Docket #1665 Date Filed: 08/14/2024

UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re: TEHUM CARE SERVICES, INC.[1] Debtor.	Chapter 11 Case No. 23-90086 (CML)

WINDHURST'S WITNESS AND EXHIBIT LIST FOR HEARING ON AUGUST 16, 2024

Antoinette Windhurst, individually and on behalf the Estate of David Windhurst (collectively "Windhurst"), files this Witness and Exhibit List for the hearing to be held on August 16, 2024 at 1:00 p.m. (prevailing Central Time) regarding Windhurst's *Motion for Relief from the Automatic Stay* (DE 1573).

Witnesses

1. **Michael J. Crawford**, attorney at Crawford Law, PLLC. Michael Crawford is counsel of record for Antoinette Windhurst, individually and on behalf of the estate of David Windhurst related to a wrongful death personal injury case filed against Corizon Health, among other defendants, in pending litigation in Pima County, Arizona.

2. Any witness called or listed by any other party in interest.

[1] The last four digits of the Debtor's federal tax identification number is 8853. The Debtor's service address is: 205 Powell Place, Suite 104, Brentwood, Tennessee 37027.

2390086240814000000000003

Exhibits

Exhibit No.	Description	Offered	Objection	Admitted/Not Admitted	Disposition
1.	Complaint, Arizona Superior Court, Pima County Case No. C20175978				
2.	Declaration of Nathan S. Rothschild in Support of Windhurst's Motion for Relief from the Automatic Stay				
3.	Windhurst's Proof of Claim				
4.	Any exhibit identified or offered by any other party				

DATED: August 14, 2024

MESCH CLARK ROTHSCHILD

By: *\/s/Frederick J. Petersen*

Frederick J. Petersen
Arizona Bar No. 019944
(Admitted pro hac vice)
259 N. Meyer Avenue
Tucson, AZ 85701
Telephone: (520) 624-8886
Email: fpetersen@mcrazlaw.com
Attorney for Antionette Windhurst, individually and as Personal Representative of the Estate of David Windhurst, deceased

CERTIFICATE OF SERVICE

I certify that on August 14, 2024, I cause a copy of the foregoing document to be served by (a) the Electronic Case Filing System for the United States Bankruptcy Court for the Southern District of Texas to all parties authorized to receive electronic notice in this case, and (b) via electronic mail (where available) on the following parties listed below.

Gray Reed
Jason S. Brookner, Michael W. Bishop,
Aaron M. Kaufman, Lydia R. Webb,
Amber M. Carson
1300 Post Oak Blvd. Suite 2000
Houston, TX 77056
Email: jbrookner@grayreed.com
Email: mbishop@grayreed.com
Email: akaufman@grayreed.com
Email: lwebb@grayreed.com
Email: acarson@grayreed.com

Kevin Epstein, United States Trustee
United States Department of Justice
Office of the United States Trustee
515 Rusk Street, Suite 3516
Houston, TX 77002
Email: ha.nguyen@usdoj.gov
Email: andrew.jimenez@usdoj.gov

Tehum Care Services, Inc.
Russell Perry, Chief Restructuring Officer
Ankura Consulting Group, LLC
2021 McKinney Ave., Ste. 340
Dallas, TX 75201
Email: russell.perry@ankura.com

/s/Frederick J. Petersen
Frederick J. Petersen

4855-2644-7830, v. 1

FILED
TONI L. HELLON
CLERK, SUPERIOR COURT
12/22/2017 1:57:29 PM
BY: ALAN WALKER
DEPUTY

Case No. C20175978
HON. LESLIE MILLER

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MESCH CLARK ROTHSCHILD
259 North Meyer Avenue
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By: Michael J. Crawford, # 13802
96126-1/lav
Attorneys for Plaintiffs

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ARIZONA SUPERIOR COURT

PIMA COUNTY

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ANTOINETTE WINDHURST, a single/widowed woman on behalf of herself and as Personal Representative of the Estate of her deceased husband, DAVID WINDHURST,

Plaintiffs,

-vs-

ARIZONA DEPARTMENT OF CORRECTIONS, a governmental entity; CHARLES RYAN, in his individual capacity as the Director of Arizona Department of Corrections; STATE OF ARIZONA, a governmental entity; CORIZON HEALTH, INC., a business domiciled in Arizona; and JOHN DOES and JANE DOES 1-10, married couples; ABC PARTNERSHIPS 11-20; and/or XYZ CORPORATIONS 21-30, fictitious entities,

Defendants.

No.

COMPLAINT
(Wrongful Death; Medical Malpractice; Adult Protective Service Act/A.R.S. §46-451, et seq.)

(Jury Trial Requested)

(Honorable ____________________)

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Plaintiffs, for their complaint, allege as follows:

THE PLAINTIFFS

1. David Windhurst ("David"), age 56 (DOB: 6/24/1960) died on December 25, 2016, in Pima County, Arizona.

2. Antoinette Budnick Windhurst was married to David Windhurst at the time of David's death on December 25, 2016.

3. On December 6, 2017, the Maricopa County Superior Court in Case No. PB2017-001475 appointed Antoinette Windhurst as Personal Representative of David Windhurst's estate.

4. At the time of his death, David Windhurst was a resident of Pima County, Arizona, residing in the Arizona State Prison Complex in Tucson ("ASPC-T").

THE DEFENDANTS

5. Defendant Charles Ryan is the Director of the Arizona Department of Corrections.

6. Defendant Charles Ryan is a resident of Maricopa County, Arizona.

7. Defendants State of Arizona and the Arizona Department of Corrections are governmental entities that provided healthcare to David Windhurst either through direct employment of medical clinical personnel and/or through its contract with Corizon Health, Inc. and/or contracts with other healthcare providers.

8. Defendant Corizon Health, Inc., conducted business in Arizona and provided healthcare to David Windhurst through its agents and employees.

JURISDICTION

9. The substantial majority of the events giving rise to this Complaint occurred in Pima County, Arizona.

10. This matter exceeds the applicable compulsory arbitration limits such that it is not subject to compulsory arbitration.

11. Plaintiffs have a legal right to a jury trial if this case is not resolved or

1 disposed of by motion.

2 12. This Court has personal and subject matter jurisdiction over this matter.

3 13. Venue is proper in this county.

4 **GENERAL ALLEGATIONS**

5 14. In 2016, David Windhurst was an inmate at the Arizona Department of
6 Corrections ("ADOC"), Inmate #288503.

7 15. He was housed at the Arizona State Prison Complex in Florence ("ASPC-F) in
8 the beginning of the year and ASPC-T in the latter part of the year.

9 16. At the time of his incarceration, David Windhurst was medically fragile,
10 having a high thoracic spinal cord injury with bilateral above-the-knee limb amputation,
11 with his left hip having been fully disarticulated (amputation through the hip joint).

12 17. At the time of his incarceration, David Windhurst had multiple complex
13 medical issues including, but not limited to, pressure ulcer wound care/management with a
14 history of chronic pressure ulcers in his perineum and sacral areas; suprapubic catheter care,
15 infectious prevention and management; Type I diabetes mellitus (insulin dependent);
16 anemia; hypertension; chronic kidney disease; chronic pan, neuropathy; alterations in bowel
17 function due to multiple skin flap procedures resulting in the relocation of his rectum;
18 muscle spasms; and hypothyroidism.

19 18. Consistent with the ADOC Department Manual, Chapter 1100, the ADOC
20 assumed responsibility for the delivery of "appropriate and uninterrupted healthcare" for
21 David Windhurst to manage these various complex chronic conditions.

22 19. On February 6, 2016, the ADOC received a Critical Urine Culture Result of
23 David Windhurst, which was positive for MRSA, Methicillin Resistant Staphylococcus
24 Aureus.

25 20. Despite this Critical Urine Culture result, Defendants' agents and/or
26 employees ignored the signs and symptoms and denied and/or delayed David Windhurst

from getting appropriate medical treatment.

21. It was not until February 27, 2016, over 21 days later, when David Windhurst's medical condition was critical that Defendants' employees and/or agents addressed his acute medical condition.

22. It was at this time that he was transported to Mountain Vista Medical Center in Phoenix.

23. When David Windhurst arrived at Mountain Vista Medical Center on February 27, 2016, he was severely septic and in acute respiratory and renal failure from MRSA.

24. At the time, he was intubated and placed on a ventilator.

25. David Windhurst remained at Mountain Vista Medical Center from February 27, 2016, to April 7, 2016, in the Intensive Care Unit for nearly his entire hospitalization.

26. Because he was so clinically deteriorated prior to the hospital transfer, he was unable to be weaned from the ventilator and had a tracheotomy tube placed on March 13, 2016.

27. Additionally, for similar reasons, the deterioration or tracheotomy affected his swallowing reflex and a feeding tube (PEG) was also placed.

