UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION

CASE NO.

CYNTHIA MURPHY, as the
Personal Representative of the
Estate of Tristin Murphy, on behalf
of the Estate, and his Survivors,

Plaintiff,

vs.

FLORIDA DEPARTMENT OF
CORRECTIONS, an agency of the
State of Florida; and PATRICIA BANCHS,
in her individual capacity;

Defendants.

____

COMPLAINT and JURY DEMAND

Plaintiff, Cynthia Murphy, as the Personal Representative of the Estate of Tristin Murphy, on behalf of the Estate and his Survivors, sues Defendants, the Florida Department of Corrections (FDC) and Patricia Banchs, and alleges as follows:

PRELIMINARY STATEMENT

1. Tristin Murphy entered the custody of the FDC in the throes of a mental health crisis. During his initial psychological assessment, he was actively psychotic, delusional, and hallucinating. He had been previously diagnosed with schizophrenia, was prescribed psychotropic medications, and had attempted suicide in the past. But rather than immediately assign him to the intensive level of care that he obviously needed—such as an inpatient mental health unit—he was placed in the general population. Predictably, FDC staff at South Florida

Reception Center (SFRC) failed to provide him with his medications, failed to ensure he received a follow-up psychiatric appointment, and then inexplicably assigned him to a work squad where he had access to dangerous equipment. Tragically, on his first day of that detail, and just a year and half away from his expected release date, Tristin severed his own neck with a chainsaw and died.

2. Sadly, these critical failures in protecting incarcerated people with serious mental illnesses are commonplace at SFRC. A series of audits by the Correctional Medical Authority, an oversight body, has identified serious deficiencies in the treatment of those with mental illness. To this day—nearly two years after the first audit—SFRC is still not in full compliance with these standards, putting all incarcerated people with mental illnesses at substantial risk of serious harm.

3. Tristin leaves behind a wife, two children, a mother, and a father who had hoped to welcome him home after his short sentence. Plaintiff Cynthia Murphy, Tristin's mother and the Personal Representative of his Estate, seeks damages under state and federal law for the tragic and untimely death of her son.

JURISDICTION AND VENUE

4. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 in that this is a civil action arising under the Constitution of the United States and federal law.

5. Jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1343(a)(3) in that this action seeks to redress the deprivation, under color of state law, of rights secured to the Plaintiff by the Constitution and laws of the United States.

6. This Court has supplemental jurisdiction over the state law claims pursuant to 28 U.S.C. § 1367.

7. Venue lies in the Southern District of Florida pursuant to 28 U.S.C. §1391(b). The Defendants are located in this District and all of the acts and omissions complained of herein occurred and will continue to occur in the Southern District of Florida.

8. Plaintiff has complied with all applicable pre-suit notice provisions of Section 768.28, Florida Statutes.

PARTIES

9. Plaintiff Cynthia Murphy is the duly appointed Personal Representative of the Estate of Tristin Murphy, having been appointed Personal Representative by the Probate Division of the Circuit Court in and for Charlotte County, Florida, File No. 21001221CP.

10. At all material times, Tristin Murphy was a prisoner in the custody of Defendant Florida Department of Corrections.

11. This action is brought by Cynthia Murphy, the mother of Tristin Murphy, in her capacity as Personal Representative of the Estate of Tristin Murphy and on behalf of his survivors.

12. Plaintiff brings this action on behalf of the following survivors who are currently known:

a. The Estate of Tristin Murphy;

b. Deborah Kay Murphy, Tristin's wife;

c. Cynthia Murphy, Tristin's mother; and

d. Dennis B. Murphy, Sr., Tristin's father.

13. Tristin is also survived by his two minor sons, C.L.M. (currently 15 years old), and C.G.M. (currently 8 years old). Prior to his death, Tristin executed a Last Will and

Testament leaving the remainder of his property and assets to C.L.M. and C.G.M., regardless of the legal status of Tristin's parental rights.

14. Defendant Florida Department of Corrections (FDC) is an Agency of the State of Florida, subject to a suit for wrongful death pursuant to the Wrongful Death Act, Fla. Stat, §§ 768.16–786.27. The FDC is charged by law with the responsibility to maintain all its facilities, including South Florida Reception Center (SFRC), in a safe and secure manner which complies with the applicable rules and regulations of the FDC and proper correctional practices.

15. Defendant Patricia Banchs was at all relevant times a Psychiatric Advanced Practice Registered Nurse working at SFRC, and employed by Centurion of Florida, LLC (Centurion), the company hired by FDC to provide medical and mental health care to people in FDC custody. She was acting under color of state law at all relevant times. She is sued in her individual capacity.

16. At all times material to this action, all correctional and medical staff mentioned herein were duly appointed, qualified, and acting officers, employees, and/or agents of the FDC, and were acting under color of state law.

FACTUAL ALLEGATIONS

Tristin Murphy

17. Tristin Murphy grew up in Charlotte County, Florida, and lived there most of his life. He was raised by his parents Cynthia and Dennis, completed his high school education and later began working for a landscaping company.

