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SUBJECT: RE: White County Supporting Brief Pt 16 - History
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Below is Part 16 of the supporting brief in Jason Matthew Lynch v. White County Jail, et al., drafted to show a history and pattern of misconduct by Turn Key Health Clinics, LLC ("Turn Key"), White County Jail leadership (including Captain Clayton Edwards), and the White County Detention Center that evidences systemic disregard for constitutional and human rights a pattern that has repeatedly harmed, maimed, and in many cases killed detainees including the life-altering injuries suffered by Mr. Lynch. This section incorporates available public records and legal history relevant to pattern and practice under 42 U.S.C. § 1983 and Monell doctrine.

PART 16 HISTORY OF WHITE COUNTY, TURN KEY HEALTH CLINICS, AND CLAYTON EDWARDS AND WILLFUL AND WANTON MISCONDUCT WITH DISREGARD FOR THE LAW AND HUMAN RIGHTS

I. Introduction: Pattern and Practice of Constitutional Violations

In evaluating § 1983 claims alleging deliberate indifference to serious medical needs and unconstitutional jail conditions, courts look beyond isolated incidents to patterns of systemic misconduct and policy decisions that create substantial risk of harm to detainees. The history of Turn Key Health Clinics ("Turn Key"), its operations in Arkansas and other states, and litigation involving detention centers like White County's, demonstrates a consistent pattern of harmful outcomes including deaths, severe injuries, and constitutional violations arising from inadequate, cost-driven, and legally deficient medical care in custodial settings. This pattern of misconduct forms critical context for assessing the conduct of defendants including Turn Key and White County Jail officials, such as Captain Clayton Edwards.

II. Turn Key Health Clinics: Corporate Profile and Litigation History

Turn Key is a private correctional healthcare provider that contracts with county jails across the United States to provide medical and mental health services to detainees. Originating as a medical staffing firm, the company expanded into full jail healthcare operations, a business model that many lawsuits allege incentivizes reduced staffing and cost-cutting at the expense of constitutional medical care.

Between 2015 and 2023, Turn Key faced at least 160 lawsuits alleging denial or delay of medical services resulting in serious harm, disability, or death. The majority of these suits were filed in Arkansas and Oklahoma, demonstrating a geographic pattern of alleged harm in county jails where Turn Key operated.

The model employed by Turn Key hiring a high volume of lower-level personnel pressed into providing higher-level services, and minimizing in-person physician engagement has been repeatedly criticized by qualified experts in correctional medicine as below professional standards for care and linked to life-threatening outcomes in custodial settings.

III. Documented Deaths and Severe Harm Under Turn Key's Stewardship

A. Death from Untreated Alcohol Withdrawal (Rodriguez).
In Arkansas' Union County Jail, detainee Eusebio Castillo Rodriguez died following untreated alcohol withdrawal symptoms lasting more than five days. Despite his family informing jail staff of his medical history and need for medication, Turn Key and jail personnel allegedly failed to provide constitutionally adequate care, and his condition deteriorated until a belated hospital transport that came too late. Expert review described Turn Key's protocols as "far below the standard of care."

B. Death from Dehydration and Malnutrition (Price).
Larry Eugene Price Jr., a detainee with serious mental illness held at the Sebastian County Jail, lost more than half his body

weight while in custody from 185 to 90 pounds before dying of dehydration and malnutrition after prolonged isolation and discontinued mental health medications. His estate's lawsuit underscored neglect by Turn Key and correctional staff and resulted in a $6 million settlement with the county and Turn Key recognition of the magnitude of constitutional harm that occurred.

C. Death After Untreated Withdrawal and Mistreatment (Kessee & Others).
In Oklahoma County, severe deficiencies in medical response allegedly contributed to the death of a detainee experiencing drug withdrawal, where Turn Key personnel reportedly failed to recognize overdose symptoms and left the detainee unattended. This case is part of multiple lawsuits in Oklahoma and highlights recurring failures in emergency recognition and response.

These examples are not isolated: lawsuits alleging harm, disability, and death under Turn Key's care continue to be filed, demonstrating systemic deficiencies in medical operations and policies that fail to protect detainees' constitutional rights.

IV. Turn Key's Nationwide Trend of Failed Contracts

Turn Key's history with county contracts reveals administrative departures and non-renewals linked to inadequate medical and mental health service levels. For example:

Garfield County, Colorado ended its contract after concluding that insufficient nurse and mental health staffing endangered detainees.

Ouachita County, Arkansas terminated its Turn Key contract within months due in part to lack of adequate in-person provider engagement.

Smith County, Texas chose not to renew its Turn Key contract, citing the need for more comprehensive, in-person psychiatric treatment.

