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**UNITED STATES DISTRICT COURT FOR THE DISTRICT OF IDAHO**

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| KIM and SHAUNA QUICK, individually and as representatives of the ESTATE OF LANCE ALLEN QUICK (DECEASED),<br><br>Plaintiffs,<br><br>vs.<br><br>BANNOCK COUNTY, IDAHO, et al.,<br><br>Defendants. | **COMPLAINT & JURY DEMAND**<br><br>Case No.:<br><br>Judge: |

Plaintiffs, by and through undersigned counsel of record, hereby submit this complaint against Defendants, and assert the following allegations in their totality and in the alternative:

## PARTIES

1. Plaintiffs Kim and Shauna Quick are residents of Bannock County, State of Idaho. Kim and Shauna are the natural parents of Lance Allen Quick, and the heirs and representative of his estate under Idaho law.

2. Defendant Bannock County is a political subdivision of the State of Idaho.

3. Defendant Lorin Nielsen is, and was at all relevant times, the Sheriff of Bannock County. At all relevant times, Nielsen was the final policymaking authority with respect to the Bannock County Detention Center (hereinafter the "Jail"), and all actions taken or not taken by Nielsen were in such capacity.

4. M. Billings, J. L. Clark, J. Ferrin, E. Ivins, L. Hapke, A. K. Huff, J. L. Jackson, A. E. Luce, T. Ranere, E. Schei, S. Sosa, Chance Topliff, Matthew Tyrell, R. E. Vandyke, and E. Woodard (hereinafter "Jailers") are, or were at all relevant times, employees or Jailers in the Bannock County Jail. Upon information and belief, each of these defendants is a resident of the State of Idaho.[1]

5. Zhanna Crystal, Allison Jorgenson, Tina Morrison, and Melanie Sparrow are health care professionals who are employed by, or contract with, Bannock County. Upon information and belief, each of these defendants is a resident of the State of Idaho.

6. At all times relevant to this Complaint, each of the individual defendants was acting within the course and scope of his or her employment or contract with Bannock County.

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[1] Plaintiffs are unable to determine at this time which Jailer(s) performed certain actions described herein. For example, plaintiffs cannot know at this time to which Jailer(s) they spoke on telephone calls, and the Jail refused to provide a copy of its Jail phone logs. The identity of specific Jailers will be determined through discovery. When available, a Jailer's identity is specified below.

## JURISDICTION AND VENUE

7. This action arises under the Fourteenth Amendment to the Constitution and 42 U.S.C. § 1983. Accordingly, this Court has jurisdiction pursuant to 28 U.S.C. §1331 and 1343(a)(3). The Court has supplemental jurisdiction over state law claims pursuant to 28 U.S.C. § 1367.

8. The claims made in this Complaint occurred and arose in Bannock County, State of Idaho. Accordingly, venue is proper under 28 U.S.C. § 1391.

## INTRODUCTION

On December 8, 2018, Lance Allen Quick, son of Bannock County Coroner Kim Quick, was booked into the Bannock County Jail on a misdemeanor. Six days later, he was dead.

Throughout his incarceration, the County Sheriff and his Jailers knew that Lance was bipolar, that he was experiencing a psychotic episode, and that he needed his medications. Lance's father even told the Sheriff which medications, and the physical harm that Lance would suffer if he did not get them. A nurse friend of Lance's offered Jailers the names of Lance's doctors and prescriptions, but the Jailers would not take the information.

For nearly a week, Jailers watched Lance Quick die. His behavior became increasingly erratic, and Jailers noted that Lance did not even "understand the concept" of eating or drinking. Over time, he grew visibly weaker from lack of food and water, to the point that Jailers began logging whether Lance was "still breathing." On December 14, Lance died from dehydration.

A simple IV would have saved Lance's life. Taking Lance to a hospital for a medical exam and prescriptions would have saved Lance's life. The Jail refused to transport Lance to the

ER, however, because it would have been a "burden" for a law enforcement officer to accompany him, as the hospital required.

After Lance's death, Bannock County Sheriff said, "we're not equipped [to handle mentally ill inmates], we're not trained, and we don't want to be." This statement illustrates the concerns that have led the Plaintiffs to file this action.

**FACTS**

Day 1 *(Saturday, December 8, 2018)*

9. On Saturday, December 8, 2018, at approximately 7:19 p.m., Lance Allen Quick ("Lance") was brought into the Bannock County Jail by Pocatello Police officer Shannon Bloxham. Lance had recently turned 40, and owned his own home inspection business As friends described, Lance was kind and funny when on his medications – "No matter where or when we would run into one another around town, you always felt better when you would have a conversation with Lance."

10. Lance was booked on suspicion of misdemeanor DUI. Pocatello officers had determined that Lance had not been drinking, but perceived from his behavior that he was under the influence of some drug.

11. Upon information and belief, Officer Bloxham informed the Jailers on duty of some or all the following information she had been told by Lance: That Lance was diagnosed with bipolar disorder, and that Lance took medication (Lamictal as an anti-depressant to treat psychiatric disorders, and Lithium which is an anti-psychotic medication to treat mood disorders).

12. The Jail's records also included a Bannock County Jail Discharge Summary for Lance from about two weeks earlier stemming from an earlier medical-related incident. This Jail record stated, "The following is a list of medications prescribed by the facility physician" on November 21, 2018: Ambien (10mg), Lamictal (200 mg), Seroquel (50 mg) and Lithium (600 mg).

13. After Lance's death, Sheriff Nielsen acknowledged that it was a regular occurrence for persons with mental illness to be incarcerated in the Jail. Although the number is fluid, Nielsen estimated that 10 or 12 percent of the Jail's inmates have a mental illness or are experiencing a mental episode.

14. Sheriff Nielsen acknowledged that, at the time of Lance's incarceration, the Bannock County Jail was not equipped or trained to handle inmates with mental illnesses, and that he "did not want to be." At a December 17, 2018, press conference, Nielsen stated:

> We are not equipped, we are not trained, and I don't want to be. This is a special condition that needs to be taken care of by proper authorities. And we aren't those proper authorities. I'll hold somebody for a crime. I'm good at that. But for a mental condition from which they are caused – which causes those crimes, I'm not equipped, I don't want to be equipped, and there isn't a jail in this state that wants to be able to take on the State's problem with mental illness.

15. Jailers knew, and it was patently obvious, that if Lance did not receive proper medical attention, his condition would worsen. As Sheriff Nielsen stated on December 17, 2018:

> My jail is made for the secure incarceration of those that have been charged with or convicted of crime. Period. You can't tell me or any other person that thinks properly – and I know you can fill in the words – that rehabilitation inside a drunk tank or a jail cell is good for somebody to be able to come out of their medically mental problem. It will only exacerbate it, it'll only make it worse.