18. He was married at 24 years old, and he and his wife had two children together.

19. Tristin supported his family in numerous ways. He worked as a chef in his family's restaurant, and was also in the landscaping business. At one point he even created his own landscaping company, intending to go into business for himself.

20. He and his wife lived together in Charlotte County, raising their two children with the help of his parents Cynthia and Dennis.

<u>Tristin's Mental Health Unravels</u>

21. Unfortunately, Tristin's life began to unravel when he started showing the signs and symptoms of schizophrenia. He began hearing voices and responding to internal stimuli. He had paranoid delusions, would act erratically, and would experience extreme emotional swings causing him to lash out.

22. His mental illness led to several encounters with the criminal justice system.

23. Tristin was arrested on or about February 21, 2018, and taken to the Charlotte County Jail.

24. He attempted suicide in the jail roughly six days after his arrest.

25. He experienced several psychotic episodes in the jail, and spent months in solitary confinement. He was put in a restraint chair at various times.

26. His mental condition deteriorated so much that, in September 2018, Tristin was found incompetent to proceed in his criminal case and was sent to the South Florida Evaluation and Treatment Center (SFETC), a state hospital. He was eventually diagnosed with schizophrenia.

27. He refused his medications and required court-ordered involuntary psychotropic medications in December 2018. He stayed at SFETC until approximately January 2019.

28. After he was forced to resume his medications, his condition stabilized. He resolved his criminal case and was released with a sentence of time served and probation.

29. After his release from jail, Tristin quickly found a job with a landscaping company and worked hard to rebuild his life.

30. Unfortunately, he continued to experience severe symptoms of his mental illness. The hallucinations, paranoid delusions, internal stimuli, and mood swings returned. In December 2019, Tristin's symptoms overwhelmed him, and he drove his truck into a lake outside the Charlotte County Jail.

31. He was arrested and charged with Littering Over 500 Pounds, a third degree felony, and a Violation of Probation.

32. Immediately after being booked into the Charlotte County Jail, he was involuntarily committed pursuant to Florida's Baker Act because he continued to exhibit psychotic behavior and refused psychotropic medications. He was transferred to a Crisis Stabilization Center at Charlotte Behavioral Health, a Baker Act facility.

33. Within seven days, he was transferred back to the Charlotte County Jail, where he spent the next year in and out of psychotic episodes. At various points, he stopped eating, was put in solitary confinement, exhibited manic and bizarre behavior, destroyed jail property including his clothing and tablet, and experienced vivid hallucinations and paranoia.

34. In September 2020, Tristin was again found incompetent to proceed in his criminal case.

35. However, because of a lack of beds, he was not transferred to SFETC for competency restoration until March of 2021. Once transferred to SFETC, he was diagnosed with Schizoaffective Disorder, Bipolar Type. He returned to the jail at the end of April 2021.

36. He was eventually deemed competent to proceed, and in May 2021, he was sentenced to 36 months in FDC custody, and given over 500 days of credit for time served.

37. Before he was transferred to FDC custody, however, he experienced further psychotic episodes. Tristin's mother Cynthia, who was in regular contact with Tristin while he was in the jail via video visitation, contacted the jail numerous times expressing serious concerns for his mental health, informing the jail that he was obviously experiencing a mental health crisis and asking them to intervene. Tristin told Cynthia that he wanted someone to kill him and bury him in Charlotte County. Cynthia reported this to jail officials.

38. Jail staff put Tristin on suicide watch.

39. All of the aforementioned information was documented in Tristin's records.

Tristin Enters FDC Custody

40. Tristin entered FDC custody on or about July 15, 2021, at South Florida Reception Center (SFRC).

41. Part of the transfer paperwork that accompanied Tristin was an Intra-System Transfer Form from the Charlotte County Jail.

42. The transfer paperwork provides correctional and medical staff with important information on how a person newly entering prison may react to a correctional setting, and allows staff to take appropriate action.

43. In particular, it is well known among correctional and medical staff that it is critical to review the transfer paperwork of an incoming prisoner, and especially previous mental health information, to determine whether action should be taken to ensure continuity of care and minimize the risk of suicide.

44. Upon information and belief, FDC staff, including medical and mental health staff, were aware of the need to review the transfer paperwork, the risk of suicide when someone enters FDC custody, and the need to take immediate appropriate action.

45. In fact, FDC policy requires medical staff to review the records of all newly arrived prisoners.

46. When Tristin entered FDC custody, the Intra-System Transfer Form from the Charlotte County Jail noted the following:

a. Tristin had attempted suicide shortly after he entered the Charlotte County Jail.

b. He had been diagnosed with Adult Antisocial Personality Disorder and Substance-Induced Psychotic Disorder.

c. He had been prescribed Aripiprazole, which had been ordered by a state hospital.

d. He was being seen by mental health staff.

e. He had a history of psychiatric hospitalizations.

f. He had a history of taking psychotropic medications.

