow in depth neuro exam…"

128. NP Van Zandt's assessed Mr. Ramey's condition with gross deliberate indifference, writing, "Report of Falls and dehydration medication seeking behavior."

129. No one at the jail, including NP Van Zandt or Dr. Andrewes took Ramey's complaints seriously. With no medical basis they chose to interpret variable waxing and waning symptoms as malingering, i.e. that he was faking symptoms in order to get Gabapentin.

130. During the early morning hours of September 7th an LPN nurse found Ramey lying on the floor of his cell and he told her he could not get up and step to the door for his medications.

131. After correctional helped him to his bunk he was unable to answer any questions follow directions but said "I can't hear or see anything."

132. The nurse wrote Ramey's right eye appeared to be crossed inward and his left pupil was fixed and dilated. His hand grip was weak on both hands and he was so debilitated he could not push against the nurses hands.

133. Mr. Ramey shouted "Help me. I need help, something is wrong." Another nurse who was present confirmed that Ramey's right eye was different from his baseline.

134. Once again Mr. Ramey's pulse rate was abnormal, 118 BPM.

135. An LPN notified Dr. Andrewes, who authorized an advanced life support ambulance to transport Ramey for further evaluation at St. Vincent's.

136. Dr. Andrewes' referral to St. Vincent's on a Correct Care Solutions Form said nothing about Ramey's alleged medication seeking behavior. Instead the referral identified Ramey's decreased hearing, decreased vision – his left pupil fixed and his right eye "crossed inwards pt. has a history of seizure onset unknown if pt. sustained a head injury."

137. Notes of the Paramedics who transported Mr. Ramey indicate that "(medical) states pts. Left eye also crooked. Pt. also complaining of chest pain, neck pain. Pt. also states he has been falling a lot lately. . . Pt. in medical watch bay due to falls."

138. An EKG conducted by the paramedics was abnormal and was suggestive of an abnormal sinus rhythm and a sinus tachycardia.

139. The emergency room examination of Mr. Ramey at St. Vincent's recognized he had significant and abnormal changes in his electrocardiogram, possibly consistent with ischemia. Although Mr. Ramey reported not being able to hear and having his right eye crossed based on information from the jail the ER doctor concluded head trauma was self-inflicted and his crossed eye was volitional.

140. Mr. Ramey was admitted to St. Vincent's by internist Venkateswara Davuluri (Dr. Davuluri) an internist/hospitalist employed by St. Vincent's.

141. Dr. Davuluri who was aware of Ramey's falls, hearing loss and visual loss, diagnosed Mr. Ramey with atypical migraines, and with atypical neurological signs, left sided weakness and chest pain.

142. Although Ramey's clinical presentation involved a neurological problem Dr. Davuluri did not order a neurology consultation on STAT basis (e.g. on rush or urgent basis).

143. A brain MRI showed no infarction but noted two white matter changes.

144. Because of his abnormal sinus rhythm, Ramey was referred for consultation with Dr. Wholey' an interventional cardiologist at St. Vincent's, who obtained Mr. Ramey's signature on a consent form for a cardiac catherization in order to evaluate for possible coronary artery disease.

145. On September 8th defendant internist Praveen Devineni examined Mr. Ramey who complained reiterated his earlier neurological complaints of left sided headaches, vision problems, difficulty hearing, and recurrent falls.

146. Dr. Devineni's ocular exam of Ramey noted a slight abnormality in the position of the right eye.

147. Mr. Ramey's ocular symptoms at the time of his admission were consistent with increased intracranial pressure from CM.

159. Dr. Fehr knew that CM, a type of meningitis, was a life threatening medical condition requiring immediate intervention to save the patient's life and to prevent or mitigate substantial disability.

160. She also knew that if she suspected one or more life threatening conditions in her patient, it would be impermissible under applicable standards of care to act, or not to act, based on the premise of a more benign diagnosis without ruling out the more serious conditions.

161. Dr. Fehr knew at the time she treated Ramey that prompt detection was key to improving clinical outcomes and survival in patients with meningitis.

162. Despite suspecting meningitis on September 8th Dr. Fehr did not ask for a consultation with an infectious disease doctor; nor did she push for the ophthalmology exam that she knew would likely be revealing as to the existence or non-existence of a meningeal infection.

