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

THE ESTATE OF LEWIS JORDAN, JR., by and through personal representative and next friend, LEWIS JORDAN, SR.; and RACHAEL WATERHOUSE *ex rel*. R.J. and L.J., minors;

Plaintiffs,

v.

STATE OF ALASKA, DEPARTMENT OF CORRECTIONS;
CORRECTIONS OFFICER OUELLETTE;
CORRECTIONS OFFICER CURNEY; and
JOHN DOES 1-10;

Defendants.

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**CIVIL RIGHTS COMPLAINT AND JURY DEMAND**

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The Plaintiffs, Lewis Jordan, Sr., in his capacity as next friend and personal representative of the Estate of Lewis Jordan Jr., and Rachael Waterhouse, on behalf of R.J. and L.J., both minors ("Plaintiffs"), by and through their attorneys, Zachary D. Warren and Annika K. Adams of HIGHLANDS LAW FIRM, and Ruth Botstein of the ACLU OF ALASKA FOUNDATION, bring this Civil Rights Complaint and Jury Demand, and allege the following:

## I. INTRODUCTION

1. Lewis Jordan Jr. was a detainee at the Goose Creek Correctional Complex ("Goose Creek") who died because of the deliberate indifference of the Defendants.

2. More specifically, Mr. Jordan died of bacterial meningitis, which developed when the Defendants callously failed to treat an ear infection for days on end—ignoring his pleas for help and the obvious signs that he was in grave danger.

3. On or about March 5, 2023, Mr. Jordan started feeling a stabbing pain in his ear and associated flu-like symptoms. These are obvious signs of an acute ear infection. He was otherwise of good health, had no history of malingering, and was generally known for his physically strong and vivacious presence.

4. Over the ensuing days, he became visibly weaker, sicker, and finally unable to even get out of bed or walk around his assigned housing unit as his raging ear infection turned into acute spinal meningitis.

5. Throughout this time period, Mr. Jordan repeatedly requested permission from Defendants Ouellette and Curney, among others, to visit the medical unit for an evaluation and treatment. Even as his pleas grew more desperate, he was never permitted the opportunity to see a medical provider to diagnose his illness.

6. To be clear, any qualified medical provider—indeed, likely any adult with some semblance of common sense—would have easily ascertained that Mr. Jordan had an acute ear infection, which is quickly, consistently, and cheaply remedied with basic oral antibiotics.

7. But he never got the chance. Mr. Jordan was completely denied any access to medical care no matter how desperate his pleas—or those of the other detainees who pled on his behalf given the obvious and severe nature of his distress.

8. In the early morning hours of March 10, 2023, Mr. Jordan was found unresponsive in his cell and was transported to Mat-Su Regional Hospital.

9. On April 27, 2023, Mr. Jordan died when his family made the heart-wrenching decision to remove him from life support.

10. Had he seen a medical provider for an appropriate assessment and treatment at any point in the days leading up March 10, 2023, he would still be alive today.

## II. JURISDICTION AND VENUE

11. This action arises under the Constitution and laws of the United States, including 42 U.S.C. § 1983, § 1988, and the laws of the State of Alaska, including, without limitation, A.S. § 09.55.580.

12. Jurisdiction is conferred upon this Court pursuant to 28 U.S.C. §§ 1331 and 1343 relative to the federal claims. Jurisdiction for the supplemental state law claims is conferred upon this Court by 27 U.S.C. § 1367.

13. Venue is proper within the District of Alaska pursuant to 28 U.S.C. § 1391(b) because all of the events giving rise to the claims in this matter occurred within the District of Alaska.

## III. PARTIES

14. At all times relevant to this Complaint, Lewis Jordan Jr. ("Lewis" or "Mr. Jordan") was a citizen of the United States and a resident of the State of Alaska.

15. Plaintiff Lewis Jordan, Sr. is a citizen of the United States and a resident of the State of Georgia.

16. Plaintiff Rachael Waterhouse is a citizen of the United States and a resident of the State of Alaska. R.J. and L.J. are citizens of the United States and residents of the State of Alaska, and are the biological offspring of Rachael Waterhouse and the decedent, Lewis Jordan, Jr.

17. At all times relevant to this Complaint, Defendant Ouelette was a citizen of the United States and a resident of the State of Alaska, and acting within the course and scope of their duties under color of state law as an officer of the Alaska Department of Corrections.

18. At all times relevant to this Complaint, Defendant Curney was a citizen of the United States and a resident of the State of Alaska, and acting within the course and

scope of their duties under color of state law as an officer of the Alaska Department of Corrections.