47. Aripiprazole is also known by the brand name Abilify, and is an antipsychotic drug used to treat the symptoms of disorders such as schizophrenia and bipolar disorder.

48. On or about July 15, 2021, Licensed Practical Nurse (LPN) Lisa Bonitto evaluated Tristin and noted that he had been receiving mental health treatment and that he was taking Abilify. Tristin informed her that he was taking psychotropic medications.

49. Bonitto was an employee of Centurion, the company that contracted with FDC to provide medical and mental health care to people in FDC custody, and therefore an agent of FDC.

50. Upon information and belief, Bonitto reviewed the Intra-System Transfer Form that accompanied Tristin, and knew that it was critical that Tristin continue taking his medications.

51. However, Tristin did not receive his needed medications for at least six days.

52. FDC negligently failed to ensure that Tristin receive his medications during this time.

Tristin Is Actively Psychotic During His Psychiatric Evaluation

53. Despite not receiving his needed medications, Tristin did not see any mental health provider for at least six days.

54. On or about July 22, 2021, Tristin finally had a psychiatric evaluation with Defendant Patricia Banchs, a Psychiatric Advanced Practice Registered Nurse.

55. Banchs was an employee of Centurion, the company that contracted with FDC to provide medical and mental health care to people in FDC custody, and therefore an agent of FDC.

56. During the evaluation, Tristin was in the midst of a psychotic episode.

57. During the evaluation, Tristin was speaking to himself, rambling about a man with no skin and being tortured by the FBI. He was wringing his hands and rocking back and forth. He was delusional, believing that someone else was in his head, and was hearing voices.

58. Tristin was so actively psychotic that Banchs could not properly assess him. Banchs was so concerned that she called security during the evaluation.

59. During the evaluation, Tristin exhibited lip-smacking and random mouth opening, which are often associated with the use of antipsychotic medications.

60. During the evaluation, Tristin informed Banchs that he had been taking Abilify in the Charlotte County Jail, that he had been hearing voices for about three years, that he had been held in solitary confinement in the Charlotte County Jail for one and a half years, and that he had been sent to the state hospital for inpatient psychiatric treatment.

61. During this evaluation, Tristin notified Banchs that he had not received his psychiatric medications for at least five days.

62. During and after the evaluation, Banchs noted the following:

a. Tristin had a history of being treated at a state mental hospital.

b. Tristin had been treated with antipsychotic medications in the past.

c. Tristin was wringing his hands and rocking back and forth.

d. Tristin was actively hallucinating (he was hearing voices).

e. Tristin was delusional (he believed someone else was in his head).

f. Tristin’s mood was anxious, depressed, irritable, labile, and fluctuating.

63. As part of the evaluation, Banchs reviewed Tristin’s transfer paperwork, including the Inter-System Transfer Form that noted that Tristin had previously attempted suicide while incarcerated.

64. Banchs diagnosed Tristin with schizophrenia.

65. Tristin’s schizophrenia substantially limited several major life activities, including but not limited to thinking, caring for himself, learning, concentrating, communicating, and interacting with others.

66. People diagnosed with schizophrenia face a substantially increased risk of suicide compared to the general population.

67. Upon information and belief, Banchs knew that people diagnosed with schizophrenia face a substantially increased risk of suicide compared to the general population.

68. People who have attempted suicide in the past face a substantially increased risk of suicide compared to the general population.

69. Upon information and belief, Banchs knew that people who have attempted suicide in the past face a substantially increased risk of suicide compared to the general population.

70. Banchs prescribed Haldol for Tristin. Haldol is a powerful psychotropic medication used to treat the disordered thoughts, perceptions, and behaviors associated with conditions such as schizophrenia.

71. Banchs prescribed Abilify for Tristin.

72. The FDC assigns a Mental Health Grade to every incarcerated person. This is sometimes referred to as the person's "S-grade."

73. The grading system is generally as follows:

a. S-1 means the person demonstrates no significant impairment in their ability to adjust within an institutional environment, and does not exhibit the symptoms of a mental disorder.

b. S-2 means the person exhibits mild impairment associated with a diagnosed mental disorder, but the impairment is not so severe as to prevent satisfactory adjustment in general inmate housing with the

assistance of mental health case management, psychological services, and counseling.

c. S-3 means the person shows moderate impairment in adaptive functioning due to a diagnosed mental disorder, but the impairment is not so severe as to prevent satisfactory adjustment in general inmate housing with the assistance of mental health case management, psychological services, counseling, and psychiatric consultation for psychotropic medications. All incarcerated people who are taking, or who are determined to need, psychotropic medications, are assigned to at least level S-3.

d. S-4 means the person has a mental impairment that significantly compromises their ability to adapt to the demands of a general incarceration environment. People with this grade are placed in an inpatient level of care called a Transitional Care Unit (TCU), which is a structured residential environment with more intensive monitoring and supervision.

e. S-5 means the person is experiencing such acute and debilitating symptoms of mental impairment that they cannot be adequately evaluated and treated in a mental health infirmary or Transitional Care Unit. People with this grade are placed in an inpatient level of care called a Crisis Stabilization Unit (CSU), which is intended for rapid stabilization of acute symptoms or conditions.

f. S-6 means the person must be placed in a Corrections Mental Health Treatment Facility (CMHTF), which is reserved for people whose mental

disorders are so incapacitating as to render them unable to understand the nature and consequences of their mental illness and their need for mental health care. It is a highly structured residential setting that provides intensive mental health care. Patients are placed in a CMHTF involuntarily on an emergency basis or by court order.