163. Instead she adopted a plan to obtain a brain MRI and, if the MRI was negative, to then "do a lumbar puncture. Also check acetylcholinesterase antibodies TSH, CPK, sedimentary rate, PRP, ANA rheumatoid factor."

164. The purpose of the lumbar puncture was to rule out or reveal meningitis or any of its variants, including CM.

165. If CM or another variant of meningitis is suspected in a patient lumbar puncture to obtain and test spinal fluid is the preferred diagnostic approach.

166. But Dr. Fehr knew when she treated Mr. Ramey that there were other less invasive diagnostic techniques for detecting CM, including a Cryptococcal Antigen Flow Assay (CRAG LFA).

167. Ramey's medical record from St. Vincent's contain a similar medical consent form to the one used for his cardiac catherization.

168. The consent form for spinal tap, while undated, appears to have been circulated on September 8, 2016.

169. But unlike the consent form for cardiac catherization which Mr. Ramey had previously signed, the consent form for a "Spinal Tap" did not bear the signature of Dr. Fehr or even Ramey's name.

170. The blank consent form did not list risks or benefits of, or alternatives to, the procedure, nor did it explain reasons for the necessity of a Spinal Tap or lumbar puncture, i.e. that failure to diagnose and treat could lead to severe neurological sequelea or death.

171. Indeed, there is no written indication as to whether Mr. Ramey refused the spinal tap or failed to sign the form for any other reason.

172. On September 9 Ramey was seen at the hospital by physician assistant Heather Mortell at 5:15 am in the morning for a complaint that he had fallen while walking to the bathroom.

173. That same morning Dr. Devineni saw Mr. Ramey and realized that the eye exam was abnormal - - Ramey's right eye was deviant. He also had pustules on his right arm.

174. Ramey was also seen by hospitalist Dylan Vendryes, M.D., who requested an eye consultation with ophthalmologist Alan Moss as well as an audiology consult.

175. On September 10 at 0215 hours in the morning by Dr. S. Abraham, a medical resident, observed that Mr. Ramey was not communicating. She tried to speak with him, but he said only "Please help me," started crying and did not communicate further.

176. On September 10th Dr. Kandimalla saw Mr. Ramey and also noted an abnormal eye exam, the left eye with no lateral movement, and the right eye was deviated inward.

177. Given Dr. Fehr's neurological assessment and the abnormal ocular findings, Dr. Kandimalla also knew or should have known that he had to assume that Ramey had meningitis until proven otherwise.

178. According to Dr. Kandimalla Ramey refused a lumbar puncture.

179. Dr. Kandimalla diagnosed Ramey with atypical migraine, noted that he would not give him more pain medication and would discharge him back to jail if he continued to refuse a lumbar puncture.

180. Dr. Kandimalla did not order an infectious disease consult or inquire about why Ramey had not had an ophthalmology exam as was requested upon his admission.

181. On September 11, when Ramey was examined by the hospital medical team, he continued to complain of deafness, worsening eyesight and neck pain, an ominous sign of meningitis, and spoke incoherently at one point weeping as he asked "Am I a bad person? I don't know."

182. According to the progress note from this exam Mr. Ramey was not able to decide about having a spinal tap.

183. The record does not show any further offer of a consent form for the spinal tap explaining the need, benefits, or risks of the procedure.

184. Members of the team requested an additional consultation by Dr. Fehr.

185. Dr. Fehr saw Ramey during her morning rounds on September 11. The exam note has two perfunctory written entries, "Communication difficult pt. refusing LP would repeat MRI with contrast if negative may need to get outside permission for LP."

199. There was no medical justification for Dr. Kooper to have concluded Ramey was malingering.

200. On September 12th at 6:08 pm a Brain MRI scan requested by Dr. Kandimalla had to be aborted because Ramey was unable to follow directions and was at risk of falling from his stretcher due to "pt. confusion/uncooperative.

