IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

Leticia Vargas, Administrator of the Estate of Angel Cruz,	)	
Plaintiff,	)	
-vs-	)	
	)	18-cv-1865
County of Cook, Augustus Alabi, Lorraine Chatman, Helen Kanel, Cherri Krzyzowski, Manuel Manalastas, and Dr. Steve Paschos,	)	*(Judge Seeger)*
Defendants.	)	

SECOND AMENDED COMPLAINT

Plaintiff files this second amended complaint with the written consent of defendants and, by counsel, alleges as follows:

1. This is a civil action arising under 42 U.S.C. § 1983. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. § 1343 and 28 U.S.C. § 1367.

2. Pursuant to an order of the Circuit Court of Cook County, Case Number 18 P 1409, plaintiff Leticia Vargas, the mother of Angel Cruz, deceased, serves as the Administrator of her son's estate.

3. Plaintiff's decedent was mentally ill and morbidly obese when he entered the Cook County Jail as a pre-trial detainee on March 15, 2016.

4. Plaintiff's decedent died at the Jail in the early morning hours of March 20, 2016 from a pulmonary embolism caused by deep vein thromboses that resulted from his medical treatment at the Jail.

5. Defendant County of Cook is an Illinois body politic that provides health care services at the Cook County Jail and is the potential indemnifier of the other defendants.

6. Defendants Augustus Alabi, Lorraine Chatman, Helen Kanel, Cherri Krzyzowski, Manuel Manalastas, and Dr. Steve Paschos ("individual defendants") were at all relevant times employed by defendant County to provide medical and psychiatric services to detainees at the Cook County Jail. Plaintiff sues these defendants in their individual capacities.

7. As described below with greater specificity, plaintiff's decedent suffered great pain and suffering and died because of the failure of the individual defendants to take reasonable measures to provide treatment for the serious medical needs of plaintiff's decedent. Plaintiff brings claims under 42 U.S.C. § 1983 against the individual defendants and under state law against defendant County of Cook, invoking the doctrine of *respondeat superior*. Plaintiff does not assert any federal claim against the County.

8. Plaintiff's decedent was processed into the Jail on March 15, 2016.

9. Intake personnel at the Jail accurately recorded in Jail records that plaintiff's decedent was morbidly obese, exhibiting signs of serious mental illness and, immediately before his admission to the Jail, had been treated at a hospital where he had been diagnosed with schizophrenia, paranoid type.

10. Plaintiff's decedent was assigned to an "Acute Care Unit" known as "2N" at the Cermak Hospital within the Cook County Jail, and he remained in that unit throughout his stay at the Jail.

11. Shortly before 6:00 p.m. on March 18, 2016, defendant Dr. Paschos made an entry into the medical chart that plaintiff's decedent was covering his room in feces, urine, and trash and was acting violently, including jumping off his bed and attempting to hit his head against the wall.

12. Defendant Dr. Paschos ordered that plaintiff's decedent be placed into restraints and instructed personnel at the Jail to immobilize plaintiff's decedent by placing his arms, legs, and waist into restraints attached to decedent's bed.

13. Defendant Dr. Paschos made the chart entry and ordered that plaintiff's decedent be placed in restraints without personally assessing plaintiff's decedent.

14. At all relevant times:

a. A reasonable physician would have known that placing a morbidly obese patient, like plaintiff's decedent, into restraints created a significant risk of deep vein thromboses of the legs and a pulmonary embolism;

b. The standard of care required that a physician conduct an in-person assessment before ordering that a patient be immobilized by placing his arms, legs, and waist into restraints;

c. The standard of care for a physician treating a patient like plaintiff's decedent who was morbidly obese and who was to be immobilized in restraints required that the patient receive anticoagulant prophylaxis, such as subcutaneous heparin, or that the patient be given regular "range of motion exercises" to mitigate the risk of clot formation;

d. The standard of care required that the time a patient is held in restraints be minimized;

e. The standard of care required that a physician conduct an in-person examination of the patient every four hours either individually or in consultation with a registered nurse or higher-level practitioner to determine if the patient should continue to be restrained and that the patient be released from restraints if the physician did not order that restraints be continued; and

f. The standard of care required all medical personnel in contact with the patient to be attentive to signs of labored breathing by the restrained patient.