19. At all times relevant to this Complaint, Defendant John Does 1-10 were citizens of the United States and a residents of the State of Alaska, and acting within the course and scope of their duties under color of state law as agents and/or contractors of the Alaska Department of Corrections. (Defendants Ouellette, Curney, and John Does 1-10 are each a "Defendant," and collectively are the "Individual Defendants.")

20. At all times relevant to this Complaint, the Alaska Department of Corrections was an agency of the State of Alaska, and responsible for the care of incarcerated individuals, including the provision of adequate medical care.

## IV. FACTUAL ALLEGATIONS

***The Individual Defendants Ignored Obvious and Serious Medical Needs for a Prolonged Period and Acted as Gate-Keepers Relative to Accessing Medical Care***

21. Lewis Jordan, Jr. was a Black man, a father, a son, and a friend who was loved by many people. But at the Alaska Department of Corrections' ("ADOC") Goose Creek Correctional Complex ("Goose Creek"), Lewis was ignored, denied even the most basic medical care, and treated as though his life didn't matter.

22. On or about March 5, 2023, Lewis began to complain to Goose Creek staff, specifically including Defendants Ouellette and Curney, about a painful and severe earache and headache.

23. Lewis did everything he could within ADOC and Goose Creek's systems to advocate for himself. He completed multiple Requests for Interview ("RFIs"), which are written requests to be permitted to go to the medical unit at Goose Creek to receive medical care, and literally begged and pleaded with staff to be seen for assessment and diagnosis by a qualified medical provider.

24. Over the ensuing days, Lewis verbally told correctional staff in his unit, including the Individual Defendants, numerous times, that he was in severe and worsening pain.

25. Starting on March 5, 2023, he would approach correctional staff, specifically including Defendants Ouelette and Curney, and request medical assistance for symptoms that were clearly indicative of a severe ear infection, yet he was repeatedly denied access to medical staff.

26. Lewis similarly told medical staff when they came to his unit for "med line," the process of handing out medications to incarcerated individuals by medical personnel, that he was getting more and more ill as the days went by.

27. Importantly, because of the way medical care is provided specifically in Goose Creek, the medical staff who hand out medications at "med line" are not empowered to evaluate or assess any medical complaints by detainees or prisoners; instead, detainees and prisoners are uniformly required to complete an "RFI" or seek permission through the correctional officer(s) assigned to their respective housing units to gain in-person access to

the medical staff who operate exclusively within the Medical Unit—which is on the other side of the Goose Creek campus.

28. Only mid-level prescribers and physicians, who operate exclusively within the Medical Unit, are permitted under the policies and procedures of ADOC and upper-level decision-makers within the Goose Creek facility to make diagnostic and treatment decisions with respect to serious medical conditions.

29. For individuals incarcerated at Goose Creek, there is no way to declare a medical emergency or appeal to medical providers directly regarding any potential medical issues, including severe and/or urgent conditions, even if they could be life-threatening.

30. As a result, correctional officers, who are not medical providers and are therefore unable to diagnose medical issues, are in a position of gate-keeping requests for medical care, even in situations where access to medical care is a life-or-death matter, as it was for Lewis.

31. Lewis's pleas to Defendants Ouellette, Curney, and John Does 1-10, were ignored in the days that followed March 5, 2023. He became so visibly sick during this time that he had trouble walking and talking. Any person—whether correctional officers, medical, or lay—could readily see the urgent need for medical care.

32. On numerous occasions, Lewis would slowly and with tremendous effort—sometimes even requiring the assistance of other detainees or prisoners—make his way to the podium where correctional staff sat and proceed to beg them to call medical to his unit or give him permission to travel to the Medical Unit. Correctional and medical staff at

Goose Creek knew that Lewis was sick, but did nothing to help him, and the Individual Defendants refused him permission to seek help at the Medical Unit.

33. Throughout this period, according to numerous witnesses, Lewis behaved like a person experiencing a slow-motion medical crisis. In the earlier parts of his illness, he would setup a chair (with a wet rag over his head) near the podium—and in plain view of Defendants Ouelette and Curney—where he would routinely slump over, drift in and out of consciousness, and even fall out of his chair, but was still unable to gain the sympathies of the responsible officers.

34. During this time, Lewis also submitted several RFIs to be seen by medical staff at Goose Creek. These written RFIs went unanswered by medical staff.