28. On April 7, 2016, David Windhurst returned to the ADOC, and was placed in the ASPC-T unit.

29. Sometime in June 2016, his feeding tube was removed and in July 2016 the tracheotomy tube was removed.

30. In early September 2016, David Windhurst developed a rash on his chest and shoulders.

31. No specialist skilled in complex disease management was consulted nor were any labs ordered to assist in a differential diagnosis regarding the rash David Windhurst developed in early September 2016.

32. By October 30, 2016, David Windhurst reported feeling that he had "bugs" below his skin.

33. At this time, David Windhurst's urine was described as light brown.

34. On November 10, 2016, a "lump" on the side of David Windhurst's jaw was described as a "tumor like, hard raised, red and painful" area, and David's mental status was described as confused.

35. On November 11, 2016, David's urine tested positive via a urine dipstick for blood, white blood cells and protein from a sample described as cloudy, brown/pink urine, which was also described as dark-blood tinged urine.

36. Also on that day, David's neck mass worsened.

37. Despite this, no lab studies to ascertain renal function or systemic infection status were ordered.

38. No connection was documented to suggest nurses were seeing symptoms consistent with renal failure and possible uremic pruritus.

39. No request for kidney or infectious disease specialist support was made.

40. On November 12, 2016, David complained of right ear pain and a lump on the side of his jaw.

41. By November 14, 2016, David's eardrum ruptured with malodorous/purulent drainage and the lump was classified as lymphadenitis (swollen lymph node).

42. Despite the deterioration of David's condition, no appropriate diagnostic tests and/or referral to physician specialists were made or ordered.

43. Also on November 14, 2016, David was described as "very pale" with a "glassy glaze" and "delusional."

44. Despite David having an infected ear, infected lymph system, infected urine and unexplained body rash, no recommendation for physician diagnosis or intervention was made.

1 45. The nursing staff merely continued to document David's decline without
2 appropriate intervention or advocacy.
3 46. In the early morning hours of November 15, 2016, David Windhurst's further
4 clinical decline was noted as having decreased urine output, tea colored urine with signs and
5 symptoms of dehydration, low blood pressure and low sugar levels.
6 47. On the afternoon of November 15, 2016, David's urine culture result showed
7 large amounts of particularly resistant bacteria named Pseudomonas Aeruginosa, often
8 associated with facility-acquired infections.
9 48. Despite the changes in David's mental status, his chaotic blood sugars, his
10 need for IV fluids for poor intake and low urine output, no lab chemistry studies were
11 ordered, intake and output balances were not scrutinized, weights were not taken, and
12 specialists were not consulted.
13 49. David's clinical presentation in November 2016 was nearly identical to that
14 experienced in February 2016 when David was diagnosed with acute respiratory failure and
15 severe sepsis.
16 50. On November 16, 2016, David's blood sugar was dangerously low at 52
17 mg/dl.
18 51. After intervention, repeat blood sugars remained low at 55 mg/dl and 67
19 mg/dl.
20 52. Still no physician was called and no lab or other diagnostic tests were ordered.
21 53. At this time, David's right neck mass was now described as "greatly
22 enlarged," his lips were documented as "very dry" and his nurses continued to describe
23 David as "glassy eyed," and his urine output was described as "yellow with brown/pink
24 clusters of tissue looking concretions."
25 54. Despite this, nursing staff continued to morbidly document David's clinical
26 decline rather than intervene on his behalf as would be expected and required in their well-

understood role as patient advocate.

55. By 12:55 a.m. on November 18, 2016, ADOC staff stated that David "was not doing well," "had a hard time swallowing," and was "confused" with a slow reaction.

56. By 2:53 a.m. on November 18, 2016, David's lungs were so full of fluid that the nurse documented "[w]et rales were noted from the doorway."

57. On November 18, 2016, between 12:55 a.m. and 5:34 a.m., nurses attempted to reach the on-call Advanced Practice Registered Nurse ("APRN") and physician six times, without response.

58. At 5:34 a.m., the doctor working for Defendants did not come in and assess David but merely ordered 40 mg of IVP Lasix for a patient whose last documented blood pressure was 86/47.

59. On November 18, 2016, at 5:54 a.m. David coded.

60. At that time, he was transported to Banner University Medical Center – South Campus ("BUMC").

61. Upon arrival at BUMC, David was diagnosed with uroseptic shock, renal failure, anemia and oropharyngeal (mouth and throat) ulcerations.

62. The cause of David's sepsis was documented as probable from infected urinary catheter or the decubitus ulcers. He was also diagnosed with bilateral pneumonia.

63. From November 18, 2016, to December 25, 016, David endured an extensive hospital course at BUMC that included multiple ICU stays.

64. David was deemed clinically unable to undergo conscious sedation anesthesia to have a feeding tube (PEG) tube placed again in his abdomen, thought to be related to his previous protracted hospital stay for respiratory failure and severe sepsis.

65. On December 25, 2016, while still at BUMC, David Windhurst died approximately one month before his scheduled release from the ADOC.

COUNT ONE

**(WRONGFUL DEATH:A.R.S. §12-611, *et seq.;*
MEDICAL MALPRACTICE: A.R.S. §12-561, *et seq.)***

66. Antoinette Windhurst is a wrongful death claimant pursuant to A.R.S. §12-612(A).

67. Defendants have a non-delegable duty for the care, custody and control of inmates within the Arizona State Prison Complex system.

68. Defendants' non-delegable duty includes adequate medical care.

69. Defendants also have a statutory duty to provide adequate medical care pursuant to A.R.S. §31-201.01.

70. Defendants were required to provide care to David Windhurst commensurate with what would be available in the community.

71. The standard of care required that David receive more than just monitoring of his decline into severe sepsis from systemic and persistent mismanagement of his diabetes, kidney disease, wound care, peptic ulcer disease and other chronic conditions.

72. Despite David's multiple and complex chronic conditions, Defendants consistently and improperly delegated his care to family practice nurse practitioners with limited oversight from family practice or necessary specialist physicians.

73. Defendants engaged in systematic repetitive negligent care.

74. Defendants had a duty to David, breached their duty, and caused David's death by failing to provide appropriate assessment, intervention, and timely transfer to the acute-care setting.

75. Defendants also consistently violated the Nurse Practice Act and Arizona regulations requiring advanced practice registered nurses to refer a patient to a physician and consult with other healthcare providers when a condition is beyond the APRN's knowledge and experience in direct violation of A.R.S. §§32-1601 and 32-1606; and

Arizona Administrative Code R4-19-508.

76. Under A.R.S. §31-201.01, Charles Ryan was required to provide medical and health services to prisoners.

77. The ADOC, through Charles Ryan, further promulgated a policy stating that "the assistant director for ADC Health Services Contract Monitoring Bureau shall hold the contract providing health services accountable to ensure all inmates are provided access to scheduled and emergency (as needed) healthcare." The policy also required that "appropriate and uninterrupted healthcare be provided to inmates with chronic health conditions."

78. David Windhurst did not receive appropriate chronic healthcare commensurate with his complex medical management needs. His various chronic conditions collectively required consistent specialist oversight for safe management, which did not occur.

79. David Windhurst never received an infectious disease specialist consult even when experiencing a rash over 60% of his body, a ruptured eardrum and acute mass in the area of his parotid gland, purulent drainage from his decubitus wounds, and significant antibiotic resistant urine cultures.

80. David Windhurst was not even afforded regular face-to-face family practice physician visits. Instead, his complex care was entirely mismanaged by nurses and family nurse practitioners outside of the appropriate scope of practice.

81. Defendants failed to follow state law and its policies and procedures related to inmate healthcare to ensure adequate healthcare and access to emergency healthcare for David Windhurst. These failures fell below the standard of care.

82. Defendants are liable for the acts and omissions of their employees and/or agents acting within the course and scope of their employment or contract.

83. Defendants, each of them, breached the applicable standard of care they owed

to David Windhurst by failing to provide adequate medical treatment to him.

84. Defendants, through their employees and/or agents, failed to exercise that degree of care, skill and learning that would be expected under similar circumstances of a reasonably prudent healthcare provider within this State in negligently monitoring, evaluating, and treating David Windhurst.

85. Defendants' breach of the applicable standard of care directly and proximately caused David Windhurst's death; and, thus, injury to Plaintiffs.

COUNT TWO

(ADULT PROTECTIVE SERVICE ACT ["APSA"]: A.R.S. §46-451 *et seq.*)

86. Plaintiffs allege and incorporate all prior paragraphs herein.

87. Defendants are each an enterprise, as defined by A.R.S. §46-455(Q), that assumed a legal duty to provide care to David Windhurst.

88. David Windhurst was a "vulnerable adult" as defined by A.R.S. §46-451(A)(9) when he was at the ASPC-F and ASPC-T in 2016.

89. David Windhurst was injured by Defendants' negligent acts or omissions.

90. Defendants were independently negligent and also derivatively negligent for the acts of their employees and/or agents.