15. As explained more fully below, the conduct of the individual defendants fell below these standards and constituted unreasonable medical care.

16. Jail personnel followed the order of defendant Dr. Paschos and placed plaintiff's decedent into restraints at about 6:00 p.m. on March 18, 2016; plaintiff's decedent remained in restraints for about 17.5 hours until about 11:30 p.m. on March 19, 2016.

17. Dr. Paschos did not administer nor prescribe anticoagulant prophylaxis to plaintiff's decedent at any time.

18. At all relevant times, a reasonable registered nurse would have known that a morbidly obese patient, like plaintiff's decedent, who was being held in restraints without having been prescribed anticoagulant prophylaxis, must receive regular "range of motion exercises."

19. The requirement for regular "range of motion exercises" was implemented through an official policy at the Jail that required a nurse to assist the patient to exercise each limb for not less than ten minutes every 2 hours.

20. At all relevant times, a reasonable registered nurse would have known that a person held in restraints, like plaintiff's decedent, needed to be assessed regularly and that a determination whether to continue the restraint order be made by a physician every 4 hours.

21. The requirement for regular assessments and continuation orders every 4 hours was implemented through an official policy at the Jail.

22. Defendant Kanel worked as a nurse on 2N on March 18, 2016 from 3:00 p.m. until 11:00 p.m.

23. During defendant Kanel's shift, the standard of care required that a physician decide whether to renew the restraint order at or about 10:00 p.m.

24. At about 10:30 p.m. on March 18, 2016, defendant Kanel continued the order to hold plaintiff's decedent in restraints.

25. Defendant Kanel failed to assess plaintiff's decedent before making the order and failed to consult with Dr. Paschos or any other physician before continuing the order to hold plaintiff's decedents in restraints.

26. During defendant Kanel's shift, the standard of care required that a nurse exercise each limb of plaintiff's decedent ("range of motion exercises") for at least ten minutes every two hours, at about 8:00 p.m. and at about 10:00 p.m.

27. Defendant Kanel was aware that plaintiff's decedent required regular range of motion exercises.

28. Defendant Kanel did not provide ten minutes of range of motion exercises at 8:00 p.m., at 10:00 p.m., or at any other time.

29. Defendant Kanel's conduct fell below the standard of care and was unreasonable medical care.

30. Defendant Chatman worked the "overnight shift" as a nurse on 2N from 11:00 p.m. on March 18, 2016 to 7:00 a.m. on March 19, 2016.

31. During defendant Chatman's shift, the standard of care required that a physician decide whether to renew the restraint order at or about 2:30 a.m.

32. Defendant Chatman spoke with defendant Dr. Paschos by telephone at around 1:00 a.m. and Paschos instructed her to continue plaintiff's decedent in restraints.

33. Defendant Chatman did not thereafter receive further instructions from Dr. Paschos or any other physician and, at about 3:55 a.m. without having assessed plaintiff's decedent, she continued the order to hold plaintiff's decedent in restraints.

34. During defendant Chatman's shift, the standard of care required that a nurse exercise each limb of plaintiff's decedent ("range of motion exercises") for at least ten minutes every two hours, at about 12:00 midnight, 2:00 a.m., 4:00 a.m., and 6:00 a.m.

35. Defendant Chatman was aware that plaintiff's decedent required regular range of motion exercises.

36. Defendant Chatman entered plaintiff's decedent's cell at about 12:21 a.m., 12:59 a.m., 4:56 a.m., and 6:00 a.m., but did not on any occasion remain in the cell long enough to provide the ten minutes of range of motion exercises.

37. Defendant Chatman's conduct fell below the standard of care and was unreasonable medical care.

38. Defendant Manalastas worked as a nurse on 2N from 7:00 a.m. until 3:30 p.m. on March 19, 2016.

39. During defendant Manalastas's shift, the standard of care required that a physician decide whether to renew the restraint order at or about 8:00 a.m.