35. As of March 8, 2023, Lewis was largely unable to leave his cell, even for a shower, meals, or to contact staff during "med line," who could have easily checked-in on him or monitored his situation as it was obviously worsening.

36. During this period, other inmates felt compelled to advocate on his behalf by requesting Defendants Ouelette and Curney to allow Lewis access to the Medical Unit, or to otherwise contact medical and request an immediate assessment of his dire condition.

37. Each of these requests were refused.

38. Word began to spread among detainees and prisoners within Lewis's housing unit that he was experiencing a very serious—and atypical—medical event. Incarcerated individuals took it upon themselves to try and provide some semblance of comfort and monitoring given that the staff refused to do so.

39. Throughout this period, Lewis had been exhibiting obvious signs of an extremely high temperature, acute headache and ear pain, dizziness, delirium, extreme lethargy—all signs of a serious medical need.

40. Early diagnosis and intervention are important with respect to infections, particularly ear infections, which are especially risky given the ease with which the infection can pass to surrounding tissues, including the brain and spinal cord.

41. It is well-known within the medical community that ear infections—if left untreated for too long—can turn into meningitis, which can be fatal and require immediate and aggressive medical intervention.

42. By treating the ear infection within the acceptable standard of care, oral antibiotics are very likely to entirely resolve the issue and prevent any spread which might result in meningitis.

43. Even if the treatment fails to immediately resolve the underlying infection, any competent medical professional will implement a stringent monitoring program to ensure the infection does not spread to the blood, brain, or spine, which carries a known risk of death.

44. By March 9, 2023, other individuals in his unit began pleading with correctional officers, including Mr. Ouellette, to take Mr. Jordan to the medical unit or otherwise have medical staff examine and treat Mr. Jordan.

45. Several individuals in Mr. Jordan's unit witnessed Mr. Jordan plea for medical care in an obvious state of desperateness and watched correctional officers ignore him.

46. Later that same day, Mr. Jordan's pain became so unbearable that he went door to door to each cell in his unit to ask residents of his unit if they had any Tylenol or Ibuprofen that he could have.

47. By this point, Mr. Jordan was in such extreme pain that he had difficulty speaking and walking.

48. According to witnesses, in the very early morning on March 10, 2023, exasperated and visibly severely sick, Lewis drug himself out of bed and nearly crawled to the podium where Defendant Curney sat. Mr. Jordan stood in front of Defendant Curney for a long period of time trying to get Defendant Curney's attention.

49. Defendant Curney, who was on the phone, ignored Mr. Jordan and denied Mr. Jordan medical care through his gatekeeping role.

50. Despite trying to get Defendant Curney's attention, and despite showing visible, objective signs of experiencing a medical emergency, Defendant Curney ignored Mr. Jordan and did not request medical assistance for him, nor did he follow-up with Lewis afterwards.

51. Approximately an hour later and feeling nauseous, Lewis went to the restroom, where he encountered another individual in his unit. Mr. Jordan complained

about his severe earache and headache and asked the individual for ibuprofen, which he provided to Lewis.

52. Just a couple of hours later, Lewis's cellmate heard a moaning sound and found him unresponsive, laying on the floor, bleeding, and covered in vomit.

53. The cellmate began banging on the partition and finally got the attention of Defendant Curney, who only then called for assistance from other officers and medical staff.

54. When correctional officers responded to Lewis's cell, they immediately rejected the reality of his obvious medical emergency—part of the culture and training within ADOC—and instead fixated on the unsupported idea that Lewis was experiencing an overdose.

55. The responding officers then called medical staff to his cell, put a spit hood on Lewis and shackled him. Lewis was then transported to Mat-Su Regional Center.

***Dismissing Serious Medical Problems and Acting as Gate-Keepers for Medical Care is a Widespread Problem through ADOC including Goose Greek***

56. This is a case study relative to a broader problem at Goose Creek; specifically, that officers are routinely dismissive of serious medical problems, and quickly attribute any symptoms of major illness to malingering or illegal substance use.

57. At the time officers responded to his cell, Lewis was in-and-out of consciousness, and, at times, behaved a way that was highly dysregulated. This is known as "altered mental status" and is a known and prominent feature of someone experiencing

acute meningitis. Coupled with high fever and an untreated ear infection, any medical professional would realize that altered mental state is diagnostic of a life-threatening infection, and immediately obtain blood cultures to determine the extent of the infection.