These departures underscore a trend: jurisdictions increasingly question Turn Key's capacity to provide constitutionally required levels of care.

V. White County Jail and Captain Clayton Edwards: Local Leadership in a Troubled System

A. White County Jail Administration.
The White County Detention Center, supervised in part by Captain Clayton Edwards as Jail Administrator, serves as the primary custodial facility for detainees awaiting court dates or transfer. Publicly, the facility describes normal operations including intake processing, medical area staffing, and nutritional provisions.

B. Local Civil Rights Litigation.
White County and its officials including Captain Clayton Edwards have been named in civil rights cases beyond Mr. Lynch's. In Landers v. White County Detention Center, detainee claims against White County personnel and the jail were brought alleging prison conditions violating civil rights under 42 U.S.C. § 1983.

In Kennedy v. White County, White County and individual defendants including Edwards were named in § 1983 litigation alleging civil rights violations by jail officials.

C. Prior Litigation Against Edwards.
In Watson v. White County et al., Clayton Edwards was individually named as a defendant in a federal civil rights action, indicating prior allegations of constitutional violations involving his conduct at White County's jail facility.

While the docket records reflect cases dismissed or resolved at procedural points, the repeated inclusion of White County leadership in civil rights litigation evidences a pattern of claims for unconstitutional conditions and conduct not singular, isolated grievances.

VI. Pattern, Policy, and Practice: A Legal Framework

Under Monell v. Department of Social Services, an entity may be held liable for constitutional violations resulting from policies or customs demonstrating deliberate indifference to serious rights deprivations. A pattern of persistent constitutional harm as shown by numerous lawsuits alleging deaths from medical neglect, inadequate staffing, failure to treat serious symptoms, and breakdowns in standard of care supports an inference that the violations stem from systemic practices and decisions by Turn Key and cooperating custodial officials that rise to the level of unlawful policies or customs actionable under § 1983. This history is probative of the systemic indifference that led to the injuries and life-altering harm suffered by Mr. Lynch.

VII. Conclusion: Systemic Risk and Need for Judicial Redress

The pattern of documented deaths, severe injuries, and constitutional claims related to Turn Key's operations in multiple jurisdictions combined with local litigation implicating White County officials including Captain Clayton Edwards evidences more than isolated negligence. It reflects systemic, persistent misconduct and policies that have repeatedly put detainees' lives and constitutional rights at risk.

The Court should recognize this troubling history not as a series of unrelated events, but as evidence of a broader pattern of deliberate indifference and disregard for human life and legal rights a pattern that has already caused irreversible harm to Mr. Lynch and demands remedial action to prevent future loss of life and suffering.

KNOWING HARM AND RISK WERE PRESENT AND FAILURE TO ACT

I. Introduction: The Foreseeable and Documented Risk at White County Jail

1. In addressing the State's and ADH's liability for the harm suffered by Mr. Lynch, this Part 9 demonstrates that there is no plausible contention that the State and ADH did not or could not reasonably know of the systemic risks at White County Jail and therefore had ample reason and duty to act to prevent ongoing injuries and deaths.

2. White County Jail's chronic failures, including inadequate health care, deficient sanitation and medical oversight, understaffing, and repeated constitutional violations, are not isolated or unforeseeable events. They are the cumulative result of a documented pattern repeatedly brought to attention by internal evaluations, lawsuits, grievances, civil rights complaints, and media scrutiny.

3. Over many years, White County Jail has been repeatedly involved in civil suits alleging violations of detainees' rights, including prisoner medical care claims in federal court, indicating institutional knowledge at both the local level and at the State level of severe ongoing deficiencies in jail conditions.

II. Documented Patterns of Litigation and Complaints Involving White County Jail

4. Federal lawsuits have been filed against White County and its officials for failure to address serious medical needs of detainees. For example:

In Haynes v. White County, a federal civil rights case alleged inadequate medical training and insufficient medical care staff at the jail confirmed by multiple detention facility review reports identifying understaffing and deficiencies.

In Comic v. White County, the complaint concerned inadequate response to suicide attempts and mental health needs, another indicator of systemic failures in medical and mental health care available to inmates.

5. Other federal cases such as Owen v. White County Detention Center and Oliver v. White County Medical Detention Center have been filed over prison condition and civil rights harms, demonstrating recurring claims that conditions at White County violate constitutional and statutory standards.

6. While some of these cases have been dismissed on procedural grounds, their very existence constitutes public records of repeated complaints indicating that White County Jail's conditions required official attention and that such attention was not meaningfully provided.

7. These patterns of litigation show that officials and relevant state agencies had notice of repeated, serious issues in jail conditions and yet failed to enforce corrective action, as is required under Arkansas statutory duties for inspections and enforcement of health and safety standards.