16. During the booking process, Lance asked to be taken to the hospital, but Jail personnel refused.

17. While still in the initial booking area, Lance exhibited odd behavior in front of Jail staff, including fidgeting, acting as if his legs would not support him, and repeatedly rolling his ankles.

18. Shortly after the arrest, a Pocatello officer informed Jodi Oram, a close friend of Lance's, that Lance had been arrested. Ms. Oram then called the Jail. A Jailer told Ms. Oram that Lance was acting drunk. Ms. Oram asked if she could post bail to obtain Lance's release, but the Jailer said no, as the next day was Sunday. The Jailer said Lance would be arraigned on Monday.

19. Ms. Oram told the Jailer that she wanted to talk to the arresting officer about Lance's mental health issues. She was told that the arresting officer was presently with Lance.

20. Lance was not weighed in the booking process, but a medical record from November 27, 2018, recorded his weight as 169 lbs.

21. Jailers completed the booking process, then placed Lance in booking cell 6, which does not have a camera.

22. Jail records provided to Plaintiffs contain no log entries for December 8 other than a notation that Lance had been assigned to Cell 6.

23. Later that evening, Ms. Oram called the Jail again and asked to speak with Lance. A Jailer replied that Lance was not in a position to speak to anyone, that he was incapacitated. Ms. Oram thought that, because Lance had been booked on a "DUI," perhaps he was intoxicated and everything would be fine the next morning and he would call her.

24. Ms. Oram notified Kim and Shauna Quick that their son Lance was in the Bannock County Jail. Kim Quick was the Bannock County Coroner, and had worked closely

with the Bannock County Sheriff's Office for several years. The Quicks assumed that Lance would be allowed to make a phone call, and that they would soon hear from him.

Day 2 *(Sunday, December 9, 2018)*

25. Jail records provided to Plaintiffs do not contain any log entries for December 9, 2018.

26. When Kim and Shauna Quick had not received a call by Sunday morning, they called the Jail and asked why they had not heard from Lance. A Jailer responded that Lance was "incapacitated." Mrs. Quick then asked if Lance could be told that his mother had called. The Jailer refused, stating that jailers were not an answering service and did not give messages to inmates.

27. Lance was not given any medications, and his behavior became increasingly erratic. For example, he was seen picking up his sleeping mat and tossing it against the cell window. At about 9:40 p.m., Jailers removed the mat and did not give Lance anything else to sleep on for the rest of the night.

**Day 3** ***(Monday, December 10, 2018)***

28. At about 4:36 a.m., Jailers entered Booking Cell 8 and removed its current occupant. Jailers then handcuffed Lance and moved him into Cell 8.

29. Cell 8 is a one-person cell with no bed, no toilet, and no sink. There is a drain in the middle of the floor, a blanket, and a floor mat. The cell is roughly 6' x 10'.

30. Lance was placed in Cell 8 because of his "behavior". Jailers knew that Lance was behaving erratically, was experiencing a mental episode or illness, and needed close observation.

31. Cell 8 has a camera with a live feed to central command. With some gaps, this camera recorded the last days of Lance Quick's life as he grew sicker and more disoriented, weakened and died.[2]

32. Despite the knowledge that Lance was experiencing a serious mental episode, no one in the Jail ever made any effort to contact a physician, or Lance's father, the County Coroner. The Jail had money in the budget for contract physician services (and a constitutional duty to do so when an inmate had serious medical needs).

33. The refusal of Bannock County jailers to take any steps to determine what treatment or medications Lance needed was consistent with the policies of Sheriff Nielsen, who believes that jails should not have to "research" inmates' medical circumstances even when they are exhibiting obvious signs of illness. After Lance's death, Nielsen stated:

> We can't get them on psychotropic drugs and those types of things without having a doctor be able to take a look at them. It's just not a matter of like insulin, you have to

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[2] The gaps in Cell 8 video identified by Plaintiffs appear to be: **12/10/18:** 04:50:00 am – 05:45:51 am; 05:55:02 am – 06:25:00 am; 06:55:00 am – 07:23:29 am; 07:40:01 am – 09:13:15 am; 09:25:01 am – 10:59:59 am; 11:09:59 am – 11:15:30 am; 11:45:00 am – 11:45:29 am; 12:34:58 pm – 12:59:55 pm; 01:15:01 pm – 01:15:29 pm; 01:45:03 pm – 03:15:29 pm; 03:39:58 pm – 04:34:57 pm; 05:00:06 pm – 05:00:29 pm; 05:20:02 pm – 07:29:59 pm; 07:45:00 pm – 10:45:29 pm; 11:00:02 pm – 11:15:29 pm; 11:30:02 pm – 11:45:56 pm – **12/11/18:** 12:00:04 am – 02:45:03 am; 04:20:07 am – 01:20:00 pm; 01:39:59 pm – 03:10:04 pm; 03:25:01 pm – 04:35:00 pm; 06:00:03 pm – 07:35:00 pm; 07:45:08 pm – 09:34:56 pm; 10:00:01 pm – 10:40:32 pm; 10:57:22 pm – 11:10:00 pm; 11:24:58 pm – **12/12/18:** 12:29:59 am 12/12/18: 12:49:59 am – 04:10:29 am; 04:25:00 am – 05:19:58 am; 05:35:01 am – 06:35:03 am; 06:55:01 am – 08:10:04 am; 08:25:05 am – 09:22:03 am; 09:45:02 am – 10:20:04 am; 10:39:59 am – 10:55:30 am; 11:17:31 am – 12:25:00 pm; 12:44:56 pm – 03:30:01 pm; 03:45:00 pm – 08:15:05 pm; 08:30:02 pm – 08:35:05 pm; 08:50:00 pm – 09:04:52 pm; 09:20:00 pm – **12/13/18:** 12:15:04 am 12/13/18: 12:34:48 am – 01:27:22 am; 01:27:16 am – 03:55:07 am; 04:15:02 am – 04:39:56 am; 04:55:00 am – 05:35:11 am; 05:55:06 am – 06:39:59 am; 06:55:02 am – 07:00:13 am; 07:15:02 am – 10:20:09 am; 11:00:05 am – 02:05:05 pm; 02:30:02 pm – 02:40:01 pm; 03:00:00 pm – 04:40:04 pm; 05:10:00 pm – 05:54:57 pm; 06:39:31 pm – 06:49:55 pm; 07:05:08 pm – 08:09:59 pm; 08:30:04 pm – 08:45:11 pm; 09:15:02 pm – 09:59:55 pm; 10:15:04 pm – **12/14/18:** 12:35:03 am 12/14/18: 01:00:05 am – 03:04:51 am; 03:29:50 am – 06:29:25 am.

take insulin. Well, you have to know exactly what kind? What amount? What is going to fit this particular person's diagnosis to be able to get them the help that they need to bring them back to normal function. I am not equipped for that, never have been. And we need a psychiatrist or somebody with – I do have mental health counselors, but I don't have mental health physicians.