58. But because responding officers and medical staff Goose Creek simply assumed—without evidence—that Lewis was experiencing an overdose, and excluded all other potential causes as a result, Lewis did not receive any appropriate diagnostic procedures in the hours following the response to his cell, aside from the administration of Narcan.

59. As staff were administering Narcan, which can be life-saving if the patient has ingested opiates, other detainees and prisoners were imploring staff to take other measures and emphasized the fact that Lewis had not ingested any drugs—aside from ibuprofen.

60. Tests later confirmed that Lewis had not ingested any substances—aside from ibuprofen—and was, in fact, not experiencing an overdose. Instead, he was experiencing the predictable effects of an untreated infection.

61. Notwithstanding the fact that there was no evidence that Lewis ingested any substances aside from ibuprofen, Goose Creek staff told Mat-Su Regional Center that Lewis overdosed.

62. While they began initially treating Lewis as such, relying on the unfounded claims by Goose Creek staff, the medical team at Mat-Su Regional Medical Center

determined that Lewis did not have any drugs in his system, and had not overdosed, but was actually suffering from severe and untreated meningitis.

63. This diagnosis—and subsequent intervention—was severely delayed due to the baseless claims that Lewis had ingested illegal drugs from Goose Creek staff, further compounding the problem and decreasing the likelihood that Lewis would ever recover from the deliberate indifference to his serious medical needs which started days before.

64. Due to severity of his condition and the delays in obtaining medical care, medical providers at Mat-Su Regional Medical Center placed Lewis in a medically induced coma, but he never recovered. Instead, Lewis fought for his life for weeks, experiencing immense pain, seizures, paralysis, and extreme distress, before his untimely death on April 27, 2023.

65. Through testing and observation, Mat-Su staff dispelled the false narrative provided by the Individual Defendants that Lewis was suffering the effects of an overdose, and had not taken any illegal drugs, but was rather suffering from an untreated severe bacterial meningitis infection.

***Meningitis is Treatable with Adequate Medical Care***

66. Meningitis is easily diagnosed by a variety of tests, including blood work, CT scans, MRI scans, and a spinal tap.

67. Meningitis is easily treated if medical care is provided once symptoms develop. Antibiotics and sometimes corticosteroids are administered to patients suffering

from meningitis, and most individuals survive a meningitis diagnosis with no long-term complications.

68. Urgent intervention is key to preventing serious complications of an infection which turns into meningitis.

69. A delay in providing antibiotics to treat bacterial meningitis can result in seizures, paralysis, stroke, and death—all of which Lewis suffered.

70. But by the time Mr. Jordan received medical care from Mat-Su Regional Hospital, he had already lost consciousness due to the progression of his meningitis.

71. Over the next few days, Mr. Jordan remained largely unresponsive and non-verbal.

72. According to medical records from Mat-Su Regional Hospital, Lewis was in-and-out of consciousness—sometimes awake but confused, at times able to answer a few simple questions, and at other times unable to speak or move.

73. Mr. Jordan continued to suffer from seizures and when he woke was scared and confused.

74. Mr. Jordan's condition at Mat-Su Regional Hospital was "serious" as he was "unresponsive" and "not following commands or making any meaningful movements."

75. After weeks of care, and with no reasonable prospects for recovery, the family was forced into a position of stopping life-sustaining treatment.

76. Mr. Jordan's death—which began as a simple ear infection—was entirely preventable, had anyone employed by the ADOC and Goose Creek, including the

Individual Defendants, done anything when he told them he was severely ill, and when his condition visibly deteriorated quickly over the course of a few days.

77. Instead, the Individual Defendants ignored his verbal and written pleas for help, callously allowed him to suffer, and waited until it was too late to take any semblance of action.

78. Defendants Ouellette and Curney recklessly gambled with his life by gate-keeping Lewis' access to qualified medical personnel.

79. The Individual Defendants, including Defendants Oullette and Curney, had multiple opportunities to take any kind of action to save Lewis' life, but instead deliberately disregarded his requests and visible signs of serious illness on numerous separate occasions.

***Beyond the Deliberate Indifference of the Individual Defendants, the Medical Delivery System at Goose Creek is Fundamentally Flawed***

80. Moreover, the medical delivery system at Goose Creek is fundamentally flawed, and is a moving force in the untimely death of Lewis Jordan, Jr.