74. Under FDC policy, FDC staff can also send incarcerated people to the infirmary for mental health observation.

75. Tristin was experiencing acute and debilitating symptoms. He was actively psychotic and could not be properly treated in his current state and with his current level of care. It was obvious that he could not adapt to the demands of a general incarceration environment. Tristin desperately needed immediate inpatient mental health care, which he would have received had he been given a mental health grade of S-4 or above.

76. Incredibly, despite Tristin's symptoms, Banchs assigned Tristin a mental health grade of S-3, and merely recommended that he have an outpatient mental health appointment within 14 days. This resulted in Tristin being sent to the general population rather than an inpatient unit.

77. Tristin met the criteria in FDC policy for admission to an inpatient mental health unit.

78. Given his symptoms and history, Banchs knew that Tristin exhibited a strong likelihood of suicide, yet disregarded that risk with more than gross negligence, exhibiting deliberate indifference to Tristin's serious medical needs.

79. On or about that same date—July 22, 2021—Leslie Morrison, a mental health nurse and Behavioral Health Specialist, evaluated Tristin, either with Banchs or separately.

80. Morrison was an employee of Centurion, the company that contracted with FDC to provide medical and mental health care to people in FDC custody, and therefore an agent of FDC.

81. As a result of that evaluation, Morrison made two separate entries (called Mental Health Encounters) into the FDC and/or Centurion computer system.

82. In the first entry, she noted that Tristin had a recent psychiatric hospitalization, that he was prescribed Abilify, and that he had engaged in self-injury or attempted suicide. She also noted that Tristin was mumbling, seemed distracted, had a history of auditory hallucinations, and was responding to internal stimuli.

83. In the second entry, Morrison noted that he had attempted suicide in 2021 in the Charlotte County Jail, and that the circumstances surrounding the attempt included hearing voices in his head.

84. Upon information and belief, Morrison reviewed Tristin's transfer paperwork, including the Intra-System Transfer Form.

85. Morrison did not recommend that Tristin receive any kind of immediate intervention, nor did she recommend a change in Tristin's S-grade, nor did she recommend that Tristin be transferred to a higher level of care such as an inpatient mental health unit.

86. On or about that same date—July 22, 2021—Paul Costa, the Supervising Psychologist, reviewed Tristin's file.

87. Costa was an employee of Centurion, the company that contracted with FDC to provide medical and mental health care to people in FDC custody, and therefore an agent of FDC.

88. Upon information and belief, Costa read the notes recorded by Banchs and Morrison, and the transfer paperwork accompanying Tristin, including the Intra-System Transfer Form.

89. Dr. Costa did not order that Tristin receive any kind of immediate intervention, nor did he order a change in Tristin's S-grade, nor did he order that Tristin be transferred to a higher level of care such as an inpatient mental health unit.

90. Tristin was not seen by a mental health provider within 14 days, in violation of FDC policy.

91. In fact, Tristin never saw another mental health provider while in FDC custody, which was for approximately the next 55 days.

92. This failure was due, in part, to the severe and chronic understaffing at SFRC.

93. FDC mental health providers and staff failed to conduct a Biopsychosocial Assessment, or document it, in violation of FDC policy.

94. FDC mental health providers and staff failed to formulate an Individualized Service Plan, or document it, in violation of FDC policy.

95. FDC mental health providers and staff failed to complete a Mental Health Screening Evaluation Form (DC4-624B), in violation of FDC policy.

96. For the remainder of Tristin's incarceration, FDC staff negligently failed to ensure that Tristin was consistently given his medications.

97. Tristin did not receive his medications on at least two days in July 2021, and at least five days in August 2021.

98. At least once, Tristin did not receive his medications for three days in a row. FDC staff negligently failed to take action or document any such action, in violation of FDC policy.

99. FDC staff recorded that Tristin refused his medications five times within a month. FDC negligently failed to notify the prescribing clinician and failed to document it, in violation of FDC policy.

<u>Tristin Is Transferred to the SFRC South Unit</u>

100. On or about September 10, 2021, Tristin was transferred to the South Unit of SFRC.

101. The South Unit is part of SFRC and is operated by the same administration.

102. The Health Information Transfer/Arrival Summary form that was completed with his transfer noted that Tristin was "[c]urrently being treated for mental health problems" and that he suffered from delusions, psychosis, and paranoia. The form also noted that he was taking Abilify but that he did not have his medications with him, and that he was supposed to receive a mental health follow-up appointment.