***

We still need constitutional caring for those that have been convicted or those that have been charged with crimes. Yeah, they should not be out in society. Yes, they have to be protected to be able to go to court before they're found guilty. But if there's a medical condition, they can be cured or helped by medical. We are not a medical facility here.

I do have a clinic, like any other town would have for their people. But that Clinic is not scaled to be able to take care of the issues that come from mental illness.

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This man has not been able to communicate with us normally since he's been incarcerated. And so we would have to do the research, I've got 300 and some odd inmates in here, that's not an easy thing to do. This is just not the place.

34. On Monday, December 10, Lance's friend Ms. Oram checked an online court website to see when Lance would be released. She noticed that the scheduled 1:30 p.m. arraignment had been "vacated." Ms. Oram called the Jail to ask what had happened with the hearing, and was told that it was canceled because Lance was "incapacitated." As Sheriff Nielsen later stated, "By the time we were having availability for him to go to arraignment on that charge, he was too incoherent to be able to face arraignment."

35. Ms. Oram then asked to speak with Lance. Her request was refused on the stated ground that Lance was "incapacitated." Ms. Oram, who is a nurse, asked to speak to the Jail's medical team. She stated that Lance had PTSD and was bipolar. She said she was certain that Lance was having a manic episode, and that he needed to be hospitalized. Ms. Oram stated that

she knew Lance's prescriptions and his health care providers, and that Lance needed his medications. The Jailer said "our medical team is on that," or words to that effect.

36. As reflected by the Cell 8 video, Lance was getting little or no sleep, and his behavior was becoming increasingly erratic. Some examples on December 10 included:

a) At 4:48 a.m., "While I was working in central control, I was looking at the camera in cell 8, when I observed an inmate later identified as Lance Quick, getting something out of his right pocket (appeared to be piece of paper) and placing it in his mouth, I contacted booking via telephone." (Officer A K Huff)

b) At about 7:24 a.m., Lance peeled a hard boiled egg and rubbed it onto his hair, arms, and chest.

c) At about 11:28 a.m., Lance "washed" his genitals and backside with what appears to be applesauce.

d) At about 12:25 p.m., Lance attempted to adhere slices of bread to his genitals, and became visibly confused when they would not stay in place. After some contemplation, Lance made a gesture to the camera like "I've got it!" He pulled on his boxers and then placed the bread inside.

37. At about 7:56 p.m., Kim and Shauna called Sheriff Neilsen and asked if he was in town. Nielsen stated that he was not, that he was attending a law enforcement event out of town. Mr. Quick asked if Nielsen was aware that Mr. Quick's son was in custody. Mr. Quick told Sheriff Nielsen that Lance was bipolar, that he needed his medication, and that he needed to be in the hospital. Nielsen said he would check on it.

**Day 4 *(Tuesday, December 11, 2018)***

37. At about 2:50 a.m., Lance was given a shower for the first time since his arrival at the Jail.

38. At about 3:51 a.m., a Jailer noted: "While in booking Inmate Lance Quick was moved from cell 8 to cell 7 to deep clean 8. While the trustee was cleaning he *[sic]* showed me the mat which was covered in feces. I instructed the trustee to throw away that mat."

39. The trustee in question was Savana Howerton. Ms. Howerton states:

> I was absolutely shocked by what I saw upon entering the cell. I was immediately disgusted and overwhelmed by what I saw. The smell was the first thing I noticed. There was urine and feces EVERYWHERE. There was urine all over the floor. There was feces on the floor, the walls, Lance's mattress and blankets and in a milk carton given to him at meal time. There was fresh feces (that was wet) as well as dry feces, making it clear that it had been there for a while. The feces ha[d] been on the walls so long that it had stained them.

40. At about 4:54 a.m., Jailer Ranere tried to speak with Lance through the cell door. Ranere logged:

> I asked QUICK if he was withdrawing from something to which he responded "OH GOD, YES!" however he wouldn't tell me what from. So I told him I'm going to figure out what's going on. "He said that was a good one" I obviously responded with what was. He said "Me and Jodi are going to figure this out." "When she took the beach house ... that was a good one" I asked if this was recently he stated "that was a good one". Unable to be booked in at this time. Nurse notified of possible withdrawal.

41. At this point, trustee Howerton noticed that Lance was talking differently than when he first arrived. For example, on one occasion she heard Lance exclaim, "You need to read the Bible! I am the Alpha and the Omega!" Before the change in Lance's communication, Howerton had heard Lance ask a Jailer for his medications.

42. At about 2:16 p.m., Lieutenant. Johnson asked Corporal Luce to "have medical go talk with Inmate Quick." Luce told "Nurse Melanie" of the request.

43. Between 2:16 p.m. and 4:56 p.m., Cpl. Luce prepared an "Affidavit Supporting the Need for Detention Without a Hearing 66-320/66-329 Administrative Hold." Under penalty of perjury, Cpl. Luce declared:

> I, Cpl Luce, a Peace Officer,... have taken the above name person into custody as an alleged emergency patient as of Date: 12-11-18 at Time: 1530 hours [3:30 p.m.] because I believe that he/she is:
>
> [X] Gravely disabled due to mental illness as evidenced by: his actions of talking to things as if someone is there.
>
> ***
>
> [X] He/she is currently detained at the Bannock County Detention Center.
>
> I understand that this hold will expire in twenty-four (24) hours including weekends and holidays unless the court orders a temporary custody order requiring the person to be held in a facility and requiring an examination of the person by a designated examiner per Idaho Code.

44. Cpl Luce faxed the signed affidavit to Magistrate Judge Bryan K. Murray at about 4:06 p.m., along with a proposed Temporary Custody Order. The proposed order stated, among other things:

> [X] the Respondent [Lance Quick] has been taken into custody and detained as an alleged emergency patient for observation, diagnosis, evaluation, care or treatment of mental illness pursuant to Idaho Code § 66-326 and
>
> [X] the Respondent is gravely disabled due to mental illness...
>
> It is here by ordered that the Respondent be held in a facility for observation, diagnosis, evaluation, care or treatment of mental illness; provided, however, that the Respondent shall not be detained in a nonmedical unit used for the detention of individuals charged with or convicted of penal offenses....

45. The order was signed at about 4:25 p.m. by Judge Murray. A copy was transmitted back to Cpl. Luce.

46. Judge Murray's order called for Lance to be held in a facility for observation, diagnosis, evaluation, care or treatment of mental illness. The order stated that Lance "shall not be detained in a nonmedical unit used for the detention of individuals charged with or convicted of penal offenses." The Temporary Custody Order authorized the Sheriff, his Jailers, or any other local law enforcement to transport Lance to an appropriate facility.

47. No effort was made at that time to transport Lance to a medical facility. Instead, despite the language of the order, the Jailers continued to house Lance in a cell used for the detention of individuals charged with penal offenses.