81. Specifically, the ADOC is deliberately indifferent to serious medical needs because, among other failures, the medical delivery system:

a. Requires non-medical personnel to make discretionary decisions regarding the seriousness of medical complaints by detainees and prisoners;

b. Gate-keeps access to medical personnel by requiring detainees and prisoners to go through correctional officers—who are not medical personnel and unqualified to make diagnostic decisions regarding medical complaints—as a means to obtaining medical care;

c. Utilizes an "RFI" system which has no mechanism for identifying particularly time-sensitive (and even life-threatening) complaints, which require immediate attention;

d. Often completely failing to respond to RFIs or delaying meaningful responses for weeks or more.

82. The gate-keeping system is so severe that many detainees and prisoners report having to create a ruse in order to physically and directly appeal to medical staff for serious and urgent medical issues, including gaining access to part of the Goose Creek campus that contains the Medical Unit under false pretenses, which risks disciplinary charges, changes in custody level, and restriction of privileges, simply because there is no other choice and doing so might be the only opportunity to actually appeal to a medical professional in a life-or-death situation.

***ADOC Fails to Report In-Custody Deaths as a Tactic for Avoiding Scrutiny***

83. Rather than take any accountability for Lewis's death, and the deaths of others who have similarly died preventable deaths, the ADOC failed, and continues to fail, to report in-custody deaths as such. In doing so, the ADOC seeks to avoid accountability for the individual and systemic practices that led to his death—and that of so many others.

84. While Lewis was in a coma and fighting for his life at Mat-Su, ADOC officials unilaterally paroled him once it became clear that Lewis would not recover.

85. ADOC took this action, as it has with several other individuals, so that it would not have to report Lewis's death as an in-custody death. This practice has allowed ADOC to avoid investigation and scrutiny into its unconstitutional conditions of confinement, including its unconstitutional and systemic policies and practices relative to gate-keeping medical care for far too long.

86. Lewis's death was caused by the deliberate indifference of correctional and medical staff at Goose Creek and the way in which ADOC prohibits individuals in its custody from accessing medical care. This Court should not turn a blind eye to the deaths that ADOC causes.

87. Not only did ADOC fail to provide adequate medical care to Lewis while he was alive, ADOC also failed to report his death as an in-custody death.

88. In-custody death reporting is mandatory pursuant to the Death in Custody Reporting Act, Pub. L. No. 113-242. ADOC is required to submit quarterly reports to the Bureau of Justice Assistance describing the death of every individual who dies in its custody, including the location and type of facility the individual was housed in, the individual's sex, race, ethnicity, age, the circumstances surrounding the death, and whether an autopsy was conducted.

89. The Bureau of Justice's Mortality in Correctional Institutions, responsible for collecting data pursuant to the Death in Custody Reporting Act from 2001-2019,

mandated that deaths like Mr. Jordan's should be reported as in-custody deaths. Specifically, it stated that

> "custody refers to the physical holding of a person in a facility or to the period during which a correctional authority maintains a chain of custody over such person. For instance, if a prison transports an ill prisoner to a hospital for medical services and that prisoner dies in the hospital while in the chain of command of the prison, then that death is counted as a death in custody."[1]

90. Furthermore, the Bureau of Justice Assistance ("BJA"), which administers and enforces the Death in Custody Reporting Act today, also mandates that deaths like Mr. Jordan's are in-custody deaths which must be reported. The BJA requires that

> "[i]f the incarcerated person, absent the medical condition, would have been in prison at the time of death, it counts as a reportable death. Although the person was not physically in a correctional facility at the time of death, the death is still one of an incarcerated individual."[2]

91. Despite this long-standing requirement, there are several instances of ADOC failing to report deaths in hospitals that began as illnesses in its facilities, including the instant case.

92. To circumvent its reporting requirements, ADOC unilaterally paroled Lewis once it became clear that he would not regain consciousness.

93. Specifically, ADOC medically paroled Lewis under Alaska Stat. § 33.16.085, which provides that "upon application by the prisoner or the commissioner" a prisoner may "be released by the board on special medical parole if the board determines

[1] https://bjs.ojp.gov/content/pub/pdf/msfp0119st.pdf
[2] https://bja.ojp.gov/funding/performance-measures/DCRA-Reporting-Guidance-FAQs.pdf

that because of the prisoner's severe medical or cognitive disability, the prisoner will not pose a threat of harm to the public if released on parole." Alaska Stat. § 33.16.085(a)(2)(B).

94. While the ability to medically parole individuals makes intuitive sense in certain circumstances, ADOC uses this power to shield itself from scrutiny for deaths that occur as a result of its inadequate medical care, including Mr. Jordan's.