103. FDC medical staff at the SFRC South Unit reviewed the Health Information Transfer/Arrival Summary form.

104. Upon information and belief, the receiving staff at the SFRC South Unit accessed Tristin's medical and mental health records that had been created within the FDC and that had arrived with Tristin from the Charlotte County Jail.

105. On or about September 13, 2021, Dr. Charlemagne Marius, a medical doctor at the SFRC South Unit, reviewed the Health Information Transfer/Arrival Summary form.

106. Dr. Marius was an employee of Centurion, the company that contracted with FDC to provide medical and mental health care to people in FDC custody, and therefore an agent of FDC.

107. Upon information and belief, Dr. Marius also reviewed Tristin's medical and mental health records that had been created within the FDC and that had arrived with Tristin from the Charlotte County Jail.

108. However, neither Dr. Marius nor any other FDC staff ordered or recommended that Tristin receive any kind of immediate intervention, a change in Tristin's S-grade, or a transfer to a higher level of care such as an inpatient mental health unit.

109. Nurse Espinoza, a Licensed Practical Nurse, merely completed a Staff Request/Referral form that requested a "routine" referral to mental health, which required a response within 7 days.

110. After Tristin's transfer to the South Unit, Tristin never received any of his prescribed medications.

111. In fact, for at least six days prior to Tristin's death, FDC staff negligently failed to ensure that he receive his psychotropic medications.

112. Tristin continued to exhibit obvious signs of mental illness. He continued to act strangely, was consistently talking to himself, exhibited delusional and paranoid thinking, and was hallucinating.

Tristin Is Assigned to an Outside Grounds Work Squad

113. On or about September 14, 2021, FDC staff assigned Tristin to an outside grounds work squad.

114. This work detail involves performing various forms of landscaping and other work for the prison grounds, including work that is outside the prison's perimeter fence. Members of the outside grounds work squad have access to dangerous and sharp tools such as chainsaws, sharp knives, and lawnmowers.

115. FDC staff negligently failed to ensure that Tristin was medically or psychiatrically cleared to work on the outside grounds squad before assigning him to that work detail.

116. Upon information and belief, FDC staff conducted no screening procedure to ensure that it was safe and appropriate for Tristin to be assigned to the outside grounds work squad.

117. Alternatively, upon information and belief, FDC staff assigned Tristin to the outside grounds work squad, with access to dangerous equipment, despite knowing that Tristin had a psychiatric grade of S-3, had attempted suicide in the past while incarcerated, and suffered from psychosis, delusions, and paranoia.

Tristin Commits Suicide

118. In the days leading to his death, it became obvious that Tristin was suffering from serious mental health symptoms.

119. It was known to the men in Tristin's dorm that he was mentally ill. Tristin had been acting strangely and was talking to himself.

120. On or about September 16, 2021, Tristin's signs of mental illness continued. He was up early, around 4 a.m., and was talking and cursing to himself.

121. On that same date, Tristin reported for duty on the outside grounds work squad.

122. There were approximately 34 other incarcerated people assigned to a work squad who were present and waiting to start work.

123. FDC employee Sergeant Jose Arambula was supervising the work squad. Although there were supposed to be two other corrections officers present to supervise that number of people, those two corrections officers had stepped away, leaving Sergeant Arambula alone with the 34 members of the squad.

124. Arambula was unable to properly supervise this number of incarcerated people on an outside grounds work squad.

125. At approximately 8:40 a.m., Arambula asked the incarcerated members of the work squad whether any of them had experience working with a chainsaw.

126. Tristin indicated that he had experience working with a chainsaw. Arambula did nothing to verify this, nor did he ask Tristin any follow-up questions. Instead, he let Tristin access the chainsaw.

127. In front of approximately 33 other incarcerated people, Tristin started the chainsaw, and then cut his own neck with it. Tristin began bleeding profusely and eventually fell to the ground and lost consciousness. The chainsaw penetrated his tongue, trachea, and esophagus.

128. Tristin suffered from intense and severe pain and anguish.

129. Emergency personnel responded to the scene, and Tristin was pronounced dead. He was 37 years old and a year and half from his expected release date.

130. One witness reported that it was the most horrific thing he had ever seen.

131. An emergency alert describing the incident was sent via email to various FDC staff members around the state. Several FDC staff members responded, expressing shock and

horror at what had happened. Some expressed shock that incarcerated people—particularly those with mental health conditions—were permitted to access chainsaws. Some expressed that a proper clearance procedure had not been followed.

South Florida Reception Center Fails Numerous Audits

132. SFRC has an unfortunate history of failing to protect incarcerated people with serious mental illnesses.

133. The Correctional Medical Authority (CMA) is an independent state agency that conducts audits of the medical and psychological care provided to people incarcerated in the FDC, and provides reports detailing its findings. *See* Fla. Stat. § 945.601, *et seq*. One of the CMA's purposes is to ensure "that adequate standards of physical and mental health care for inmates are maintained at all Department of Corrections institutions." Fla. Stat. § 945.603.