201. On September 13th Dr. Fehr saw Mr. Ramey briefly at approximately 2pm, 48 hours after her September 11th exam.

202. This time Dr. Fehr found Ramey to be somnolent but "arousable."

203. She noted Ramey "Remains uncooperative when he opened his eyes they were conjugate with no deviation of the right eye. Pupils equally dilated and reactive. Corneal present. Face symmetric. Impression: "altered mental status of unclear etiology difficult to tell what is real and what may be malingering the early objective finding was the ocular palsy and today became better on my limited exam: Recommend still try to obtain LP if not possible would return patient to jail."

204. Dr. Fehr knew that presenting clinical symptoms for CM or and other meningitis variants are typically indolent and protracted, with symptoms waxing and waning for weeks.

205. But because Dr. Fehr knew that because Ramey was as a prisoner she could have contacted the jail and obtained authorization for the spinal tap i.e.. on September 11 Dr. Fehr wrote in a St. Vincent's progress note "Repeat MRI with contrast if negative may need to get permission for LP."

206. Dr. Fehr was grossly negligent by not calling the WCSO for the consent of the Deputy Supt. In charge of medical care, and by failing to insist the aborted brain MRI originally scheduled for September 12 be rescheduled on a STAT basis.

207. She was also grossly negligent by failing to insist on a renewed Opthalmology consult (e.g. she thought earlier there was an objective ocular palsy finding "and today became better on my limited exam").

208. On September 13 Mr. Ramey was also examined by Dr. Kandimalla and his residents. Team notes state Ramey continued to complaint of poor vision, hearing loss, and was "is noted to hear at times Even the eye palsy looks normal at times."

209. One of Kandimalla's internal medicine residents, Nimy John, suggested and scheduled Ramey for an Opthalmology consult with Dr. Joanne Haney-Tilton due to "acute vision loss."

210. During the exam Ramey complained of not being able to see or hear and told Dr. Kandimalla "Not my fault" when he was informed that the psychiatrist "thinks u are faking."

211. Dr. Kandimalla confirmed Ramey's "right eye with conjugate on waking from sleep afterwards nasal deviation?" "Conjugate" means a deviation to the right and a temporay palsy.

212. Dr. Kandimalla agreed with his residents and continued to conclude that Ramey's diagnosis was that of recurrent falls PMH anxiety, PTSD, atypical migraine? Seizure v. pseudoseizures, s/p consult with Dr. Fehr", "Lumbar puncture couldn't see enough to obtain, Psych consult ? Malingering."

213. Dr. Kandimalla's clinical thought process was also infected by Dr. Kooper's finding of malingering. The mere consideration of "Seizure v. pseudoseizure" suggests suspicion of malingering i.e., pseudoseizure is a type of nonepileptic seizure that results from psychological conditions rather than a brain function.

214. However, Dr. Kandimalla's "Attending note" states: "As above [resident evaluation] I have seen and examined the patient and agree with evaluation plan to with Opthalmologist & ENT **RISK MANAGEMENT**." (Emphasis supplied).

215. But the ophthalmology consult was not requested on a STAT or rush basis even when Dr. Kandimalla recognized there was a serious medical diagnostic issue sufficient to report the case of Mr. Ramey to Risk Management on September 13.

216. A complete blood count ordered of Ramey on September 13 demonstrated he had an elevated white blood cell count of 14.7. His elevated WBC was indicative that his immune system was fighting an infection.

217. On September 14th at approximately 0051 hours, nursing notes entered in the St. Vincent's electronic record (Kardex) show Ramey was extremely drowsy and unable to follow commands (due to) loss of hearing and loss of sight.

218. Ramey's pupils were equal and round 3+ and sluggish and Ramey continued to be surrounded by the correctional officers from the WCSO.

219. Without a doubt, Ramey was already in the throws of experiencing altered mental status. Nurses found he was also incontinent of urine and had poor food intake.

220. In addition, Ramey's blood pressure was running high and they were planning to start him in the morning with blood pressure medication.

221. Ramey's alarming clinical presentation should have been sufficient to get an MRI on a STAT basis and an infectious disease consult. But the Team notes were also infected by Dr. Kooper's poison pill, "Psych believes complaints are behavioral in nature. Pt. remains on bedrest for tendency to throw himself onto the ground."