95. ADOC used the medical parole statute to circumvent its requirement to report Jimmie Singree's death as an in-custody death in 2023. Mr. Singree suffered from a medical emergency and was transported to an outside hospital while brain dead, and was unilaterally released from custody by ADOC. His death was not reported as an in-custody death.

96. ADOC also failed to report the in-custody death of Angelena McCord, who suffered a seizure at Hiland Mountain Correctional Facility, was transported to Alaska Regional Hospital, and died a few days later on October 10, 2023. Similarly, ADOC dismissed criminal charges pending against her once it was clear she would not recover from her illness.

97. Because Angelena was technically released from custody at the time of her death, ADOC did not count her death as in-custody. Had Angelena not become so gravely ill while in-custody that she needed to be transported to the hospital, she would have remained in ADOC's custody.

98. The failure to count Lewis's death, and others, as an in-custody death results in inaccurate statistics about the conditions of ADOC prisons, and insulates the department

from scrutiny relative to its insufficient medical training and supervision of medical staff and inadequate policies and procedures regarding the provision of medical care to individuals who rely solely on ADOC for such care.

99. This tactic also relieves the ADOC from the responsibility to facilitate an autopsy or provide any information to a coroner or medical examiner, which acts as a barrier to transparency regarding in-custody deaths.

100. In this case, ADOC officials informed Lewis' family of his hospitalization, explicitly stating that he was suffering the very serious effects of an overdose—which they knew to be untrue.

101. At the time this was communicated, ADOC officials were well aware that an untreated infection—which had morphed into severe bacterial meningitis—caused Lewis' hospitalization. But Lewis was in a medically induced coma at that point and unable to immediately communicate as much to his family.

102. Only later did the family learn that Lewis did not, in fact, have any illegal drugs in his system and that his untimely death was the result of deliberate indifference by the Individual Defendants and the systemic failures of ADOC.

103. Reporting all deaths which result from acute illnesses that begin while an individual is in-custody of the ADOC "is surely an obligation of government when it incarcerates so many of its citizens."[3]

[3] 159 Cong. Rec. H00000-55, 159 Cong. Rec. H00000-55, H8048

104. Even taking into account ADOC's failure to report several deaths as in-custody, the number of individuals who have died in ADOC facilities is alarming.

105. Equally as alarming is ADOC's failure to disclose documents and video surveillance footage to individuals' families and personal representatives before and during litigation.

106. Indeed, Mr. Jordan is only one of several individuals who have lost their lives in ADOC facilities in recent years, and his death, like so many others, remains a black box due to both ADOC's reporting failures and failures to provide documentation to family members.

107. For example, in 2020, ADOC reported ten in-custody deaths. One individual was 27-year-old Natalia Andreaknoff, who was in the care of Hiland Mountain Correctional Center when she died by suicide. When Natalia's estate tried to get documents and video surveillance to get answers and closure of her death, ADOC claimed that the records were exempt from its initial disclosures requirement.

108. After delaying disclosure, ADOC moved to have all of its records regarding Natalia's death covered under an extensive protective order, despite that Natalia's estate objected to the protective order.

109. In 2022, ADOC reported a record 22 in-custody deaths. Among the 22 individuals reported was James Rider, who died by suicide at Mat-Su Pretrial Facility after ADOC officials ignored his pleas for mental health care.

110. In 2023, ADOC reported ten in-custody deaths, failing to report the deaths of three individuals who died following medical emergencies that began while they were in the custody and care of ADOC.

111. ADOC also fought disclosure of documents regarding Mr. Singree's death in 2023. Following his death, Mr. Singree's family opened an estate and attempted to gather information, documents, and medical records regarding his death.

112. ADOC claimed that disclosing documents about how and why Mr. Singree died to Mr. Singree's estate would be too costly and disrupt staff time and resources.

113. By failing to adhere to discovery obligations, refusing to disclose institutional records before and during litigation, failing to report deaths as in-custody, and gatekeeping records of in-custody deaths under overbroad protective orders, ADOC ensures that the true scope of its failures to prevent in-custody deaths and violations of the Constitution will never be brought to light.

## V. CLAIMS FOR RELIEF

### FIRST CLAIM FOR RELIEF
### 42 U.S.C. § 1983 – Eighth Amendment Inadequate Medical Care
(Plaintiff Estate Against Individual Defendants)

114. Plaintiff hereby incorporates all other paragraphs of this Civil Rights Complaint and Jury Demand as if set forth fully herein.