134. In April 2017, the CMA conducted a Physical and Mental Health Survey of SFRC. It found "serious deficiencies" that "were related to psychiatric medication services, the use of psychiatric restraints when less restrictive alternatives were available, and the assessment and treatment of inmates at imminent risk of self-harm." The findings were so serious that the CMA transmitted the findings to the FDC using its emergency notification procedures, which are reserved for deficiencies that are "life-threatening or otherwise serious." Fla. Stat. § 945.6031(3).

135. A Corrective Action Plan was prepared, requiring FDC to take steps to remedy the noted deficiencies.

136. The CMA subsequently conducted follow-up assessments to determine whether the Corrective Action Plan had been complied with, or whether deficiencies remained.

137. The November 2017 Corrective Action Plan Assessment noted that numerous deficiencies remained.

138. The March 2018 Corrective Action Plan Assessments noted that numerous deficiencies remained.

139. The August 2018 Corrective Action Plan Assessments noted that numerous deficiencies remained.

140. SFRC did not fully resolve all deficiencies noted in the April 2017 survey until approximately December 2018—a year and a half later.

141. However, the period of alleged compliance did not last long. In November 2021, just a month and a half after Tristin's death, the CMA conducted another Physical and Mental Health Survey of SFRC.

142. The survey noted several deficiencies, including the following at the SFRC Main Unit:

a. Psychotropic medications were not continued as ordered from the county jail without interruption, including instances where medication was abruptly discontinued without medical rationale.

b. Records were not requested from the community mental health provider for patients with prior mental health treatment.

c. For outpatient mental health services, the frequency of clinical contacts was insufficient.

d. Patients did not receive psychiatric medications as prescribed.

143. At the SFRC South Unit, the survey found the following deficiencies:

a. Follow-up mental health sessions were not completed in a timely manner.

b. The Abnormal Involuntary Movement Scale (AIMS) form was not completed at the required intervals.

c. Outpatient therapeutic groups were not provided to meet the needs of the inmate population—in fact, therapeutic groups were not being offered at all at the South Unit.

144. Months later, the CMA conducted a follow-up review to determine whether the deficiencies had been corrected. But the CMA's July 2022 Corrective Action Plan Assessment noted that deficiencies persisted. Specifically, at the SFRC Main Unit, the following deficiencies remained:

a. Psychotropic medications were not continued as ordered from the county jail without interruption.

b. Records were not requested from the community mental health provider for patients with prior mental health treatment.

c. For outpatient mental health services, the frequency of clinical contacts was insufficient.

d. Patients did not receive psychiatric medications as prescribed.

145. The July 2022 Corrective Action Plan Assessment noted the following deficiencies at the SFRC South Unit:

a. Follow-up mental health sessions were not completed in a timely manner.

b. The Abnormal Involuntary Movement Scale (AIMS) form was not completed at the required intervals.

c. Outpatient therapeutic groups were not provided to meet the needs of the inmate population.

146. Months later, the CMA conducted yet another review to determine whether the deficiencies had been corrected. The CMA's November 2022 Second Corrective Action Plan Assessment noted that deficiencies still persisted. Specifically, at the SFRC Main Unit, the following deficiencies remained:

a. Psychotropic medications were not continued as ordered from the county jail without interruption.

b. Patients did not receive psychiatric medications as prescribed.

147. The November 2022 Second Corrective Action Plan Assessment noted the following deficiency at the SFRC South Unit:

a. Outpatient therapeutic groups were not provided to meet the needs of the inmate population.

148. Months later, the CMA conducted yet another review to determine whether the deficiencies had been corrected. The February 2023 Third Corrective Action Plan Assessment noted that deficiencies still persisted. Specifically, at the SFRC Main Unit, the following deficiencies remained:

a. Psychotropic medications were not continued as ordered from the county jail without interruption.

b. Patients did not receive psychiatric medications as prescribed.

149. The February 2023 Third Corrective Action Plan Assessment noted the following deficiency at the SFRC South Unit:

a. Outpatient therapeutic groups were not provided to meet the needs of the inmate population.

150. Months later, the CMA conducted yet another review to determine whether the deficiencies had been corrected. The August 2023 Fourth Corrective Action Plan Assessment noted that deficiencies still persisted. Specifically, at the SFRC Main Unit, the following deficiencies remained:

a. Patients on self harm observation status were not observed at the frequency ordered by the clinician.

b. Psychotropic medications were not continued as ordered from the county jail without interruption.

c. The biopsychosocial assessment (BPSA) was not being completed as required.

d. The Individualized Service Plan was not being completed as required.

e. Patients were not receiving prescribed psychiatric medications as prescribed.