91. Injury to a vulnerable adult caused by negligent acts or omissions constitute "abuse" under A.R.S. §46-451(A)(1)(b).

92. Antoinette Windhurst has standing to bring this APSA claim, pursuant to A.R.S. §46-455(B) and A.R.S. §46-455(O).

93. Defendants' conduct here constitutes an "evil mind" pursuant to RAJI (Civil) Personal Injury Damages 4, such that Plaintiff is entitled to punitive damages. See A.R.S. §46-455(H)(4).

COUNT THREE
(PUNITIVE DAMAGES)

94. Plaintiffs allege and incorporate all prior paragraphs herein.

95. Defendant Ryan is an official policymaker responsible for promulgating appropriate policies and procedures at the ASPC-F and the ASPC-T.

96. Defendants operated the ASPC-F and the ASPC-T in a manner in which he knew or should have known that David Windhurst would suffer physical harm.

97. Defendants pursued a course of conduct knowing or having reason to know that it or they created a substantial risk of significant harm to David Windhurst so as to justify an award of punitive damages.

98. Defendants consciously and deliberately disregarded David Windhurst's interests and rights.

99. As a direct and proximate result of the aforementioned negligence, reckless and intentional acts, David Windhurst died.

WHEREFORE, Plaintiffs ask this Court to enter judgment in her favor and against Defendants as follows:

a. For wrongful death damages recoverable by RAJI (Civil) 5th Personal Injury Damages 3, A.R.S. §§12-613, 46-455(H)(4), and applicable law;

b. For all APSA damages recoverable by A.R.S. §46-455(H).

c. For punitive damages pursuant to RAJI (Civil) 5th Personal Injury Damages 4, A.R.S. §46-455(H)(4), and applicable law.

d. For costs in accordance with A.R.S. §§12-332 and 46-455(H)(4).

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

. . .

1 Dated December 22, 2017.

2 MESCH, CLARK ROTHSCHILD, P.C.

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4 By *s/Michael J. Crawford*

5 Michael J. Crawford

Attorneys for Plaintiffs

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UNITED STATES BANKRUPTCY COURT
SOUTHERN DISTRICT OF TEXAS
HOUSTON DIVISION

In re: TEHUM CARE SERVICES, INC.[1] Debtor.	Chapter 11 Case No. 23-90086 (CML)

DECLARATION OF NATHAN ROTHSCHILD IN SUPPORT OF
WINDHURST'S MOTION FOR RELIEF FROM THE AUTOMATIC STAY
[Relates to Docket No. 1573]

NATHAN S. ROTHSCHILD, under the penalty of perjury, declares as follows:

1. I am over 21 years of age. If called to testify, I would make the below statements under oath, based on my first-hand knowledge of the matters addressed below.

2. I am a shareholder at the law firm Mesch Clark Rothschild, located in Tucson, Arizona.

3. I am counsel of record for Antoinette Windhurst, individually and on behalf of the estate of David Windhurst related to a wrongful death personal injury case filed against Corizon Health, among other defendants, in Pima County, Arizona.

4. The Windhurst matter is not currently scheduled for trial. The pending proceeding is stayed by operation of the Tehum Care Services, Inc. bankruptcy case.

5. On June 13, 2024, the Pima County Superior Court conducted a status hearing regarding the pending matter. The Defendants were represented by counsel.

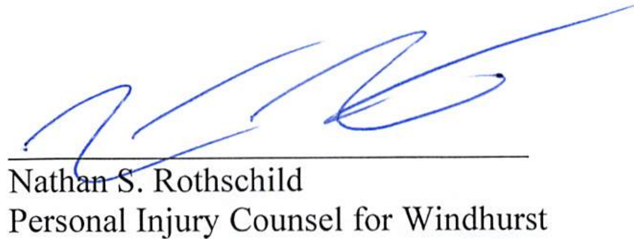
6. The Superior Court was informed that the automatic stay arising from this bankruptcy case remained in place, so no substantive deadlines could be set.

[1] The last four digits of the Debtor's federal tax identification number is 8853. The Debtor's service address is: 205 Powell Place, Suite 104, Brentwood, Tennessee 37027.

7. The Superior Court was also informed that this Stay Relief Motion was filed, and being briefed to the Court.

8. The Superior Court reviewed its calendar and indicated that if being scheduled on that date, the earliest a jury trial could be set would be August 2025.

Dated: July 1, 2024



Nathan S. Rothschild
Personal Injury Counsel for Windhurst

Fill in this information to identify the case:

Debtor 1 Tehum Care Services, Inc.

Debtor 2 (Spouse, if filing) ____________________

United States Bankruptcy Court for the: Southern District of Texas

Case number 23-90086

Official Form 410

Proof of Claim

04/22

Read the instructions before filling out this form. This form is for making a claim for payment in a bankruptcy case. Do not use this form to make a request for payment of an administrative expense. Make such a request according to 11 U.S.C. § 503.

Filers must leave out or redact information that is entitled to privacy on this form or on any attached documents. Attach redacted copies of any documents that support the claim, such as promissory notes, purchase orders, invoices, itemized statements of running accounts, contracts, judgments, mortgages, and security agreements. **Do not send original documents;** they may be destroyed after scanning. If the documents are not available, explain in an attachment.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Fill in all the information about the claim as of the date the case was filed. That date is on the notice of bankruptcy (Form 309) **that you received.**

Part 1: Identify the Claim

1. Who is the current creditor?

Antoinette Windhurst
Name of the current creditor (the person or entity to be paid for this claim)

Other names the creditor used with the debtor ____________________

2. Has this claim been acquired from someone else?

☑ No
☐ Yes. From whom? ____________________

3. Where should notices and payments to the creditor be sent?

Federal Rule of Bankruptcy Procedure (FRBP) 2002(g)

Where should notices to the creditor be sent?	Where should payments to the creditor be sent? (if different)
Name: Frederick J. Petersen	Name:
Number Street: 259 N. Meyer Ave.	Number Street:
City: Tucson State: AZ ZIP Code: 85701	City State ZIP Code
Contact phone: 520-624-8886	Contact phone:
Contact email: fpetersen@mcrazlaw.com	Contact email:

Uniform claim identifier for electronic payments in chapter 13 (if you use one):

__ __

4. Does this claim amend one already filed?

☑ No
☐ Yes. Claim number on court claims registry (if known) ______ Filed on ______ MM / DD / YYYY

5. Do you know if anyone else has filed a proof of claim for this claim?

☑ No
☐ Yes. Who made the earlier filing? ____________________

Part 2: Give Information About the Claim as of the Date the Case Was Filed

6. Do you have any number you use to identify the debtor?

☑ No
☐ Yes. Last 4 digits of the debtor's account or any number you use to identify the debtor: ____ ____ ____ ____

7. How much is the claim?

$ 10,000,000.00 . **Does this amount include interest or other charges?**

☑ No
☐ Yes. Attach statement itemizing interest, fees, expenses, or other charges required by Bankruptcy Rule 3001(c)(2)(A).

8. What is the basis of the claim?

Examples: Goods sold, money loaned, lease, services performed, personal injury or wrongful death, or credit card.

Attach redacted copies of any documents supporting the claim required by Bankruptcy Rule 3001(c).

Limit disclosing information that is entitled to privacy, such as health care information.

Wrongful death/vulnerable adult.

9. Is all or part of the claim secured?

☑ No
☐ Yes. The claim is secured by a lien on property.

Nature of property:

☐ Real estate. If the claim is secured by the debtor's principal residence, file a *Mortgage Proof of Claim Attachment* (Official Form 410-A) with this *Proof of Claim.*
☐ Motor vehicle
☐ Other. Describe: ____________________

Basis for perfection: ____________________

Attach redacted copies of documents, if any, that show evidence of perfection of a security interest (for example, a mortgage, lien, certificate of title, financing statement, or other document that shows the lien has been filed or recorded.)

Value of property: $__________

Amount of the claim that is secured: $__________

Amount of the claim that is unsecured: $__________ (The sum of the secured and unsecured amounts should match the amount in line 7.)

Amount necessary to cure any default as of the date of the petition: $__________

Annual Interest Rate (when case was filed)_______%

☐ Fixed
☐ Variable

10. Is this claim based on a lease?

☑ No
☐ Yes. **Amount necessary to cure any default as of the date of the petition.** $__________

11. Is this claim subject to a right of setoff?

☑ No
☐ Yes. Identify the property: ____________________

12. **Is all or part of the claim entitled to priority under 11 U.S.C. § 507(a)?** A claim may be partly priority and partly nonpriority. For example, in some categories, the law limits the amount entitled to priority.	☑ No ☐ Yes. *Check one:*	**Amount entitled to priority**
	☐ Domestic support obligations (including alimony and child support) under 11 U.S.C. § 507(a)(1)(A) or (a)(1)(B).	$________
	☐ Up to $3,350* of deposits toward purchase, lease, or rental of property or services for personal, family, or household use. 11 U.S.C. § 507(a)(7).	$________
	☐ Wages, salaries, or commissions (up to $15,150*) earned within 180 days before the bankruptcy petition is filed or the debtor's business ends, whichever is earlier. 11 U.S.C. § 507(a)(4).	$________
	☐ Taxes or penalties owed to governmental units. 11 U.S.C. § 507(a)(8).	$________
	☐ Contributions to an employee benefit plan. 11 U.S.C. § 507(a)(5).	$________
	☐ Other. Specify subsection of 11 U.S.C. § 507(a)(__) that applies.	$________

* Amounts are subject to adjustment on 4/01/25 and every 3 years after that for cases begun on or after the date of adjustment.