115. At all times relevant to the allegations in this Civil Rights Complaint and Jury Demand, the Individual Defendants acted under color of state law.

116. All of the Individual Defendants are persons under 42 U.S.C. § 1983.

117. At all relevant times, Lewis Jordan Jr. had a clearly established right under the Eighth Amendment to the United States Constitution to be free from deliberate indifference to his known serious medical needs. At no time during Mr. Jordan's incarceration would a reasonable prison official have thought it was lawful to deny Mr. Jordan his constitutional right to adequate medical care.

118. Under the Eighth Amendment, prison officials must provide adequate medical care to prisoners, who rely entirely on them for their medical needs.

119. While Mr. Jordan was in the custody of the ADOC and housed at Goose Creek Correctional Facility, he was entitled to receive adequate medical care for his serious medical need—an acute ear infection and meningitis.

120. Acting with deliberate indifference to Mr. Jordan's right to receive adequate medical care, the Individual Defendants denied Mr. Jordan medical care by acting as gatekeepers to medical services at Goose Creek Correctional Facility and/or by failing to render medical care to him when his physical health was obviously deteriorating.

121. The denial of adequate medical care by the Individual Defendants caused Mr. Jordan to suffer from substantial harm which served no penological purpose – namely, severe pain in the days leading to his death, and his eventual loss of consciousness and death.

122. The Individual Defendants knew or should have known that the denial of medical care to Mr. Jordan would cause him to be subjected to substantial harm, including his foreseeable and preventable death.

123. The Individual Defendants' acts and omissions were the proximate cause of Mr. Jordan's death and the deprivation of his constitutional rights under the Eighth Amendment.

124. The Individual Defendants' acts and omissions were conducted within the scope of their official duties and employment, as they were responsible for either alerting medical professionals to Mr. Jordan's condition or providing medical care to him.

**SECOND CLAIM FOR RELIEF**
**Negligence Resulting in Wrongful Death with Loss of Consortium**
(Plaintiffs Against Defendants)

125. Plaintiffs hereby incorporate all other paragraphs of this Civil Rights Complaint and Jury Demand as if set forth fully herein.

126. At all relevant times, the Individual Defendants were acting under color of state law and within the scope and course of their employment.

127. The Alaska Department of Corrections is vicariously liable for the negligent conduct of the Individual Defendants.

128. The Alaska Department of Corrections is also directly liable as it breached the duty to exercise reasonable care in the training and supervision of their employees and endorsing certain conduct of its employees that caused the death of Lewis Jordan, Jr.

129. The Alaska Department of Corrects is also directly liable as it breached the duty to provide policies and procedures that facilitate the reasonable medical care for incarcerated individuals, including, without limitation, permitting reasonable and timely access to medical providers who are qualified to make diagnostic and treatment decisions

and maintaining a system which can diagnose particularly time-sensitive and life-threatening medical issues.

130. As a direct and proximate result of the Individual Defendant's breach of their duty to provide reasonable care and treatment to the Plaintiff in the operation of a detention facility, including, without limitation, exercising their duty to obtain necessary medical care, the Plaintiff was harmed and suffered injuries.

131. The Alaska Department of Corrections knew or should have known of the lack of supervision, experience, and training among their employees and agents was likely to harm incarcerated individuals in need of medical care, including Lewis Jordan, Jr.

132. In failing to exercise reasonable care in the training and supervision of their employees and agents, as it relates to their providing reasonable supervision of inmates and detainees, the Alaska Department of Corrections negligently and proximately caused Lewis Jordan, Jr.'s death.

133. The Alaska Department of Corrections through its agents and medical providers owed a duty of care to Lewis Jordan, Jr., both with respect to the direct provision of medical care, but also with respect to establishing appropriate protocols in the management and assessment of inmates presenting with serious medical conditions.

134. The Alaska Department of Corrections knew or should have known of the lack of sufficient policies and procedures relative to the provision of medical care—and particularly a mechanism for timely assessment and diagnosis of time-sensitive and life-threatening medical conditions—was likely to harm incarcerated individuals in need of

medical care, including Lewis Jordan, Jr.

135. During his life, Lewis financially supported his two minor children, R.J. and L.J., and maintained relationships with them and his stepchildren, and provided their mother, Rachael, with money, clothing, and a security deposit for the family's home.

136. Lewis was also a father figure to his partner Rachael's two children from a previous relationship.

137. Each of these individuals—indeed, many people who knew Lewis—miss him deeply.

138. As a result of such negligence, the Plaintiffs have suffered damages, losses, and injuries in an amount to be determined at trial. These damages include, without limitation, pain and suffering, grief, upset, loss of society and companionship, anger, depression, and all other non-economic damages allowed under the Alaska Wrongful Death Act.