222. The morning rounds and team progress notes from September 14th document Ramey's rapid deterioration, "pt. not eating since yesterday" "stilled altered [mental status]" "vision loss and decrease vision."

223. The residents/Team Progress notes demonstrate that Ramey belonged in an intensive care unit and not in a regular unit:
    - The team learned the ophthalmologist was scheduled to see him;
    - That an ENT consult was in place
    - That Ramey's neck was positively stiff and he showed a positive Kearning test (e.g. a test positive for the inflammation of the meninges that is conducted when meningitis is suspected)

224. Members of the internal medicine team held backon transferring Mr. Ramey to a more acute unit because they were aware Ramey had been evaluated by "Dr. Fehr [who] was not sure whether the patient is malingering wants MRI brain contrast."

225. The attending doctor supervising the internal medicine residents agreed with the plan noting "Pt. does not interact He can't 'hear' He cannot see."

226. On September 15, at 12:15 pm. Ramey was examined by ophthalmologist Joanne Hanney Tilton who noted he was "not verbal."

227. Dr. Hanney-Tilton had alarming objective findings from this examination: Mr. Ramey's retina was dilated, had optic nerve edema, swelling, and pressure elevation causing her to diagnose "Optic Neuritis on unclear cause."

228. Dr. Hanney-Tilton enumerated possible diagnoses that explained Ramey's clinical presentation: "MS [multiple sclerosis], infections, medication. I am very concerned about infection given his lack of responsiveness."

229. Dr. Hanney-Tilton suggested in her medical plan: "Lumbar puncture to rule out infectious process."

230. On September 14th at 1:30 pm Dr. Fehr contacted the WCSO and obtained consent from the Jail Deputy Superintendent in charge of the medical department, David Tuttle – who signed the consent form on behalf of Mr. Ramey.

231. At 5 pm Mr. Ramey was examined by St. Vincent's ENT specialist, Joseph Sidari, M.D., who noted altered mental status and acute hearing loss.

232. Dr. Sidari found Mr. Ramey somnolent and was not able to elicit any history from him.

233. He concluded Ramey's hearing loss "could be due to central [nervous system] etiology" and that he was deferring to a neurology recommendation for treatment of cerebrospinal fluid infection.

234. Progress notes from St. Vincent's document that Dr. Fehr examined Mr. Ramey on September 14th at 5:40pm. And wrote: "LP [lumbar puncture] obtained via the jail also done on an emergency basis r/o infection. Several attempts at 2 levels made with no scissors patient then placed in a seated position success achieved in that period 12 cc was removed for analysis before CSF stopped flowing fluid was clear colorless."

235. A September 14th addendum prepared by internal medicine shows that Ramey's cerebrospinal fluid had abundant white blood cells and yeast and he was "started empirically on vancomycin + ceftriaxone + fluconm? As per Dr. Imola Daniel Infect. Disease."

236. Once it was confirmed that Mr. Ramey had CM he received Amphotericin B intravenously-- a powerful antifungal medication that fights fungal infections.

237. But instead of immediately being transferred to intensive care or to the UMass Memorial Medical Center, Mr. Ramey remained on a regular floor at St. Vincent's.

238. The St. Vincent's nursing Kardex file documents that on September 14 at approximately 11pm Mr. Ramey became restless in his bed thrashing his arms and legs, causing staff to order restraints.

239. His pupils became sluggish and slow to respond to stimuli. He was confused "moaning at times, unable to follow commands" and was kept on seizure precautions.

240. Ramey continued to be incontinent of urine and was sedated with antipsychotic medication.

241. It was not until September 15 at 1:00 am that STAT testing was ordered for blood work, electrocardiogram and other tests.

242. At 1:25 am Ramey's developed premature ventricular contractions, his heart rate ranged between 140 and 170 and his oxygen saturation dropped and he became bradycardic.

243. At 1:47 am an emergency code blue was called after Mr. Ramey's blood pressured dropped, his tongue became swollen and he went into cardiac arrest.

244. After 5 minutes of CPR (4 cycles) staff managed to obtain spontaneous circulation (ROSC).

245. At 2:14 am Ramey was transferred to the St. Vincent's intensive care unit (ICU).

246. Later on Sept. 15 Dr. Fehr saw Mr. Ramey and confirmed Ramey his spinal fluid was positive for cryptococal meningitis.