48. At about 6:15 p.m., Nurse Melanie Sparrow went to Lance's cell. Prior to this visit, Lance had on multiple occasions made (patently irrational) attempts to get out of the cell. For example, he had repeatedly pounded on the cell door and window, and had tried to get his fingers underneath the cell door to pull it open.

49. When the Jailer and nurse stood in the doorway of the cell, Lance unsuccessfully attempted to run out of the cell.

50. At 6:27 p.m., Sheriff Nielsen called Kim Quick's cell phone. Nielsen said he was upset that Lance had not yet been transferred, and that he would make sure it was dealt with. Mr. Quick told Nielsen that Lance had been on his medications for years, that he needed the medications, and that he needed to be hospitalized. He told Nielsen that the longer Lance went without his medications, the worse it was going to be getting back. Mr. Quick told Nielsen that as things progress, Lance was going to suffer irreversible physical damage. He said that Lance's need for his medications was like a diabetic's need for his insulin – "yours is insulin, his is Lithium and Lamictal." Nielsen said that a Designated Examiner (DE) was with Lance as they

were speaking, doing the paperwork, and that Lance would be out within 12 hours or less. The Quicks were relieved. (There was no examiner with Lance at that time. The DE did not see Lance until the next afternoon.)

51. As reflected by the camera feed, Lance's behavior had been increasingly incoherent throughout the day. At about 7:41 p.m., Lance appeared to soak his underwear in liquid from or near the drain in the floor, then wring it out into his mouth and onto his head.

52. At this time, Jailers knew that Lance was pacing a lot and talking to himself. They knew he was not eating or drinking regularly, and that he was exhibiting strange behavior with both food and water. For example, at about 11:18 p.m., Jailer Lanere logged that Lance was "Given three (3) cups of water at this time. However it should be noted the third one was not taken but dumped on his mat. Inmate refused to give the cup back at this time."

**Day 5** ***(Wednesday, December 12, 2018)***

53. At about 12:31 a.m., Jailer Ranere wrote that Lance was "Offered and accepted a single cup of water at this time. QUICK took one sip and poured the rest on his mat."

54. At about 6:40 a.m., Jailer Ferrin logged that "Inmate Quick at breakfast 0628 hours put all his food down the drain."

55. In the morning, Lance's friend Ms. Oram called the jail and said that Lance was supposed to be released; was there anything that she needed to do for that to happen? A Jailer told Ms. Oram that the Jail had no release order.

56. Kim and Shauna Quick were also looking for Lance. They called the local hospital, but were told that Lance was not there. When they could not locate him, they called the jail. The Quicks said they were told that Lance was supposed to be released, and they were

trying to find him. The Jailer told them that Lance was still at the Jail, and was incapacitated. The Quicks then indicated that Lance was supposed to have been transferred to the hospital. The Jailer asked who had told them that, and the Quicks indicated it was Sheriff Nielsen. The Jailer responded that he had not heard anything about it, and that Lance had to go before a judge.

57. At about 10:27 a.m., Jailer Luce logged:

> Attempted to pull him out to clean his cell as he has thrown his garbage all under the door, and it stinks of pee. He didn't want to follow instructions at this time. He has been dancing around naked in his cell all morning, along with making "snow angels on the floor". He also has been yelling sporadically and banging on the walls.

58. The camera feed continued to display Lance's irrational behavior. For example, at about 11:06 a.m., he began to "wash" the floor with a piece of ham. (He often wiped the floor and walls with his blanket or jumpsuit.)

59. At about 11:10 a.m., Lance, completely naked, played with a spoon against a wall, started hopping around the cell, and then screamed.

60. At about 2:50 p.m., Designated Examiner Marty Cooke from the Idaho Department of Health and Welfare examined Lance. Cooke concluded that Lance was "mentally ill" and "gravely disabled," and "lack[ed] the capacity to make informed decisions about treatment." Cooke wrote that Lance had an "unspecified psychosis," was "disoriented, delusional, not attending to basic living skills, [and] has appeared to be responding to internal stimuli."

61. At about 3:08 p.m., Cooke faxed the Jail a "list of possible community hospitals for Lance Quick." The list included seven local hospitals: Portneuf Behavioral Health Services (Pocatello), Safe Haven (Boise), EIRMC Behavioral Health Center (Idaho Falls), St. Luke's-

Canyonview (Twin Falls), Intermountain Hospital (Boise), West Valley Medical Center (Caldwell), and Kooenai Health (Coeur D'Alene).

62. At about 7:37 p.m., Jailer Topliff left a message with Portneuf Medical Center to speak with someone about having Quick admitted to a behavior health center. At about 9:30 p.m., Topliff logged that he had spoken with an employee of Portneuf's behavioral health unit. This employee had advised Topliff that although there was no room at Portneuf's behavioral health unit for an admission, Lance could still be brought to the hospital itself for testing and other medical treatment, as long as he was accompanied by a Jailer. Topliff wrote:

> Just spoke with Cindy BHAT worker. Cindy advised that they are limited in the patients they are currently accepting at BHS due to the level of acquity [sic] of the current patients. Cindy advised that Quick could be brought to PMC and the process started. I advised her that I would call PEAK Transport to get him up their. Cindy advised that she believed a Law enforcement officer must standby and not just PEAK. I questioned that with, it's been done before and we contracted with PEAK to ease the burden on us. Cindy advised she would call the house supervisor and get back with me on that. Once I hear from Cindy, pending the outcome of that question. Arrangements will be underway to get Quick out of jail.

63. This resistance to having a Jailer accompany Lance to the hospital instead of having a private ambulance take him was consistent with the views and policy of the Bannock County Sheriff that jailers should not have to transport mentally ill patients to hospitals for treatment. At his December 17, 2018, press conference, Sheriff Nielsen complained, "Our state, the lowest in all of the nation in mental health, we're still putting handcuffs on mental illness people, putting them in the back and having law enforcement transport them from hospital to hospital. Any other disease it would be done by an ambulance."

64. Lance, meanwhile, continued to exhibit bizarre behavior and restlessness. For example, at about 8:35 p.m., Lance lay naked on the floor mat, repeatedly spun himself around, and tried to throw his blanket under the cell door.

65. At about 8:42 p.m., jail logs recorded, "tried offering QUICK a cup of water a few minutes ago. However, inmate wouldn't come get the cup from me. Water not given."

66. At about 8:51 p.m., Kim and Shauna Quick placed another call to Sheriff Nielsen's cell phone, and left a voice mail when he did not answer.

67. At about 9:14 p.m., Jailer Ranere wrote, "Tried giving cup of water at this time. QUICK grabbed cup a[nd] turned i[t] upside down on the ground. No water was drank."