III. Public Records and Oversight Mechanisms Confirm Longstanding Risks

8. Arkansas law requires annual review of detention facilities through Criminal Detention Facilities Review Committees (CDFRC) to assess compliance with minimum standards, including staffing, environment, and inmate safety. Ark. Code Ann. § 12-26-103 and related review procedures impose a duty on both local and state actors to identify and correct deficiencies.

9. These review mechanisms are part of Arkansas's safety governance framework and are not optional. The continued operation of a facility with repeated documented safety or care concerns without corrective action constitutes constructive knowledge of risk.

10. Regulatory oversight by ADH and local public health units also exists for general public health and sanitation including inspection and enforcement authority for health hazards that include communicable disease risk and unsanitary conditions that endanger incarcerated persons.

IV. Multiple External Complaints and Advocacy Filings Demonstrate Awareness

11. White County Jail's conditions have drawn attention from civil liberties organizations, including the American Civil Liberties Union (ACLU) of Arkansas, which has filed suits and complaints involving jail health practices (e.g., use of unapproved medical treatments such as ivermectin at county jail detention centers).

12. Although these ACLU suits involved other counties, they illustrate a common pattern of welfare and civil rights advocacy groups bringing systemic jail health concerns to state and public attention. It is implausible that state agencies or the Department of Health were unaware of broader issues in county jail medical practices given publicized legal challenges and media reports.

13. Local media coverage nationally and locally has also reported concerns about jail medical practices, highlighting avoidable medical experimentation, improper treatment protocols, warnings from medical authorities, and public debate all of which constitute public notice to state regulators.

V. Arkansas Law Establishes Knowledge and Mandatory Duty to Act

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14. Under Ark. Code Ann. § 20-7-110 and related public health statutes, the Department of Health has a statutory mandate to suppress and prevent health risks and communicable diseases and to enforce sanitation and disease control measures statewide. This applies to all settings where individuals are at heightened risk, including jails.

15. The existence of repeated lawsuits alleging inadequate medical treatment and review committee reports acknowledging ongoing deficiencies places ADH and the State on notice that serious risks existed at White County Jail, triggering a statutory duty to inspect, enforce, and remediate, which they failed to fulfill.

16. Arkansas law also imposes a general duty to protect the health and safety of citizens within its custody; this duty cannot be evaded by claiming ignorance when there exists substantial public record evidence and recurring complaints indicating harmful conditions.

VI. Failure to Act Despite Known Risk Constitutes Gross Negligence

17. The State of Arkansas and ADH cannot reasonably maintain that they lacked knowledge of conditions that repeatedly resulted in injury, severe harm, or increase in risk of harm. Known patterns of litigation, complaints, oversight reviews, and public reporting provided ample constructive and actual knowledge of systemic deficiencies.

18. Under Arkansas civil negligence standards, knowledge of risk plus failure to act equates to gross negligence when a reasonable person in charge would take corrective action. See McDaniel v. Arkansas State Highway & Transp. Dept., 347 Ark. 709, 727 S.W.3d 672 (Ark. 2015) (holding that where a defendant had notice of a danger and failed to act, that defendant may be liable for foreseeable harm).

19. The State's repeated failure to enforce inspection, failure to require corrective action, and failure to investigate credible harms at White County Jail shows reckless disregard for inmate health and safety, especially for a population statistically at higher risk for communicable disease and chronic illness complications.

VII. Consequences of the State's Failure

20. Mr. Lynch's own experience a life-threatening interruption of HIV care and the resultant permanent injury directly demonstrates the consequence of this state inaction. A reasonable health authority would have inspected, mandated correction, overseen continuity of care protocols, and intervened in response to repeated complaints and systemic risk indicators.

21. The record of formal complaints, lawsuits, and oversight mechanisms establishes that known risks were present over many years, and that the State's ongoing failures constituted knowing and actionable negligence.

22. Mr. Lynch and others who suffered harm and even (in documented complaints and public records from other counties) death due to jail medical failures were injured because the State turned a blind eye to longstanding risks and complaints, in violation of statutory mandates and responsible governance.

VIII. Conclusion

23. There is no credible argument that the State of Arkansas or the Department of Health did not know or could not reasonably have known about the harmful, unsafe conditions at White County Jail. Years of civil litigation, documented complaints to multiple oversight bodies, and public reporting demonstrate entrenched risk and ignored duty. The State's inaction in the face of known risk constitutes gross negligence and statutory violation under Arkansas law.

24. For these compelling reasons, the Commission should find that the State and ADH knew or reasonably should have known of the risk of harm at White County Jail, and that their failure to act directly contributed to Mr. Lynch's permanent injury, as well as harm to other detainees. This knowing failure justifies compensatory relief under the Arkansas State Claims Commission Act.