Part 3: Sign Below

The person completing this proof of claim must sign and date it. FRBP 9011(b).

If you file this claim electronically, FRBP 5005(a)(2) authorizes courts to establish local rules specifying what a signature is.

A person who files a fraudulent claim could be fined up to $500,000, imprisoned for up to 5 years, or both. 18 U.S.C. §§ 152, 157, and 3571.

Check the appropriate box:

☑ I am the creditor.
☐ I am the creditor's attorney or authorized agent.
☐ I am the trustee, or the debtor, or their authorized agent. Bankruptcy Rule 3004.
☐ I am a guarantor, surety, endorser, or other codebtor. Bankruptcy Rule 3005.

I understand that an authorized signature on this *Proof of Claim* serves as an acknowledgment that when calculating the amount of the claim, the creditor gave the debtor credit for any payments received toward the debt.

I have examined the information in this *Proof of Claim* and have a reasonable belief that the information is true and correct.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on date ____________
MM / DD / YYYY

Signature

Print the name of the person who is completing and signing this claim:

Name: Antoinette (First name) — (Middle name) Windhurst (Last name)

Title: Individually and as Personal Representative of Estate of David Windhurst, deceased

Company: ____________
Identify the corporate servicer as the company if the authorized agent is a servicer.

Address: 16849 E. Alamosa Avenue, Unit B (Number Street)
Fountain Hills (City) AZ (State) 85268 (ZIP Code)

Contact phone: 480-532-3627 Email: antoinettebudnick@gmail.com

In re Tehum Care Services, Inc.

In the United States Bankruptcy Court for the

Southern District of Texas, Houston Division

Case No. 23-90086

Claim of Antoinette Windhurst, individually,
and on behalf of the Estate of David Windhurst:

By filing this claim, Windhurst does not consent to the jurisdiction of this Bankruptcy Court to resolve, determine, or liquidate the wrongful death litigation pending in Arizona Superior Court. Windhurst also does not consent to this Court adjudicating claims pending by Windhurst against non-debtor third parties. Windhurst has a constitutional right to a jury trial, and the liquidation of wrongful death cases are explicitly not within the core jurisdiction of this bankruptcy court. 28 U.S.C. § 157(b)(2), (4), (5). Windhurst is filing this claim only to preserve her rights, and the filing should not be deemed a consent to jurisdiction, nor a waiver of the right for this claim to be determined in State Court.

Further, Windhurst does not acknowledge, in filing this claim, that the asserted "divisional merger" was appropriately completed, or that Tehum Care Services, Inc. is a proper, or the only proper, defendant in its case. Windhurst files this claim as an amount to be decided at trial. That is necessary because the claimed divisional merger was actively concealed from the parties and the Court in the pending Arizona action. Notably, counsel for Corizon Health appeared in Court and participated in a mediation, without disclosing that Corizon Health had undergone the claimed divisional merger. Windhurst reserves all rights to seek a determination, in the context of liquidation, the proper defendant(s), which may include Tehum Care Services, Inc., Yescare, CHS TX, or other related individuals or entities, in addition to the third-party defendants already named in the action. Disclosure by the Defendant(s), related discovery, and a determination by the Arizona Courts has been stayed by this Bankruptcy, so all rights are reserved until such determination is made.

FILED
TONI L. HELLON
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BY: ALAN WALKER
DEPUTY

Case No. C20175978
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ARIZONA SUPERIOR COURT

PIMA COUNTY

ANTOINETTE WINDHURST, a single/widowed woman on behalf of herself and as Personal Representative of the Estate of her deceased husband, DAVID WINDHURST, Plaintiffs, -vs- ARIZONA DEPARTMENT OF CORRECTIONS, a governmental entity; CHARLES RYAN, in his individual capacity as the Director of Arizona Department of Corrections; STATE OF ARIZONA, a governmental entity; CORIZON HEALTH, INC., a business domiciled in Arizona; and JOHN DOES and JANE DOES 1-10, married couples; ABC PARTNERSHIPS 11-20; and/or XYZ CORPORATIONS 21-30, fictitious entities, Defendants.	No. **COMPLAINT (Wrongful Death; Medical Malpractice; Adult Protective Service Act/A.R.S. §46-451, et seq.)** **(Jury Trial Requested)** (Honorable ____________________)

Plaintiffs, for their complaint, allege as follows:

THE PLAINTIFFS

1. David Windhurst ("David"), age 56 (DOB: 6/24/1960) died on December 25, 2016, in Pima County, Arizona.

2. Antoinette Budnick Windhurst was married to David Windhurst at the time of David's death on December 25, 2016.

3. On December 6, 2017, the Maricopa County Superior Court in Case No. PB2017-001475 appointed Antoinette Windhurst as Personal Representative of David Windhurst's estate.

4. At the time of his death, David Windhurst was a resident of Pima County, Arizona, residing in the Arizona State Prison Complex in Tucson ("ASPC-T").

THE DEFENDANTS

5. Defendant Charles Ryan is the Director of the Arizona Department of Corrections.

6. Defendant Charles Ryan is a resident of Maricopa County, Arizona.

7. Defendants State of Arizona and the Arizona Department of Corrections are governmental entities that provided healthcare to David Windhurst either through direct employment of medical clinical personnel and/or through its contract with Corizon Health, Inc. and/or contracts with other healthcare providers.

8. Defendant Corizon Health, Inc., conducted business in Arizona and provided healthcare to David Windhurst through its agents and employees.

JURISDICTION

9. The substantial majority of the events giving rise to this Complaint occurred in Pima County, Arizona.

10. This matter exceeds the applicable compulsory arbitration limits such that it is not subject to compulsory arbitration.

11. Plaintiffs have a legal right to a jury trial if this case is not resolved or

disposed of by motion.

12. This Court has personal and subject matter jurisdiction over this matter.

13. Venue is proper in this county.

GENERAL ALLEGATIONS

14. In 2016, David Windhurst was an inmate at the Arizona Department of Corrections ("ADOC"), Inmate #288503.

15. He was housed at the Arizona State Prison Complex in Florence ("ASPC-F) in the beginning of the year and ASPC-T in the latter part of the year.

16. At the time of his incarceration, David Windhurst was medically fragile, having a high thoracic spinal cord injury with bilateral above-the-knee limb amputation, with his left hip having been fully disarticulated (amputation through the hip joint).

17. At the time of his incarceration, David Windhurst had multiple complex medical issues including, but not limited to, pressure ulcer wound care/management with a history of chronic pressure ulcers in his perineum and sacral areas; suprapubic catheter care, infectious prevention and management; Type I diabetes mellitus (insulin dependent); anemia; hypertension; chronic kidney disease; chronic pan, neuropathy; alterations in bowel function due to multiple skin flap procedures resulting in the relocation of his rectum; muscle spasms; and hypothyroidism.

18. Consistent with the ADOC Department Manual, Chapter 1100, the ADOC assumed responsibility for the delivery of "appropriate and uninterrupted healthcare" for David Windhurst to manage these various complex chronic conditions.

19. On February 6, 2016, the ADOC received a Critical Urine Culture Result of David Windhurst, which was positive for MRSA, Methicillin Resistant Staphylococcus Aureus.

20. Despite this Critical Urine Culture result, Defendants' agents and/or employees ignored the signs and symptoms and denied and/or delayed David Windhurst

1 from getting appropriate medical treatment.
2 21. It was not until February 27, 2016, over 21 days later, when David
3 Windhurst's medical condition was critical that Defendants' employees and/or agents
4 addressed his acute medical condition.
5 22. It was at this time that he was transported to Mountain Vista Medical Center
6 in Phoenix.
7 23. When David Windhurst arrived at Mountain Vista Medical Center on
8 February 27, 2016, he was severely septic and in acute respiratory and renal failure from
9 MRSA.
10 24. At the time, he was intubated and placed on a ventilator.
11 25. David Windhurst remained at Mountain Vista Medical Center from February
12 27, 2016, to April 7, 2016, in the Intensive Care Unit for nearly his entire hospitalization.
13 26. Because he was so clinically deteriorated prior to the hospital transfer, he was
14 unable to be weaned from the ventilator and had a tracheotomy tube placed on March 13,
15 2016.
16 27. Additionally, for similar reasons, the deterioration or tracheotomy affected his
17 swallowing reflex and a feeding tube (PEG) was also placed.
18 28. On April 7, 2016, David Windhurst returned to the ADOC, and was placed in
19 the ASPC-T unit.
20 29. Sometime in June 2016, his feeding tube was removed and in July 2016 the
21 tracheotomy tube was removed.
22 30. In early September 2016, David Windhurst developed a rash on his chest and
23 shoulders.
24 31. No specialist skilled in complex disease management was consulted nor were
25 any labs ordered to assist in a differential diagnosis regarding the rash David Windhurst
26 developed in early September 2016.