68. At about 10:09 p.m., Jailer Topliff received confirmation from the Portneuf employee that if Lance were brought to the hospital, he would need to be accompanied by someone from the jail. Topliff wrote:

> Spoke with Cindy. All units, except BHS are on divert and BHS will not take Quick. Per Cindy, PEAK cannot bring an inmate up to the hospital for labs and admission, it must be law enforcement. Cindy said to call Andy (BHAT worker) 239-1463 or Operator 239-1000 ask for Andy, tomorrow after 0930 to see if room opened up for placement.

69. The jail declined to take Lance to the hospital under that condition, so Lance remained in his cell, his condition continuing to deteriorate. Neither Jailer Topliff nor anyone else ever attempted to contact any of the other six behavior health facilities that had been identified for them by Mr. Cooke, or any other medical facility.

**Day 6 *(Thursday, December 13, 2018)***

70. At 12:15 a.m., Lance began what was a pattern for most of the day, lying on and rolling around the floor and wrestling with the floor mat. On a few occasions during the day,

Lance attempted to stand, but appears to have been unable to remain upright more than a few seconds at a time.

71. At about 4:02 a.m., Jailer Ranere logged, "I offered QUICK a drink for several minutes tried to get him to come up to the chow port for it. However, I did not succeed at this time." 41 minutes later, Ranere again wrote, "Tried offering water again at this time. QUICK would not come get the cup."

72. At about 5:40 a.m., Jailer Ranere wrote, "Offered water at this time. QUICK could not understand the concept at this point."

73. At about 6:42 a.m., Jailer Woodward wrote, "Wouldn't take breakfast. I know he did not eat yesterday either. For this purpose I have left a tray in booking to see if by chance in the next few minutes he just happens to ask for something to eat. He is not exhibiting behavior that would suspect me to think he will do this but I figure it would be worth the effort just in case." At 11:17 a.m., Lance "refused lunch."

74. At about 10:29 a.m., Jailer Tyrrell replied to Jailer Topliff's earlier email regarding BHAT [Portneuf's behavior health unit], "I've tried both numbers several times to get a hold of Andy, but haven't had any luck. I left a message and will pass on any information when I get it." No further references to BHAT are found in any logs. No attempt was made to transport Lance to the non-behavioral unit of the hospital for medical treatment, or to contact any other medical facility.

75. At some point on December 13, Lance was seen by another Designated Examiner, Verena M. Roberts, PhD. Dr. Roberts reaffirmed DE Cooke's conclusion from the day before that Lance was mentally ill, was experiencing an unspecified psychosis, "responding to internal

stimuli, not eating, [and] unresponsive." DE Roberts wrote, "[Lance] is unresponsive, not eating cannot currently respond to questions and not aware of environment. Hence at risk of harm." She further noted that Lance was "naked in his cell, 5 days not improving."

76. At about 5:02 p.m., Jailer Jackson logged, "Would not respond to dinner call. I offered the tray to him several times and he didn't come to the chow port for the tray. I have left it in booking incase he requests food."

77. At 5:25 p.m., Sheriff Nielsen called Kim Quick's cell phone. Nielsen indicated he had just gotten back in town and said, "I'm pissed. They haven't done anything." Nielsen told the Quicks that he would take care of everything first thing in the morning. Mr. Quick told Nielsen that it was taking too long, that there was going to be permanent damage, and that Lance would never be the same physically or mentally.

78. After speaking with Sheriff Neilsen, the Quicks called Lance's friend Ms. Oram, who said she would pick Lance up when he was released. Ms. Oram met the Quicks at Lance's house where they picked up some clothing for Lance and supplies for his dog.[3]

79. At about 5:52 p.m., Jailer Tyrrell logged, "Inmate Quick refused his meal again at dinner. He was offered his meal several times during the meal pass but would not acknowledge the officers at the chow port. He has been offered water on most walks as well, but is not taken water since I have been in booking at 1500 [3 p.m.]. Medical was also notified."

80. At about 6:38 p.m., Jailer Hapke logged, "Inmate Quick has not received a meal or water to the best of my knowledge all day. I have offered however, Quick just stares and

[3] At the time of his arrest, Lance's dog was with him. Pocatello police, claiming they could not locate any family members to take custody of the dog, had taken it to the animal shelter. Ms. Oram had located the dog on Wednesday and, after calling Kim Quick, the shelter had released the dog to her.

appears to be incapable of comprehending anything anyone says. I cannot get a response from him at all."

81. At about 6:43 p.m. Jailer Hapke logged, "While conducting a walk, again I offered Inmate Quick water. He was lying on his stomach and I noticed several bruises on his back as well as a few red welts on his buttocks. Inmate Quick did not accept water."

82. At about 7:14 p.m., Jailer Schei logged, "at approximately 1855 [6:55 p.m.] I offered inmate Quick water, With me was Deputy Hapke."

83. At some point in the "late evening," "the night nurse attempted to assess patient and give him Gatorade." As reflected in the cell video, Lance was unresponsive. (No log entry was made for this interaction until 8 p.m. the following day, after Lance's death.)

84. Shortly before 11:48 p.m., the Jail placed Lance on what it called "Close Custody Watch" for the first time, marking the boxes for "mental" and "medical". At that time, Jail logs show that Lance was "lying down – asked him if he wanted juice, continued laying on the ground moaning incoherently." At that point, Lance's kidneys were failing due to dehydration, which would cause bodily pain.

85. During the evening, Lance's friend Ms. Oram called the Jail and asked them to let her see him. She urged that, if she could speak with Lance, he might listen to her. A Jailer refused, once again stating that Lance was "incapacitated."

***Day 7 (Friday, December 14, 2018)***

86. By the morning of December 14, Lance was completely unresponsive, and "would not recognize the jailers when they were there." Close Custody Watch Log entries from 12:03 a.m. until Lance's death all reflect a lack of responsiveness.

87. By 12:35 a.m., Lance was too weak to pull the blanket out from beneath him and had to roll over in order to cover himself with it. He spent the night sitting, curling up in the fetal position, and occasionally trying to get up.

88. At about 5:18 a.m., Jailer Ivins logged, "While working in booking Inmate Quick was offered water or juice every walk, Quick did not respond at any time."

89. At around 6:50 a.m., Jailer Vandyke logged, "Inmate Quick was awake but was unable/unwilling to retrieve his breakfast tray this morning. He rolled around on the floor and then sat against the wall."

90. At approximately 7:21 a.m., Jailer Billings spent approximately two seconds looking into Lance's cell. She then noted on the Close Custody Watch Log that "people want to talk to him / no response."

91. Shortly afterward, Jailers began logging whether Lance was still breathing. At approximately 07:40 a.m., Jailer Billings spent approximately five seconds looking in on Lance, and then noted on the Close Custody Watch Log that he was "on left side breathing."