247. Her exam documented his dilated pupils, papilledema (swelling of the head of the optic nerve, a sign of increased intracranial pressure), his cranial nerves were absent, his reflexes were absent and his sensory motor exam found no movement in response to painful stimuli in any of extremities.

248. A Brain MRI without contrast was demonstrated a complete loss of sulci (the grooves in between the folds of the brain), compression of the ventricles, hyperdensity of the tentorium (cerebellum), and effacement of the brain cisterns.

249. None of these conditions was evident on Mr. Ramey's previous MRI of September 8th .

250. Dr. Douglas Burd, neuroradiologist at St. Vincent's, found the new MRI results indicative of global ischemia and edema, i.e., a lack of blood flow in the brain.

251. Early hernation was also a concern identified by Dr.Burd because Ramey's cerebellar tonsils were lower than previously seen.

252. On September 15th medical staff consulted Imola Daniel, an infectious disease doctor at St. Vincent's regarding Mr. Ramey's CM diagnosis.

253. Dr. Daniel opined "As the patient comes from jail without history of immunosuppressive condition it is highly likely that he might have AIDs."

254. Dr. David Sommer a neurologist who examined Ramey on September 16 found Mr. Ramey had succumbed to brain death in the setting of CM and precipitous decline after the administration of amphotericin B. "[I]t is possible that he had an allergic reaction to amphotericin B which was part of the decline in the ___ of cerebral edema in the setting of resuscitation. It is not clear nor do I think we will ever be able to clarify completely to what extent his ultimately fatal cerebral edema was due to the underlying cryptococcal infection vs. possible reaction to amphotericin B vs. the effects of resuscitation."

255. Ramey's death certificate states he died from complications of cryptococcal meningitis and cryptococcal fungemia.

256. From mid- August 2016 until the time of his death Ramey suffered from a serious life threatening condition.

257. All defendants negligently breached their duty to Ramey by failing to provide adequate care and medical treatment to him.

258. The conduct of the St. Vincent's Defendants in failing to evaluate, test, diagnose and treat the Plaintiff's medical condition constituted a reckless or conscious disregard of the medical risks to Mr. Ramey.

259. During his confinement at the Jail, Mr. Ramey had an evident serious medical need for rigorous evaluation of a constellation variable and progressing neurological symptoms,

including altered mental status, a calling card of serious neurological disorder. The defendant members of the jail medical staff were aware of the symptoms, yet they deliberately and recklessly refused to provide the medical evaluation and care essential to his well being, resulting in the needless and extended suffering of Mr. Ramey, and ultimately to his awareness of impending death and his final demise.

260. The conduct of the Correct Care Defendants in failing to evaluate, test, diagnose and treat the Plaintiff's medical condition constituted a reckless or conscious disregard of his serious medical needs and imminent risk to his well being and his life.

261. Each defendant owed a duty to Mr. Ramey provide him adequate medical care and treatment.

262. Each individual defendant negligently breached his or her to Mr. Ramey by failing to provide him adequate care and medical treatment in accordance with acceptable standards of care.

263. Correct Care and its employee defendants knowingly engaged in a pattern and practice of failing to provide adequate and necessary medical care to inmates at the jail, including the Plaintiff. The individual Correct Care defendants acted and failed to act in this manner in obedience to the policy, practice, and usage of their employer, Correct Care.

264. The defendants engaged in a pattern and practice of failing to provide adequate and necessary care to Ramey by failing to provide appropriate physical examinations and clinical assessments.

265. Correct Care and its employee defendants acted in a grossly negligent manner, with deliberate indifference and/or with reckless disregard to Ramey's serious medical needs when they knew or should have known that he was at risk of serious medical harm.

266. Correct Care and its employee defendants violated Ramey's clearly established right to be free from deliberate indifference to his serious medical needs and well-being.

267. The Defendants' actions and failures to act resulted in unnecessary pain and suffering of Mr. Ramey.

268. Dr. Andrewes acted with deliberate indifference, failed to adequately train, supervise and discipline the medical personnel at the Jail, and the inadequate medical treatment of Mr. Ramey and its ultimate outcome were imminent, obvious and foreseeable risks of this conduct.