151. The August 2023 Fourth Corrective Action Plan Assessment noted the following deficiencies at the SFRC South Unit:

a. Aftercare plans were not being addressed on the ISP for patients within 180 days of end of sentence (EOS).

152. To this day, SFRC is still not in compliance with all the required standards.

153. All incarcerated people at SFRC with a mental illness face a substantial risk of serious harm to their health and safety.

CAUSES OF ACTION

COUNT I – NEGLIGENCE AND WRONGFUL DEATH
(against Defendant Florida Department of Corrections)

154. Plaintiff realleges and incorporates the allegations in the paragraphs preceding the Causes of Action section as if set forth herein.

155. This wrongful death claim is against Defendant FDC for negligence.

156. Defendant FDC owed Tristin Murphy a non-delegable duty to use reasonable care to ensure his safety.

157. Defendant FDC negligently failed to ensure that Tristin Murphy was properly classified and housed.

158. Defendant FDC negligently failed to assess whether it was safe and appropriate to assign Tristin Murphy to a work detail.

159. Defendant FDC negligently failed to ensure safe and appropriate working conditions for Tristin Murphy.

160. Defendant FDC negligently failed to supervise the work squad to which Tristin was assigned.

161. Defendant FDC negligently permitted Tristin to have access to dangerous tools and implementations of suicide despite knowing he was severely mentally ill, actively psychotic, and had previously attempted suicide.

162. Defendant FDC negligently failed to ensure that Tristin Murphy receive his prescribed psychotropic medications.

163. Defendant FDC negligently failed to ensure that Tristin Murphy receive his follow-up mental health appointments.

164. The negligent acts of Defendant FDC's agents and employees were done while acting within the course and scope of their employment and/or agency with Defendant FDC. Thus, Defendant FDC is vicariously liable for the actions of its agents and employees when they committed the negligent acts alleged herein.

165. The negligence of the FDC and its employees and agents, as set forth above, was the direct and proximate cause of the serious personal injuries sustained by Mr. Murphy and directly and proximately resulted in his death.

166. As a result of Defendant FDC's negligence, Mr. Murphy suffered from severe pain and anguish.

167. As a result of Defendant FDC's negligence, the Estate of Tristin Murphy and his survivors sustained damages.

COUNT II – NEGLIGENT SUPERVISION OF CENTURION
(against Defendant Florida Department of Corrections)

168. Plaintiff realleges and incorporates the allegations preceding the Causes of Action Section as if set forth herein.

169. Defendant FDC had a non-delegable duty to provide adequate medical and psychiatric care to people in its custody.

170. Defendant FDC contracted with Centurion to provide medical services to the people incarcerated in Florida prison facilities.

171. Defendant FDC owed a duty to all incarcerated people imprisoned in the Florida prison system, including Tristin Murphy, to properly supervise the medical services that were being provided by Centurion.

172. Defendant breached this duty to Tristin Murphy by, among other things, failing to ensure that psychological services were being adequately provided to people incarcerated at SFRC.

173. As a direct and proximate cause of FDC's failure to adequately supervise Centurion, Tristin Murphy died.

174. As a direct and proximate cause of FDC's failure to adequately supervise Centurion, Mr. Murphy suffered from severe pain and anguish.

175. As a direct and proximate cause of FDC's failure to adequately supervise Centurion, the Estate of Tristin Murphy and his survivors sustained damages.

COUNT III – EIGHTH AMENDMENT, 42 U.S.C § 1983
(against Defendant Patricia Banchs)

176. Plaintiff realleges and incorporates the allegations preceding the Causes of Action section as if set forth herein.

177. This count is brought under the Eighth Amendment to the U.S. Constitution via 42 U.S.C. § 1983.

178. This count is brought against Defendant Patricia Banchs, who at all material times was acting under color of state law.

179. Defendant Banchs was aware that Tristin Murphy had an objectively serious medical need.

180. Defendant Banchs was aware that Tristin Murphy faced a substantial risk of serious harm.

181. Defendant Banchs disregarded that risk with more than gross negligence.

182. Defendant Banchs disregarded the strong possibility that Tristin Murphy would commit suicide.

183. Defendant Banchs provided Tristin Murphy with grossly inadequate care.

184. Defendant Banchs provided Tristin Murphy with medical care that was so cursory as to amount to no medical care at all.

185. Defendant Banchs was deliberately indifferent to Tristin's Murphy's serious medical needs.

186. Defendant Banchs's deliberate indifference directly and proximately caused Tristin Murphy's death.

187. As a result of Defendant Banchs's deliberate indifference, Mr. Murphy sustained injuries and suffered from severe pain and anguish.

188. As a result of Defendant Banchs's deliberate indifference, the Estate of Tristin Murphy and his survivors sustained damages.