92. According to a late log entry (8:17 p.m.) by Nurse Zhanna Crystal, "In the morning on 12/14/18, Kenneth with mental health was notified that the patient needs to be seen. After Kenneth came back from seeing the patient, he told the nurse that he is transferring the patient to State Hospital. During report at 8 a.m., the night nurse reported to the morning nurse that patient is being transferred to the State Hospital per Kenneth (MH)." These alleged events do not appear on the camera footage of Lance's cell, or in the camera footage of the hallway outside Lance's cell. Nor have Plaintiffs seen reference to them in any other record.

93. At approximately 7:30 a.m., Magistrate Judge Murray arrived at the Jail. Judge Murray stood near Lance's cell but did not look into it. He was escorted to a different location in the Jail. A few minutes later, a public defender arrived. The attorney attempted to communicate with Lance by crouching down and speaking through the chow port, but Lance did not respond. The attorney was then escorted in the same direction as Judge Murray.

94. Apparently, a commitment "hearing" was then held somewhere in the Jail. Lance remained in his cell and was not present at the hearing. Judge Murray signed an order declaring that Lance was mentally ill and "gravely disabled," and "lack[ed] the capacity to make informed decisions, thus requiring medical therapeutic treatment." The order committed Lance to the custody of the Idaho Department of Health and Welfare for observation, care, and treatment.

95. The Jail did not transport Lance to the hospital for medical treatment, nor contact any other medical facility. An "Order of Disposition" was signed by DE Cooke on behalf of the Idaho Department of Health and Welfare stating:

> The undersigned designates the disposition of said person [Lance] to be:
>
> Continued inpatient hospitalization at BHS, Safe Haven, or BHC until a bed becomes available at State Hospital South, or State Hospital North. **Bannock County Jail** *[handwritten on the document].*

96. At about 8:41 a.m., Jailer Billings logged, "Did not responded *[sic]* to my offer of food and/or water." Again at 9:55 a.m., Jailer Billings again logged, "Did not responded to my offer of water and food."

97. At about 10:20 a.m., Lance rolled over onto his back and died.

98. At about 10:25 a.m., Jailer Billings looked into Lance's cell and saw him on his back, unresponsive, with his eyes open. Lance's chest did not appear to be moving, and he did not appear to be breathing.

99. Jail staff entered Lance's cell and were unable to detect a pulse. Lance was "extremely cold to the touch."

100. Jail staff began CPR and brought an AED machine to shock Lance, but were unsuccessful in their attempts to revive him.

101. EMT personnel arrived, and made the following log entry:

> Jail staff describe pt as being in this cell alone for the past 7-8 days. Pt is on a psychiatric hold, and has not been with other inmates. PT has not been eating or drinking for last 7-8 days. Pt is significantly bruised all over, Abd, legs, feet.
>
> Pt appears disheveled, gaunt and emaciated. Lips chapped, eyes sunken and open....

102. Nurse Tina Morrison logged that "Inmate Quick was taken by ambulance to Portneuf Medical Center ER at approx. 11:50 a.m."

103. A hospital nurse called Mr. Quick and told him that his son had been brought in from the Jail. She told Mr. Quick he needed to get there right away.

104. As Kim and Shauna rushed to the hospital, Sheriff Nielsen called. Mr. Quick said, "I don't have time to talk to you right now. I am so pissed. My son died or is dying!"

105. At the hospital, the Quicks' worst fears were confirmed. Mr. Quick called his deputy coroner, and when he arrived, they did a quick examination of Lance. Mr. Quick knew there would be an autopsy, so he "tagged" his son's body (placed a tag on Lance's thumb for identification). They then placed Lance's body into a bag, sealed it, and tagged it. Mr. Quick then stepped away so that another county's coroner could handle the investigation.

106. Shauna Quick called Ms. Oram and screamed that Lance was dead. Ms. Oram could not believe it. She hurried to the hospital, where she saw Lance. His face was sunken, he was bruised everywhere, his nails and toenails were broken. He was the thinnest she had ever seen.

107. Because Lance was the son of the Bannock County Coroner, the investigation was assigned to the Bingham County Coroner's office. An autopsy was performed by Ada County forensic pathologist Garth D. Warren. Dr. Warren was advised by EMTs or Jailers that "the decedent remained alone in his cell from 12/08/2018 to 12/14/2018, during which time he reportedly did not eat or drink anything. He also reportedly talked incoherently, was unaware of his environment, and was unresponsive to questions."

108. Dr. Warren concluded that the cause of Lance's death was "complications of hypernatremic dehydration and ketoacidosis secondary to a prolonged period without food or water." Dr. Warren further noted that "vitreious fluid analysis was significant for marked hypernatremia (indicative of hypernatremic dehydration) and markedly elevated levels of creatinine and urea nitrogen (indicative of renal failure)."

109. In a sign of how long and how severely Lance's body had been dehydrated, Mr. Quick noted at the hospital that "mummification" had already begun on one of Lance's toes, and Dr. Warren noted that the body showed signs of "early decomposition."

110. At the time of his death, Lance weighed 149 lbs.

111. Sheriff Nielsen has acknowledged that, while incarcerated in the Bannock County Jail, Lance did not receive the "proper treatment and the proper medication." After Lance's death, the Quicks went to the Jail to get records regarding Lance's incarceration. While there,

Sheriff Nielsen approached the Quicks and said, "I feel so bad guys, you know, you're family, we've worked together for so long." He added, "This was a homicide."

112. At the time of his death, Lance's body was so covered in bruises that it took an entire page to list them all:

> Two faint red-purple ovoid brises, measuring 1/2 and 3/4 inch in diameter, involving the distal left triceps region, just above the left elbow.
>
> Collection of pink-red bruising measuring 2 1/2 x 1 inch involving the posterior aspect of the proximal right forearm.
>
> Faint purple bruise measuring 1 x 3/4 inch involving the anterior aspect of the mid right forearm.
>
> Pink-red bruising measuring 3 1/4 inches in length x 1 1/2 inches in width involving the anterior right wrist.
>
> Multiple irregular and linear, red- brown, dried superficial abrasions ranging in size from 1/16 to ¼ inch on the knuckles of the right 2nd, 3rd, 4th and 5th fingers; faint red-purple bruising is associated with most of the abrasions.
>
> Brown, dried, partially scabbed superficial abrasion measuring 3/16 inch involving the back of the right hand, near the base of the pointer finger
>
> Collection of pink-red bruising spanning a total area of 3 x 1 1/2 inches involving the right thumb, right anatomical snuffbox and a portion of the back of the right hand; multiple small superficial abrasions are scattered within the bruising on the back of the right hand.
>
> Three small pink-red superficial abrasions ranging from 1/16 to 3/16 inch involving the back of the left thumb, near the base of the thumb.
>
> Dark red-brown superficial abrasion measuring 3/8 x 3/8 inch involving the back of the left pinky finger.
>
> Irregular, brown, dried superficial abrasion measuring 1/8 inch involving the back of the left hand, between the third and fourth knuckles.
>
> Collection of pink-red bruising and superficial abrasions measuring 4 1/4 x 3 1/2 inches involving the right knee.
>
> Faint pink-red bruise measuring 3x 1 1/2 inches involving the proximal left shin.