32. By October 30, 2016, David Windhurst reported feeling that he had "bugs" below his skin.

33. At this time, David Windhurst's urine was described as light brown.

34. On November 10, 2016, a "lump" on the side of David Windhurst's jaw was described as a "tumor like, hard raised, red and painful" area, and David's mental status was described as confused.

35. On November 11, 2016, David's urine tested positive via a urine dipstick for blood, white blood cells and protein from a sample described as cloudy, brown/pink urine, which was also described as dark-blood tinged urine.

36. Also on that day, David's neck mass worsened.

37. Despite this, no lab studies to ascertain renal function or systemic infection status were ordered.

38. No connection was documented to suggest nurses were seeing symptoms consistent with renal failure and possible uremic pruritus.

39. No request for kidney or infectious disease specialist support was made.

40. On November 12, 2016, David complained of right ear pain and a lump on the side of his jaw.

41. By November 14, 2016, David's eardrum ruptured with malodorous/purulent drainage and the lump was classified as lymphadenitis (swollen lymph node).

42. Despite the deterioration of David's condition, no appropriate diagnostic tests and/or referral to physician specialists were made or ordered.

43. Also on November 14, 2016, David was described as "very pale" with a "glassy glaze" and "delusional."

44. Despite David having an infected ear, infected lymph system, infected urine and unexplained body rash, no recommendation for physician diagnosis or intervention was made.

45. The nursing staff merely continued to document David's decline without appropriate intervention or advocacy.

46. In the early morning hours of November 15, 2016, David Windhurst's further clinical decline was noted as having decreased urine output, tea colored urine with signs and symptoms of dehydration, low blood pressure and low sugar levels.

47. On the afternoon of November 15, 2016, David's urine culture result showed large amounts of particularly resistant bacteria named Pseudomonas Aeruginosa, often associated with facility-acquired infections.

48. Despite the changes in David's mental status, his chaotic blood sugars, his need for IV fluids for poor intake and low urine output, no lab chemistry studies were ordered, intake and output balances were not scrutinized, weights were not taken, and specialists were not consulted.

49. David's clinical presentation in November 2016 was nearly identical to that experienced in February 2016 when David was diagnosed with acute respiratory failure and severe sepsis.

50. On November 16, 2016, David's blood sugar was dangerously low at 52 mg/dl.

51. After intervention, repeat blood sugars remained low at 55 mg/dl and 67 mg/dl.

52. Still no physician was called and no lab or other diagnostic tests were ordered.

53. At this time, David's right neck mass was now described as "greatly enlarged," his lips were documented as "very dry" and his nurses continued to describe David as "glassy eyed," and his urine output was described as "yellow with brown/pink clusters of tissue looking concretions."

54. Despite this, nursing staff continued to morbidly document David's clinical decline rather than intervene on his behalf as would be expected and required in their well-

1 understood role as patient advocate.

2 55. By 12:55 a.m. on November 18, 2016, ADOC staff stated that David "was not
3 doing well," "had a hard time swallowing," and was "confused" with a slow reaction.

4 56. By 2:53 a.m. on November 18, 2016, David's lungs were so full of fluid that
5 the nurse documented "[w]et rales were noted from the doorway."

6 57. On November 18, 2016, between 12:55 a.m. and 5:34 a.m., nurses attempted
7 to reach the on-call Advanced Practice Registered Nurse ("APRN") and physician six times,
8 without response.

9 58. At 5:34 a.m., the doctor working for Defendants did not come in and assess
10 David but merely ordered 40 mg of IVP Lasix for a patient whose last documented blood
11 pressure was 86/47.

12 59. On November 18, 2016, at 5:54 a.m. David coded.

13 60. At that time, he was transported to Banner University Medical Center – South
14 Campus ("BUMC").

15 61. Upon arrival at BUMC, David was diagnosed with uroseptic shock, renal
16 failure, anemia and oropharyngeal (mouth and throat) ulcerations.

17 62. The cause of David's sepsis was documented as probable from infected
18 urinary catheter or the decubitus ulcers. He was also diagnosed with bilateral pneumonia.

19 63. From November 18, 2016, to December 25, 016, David endured an extensive
20 hospital course at BUMC that included multiple ICU stays.

21 64. David was deemed clinically unable to undergo conscious sedation anesthesia
22 to have a feeding tube (PEG) tube placed again in his abdomen, thought to be related to his
23 previous protracted hospital stay for respiratory failure and severe sepsis.

24 65. On December 25, 2016, while still at BUMC, David Windhurst died
25 approximately one month before his scheduled release from the ADOC.

26

COUNT ONE

(WRONGFUL DEATH:A.R.S. §12-611, *et seq.*;
MEDICAL MALPRACTICE: A.R.S. §12-561, *et seq.*)

66. Antoinette Windhurst is a wrongful death claimant pursuant to A.R.S. §12-612(A).

67. Defendants have a non-delegable duty for the care, custody and control of inmates within the Arizona State Prison Complex system.

68. Defendants' non-delegable duty includes adequate medical care.

69. Defendants also have a statutory duty to provide adequate medical care pursuant to A.R.S. §31-201.01.

70. Defendants were required to provide care to David Windhurst commensurate with what would be available in the community.

71. The standard of care required that David receive more than just monitoring of his decline into severe sepsis from systemic and persistent mismanagement of his diabetes, kidney disease, wound care, peptic ulcer disease and other chronic conditions.

72. Despite David's multiple and complex chronic conditions, Defendants consistently and improperly delegated his care to family practice nurse practitioners with limited oversight from family practice or necessary specialist physicians.

73. Defendants engaged in systematic repetitive negligent care.

74. Defendants had a duty to David, breached their duty, and caused David's death by failing to provide appropriate assessment, intervention, and timely transfer to the acute-care setting.

75. Defendants also consistently violated the Nurse Practice Act and Arizona regulations requiring advanced practice registered nurses to refer a patient to a physician and consult with other healthcare providers when a condition is beyond the APRN's knowledge and experience in direct violation of A.R.S. §§32-1601 and 32-1606; and

Arizona Administrative Code R4-19-508.

76. Under A.R.S. §31-201.01, Charles Ryan was required to provide medical and health services to prisoners.

77. The ADOC, through Charles Ryan, further promulgated a policy stating that "the assistant director for ADC Health Services Contract Monitoring Bureau shall hold the contract providing health services accountable to ensure all inmates are provided access to scheduled and emergency (as needed) healthcare." The policy also required that "appropriate and uninterrupted healthcare be provided to inmates with chronic health conditions."

78. David Windhurst did not receive appropriate chronic healthcare commensurate with his complex medical management needs. His various chronic conditions collectively required consistent specialist oversight for safe management, which did not occur.

79. David Windhurst never received an infectious disease specialist consult even when experiencing a rash over 60% of his body, a ruptured eardrum and acute mass in the area of his parotid gland, purulent drainage from his decubitus wounds, and significant antibiotic resistant urine cultures.

80. David Windhurst was not even afforded regular face-to-face family practice physician visits. Instead, his complex care was entirely mismanaged by nurses and family nurse practitioners outside of the appropriate scope of practice.

81. Defendants failed to follow state law and its policies and procedures related to inmate healthcare to ensure adequate healthcare and access to emergency healthcare for David Windhurst. These failures fell below the standard of care.

82. Defendants are liable for the acts and omissions of their employees and/or agents acting within the course and scope of their employment or contract.

83. Defendants, each of them, breached the applicable standard of care they owed

to David Windhurst by failing to provide adequate medical treatment to him.

84. Defendants, through their employees and/or agents, failed to exercise that degree of care, skill and learning that would be expected under similar circumstances of a reasonably prudent healthcare provider within this State in negligently monitoring, evaluating, and treating David Windhurst.

85. Defendants' breach of the applicable standard of care directly and proximately caused David Windhurst's death; and, thus, injury to Plaintiffs.

COUNT TWO

(ADULT PROTECTIVE SERVICE ACT ["APSA"]: A.R.S. §46-451 *et seq.)*

86. Plaintiffs allege and incorporate all prior paragraphs herein.

87. Defendants are each an enterprise, as defined by A.R.S. §46-455(Q), that assumed a legal duty to provide care to David Windhurst.

88. David Windhurst was a "vulnerable adult" as defined by A.R.S. §46-451(A)(9) when he was at the ASPC-F and ASPC-T in 2016.

89. David Windhurst was injured by Defendants' negligent acts or omissions.

90. Defendants were independently negligent and also derivatively negligent for the acts of their employees and/or agents.