COUNT IV – AMERICANS WITH DISABILITIES ACT; 42 U.S.C. § 12101 et seq.; 28 C.F.R. § 35.130, 35.152

(against Defendant Florida Department of Corrections)

189. Plaintiff realleges and incorporates the allegations preceding the Causes of Action section as if set forth herein.

190. This count is brought against Defendant FDC for violations of Title II the Americans with Disabilities Act, 42 U.S.C. § 12101 et seq. & 42 U.S.C. § 12131, et seq., and its implementing regulations.

191. Defendant FDC is a public entity.

192. Tristin was a qualified individual with a disability.

193. Tristin had a mental impairment that substantially limited one or more major life activity.

194. Tristin had a record of having an impairment that substantially limited one or more major life activity.

195. Tristin met the essential eligibility requirements of the programs, services, and activities operated and provided by Defendant FDC.

196. Defendant FDC denied Tristin the benefits of FDC services, programs, and activities, including but not limited to safe housing and appropriate job placement and supervision, by reason of his disability.

197. Defendant FDC failed to provide Tristin Murphy with equal access and enjoyment to FDC aids, services, and benefits.

198. Defendant FDC failed to make reasonable modifications in policies, practices, and procedures, and failed to provide reasonable accommodations, to avoid discrimination against Tristin Murphy on the basis of disability.

199. Defendant FDC failed to properly accommodate Tristin's disability by failing to classify and house him, and assign him to a job, that was safe and appropriate for someone with his disability, and/or failing to modify its policies with respect to classification, housing, and job placement. As a result, these FDC programs, services, and activities subjected Tristin to a substantially increased risk of harm, thereby rendering them inaccessible to him and denying Tristin the benefits of such services.

200. Defendant failed to adopt adequate policies to ensure appropriate screening of people with disabilities in job placements to ensure they were safe for people with disabilities.

201. Tristin's need for an accommodation was obvious.

202. Defendant FDC acted intentionally and/or with deliberate indifference to Tristin's need for an accommodation and to his ADA rights.

203. As a direct and proximate cause of FDC's acts and omissions complained of herein, Tristin Murphy died.

204. As a direct and proximate cause of FDC's acts and omissions complained of herein, Mr. Murphy sustained injuries and suffered from severe pain and anguish.

205. As a direct and proximate cause of FDC's acts and omissions complained of herein, the Estate of Tristin Murphy and his survivors sustained damages.

COUNT V- REHABILITATION ACT - 29 U.S.C. § 701, et seq.; 29 U.S.C. § 794, et seq; 28 C.F.R. § 42.503, 42.520

(against Defendant Florida Department of Corrections)

206. Plaintiff realleges and incorporates the allegations preceding the Causes of Action section as if set forth herein.

207. This count is brought against Defendant FDC under Section 504 of the Rehabilitation Act, 29 U.S.C.§ 701, et seq. & 29 U.S.C. § 794, et seq., and their implementing regulations.

208. Defendant FDC is a program or activity receiving federal financial assistance.

209. Tristin Murphy was a qualified individual with a disability.

210. Defendant FDC excluded Tristin Murphy from participation in, and denied him the benefits of programs or activities, solely by reason of his disability.

211. Defendant FDC failed to properly accommodate Tristin's disability by failing to classify and house him, and assign him to a job that was safe and appropriate for someone with his disability, and/or failing to modify its policies with respect to classification, housing, and job placement. As a result, these FDC programs, services, and activities subjected Tristin to a substantially increased risk of harm, thereby rendering them inaccessible to him and denying Tristin the benefits of such services.

212. Defendant FDC subjected Tristin Murphy to discrimination by reason of his disability.

213. Defendant FDC acted intentionally and/or with deliberate indifference to Tristin's need for an accommodation and to his rights under the Rehabilitation Act.

214. As a direct and proximate cause of FDC's acts and omissions complained of herein, Tristin Murphy died.

215. As a direct and proximate cause of FDC's acts and omissions complained of herein, Mr. Murphy sustained injuries and suffered from severe pain and anguish.

216. As a direct and proximate cause of FDC's acts and omissions complained of herein, the Estate of Tristin Murphy and his survivors sustained damages.

REQUEST FOR RELIEF

WHEREFORE, Plaintiff respectfully requests and seeks the following relief:

A. All damages permitted by law, including but not limited to compensatory, nominal, and punitive damages;

B. Attorneys' fees, costs, and expenses pursuant to 42 U.S.C. § 1988, 42 U.S.C. § 12205, and 29 U.S.C. § 794a; and

C. Any other relief that is just and proper.

Jury Demand

Plaintiff demands trial by jury on all counts alleged above.

Respectfully submitted,

Dante P. Trevisani
Florida Bar No. 72912
E-mail: *DTrevisani@FloridaJusticeInstitute.org*
Ray Taseff
Florida Bar No. 352500
E-mail: *RTaseff@FloridaJusticeInstitute.org*
Florida Justice Institute, Inc.
P.O. Box 370747
Miami, Florida 33137
305-358-2081
305-358-0910 (Fax)

By: *s/Dante P. Trevisani*
Dante P. Trevisani

Attorneys for the Plaintiff