269. Dr. Andrewses acted and failed to act with deliberate indifference in not adequately supervise NP Van Zandt and other nurses working for Correct Care and the inadequate medical treatment of Mr. Ramey and its ultimate outcome were imminent, obvious and foreseeable risks of this conduct.

270. At all pertinent times up to and including September 13, 2016, Mr. Ramey was fully aware of his extremely painful and profoundly distressing neurological symptoms.

271. At all pertinent times up to and including September 13, 2016, Mr. Ramey was fully aware that despite short-term variability his symptoms were progressively worsening over time.

272. At all pertinent times up to and including September 13, 2016, Mr. Ramey was fully aware that some of his treating or consulting doctors and, and some of the other providers responsible for his medical care, believed him to be faking his symptoms.

273. At all pertinent times up to and including September 13, 2016, Mr. Ramey was fully aware that all the doctors and providers responsible for his care knew that some of their number had stated opinions that he was faking his symptoms, and Mr. Ramey knew of none – if there were any – who rejected or discounted such purported medical opinion.

274. At all pertinent times up to and including September 13, 2016, Mr. Ramey was fully aware that he was suffering from an extremely painful, distressing, and progressively disabling medical condition that was not being treated and that was worsening.

275. Prior to and including September 13, 2016, Mr. Ramey was subjected to great physical and mental pain and suffering, anxiety, anguish, and awareness of impending death.

276. On September 14, 2016, until his final loss of consciousness on or before the early morning of September 15, 2016, Mr. Ramey was subjected to great physical and mental pain and suffering, agony, anguish, and awareness of impending death.

277. On September 15, 2016, the members of Mr. Ramey's immediate family received their first notice of his hospitalization and converged at his bedside. At that time and place, and on the following day, they viewed Mr. Ramey's comatose condition on a ventilator, and doctors briefed them regarding diagnostic scans and empirical tests demonstrating the absence of brain activity and catastrophic, irreversible harm to the brain secondary to hypoxia and herniation.

278. On September 16, 2016, with the family's consent, life support was removed and Mr. Ramey died in the presence of his mother Donna Ramey, his father Michael J. Ramey, his sister Laurie Arria, sister Jennifer Truman, sister Kerri Joyce, and other members of his extended family.

COUNT I
Civil Rights 42 U.S.C. §1983 and Eight Amendment Claim
vs. Correct Care, Dr. Andrewes, NP Van Zandt

279. Each of the previous paragraphs is incorporated as if fully set forth herein.

280. The conduct of the Defendants, all performed under color of state law, denied the Plaintiff of his rights under the Eighth and/or Fourteenth Amendment to the Constitution of the United States, in violation of the Civil Rights Act of 1966, as amended, 42 U.S.C. §1983.

281. The Defendants were deliberately indifferent to Ramey's serious medical needs.

282. The conduct of the Defendants, alleged above, includes but are not limited to:

a. Failing to train and supervise staff to evaluate and treat life threatening medical conditions;
b. Failing to promulgate or implement procedures for the timely and adequate evaluation of inmates' medical conditions;
c. Failing to promulgate or implement policies and procedures for the care and treatment of life threatening conditions;
d. Failing to require staff to consult with physicians for treatment of life threatening medical conditions;
e. Failing to require physicians to examine inmates with life threatening medical conditions;
f. Failing to insure proper review of inmates' medical records;
g. Failing to provide medical care when requested by inmates;
h. Restricting emergency and/or hospital treatment for reasons unrelated to proper clinical care; and
i. Failing to provide properly qualified staff in adequate numbers to respond to inmates serious medical needs and life threatening conditions at all times, including weekends and nights;
j. Failing to treat infectious and communicable diseases of inmates
k. Failing to diagnose Ramey's condition and instead concluding he was malingering or engaging in medication seeking behavior.

283. As a direct and proximate result of the Defendants' conduct, Ramey suffered harm and the damages alleged herein

WHEREFORE, Plaintiff demands judgment against the Defendants for all losses sustained as a result of their misconduct, including but not limited to compensatory damages, interest, costs and attorneys' fees, and judgment for punitive damages.