Collection of pink-red bruises and small superficial abrasions spanning a total area of 4 x 2 1/2 inches involving the left knee.

Multiple red-purple bruises ranging in size from 1 to 3 inches in greatest dimension involving the distal right shin, medial aspect of the right ankle and top of the right foot; few small pink-red superficial abrasions ranging in size from 1/16 to 1/ inch involve the top of the right foot and top of the right second toe.

Irregular dark purple bruise measuring 4 x 1 1/2 inches involving the medial aspect of the left ankle.

Multiple faint red-purple bruises ranging in the size from 1/2 to 3/4 inch involving the top of the left foot and lateral left ankle.

113. No one has been disciplined in connection with the death of Lance Quick in the Bannock County Jail. To the contrary, on December 17, 2018, Sheriff Nielsen held a press conference at which he attempted to deflect blame for Lance's death.

114. At the press conference, Sheriff Nielsen made public statements that were false or misleading regarding the treatment of Lance Quick in his jail. Some examples include:

| **Sheriff Nielsen's statement(s)** | **Facts** |
|---|---|
| Lance died from a "heart attack" *(stated repeatedly)* | Lance died from dehydration and related conditions from a "prolonged period without food or water" |
| "We had several calls to Department of Health & Welfare to find a bed for him." *(stated in a way to suggest the calls were made throughout Lance's incarceration)* | Lance's needs went far beyond admission at a behavior health facility. He was undergoing severe physical distress, and needed emergency medical care that could (and should) have been provided by a hospital emergency room, after which he could have returned to the Jail in a stabilized condition. No calls were made regarding hospital assistance once the Jail was |

| | |
|---|---|
| | told that someone from law enforcement would have to accompany the inmate.<br><br>With respect to the separate issue of admission to a behavior health facility, no calls of any kind were made until Day 4 (Wednesday, December 12). After being told that the behavioral health facility at Portneuf did not have a bed for Lance's admission at that time, Jailers refused to check bed availability at any of the other behavioral health units that had been suggested to them by DE Cooke. |
| "While they were preparing for that paperwork to be able to transport him to State Hospital south, he went into cardiac arrest." | No court order or "paperwork" is required to transport a critically ill inmate to an emergency room or hospital for medical diagnosis and treatment. (Indeed, the constitution requires it.) In any event, the jail had already received a court order on December 11 expressly authorizing transportation of Lance to any medical facility. |
| "I should not have to have somebody in my jail for a week, let alone two or three months that we've had in the past, and when we're given an excuse the excuse is Sheriff, we know what the code says but they're safer in jail than they are on the outside." | Jail logs do not reflect anyone attempting to justify the refusal to transport Lance for medical treatment because he would be "safer" in jail. Jailers refused to take Lance for medical treatment because the hospital required a jail inmate to be accompanied by a law enforcement officer. |
| | |

115. The Quicks were in shock at their son's death. As Ms. Oram describes it, Lance's death "crushed Mrs. Quick's spirit. It broke her." Since Lance's death, Mrs. Quick experiences severe anxiety. For example, if she cannot get hold of Ms. Oram, she fears that something bad

has happened to her. She continually imagines Lance's last days. Mr. Quick is also devastated, feeling overwhelming sadness mixed with anger.

116. The Quicks miss their son, the interaction, the dinners, the holiday get-togethers, the regular phone conversations.

117. As a direct and proximate result of his treatment while detained by, and/or in the custody of, the Bannock County Jail, Lance Quick experienced extraordinary physical and mental pain and suffering, and suffered fatal injury.

118. Lance's treatment in the Bannock County Jail was in violation of state law and of the United States Constitution.

119. As a direct and proximate result of these violations, both the Estate of Lance Quick and his parents incurred loss compensable under applicable law.

**CLAIMS FOR RELIEF**

120. The headings stated under each individual cause of action are for general descriptive purposes only, and are not intended to limit the Plaintiffs' claims for relief. Plaintiffs reserve the right to assert any legal theory or claim for relief applicable to the facts set forth in this Complaint.

121. The claims for relief asserted herein are asserted individually and/or in the alternative.

## FIRST CLAIM FOR RELIEF

*42 U.S.C. §1983 – all individual defendants*

*Violation of the 14th Amendment (Failure to Provide Medical Care)*

122. Plaintiffs incorporates by reference all other paragraphs of this Complaint as though fully set forth herein.

123. The 14th Amendment to the United States Constitution granted Lance Quick the established right not to have officials exhibit deliberate indifference to serious medical needs, including those caused by physical and psychiatric conditions and withdrawal from prescription medications.

124. At all times hereto, and in performance of the acts set forth herein, Defendants acted under color of state law. At all times relevant hereto, and in performance of the acts set forth herein, Defendants actively and personally caused the violations of constitutional rights alleged herein.

125. The conduct of the defendants alleged herein, including (a) denying Lance Quick medical treatment, and (b) failing to intervene when they knew that Lance could not eat or drink for himself violated his rights under the Fourteenth Amendment.

126. As described above, each of the individual defendants made intentional decisions with respect to the conditions under which Lance was confined, which conditions put Lance at substantial risk of suffering serious harm. The defendants did not take reasonable available measures to abate that risk, even though a reasonable official in the circumstances would have recognized the high degree of risk involved (and they did in fact recognize it). By not taking

such measures, the defendants caused Lance's death. Among other things, and as described above, defendants:

a. Were aware from the inception of his incarceration that Lance Quick was seriously mentally ill, exhibiting bizarre behavior, and unable to recognize or care for his own needs;

b. Were aware that Lance needed medical treatment, including prescription and provision of medications and treatment for dehydration, and that they could get Lance such treatment at a local hospital if they were simply willing to transport him there;

c. Were aware that the Court had ordered that Lance be placed in a medical facility and not held in a cell used for the detention of persons charged with an offense;

d. Were aware that Lance Quick had not anything to eat or drink for several days; were aware that Lance's cell had no sink, toilet or other source of water;

e. Did not refer Lance for medical diagnosis or treatment, or for mental health treatment, despite his obvious and known needs;

f. Were deliberately indifferent to Lance Quick's medical and psychological needs.

127. In addition to the foregoing, defendant Nielsen was affirmatively told by Lance's father, whom Nielsen knew to be the County Coroner, of the urgent need for Lance to have his medications (including naming the medications), the significant risk of serious physical harm that Lance was facing, that he needed to receive hospital treatment.

128. In addition to the foregoing, an unidentified Jailer refused to let someone calling on Lance's behalf – a nurse – speak to the Jail's medical staff, and disregarded the caller's officer to provide the names of Lance's prescriptions and medical providers.

129. In addition to the foregoing, Jailer Topliff intentionally refused to arrange transportation of Lance to the local hospital for medical treatment because of Sheriff's Nielsen's publicly expressed views that Jailers should not have to transport mentally ill patients for medical treatment.