91. Injury to a vulnerable adult caused by negligent acts or omissions constitute "abuse" under A.R.S. §46-451(A)(1)(b).

92. Antoinette Windhurst has standing to bring this APSA claim, pursuant to A.R.S. §46-455(B) and A.R.S. §46-455(O).

93. Defendants' conduct here constitutes an "evil mind" pursuant to RAJI (Civil) Personal Injury Damages 4, such that Plaintiff is entitled to punitive damages. See A.R.S. §46-455(H)(4).

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COUNT THREE
(PUNITIVE DAMAGES)

94. Plaintiffs allege and incorporate all prior paragraphs herein.

95. Defendant Ryan is an official policymaker responsible for promulgating appropriate policies and procedures at the ASPC-F and the ASPC-T.

96. Defendants operated the ASPC-F and the ASPC-T in a manner in which he knew or should have known that David Windhurst would suffer physical harm.

97. Defendants pursued a course of conduct knowing or having reason to know that it or they created a substantial risk of significant harm to David Windhurst so as to justify an award of punitive damages.

98. Defendants consciously and deliberately disregarded David Windhurst's interests and rights.

99. As a direct and proximate result of the aforementioned negligence, reckless and intentional acts, David Windhurst died.

WHEREFORE, Plaintiffs ask this Court to enter judgment in her favor and against Defendants as follows:

a. For wrongful death damages recoverable by RAJI (Civil) 5th Personal Injury Damages 3, A.R.S. §§12-613, 46-455(H)(4), and applicable law;

b. For all APSA damages recoverable by A.R.S. §46-455(H).

c. For punitive damages pursuant to RAJI (Civil) 5th Personal Injury Damages 4, A.R.S. §46-455(H)(4), and applicable law.

d. For costs in accordance with A.R.S. §§12-332 and 46-455(H)(4).

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

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Dated December 22, 2017.

MESCH, CLARK ROTHSCHILD, P.C.

By *s/Michael J. Crawford*
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ARIZONA SUPERIOR COURT

PIMA COUNTY

ANTOINETTE WINDHURST, a single/widowed woman on behalf of herself and as Personal Representative of the Estate of her deceased husband, David Windhurst, Plaintiff, v. ARIZONA DEPARTMENT OF CORRECTIONS, a governmental entity; CHARLES RYAN, in his individual capacity as the Director of Arizona Department of Corrections; STATE OF ARIZONA, a governmental entity;	No. C20175978 **PLAINTIFF'S 19TH SUPPLEMENTAL DISCLOSURE STATEMENT** (Cumulative – additions are highlighted in yellow) (Honorable Brenden J. Griffin)

1 CORIZON HEALTH, INC., a business
2 domiciled in Arizona; and JOHN DOES
and JANE DOES 1-10, married couples;
3 ABC PARTNERSHIPS 11-20; and/or
XYZ CORPORATIONS 21-30, fictitious
4 entities,

5 Defendants.

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8 Plaintiff, pursuant to Rule 26.1(b)(1), Arizona Rules of Civil Procedure, discloses the
9 following information.

10 **PRELIMINARY STATEMENT**

11 This Disclosure Statement, and its contents, represents the product of the
12 investigation to date. This matter is only in the initial phase of discovery, and further
13 investigation and discovery may bring to light additional information that may have a
14 bearing on Plaintiffs' claims. Accordingly, this Disclosure Statement is not now intended to
15 represent Plaintiff's complete claims, but is merely a preliminary Disclosure Statement until
16 further and final supplementation. Therefore, if any part of this Disclosure Statement is ever
17 read to the jury, fairness would require that this Preliminary Statement also be read
18 indicating that, at the time it was submitted, there was only limited access to information
19 and the case had not yet been fully discovered.

20
I. <u>FACTUAL BASIS FOR EACH CLAIM:</u>
21

22 Plaintiff incorporates her Complaint and all of her disclosures and discovery,
23 including the disclosed expert affidavits, in this case. A summary of the factual basis of the
24 claims in this case (all supported by currently available medical, law enforcement, and
25 administrative records) about the events at issue follows.

26

David Windhurst ("David") was an inmate at the Arizona Department of Corrections ("ADOC"), Inmate #288503. He died while in the ADOC custody from complications associated with medical mismanagement of his care that fell below established community standards.

David was arrested in February 2014 for a probation violation and was held in custody for approximately four months. He was indicted in March of 2014 for weapons misconduct, entering a plea in June 2015. After entering the plea, David was initially held in the Maricopa County Jail until December 2015, and then he was transferred to the Arizona State Prison Complex in Florence, AZ ("**ASPC-F**"). Later in his incarceration, from April through November 2016, David was cared for at the Arizona State Prison Complex in Tucson, AZ ("**ASPC-T**").

At David's August 11, 2015, sentencing hearing, there was much discussion regarding David's multiple, complex medical conditions, and concerns, particularly related to the ADOC's capacity to provide appropriate medical management in the correctional setting given David's medically fragile history and given his worsened condition in 2014 after only an approximate four month period of incarceration.

David was a chronically ill man with a history of paraplegia from high thoracic spinal cord injury in his late teens. He had both legs amputated above the knee, with the entire lower extremity removed through the hip joint on his left side. He had multiple, complex medical issues including chronic pressure ulcers, surgical reconstruction of his skin resulting in the surgical relocation of his rectum and altered bowel function, neurogenic bladder requiring a suprapubic catheter, osteopenia, insulin-dependent diabetes, anemia, hypertension, chronic kidney disease, chronic pain/neuropathy, muscle spasms, hypothyroidism, and repetitive infections, including a known history of complications from methicillin resistant staphylococcus aureus ("MRSA").

1 While David was held in custody for approximately four months in 2014, testimony
2 was received that his stage IV bedsore doubled in size[1] and he had two ICU hospital stays,[2]
3 and required dialysis while under the ADOC care.[3] At David's August 2015 Sentencing
4 Hearing, family appeared before the sentencing judge, including one family member who
5 was a trained emergency room physician, expressing concern that further incarceration
6 would likely result in David's death from sepsis.
7 The ADOC's General Counsel, Brad Keogh, provided assurances to the Hon. Warren
8 Granville that the ADOC was " able to handle all medical conditions, including very serious
9 ones" such that the ADOC's position was that there was "no illness or condition which
10 could not be treated once a person [wa]s incarcerated."[4] Further, ADOC's own Department
11 Manual pledged to provide inmates with "appropriate and uninterrupted healthcare."[5]
12 Despite these assurances and pledges; however, the care the ADOC provided to David fell
13 below the acceptable community standards leading to his death in the early morning hours
14 of Christmas in 2016.
15 David's medical care was provided by Clinicians trained as advanced practice
16 registered nurses, commonly called "nurse practitioners" ("**NPs**"), physician assistants
17 ("**PAs**"), and physicians ("**MDs"**) (collectively, "**Clinicians**"), including but not limited to:
18 a) Deborah McGarry, NP – license # AP4908
19 b) Murray F. Young, MD – license # 52177
20 c) Lucy Burciaga, MD – license # 35181
21 d) Daniel Ross, NP – license #AP5256
22
23 [1] *State of Arizona v. Windhurst,* CR2014-408-001Sentencing Hearing Transcript dated August 11, 2015, p. 9:11-15 (hereinafter "Sentencing Transcript".)
24 [2] *Id.* at ll. 16-17.
[3] Sentencing Transcript, p. 8:1-6.
25 [4] Sentencing Transcript, Exhibit 7, Brad Keogh August 14, 2015, email, paragraph 1.
26 [5] Arizona Department of Corrections, Department Order Manual Chapter 1100 Inmate Health Services 2 (effective December 19, 2012; unchanged effective October 22, 2016).

1 e) Andrea Roberts, NP- license #AP7654
2 f) Pinky R. Castillo, NP – license #AP8820
3 g) Bonnie Goodman, DO – license #1920
4 h) Elaine Walker, PA – license #5303
5 i) Tania Hogan, NP – license # AP2914
6 j) Nicole M. Lyons – license # AP5672
7 Additionally, psychiatric care support was provided by a team of NPs and physicians that
8 included:
9 a) Jawad Riaz, MD – license #46924
10 b) Stephen Jaffe, MD – license #41153
11 c) Claudia Carpio, NP – license #AP8372
12 d) Karen Lahr, NP – license #AP8711
13 While all the Clinicians were responsible, in part, for their role in the consistent, pervasive
14 medical mismanagement of David's care and treatment, Plaintiff recognized the more
15 significant role of Clinicians Castillo, Young, McGarry, Burciaga, and Lahr.
16 David's care in the medical infirmary units was provided by licensed nurses –
17 (licensed practical nurses ("**LPNs**") and registered nurses ("**RNs**") – assisted by non-
18 licensed assistant staff, largely noted to be certified nursing assistants ("**CNAs**"). Again,
19 while, as a group, the licensed nurses providing care to David failed to assess, timely report,
20 and advocate David's behalf regarding important clinical changes in David's condition,
21 some more regularly noted names in the care continuum included:
22 a) David Osier, RN
23 b) Peggy Dionne, RN
24 c) Michele Daemmer, RN
25 d) Carrie Hughes, RN
26 e) Eva Olszewski, RN

1 f) Juliet Egbo, LPN
2 g) Monica A. Flores, RN
3 h) Nidia Salazar, LPN
4 i) Patricia Barclay, RN
5 j) Sheryl DeCasper, RN

6 The ADOC records produced thus far were lacking in progress note-type
7 documentation from December 8, 2015, through February 18, 2016. Further, the 2014
8 ADOC records were not included in the initial ADOC documents received. While
9 community standard would include a review of prior records on admission to the ADOC in
10 December 2015, it is unclear whether Clinician or nursing staff did so. Certainly the
11 sentencing hearing transcript made clear that David had significant challenges with infection
12 and prior ICU stays during a much shorter incarceration period.