COUNT II
Medical Malpractice/Wrongful Death
vs. Correct Care, Dr. Andrewes and NP Van Zandt

284. Each of the previous paragraphs is incorporated as if fully set forth herein.

285. The Defendants had a duty to provide adequate and reasonable medical care to the Plaintiff.

286. The Defendants failed and neglected to provide adequate and reasonable medical treatment to the Plaintiff and failed to meet the standard of care in her care and treatment.

287. As a direct and proximate result of the Defendants negligence Ramey suffered harm and the damages alleged herein.

WHEREFORE, Plaintiff demands judgment against the Defendants for all losses sustained as a result of their misconduct, including but not limited to all allowable compensatory damages, interest, costs and attorneys' fees, and judgment for punitive damages.

COUNT III
Negligent Failure to Supervise
vs. Dr. Andrewes

288. Each of the previous paragraphs is incorporated as if fully set forth herein.

289. As medical director of the Jail, and medical director of Correct Care, Andrewes had the duty to train and supervise her medical staff, including but not limited to her physician assistant, Defendant Van Zandt and other nurses.

290. The Defendant Somers negligently failed to train and supervise her medical staff, including but not limited to her physician assistant Defendant Titus.

291. The Defendant Andrewes negligently permitted the Defendant Van Zandt to exceed the scope of her authority to practice as a nurse practitioner as provided by the laws and regulations of the Commonwealth.

292. As a direct and proximate result of the Defendant Andrewes' negligence, the Ramey suffered harm and the damages alleged herein.

WHEREFORE, Plaintiff demands judgment against the Defendant for all losses sustained as a result of their misconduct, including but not limited to all allowable compensatory damages, interest, costs and attorneys' fees, and judgment for punitive damages.

COUNT IV
M.G.L.c . 258
vs. the Commonwealth of Massachusetts

293. Each of the previous paragraphs is incorporated as if fully set forth herein.

294. The Defendant Commonwealth negligently hired, supervised, contracted for medical services or maintained health care services provided to inmates at the Jail.

295. The Defendant Commonwealth is legally responsible for the conduct and acts of its agents or employees at its agency the Worcester County Sheriff's Office in the care and treatment of the Plaintiff during the period of his incarceration as alleged in the Complaint.

296. On or about September 13, 2018 Plaintiff gave notice and presentment under the Massachusetts Torts Claim Act by letter sent certified mail return receipt request.

297. Plaintiff complied with all conditions precedent under the Massachusetts Tort Claims Act and the Commonwealth did not resolve or compromised the claim.

WHEREFORE, the Plaintiff demands judgment against the Commonwealth for all allowable compensatory damages, interest and costs.

COUNT V

Malpractice/Wrongful Death

vs Acquisition Subsidiary No. 7 (St. Vincent's Hospital), Martha Fehr, Md, Venkateswara Rao Davuluri, Md, Praveen Devineni, M.D., Venababu Kandimalla, M.D.

298. The preceding paragraphs are hereby incorporated as if fully set forth herein.

299. At all times material hereto, the above captioned St. Vincent defendants represented themselves to be knowledgeable, competent, skilled and qualified to care for Ramey's medical condition and to treat or refer her for treatment as appropriate.

300. The defendants rendered medical care and treatment to the plaintiff, patient, so negligently, carelessly, grossly negligently and without due regard for the plaintiff's health and well-being as to injure her and cause her great harm and pain of body and mind.

301. Ramey's injuries were the direct and proximate result of the carelessness, unskillfulness, negligence, and gross negligence of defendants' in one or more of the following respects:

- The misrepresentations by the defendants to plaintiff as to the knowledge, skill and competence of the defendants in nursing and medicine;
- Defendants' failure to provide appropriate medical/nursing care;
- The failure of the defendants' to possess and exercise the degree of skill, training and care as is or should be possessed and exercised by the average qualified member of the medical/nursing profession practicing their specialty;
- The failure of the defendants' to recognize or to have knowledge to recognize their inability and lack of skill to treat the plaintiff, when they knew or should have known of the foreseeable consequences of his inability and failure to properly and skillfully provide the plaintiff with acceptable medical/nursing care and treatment;
- At all times material to this complaint Defendants Fehr, Davuluri, Fehr, Devineni and Kandimalla were agents, servants and employees of St. Vincent's.