130. As a result of the individual defendants' (in)actions described above, Lance Quick suffered a long and solitary death during a prolonged psychotic episode.

131. Defendants' actions and/or inactions violated clearly established constitutional rights of which reasonable Bannock County employees are or should be aware.

132. Lance's estate is entitled to compensatory damages in amount to be determined by the jury.

133. As the result of Defendants' unlawful actions, Plaintiffs have had to retain experienced civil rights counsel.

134. Defendants' actions manifested reckless and callous indifference to the rights and safety of Lance Quick, and punitive damages are appropriate to deter such conduct in the future.

## SECOND CLAIM FOR RELIEF

*42 U.S.C. § 1983*

*Violation of the 14th Amendment (Bannock County)*

135. Plaintiffs incorporate by reference all other paragraphs of this Complaint as if fully set forth herein.

136. As described above, Lance Quick's death resulted from systemic failures within the Jail, including the collective (in)actions of most or all of the Jail staff.

137. The actions of Bannock County jail employees were pursuant to the County's policy, practice, or custom that included, but was not limited to:

a. A policy, custom or practice of not providing mental health screening to obviously mentally ill inmates at or near the time of booking;

b. A policy, custom or practice of providing insufficient mental health care to inmates of the Bannock County Jail;

c. A policy, custom or practice of not using the on-call medical staff for consultation or treatment even when the officers recognize signs of severe mental illness;

d. A policy, custom or practice of responding to severe mental illness by withholding basic necessities, including emergency medical care;

e. A policy, custom or practice of hiring mental health staff indifferent to the medical and psychiatric needs of detainees;

f. A policy, custom or practice of not responding to corrections officer reports and questions about inmates' severe mental illness;

g. A policy, custom or practice of denying detainees medically necessary transfers to a medical facility;

h. A policy, custom or practice of failing to meet widely accepted community standards of care with regard to medical services for detainees;

i. A policy, custom or practice that tolerates and allows abuse and neglect of prisoners and detainees and creates a dangerous condition for those in their care.

138. In addition to the foregoing, Defendant was deliberately indifferent toward the proper training, equipping, and supervision of its employees and agents. For example, Sheriff Nielsen claimed to be "pissed" at the fact that, in his absence, his jailers hadn't "done anything" to help Lance.

139. In addition to the foregoing, Sheriff Nielsen's (in)actions are attributable to the County under 42 U.S.C. § 1983 because he was at all times acting as the final policymaking authority for the jail.

140. The above-described customs, practices and policies of Defendants posed a substantial risk of causing substantial harm to Bannock County inmates, and Defendants were subjectively or objectively (constructively) aware of that risk.

141. Lance's estate is entitled to compensatory damages in amount to be determined by the jury.

142. As the result of Defendants' unlawful actions, Plaintiffs have had to retain experienced civil rights counsel.

**THIRD CLAIM FOR RELIEF**

*42 U.S.C. § 1983*

*Violation of the 14th Amendment (Defendant Nielsen)*

143. Plaintiffs incorporates by reference all other paragraphs of this Complaint as if fully set forth herein.

144. Defendant Nielsen was responsible for supervision and training of the Jailer defendants throughout Lance Quick's incarceration. He was aware of the policies, customs and practices as alleged above, and that said policies, customs or practices created a substantial risk

of causing substantial harm to Bannock County detainees. Despite this knowledge, Nielsen promulgated, allowed, approved of, and/or ratified said policies, customs or practices.

145. Nielsen failed to properly supervise his subordinates resulting in the abuse, neglect and damages alleged herein, including, but not limited to, Lance Quick's otherwise avoidable death.

146. Nielsen failed to adequately train jail personnel in the need for medical treatment for mentally ill detainees when they are booked into jail; the necessity of ensuring prompt medical and psychological treatment for detainees; or to recognize emergency medical situations. As Nielsen stated it, "We're not equipped, we're not trained, and I don't want to be." Nielsen was aware that his failure to train created a substantial risk of harm to Bannock County detainees.

147. As a direct and proximate result of the actions and/or inactions of Nielsen as a person responsible for supervision and training, Lance Quick deprived of necessary hydration, medications, and as a result thereof suffered severe physical, mental, and emotional distress prior to his death.

148. The estate of Lance Quick is entitled to compensatory damages in an amount to be determined by the jury at the time of trial.

149. As the result of Defendants' unlawful actions, Plaintiffs have had to retain experienced civil rights counsel.

150. Nielsen's (in)actions were reckless and callously indifferent to Lance Quick's constitutional rights, and punitive damages are appropriate to deter such conduct.

## FOURTH CLAIM FOR RELIEF

*Idaho Code § 6-903 – All Defendants*

151. Plaintiffs incorporate by reference all other paragraphs of this Complaint as if fully set forth herein.

152. At all times hereto, and in performance of the acts and omissions set forth herein, the individual Defendants were acting within the course and scope of their employment with defendant Bannock County, and/or within the scope of a contract with the County.

153. Bannock County is responsible for the wrongful (in)actions of each of the individual defendants named herein.

154. As described above, the defendants acted in a manner that was grossly negligent, reckless, willful and wanton, and with malice, directly causing Lance Quick's death.

155. As described above, each of the individual defendants made a conscious choice as to his or her course of action, under circumstances where the risk and high probability of harm were objectively foreseeable (and, in fact, subjectively known).

156. The estate of Lance Quick is entitled to compensatory damages in an amount to be determined by the jury at the time of trial.

157. Kim and Shauna Quick are each entitled to compensatory (wrongful death) damages for the loss of their son, as described above.

## PRAYER FOR RELIEF

WHEREFORE, Plaintiffs prays for judgment against Defendants as follows:

1. A declaration and judgment that the actions of Bannock County's policies and customs involved in this incident are and were unconstitutional;

2. Economic and noneconomic damages to the estate of Lance Quick under all Claims for Relief, as sdeemed appropriate by a jury;

3. An award of such damages as under all the circumstances of the case may be just to Kim and Shauna Quick individually, as provided under applicable law and deemed appropriate by a jury;

4. Punitive damages under the First and Second Claims for Relief, and under Idaho state law if amendment to assert such a claim is granted;

5. Attorney fees and litigation expenses pursuant to 42 U.S.C. § 1988, and pursuant to Idaho law and equity to the extent they are available thereunder;

6. Costs as provided under applicable law;

7. Pre-judgment and post-judgment interest as provided under applicable law;

8. All other equitable relief deemed just and appropriate by the Court, including an order requiring Bannock County to provide training regarding medical treatment for mentally ill detainees.

**JURY DEMAND**

Plaintiffs hereby preserve the right of trial by jury and demand such on all issues so triable.

DATED this _____th day of _____, 2019.

CHRISTENSEN & JENSEN, P.C.

_____

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