13 On February 6, 2016, the ADOC received a critical urine culture result that was
14 positive for MRSA and started treatment with antibiotics. Between February 19, 2016, and
15 David's acute transfer to Mountain Vista Medical Center ("**MVMC**") on February 27, 2016,
16 the Clinician and nursing staff failed to assess, recognize, and intervene appropriately to
17 David's worsening condition. Despite the nephrologist's February 22, 2016, admonition
18 that David's blood pressure and blood sugar be tightly controlled, Clinician documentation
19 appeared to be copied forward and lacked a lung assessment or an appreciation that David's
20 blood pressure demonstrated relative hypotension that was atypical. Nursing assessments
21 and vital sign monitoring did not increase in frequency despite changes documented as early
22 as February 23, 2016.

23 When David arrived at MVMC, he was found to be hypotensive due to an infection.
24 He required intubation, mechanical ventilation, a feeding tube, and dialysis. He had a
25 tracheostomy procedure for breathing support (breathing tube) and a stomach tube (PEG
26

tube) placed for nutrition. His kidney injury was recorded as secondary to sepsis.[6] David remained at MVMC from February 27, 2016, through April 7, 2016.

On April 7, 2016, David was returned to the ADOC and placed in the ASPC-T facility. Despite David's complex hospital course prior to admission to ASPC-T and his reported oxygen desaturations during transfer, the documented Clinician plan was not detailed; rather it simply described vital sign and wound care as per routine. Nursing documentation did not demonstrate or include assessment tools or care planning to manage David's wounds consistent with their severity or with pre-incarceration protocols. During April alone, at least three different nurses made at least five notations regarding potential symptoms of possible infection, yet no temperature was taken. Further, nursing notes lacked documentation of any effort to secure infection prevention supplies that were noted as unavailable such as a properly sized suprapubic Foley catheter or wound care solution, despite chart documentation that would have made clear to nursing staff that David had been critically ill when transferred out of the ADOC in February 2016 secondary to infection.

When David followed up with the nephrologist in April 2016, a return visit one month later was recommended along with an iron profile lab study in anticipation of needing additional anemia medication given David's treatment at MVMC. Yet, there was no evidence in the medical record that David saw the nephrologist as recommended and no iron profile was completed. While this is one of many examples of care falling below accepted standards, its impact cannot be understated. When David was admitted to Banner University South Campus Medical Center in November 2016, his anemia was profound,

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[6] "Sepsis is a potentially life-threatening complication of an infection. Sepsis occurs when chemicals released into the bloodstream to fight the infection trigger inflammatory responses throughout the body. This inflammation can trigger a cascade of changes that can damage multiple organ systems, causing them to fail." https://www.mayoclinic.org/diseases-conditions/sepsis/symptoms-causes/syc-20351214.

1 with a Hemoglobin lab value of 5.7 g/dL – dangerously below the normal limit of 14-18
2 g/dL.
3 Earlier than previously detailed in Plaintiff's complaint, nursing staff began
4 documenting that David had a body rash in mid-July 2016. Yet, skin exams were rarely
5 documented by supervising Clinicians. David's skin condition was not fully evaluated
6 despite worsening symptoms over a span of months that did not respond to ointment/cream,
7 antihistamine medication, and pain medication intervention. Instead of referring David to
8 dermatology or ordering labs, Dr. Young's documentation included the assumptive
9 diagnosis that David's condition was "idiopathic and self-mutilation." Similarly, nursing
10 notes provided no documentation that Clinician orders were sought to address the itchiness
11 as David's rash worsened. By late October, David reported feeling as though he had bugs
12 crawling under his skin. Also, at this time, David's urine was described as light brown,
13 without intervention.
14 By early November, David developed a lump on the side of his jaw and had a
15 ruptured ear drum with malodorous drainage. Nursing documentation described David as
16 pale and confused, yet no attempts to obtain further diagnostic orders are documented. On
17 November 11, 2016, David's urine tested positive via a urine dipstick for blood, white blood
18 cells and protein from a sample described as cloudy, brown/pink urine, which was also
19 described as dark-blood tinged urine. No lab studies to ascertain renal function were
20 ordered, despite Clinician documentation that antibiotics were being dosed according to
21 renal function. When the nurse was unable to successfully draw the limited labs (CBC and
22 c. difficile) that were ordered, David waited four additional days to have the labs drawn.
23 And, when the limited labs results were available on November 16, 2016, there was no
24 evidence in the medical record that the nursing staff reviewed the results or reported them to
25 Clinician staff. Clinical staff documentation also provided no indication that they reviewed
26 or acted upon the significantly abnormal results. At this point, David's Hemoglobin was 7.1

g/dL and would continue to fall before he was transferred to a tertiary care center on November 18, 2016, after coding.

In the early morning hours of November 15, 2016, David's further clinical decline was noted as having decreased urine output, tea colored urine with signs and symptoms of dehydration, low blood pressure and low sugar levels. On the afternoon of November 15, 2016, David's urine culture result showed large amounts of particularly resistant bacteria named Pseudomonas Aeruginosa, often associated with facility-acquired infections. Despite the changes in David's mental status, his chaotic blood sugars, his need for IV fluids for poor intake and low urine output, no lab chemistry studies were ordered, intake and output balances were not scrutinized, weights were not taken, specialists were not consulted, and a hospital transfer was not made. David's clinical presentation in November 2016 was nearly identical to that experienced in February 2016 when David was diagnosed with acute respiratory failure and severe sepsis, and consistent with the sepsis concerns mentioned in the August 2015 sentencing hearing.

On November 16, 2016, David's blood sugar was dangerously low at 52 mg/dl. After intervention, repeat blood sugars remained low at 55 mg/dl and 67 mg/dl. David's right neck mass was now described as "greatly enlarged," his lips were documented as "very dry" and his nurses continued to describe David as "glassy eyed," and his urine output was described as "yellow with brown/pink clusters of tissue looking concretions." Despite this, neither nursing staff nor NP Pinky Castillo appreciated the criticalness of David's medical condition.

On November 17, 2016, David's blood pressure was 88/57, significantly hypotensive for a man with a history of hypertension. This important vital sign was not rechecked for three hours. He was described by nursing as glassy-eyed, unable to maintain focus, yet no Clinician presented to directly evaluate these worsening symptoms and not transfer to an acute care setting occurred.

By 12:55 a.m. on November 18, 2016, ADOC staff stated that David "was not doing well," "had a hard time swallowing," and was "confused" with a slow reaction. By 2:53 a.m., the nurse documented "[w]et rales were noted from the doorway." Between 12:55 a.m. and 5:34 a.m., nurses attempted to reach NP and physician Clinicians, collectively, six times, without response. At 5:34 a.m., Dr. Murray Young did not come in and assess David but merely ordered 40 mg of IVP Lasix. After getting the Lasix, David's blood pressure plummeted to 60/30, and he coded.

Upon arrival at Banner University Medical Center – South Campus ("BUMC"), David was hypotensive and hypoxic. He was diagnosed with septic shock, acute-on - chronic kidney injury, and anemia. He was found to have multifocal pneumonia. He required emergent dialysis, intubation, and medications to maintain his blood pressure.

Ultimately, David was unable to fully recover from what was now a repetitive onslaught severe sepsis from medical neglect and mismanagement – just as was discussed at the sentencing hearing – from consequences related to being allowed to repeatedly go in to severe sepsis from the abject failure of the ADOC Clinicians and staff to recognize when "an illness or condition becomes so severe that actual hospitalization is medically necessary."