40. At about 8:08 a.m., defendant Manalastas continued the order to hold plaintiff's decedent in restraints.

41. Defendant Manalastas failed to assess plaintiff's decedent before continuing the order to hold plaintiff's decedents in restraints and failed to consult with Dr. Paschos or any other physician before continuing the order.

42. Defendant Manalastas attempted to cover up his wrongdoing by make a false entry in jail records that Dr. Elizabeth Lassen had ordered the continuation.

43. Defendant Manalastas removed plaintiff's decedent from restraints at about 11:30 a.m. on March 19, 2016.

44. During defendant Manalastas's shift, the standard of care required that a nurse provide range of motion exercises for at least ten minutes every two hours, at about 8:00 a.m., 10:00 a.m., and 12:00 noon.

45. Defendant Manalastas was aware that plaintiff's decedent required regular range of motion exercises.

46. Defendant Manalastas entered plaintiff's decedent's cell at about 7:24 a.m., 9:30 a.m., and 11:17 a.m., but did not on any occasion remain in the cell long enough to provide the ten minutes of range of motion exercises.

47. Defendant Manalastas's conduct fell below the standard of care and was unreasonable medical care.

48. Defendant Dr. Paschos knew that the nursing staff was not contacting him every 4 hours as required by the standard of care and turned a blind eye to this failure to provide reasonable medical care.

49. As a result of the failures to properly assess plaintiff's decedent, he was held in restraints much longer than necessary and suffered physical and mental harms.

50. At about 9:45 p.m. on March 19, 2016, defendant Alabi saw plaintiff's decedent banging his head and experiencing labored breathing.

51. A reasonable nurse would have known that the labored breathing was, for a person like plaintiff's decedent who had recently been immobilized for about 17.5 hours, a symptom of pulmonary embolism and that the standard of care and reasonable medical care required an immediate assessment by a physician.

52. Defendant Alabi violated the standard of care and acted in an unreasonable manner when he failed to communicate his observation of labored breathing to Dr. Paschos or any other physician.

53. In the alternative, defendant Alabi communicated his observations to defendant Dr. Paschos and Paschos turned a blind eye to plaintiff's decedent's symptoms of pulmonary embolism and violated the standard of care by failing to conduct or order a full assessment of the labored breathing.

54. A full assessment of plaintiff's decedent's labored breathing would have caused him to be transported to a hospital to receive treatment for the pulmonary embolism and prevented the death of plaintiff's decedent.

55. At about 2:40 a.m. on March 20, 2016, defendant Krzyzowski was informed by a correctional officer that plaintiff's decedent had come to his cell door, was not wearing clothes, appeared to be dazed, had constricted pupils, and was stating "Help me, help me."

56. Defendant Krzyzowski refused to take any action in response to this report.

57. At about 2:50 a.m. on March 20, 2016, plaintiff's decedent fell to the floor in his cell and died; the cause of death was pulmonary embolism caused by deep vein thromboses of the legs.

58. Defendant Krzyzowski's refusal to provide medical assistance caused plaintiff's decedent to experience significant and unnecessary psychological trauma before his death.

59. Had defendant Krzyzowski provided appropriate medical assistance, plaintiff's decedent's would have been transported to a hospital to receive treatment for the pulmonary embolism and would likely not have died.

60. As a result of the foregoing, plaintiff's decedent experienced great pain and suffering, was deprived of his life, and the next of kin of plaintiff's decedent were deprived of his love, affection, care, attention, companionship, comfort, and protection.

61. Plaintiff hereby incorporates herein the 2-622 Certification and Report attached to the Amended Complaint, ECF No. 31 at 11-12..

62. Plaintiff demands trial by jury.

WHEREFORE plaintiff requests that judgment be entered against defendants for appropriate compensatory damages on plaintiff's medical malpractice claim and appropriate compensatory and punitive damages on plaintiff's federal claim and that the costs of this action, including reasonable attorneys' fees, be taxed against defendants.

Respectfully submitted,

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