**THIRD CLAIM FOR RELIEF**
**42 U.S.C. § 1983 – Eighth Amendment Inadequate Medical Care**
**Declaratory and Injunctive Relief**
**(Plaintiff Estate Against ADOC)**

139. Plaintiff hereby incorporates all other paragraphs of this Civil Rights Complaint and Jury Demand as if set forth fully herein.

140. At all times relevant to the allegations in this Civil Rights Complaint and Jury Demand, the ADOC operated as an agency of the State of Alaska, and maintained a

special relationship and duty with respect to the individuals held in its custody, including Lewis Jordan, Jr.

141. At all relevant times, Lewis Jordan Jr. had a clearly established right under the Eighth Amendment to the United States Constitution to be free from deliberate indifference to his known serious medical needs. At no time during Mr. Jordan's incarceration would a reasonable prison official have thought it was lawful to deny Mr. Jordan his constitutional right to adequate medical care.

142. Under the Eighth Amendment, prison officials must provide adequate medical care to prisoners, who rely entirely on them for their medical needs.

143. While Mr. Jordan was in the custody of the ADOC and housed at Goose Creek Correctional Facility, he was entitled to receive adequate medical care for his serious medical need—an acute ear infection and meningitis.

144. Acting with deliberate indifference to Mr. Jordan's right to receive adequate medical care, the ADOC failed to implement and maintain policies and procedures that facilitate the timely provision of medical care to individuals in need, including Lewis Jordan, Jr. Among other things, the ADOC failed to implement policies and procedures as follows:

a. Providing an adequate opportunity to access medical treatment for serious illnesses, including life-threatening infections;

b. As a matter of policy, requiring detainees and prisoners to seek assessment and diagnosis only within the confines of the Medical Unit, and then restricting reasonable access to the Medical Unit;

c. Assigning disciplinary charges against detainees and prisoners for seeking medical care by any means other than submitting an RFI or requesting permission from correctional officers;

d. Placing correctional officers—who are not medical personnel and have no training or qualifications with respect to assessment and diagnosis—in a position of making medical judgments about the necessity of medical care for detainees and prisoners;

e. Recklessly or intentionally concealing failures in the medical delivery system by paroling detainees and parolees—even when they are unconscious or comatose—in an effort to get them "off the books" and no longer subject to an in-custody death investigation; and

f. Systematically training—or otherwise permitting a culture—of dismissing medical complaints by detainees and prisoners, leading to delayed or improper care for serious medical needs.

145. The denial of adequate medical care by the ADOC, which was a direct result of its failure to implement constitutionally-adequate policies and procedures and associated training, caused Mr. Jordan to suffer from substantial harm which served no penological

purpose – namely, severe pain in the days leading to his death, and his eventual loss of consciousness and death.

146. The ADOC knew or should have known that the failure to implement policies and procedures for the provision of adequate medical care to Mr. Jordan would cause him to be subjected to substantial harm, including his foreseeable and preventable death.

147. The ADOC's acts and omissions, through its failure to implement adequate policies, procedures, trainings, and seeking to avoid scrutiny relative to the well-documented issues regarding in-custody deaths and the widespread lack of adequate medical care, were the proximate cause of Mr. Jordan's death and the deprivation of his constitutional rights under the Eighth Amendment.

**PRAYER FOR RELIEF**

WHEREFORE, Plaintiffs respectfully request that this Court enter judgment their favor and against Defendants, and grant:

(a) All appropriate relief at law and equity;

(b) Declaratory relief and other appropriate equitable relief;

(c) Economic losses on all claims allowed by law;

(d) Compensatory and consequential damages, including damages for emotional distress, humiliation, loss of enjoyment of life, and other pain and suffering on all claims allowed by law in an amount to be determined at trial;

(e) Punitive damages on all claims allowed by law and in an amount to be

determined at trial;

(f) Attorneys' fees and costs associated with this action, including expert witness fees, on all claims allowed by law;

(g) Pre- and post-judgment interest at the highest lawful rate;

(h) Any further relief that this Court deems just and proper; and

(i) Any other relief as allowed by law.

**PLAINTIFFS HEREBY DEMAND A JURY TRIAL ON ALL ISSUES SO TRIABLE.**

DATED this 4th day of March, 2025.


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