II. THE LEGAL THEORY UPON WHICH EACH CLAIM IS BASED:

A. Wrongful Death. Wrongful death is a statutory claim pursuant to A.R.S. §12-611 *et seq*. That statute states: "When death of a person is caused by wrongful act, neglect or default, and the act, neglect or default is such as would, if death had not ensued, have entitled the party injured to maintain an action to recover damages in respect thereof, then, and in every such case, the person who or the corporation which would have been liable if death had not ensued shall be liable to an action for damages, notwithstanding the death of

the person injured, and although the death was caused under such circumstances as amount in law to murder in the first or second degree or manslaughter." A.R.S. §12-611. "An action for wrongful death shall be brought by and in the name of the surviving husband or wife, child, parent or guardian, or personal representative of the deceased person for and on behalf of the surviving husband or wife, children or parents, or if none of these survive, on behalf of the estate." A.R.S. §12-612(A). "In an action for wrongful death, the jury shall give such damages as it deems fair and just with reference to the injury resulting from the death to the surviving parties who may be entitled to recover, and also having regard to the mitigating or aggravating circumstances attending the wrongful act, neglect or default." A.R.S. §12-613. The wrongful death damages instruction at Personal Injury Damages 3, RAJI (Civil) 5th states: "If you find [name of defendant] liable to [name of plaintiff], you must then decide the full amount of money that will reasonably and fairly compensate [name of each survivor] [separately] for each of the following elements of damages proved by the evidence to have resulted from the death of [name of decedent]. 1. The loss of love, affection, companionship, care, protection, and guidance since the death and in the future. 2. The pain, grief, sorrow, anguish, stress, shock, and mental suffering already experienced, and reasonably probable to be experienced in the future. 3. The income and services that have already been lost as a result of the death, and that are reasonably probable to be lost in the future. 4. The reasonable expenses of funeral and burial. 5. The reasonable expenses of necessary medical care and services for the injury that resulted in the death."

B. Medical Negligence/Negligence Per Se. "'Medical malpractice action' or 'cause of action for medical malpractice' means an action for injury or death against a licensed health care provider based upon such provider's alleged negligence, misconduct, errors or omissions, or breach of contract in the rendering of health care, medical services, nursing services or other health-related services or for the rendering of such health care, medical services, nursing services or other health-related services, without express or implied

consent…" A.R.S. §12-561(2). "Both of the following shall be necessary elements of proof that injury resulted from the failure of a health care provider to follow the accepted standard of care: 1. The health care provider failed to exercise that degree of care, skill and learning expected of a reasonable, prudent health care provider in the profession or class to which he belongs within the state acting in the same or similar circumstances. 2. Such failure was a proximate cause of the injury." A.R.S §12-563. The jury instruction at Medical Negligence 1, RAJI (Civil) 5th, states the elements of a medical negligence claim as: "the failure to comply with the applicable standard of care. To comply with the applicable standard of care, a health care provider must exercise that degree of care, skill, and learning that would be expected under similar circumstances of a reasonably prudent health care provider within this state. Fault is medical negligence that was a cause of injury to [name of plaintiff]. Before you can find [name of defendant] at fault, you must find that [name of defendant]'s negligence was a cause of injury to [name of plaintiff]. Negligence causes an injury if it helps produce the injury, and if the injury would not have happened without the negligence. On the claim of fault for medical negligence, [name of plaintiff] has the burden of proving: 1. [Name of defendant] was negligent; 2. [Name of defendant]'s negligence was a cause of injury to [name of plaintiff]; and 3. [Name of plaintiff]'s damages."

"A person who violates a statute enacted for the protection and safety of the public is guilty of negligence per se." *Good v. City of Glendale*, 150 Ariz. 218, 221, 722 P.2d 386, 389 (Ct. App. 1986). Such laws, as explained in RAJI (Civil 5th), Negligence 1, include regulations.

The Restat. 2d of Torts, §323 states: "One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of the other's person or things, is subject to liability to the other for physical harm resulting from his failure to exercise reasonable care to perform his undertaking if (a) his failure to exercise such care increases the risk of such harm…"). Arizona has adopted

1 Restat. 2d of Torts, §323. See, e.g., *Jeter v. Mayo Clinic*, 211 Ariz. 386, ¶72, 121 P.3d 1256,
2 1272-1273 (reversing trial court dismissal of negligence claim against health care provider
3 that lost plaintiffs' frozen embryos, and stating "Arizona courts have adopted and applied
4 Restatement §323 in the medical malpractice context"). This rule applies in "the limited
5 class of cases in which defendant undertook to protect plaintiff from a particular harm and
6 negligently interrupted the chain of events, thus increasing the risk of that harm." As stated
7 in *Thompson v. Sun City Comm. Hosp.,* "[i]f the jury finds that defendant's failure to
8 exercise reasonable care increased the risk of the harm he undertook to prevent it may from
9 this fact find a 'probability' that defendant's negligence was the cause of the damage." 141
10 Ariz. 597, 608, 688 P.2d 605, 616 (1984).

11 **C. APSA.** Defendants are each an enterprise, as defined by A.R.S. §46-455(Q)("any
12 corporation, partnership, association, labor union, or other legal entity, or any group of
13 persons associated in fact although not a legal entity, that is involved with providing care to
14 a vulnerable adult"), that assumed a legal duty to provide care to David.

15 "'Care' is 'generally defined as charge, supervision, management: responsibility for
16 or attention to safety and wellbeing." *Estate of Wyatt*, 232 Ariz. 506, ¶8, 307 P.3d at 75.

17 David was a "Vulnerable Adult" as defined by §46-451(A)(9) when he was in
18 Defendants' care and custody. David's physical impairments were to a nature and extent
19 that left him unable to protect himself from Defendants' neglect and mismanagement of his
20 extensive medical needs.

21 In order to state a successful claim for abuse or neglect under APSA, a plaintiff must
22 show that the alleged victim was a "vulnerable adult" who was "injured by neglect [or]
23 abuse" by "any person or enterprise that has been employed to provide care . . . to such
24 vulnerable adult." A.R.S. § 46-455(B); *see also Equihua v. Carondelet Health Network*, 235
25 Ariz. 504, ¶7, 334 P.3d at 196 (App. 2014). As it pertains here, "'[a]buse' means: . . .
26 [i]njury caused by negligent acts or omissions," while "'[n]eglect' means a pattern of

1 conduct without the person's informed consent resulting in deprivation of food, water,
2 medication, medical services . . . or other services necessary to maintain minimum physical
3 or mental health." A.R.S. §46-451(A)(1)(b),(6).

4 "Person" is defined at A.R.S. §1-215 as "includes a corporation, company,
5 partnership, firm, association or society, as well as a natural person…When the word
6 'person' is used to designate the violator or offender of any law, it includes corporation,
7 partnership or any association of persons."

8 On 6/20/17, the Arizona Supreme Court expanded APSA and held that an APSA
9 claim requires proof that: (1) a vulnerable adult, (2) has suffered an injury, (3) caused by
10 abuse, (4) from a caregiver. *Delgado v. Manor Care of AZ, LLC*, 395 P.3d 698, ¶1, 19
11 (2017).

12 The monetary damages allowed under APSA are set forth in A.R.S. §46-455(H)(4)
13 which states "After a determination of liability such orders may include, but are not limited
14 to…Ordering the payment of actual and consequential damages, as well as costs of suit, to
15 those persons injured by the conduct described in this section. The court or jury may order
16 the payment of punitive damages under common law principles that are generally applicable
17 to the award of punitive damages in other civil actions."

18 **D. Punitive Damages.** RAJI (Civil) 5th, Personal Injury Damages 4 states the
19 punitive damages standard as: "To recover such damages, [name of plaintiff] has the burden
20 of proving by clear and convincing evidence, either direct or circumstantial, that [name of
21 defendant] acted with an evil mind. This required state of mind may be shown by any of the
22 following: 1. Intent to cause injury; or 2. Wrongful conduct motivated by spite or ill will; or
23 3. [[Name of defendant] acted to serve his own interests, having reason to know and
24 consciously disregarding a substantial risk that his conduct might significantly injure the
25 rights of others.] [[Name of defendant] consciously pursued a course of conduct knowing
26 that it created a substantial risk of significant harm to others.] To prove this required state of

1 mind by clear and convincing evidence, [name of plaintiff] must persuade you that the
2 punitive damages claim is highly probable. This burden of proof is more demanding than
3 the standard of more probably true than not true, which applies to all other claims in this
4 case, but it is less demanding than the standard of proof beyond a reasonable doubt, which is
5 used in criminal cases. The law provides no fixed standard for the amount of punitive
6 damages you may assess, if any, but leaves the amount to your discretion. [However, if you
7 assess punitive damages, you may consider the character of [name of defendant]'s conduct
8 or motive, the nature and extent of the harm to plaintiff that [name of defendant] caused, and
9 the nature and extent of defendant's financial wealth.]"
10 Punitive damages are recoverable in an APSA claim pursuant to A.R.S. §46-455(H)
11 and case law. See, *e.g., Newman v. Select Specialty Hosp*., 356 P.3d 345, ¶9-16, 2016
12 Ariz.App. LEXIS 55, 2016 WL 1377634 (App. 2016) (reversing dismissal of punitive
13 damages instruction on APSA claim). Punitive damages are also recoverable against
14 Corizon Health, Inc., based on their medical malpractice in this case and because they
15 "consciously pursued a course of conduct knowing that it created a substantial risk of
16 significant harm to others."
17 Remainder redacted.
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