WHEREFORE, Plaintiff demands judgment against the Defendants for all losses sustained as a result of their misconduct, including but not limited to all allowable compensatory damages, interest, costs and attorneys' fees, and judgment for punitive damages.

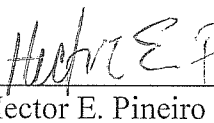
DEMANDS FOR RELIEF

The Plaintiff respectfully requests the following relief:

1. All compensatory damages recoverable;
2. All punitive damages recoverable;
3. All attorney's fees, costs and expenses allowable;
4. That the defendants be held jointly and severally liable;
5. Any and all other relief as the Court deems just and proper.

THE PLAINTIFF DEMANDS A TRIAL BY JURY.

THE PLAINTIFF
By Her Attorneys



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DATED: September 9, 2019

COMMONWEALTH OF MASSACHUSETTS

WORCESTER, ss

SUFFOLK SUPERIOR COURT
CIVIL ACTION NO.:

LAURIE ARRIA, ADMINISTRATRIX ESTATE OF MICHAEL J. RAMEY

Plaintiff

v.

CORRECT CARE SOLUTIONS, LLC, its successor company WELLPATH, LLC., COMMONWEALTH OF MASSACHUSETTS, DAVID A. ANDREWES, M.D., KATHERINE VAN ZANDT, NP., VENKATESWARA RAO DAVULURI, MD. VHS ACQUISITION SUBSIDIARY NUMBER 7, dba ST. VINCENT'S HOSPITAL, MARTHA FEHR, M.D., PRAVEEN DEVINENI, M.D., VENABABU KANDIMALLA, M.D., CORRECTIONAL OFFICERS JOHN DOE 1-5,

Defendants

PLAINTIFF'S REQUEST FOR APPOINTMENT OF PROCESS SERVER
[Mass. R. Civ. P. 4 (c)]

Now come the plaintiff and as per Massachusetts Rule of Civil Procedure 4 (c) she requests this Honorable Court to appoint as process server in this action a constable of the Office of George & Associates, 390 Main Street, Suite 1039, Worcester, Massachusetts, in order to assure a substantial savings in time. The undersigned affirms under the pains and penalties of perjury that to the best of his knowledge and belief the person to be appointed is a Constable experienced in the service of process and not a party to, or otherwise interested in, this action.

Respectfully submitted,

Respectfully submitted,
PLAINTIFF
By her attorneys,

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DATED: September 9, 2019

COMMONWEALTH OF MASSACHUSETTS

WORCESTER, ss

SUFFOLK SUPERIOR COURT
CIVIL ACTION NO.:

LAURIE ARRIA, ADMINISTRATRIX ESTATE OF MICHAEL J. RAMEY

Plaintiff

v.

CORRECT CARE SOLUTIONS, LLC, its successor company WELLPATH, LLC., COMMONWEALTH OF MASSACHUSETTS, DAVID A. ANDREWES, M.D., KATHERINE VAN ZANDT, NP., VENKATESWARA RAO DAVULURI, MD. VHS ACQUISITION SUBSIDIARY NUMBER 7, dba ST. VINCENT'S HOSPITAL, MARTHA FEHR, M.D., PRAVEEN DEVINENI, M.D., VENABABU KANDIMALLA, M.D., CORRECTIONAL OFFICERS JOHN DOE 1-5,

Defendants

UNIFORM COUNSEL CERTIFICATE FOR CIVIL ACTIONS

I am an attorney of record for the plaintiff in the above entitled matter.

In accordance with Rule 5 of the Supreme Judicial Court Uniform Rules on Dispute Resolution, (SJC Rule 1:18) which states in part, ". . . Attorneys shall: provide their clients with this information about court-connected dispute resolution services, discuss with their clients the advantages and disadvantages of the various methods of dispute resolution, and certify their compliance with this requirement[,]" I hereby certify that I have complied with this requirement.

Héctor E. Piñeiro

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DATED: September 9, 2019