# IN THE CIRCUIT COURT OF PULASKI, ARKANSAS

16th DIVISION

SEAN LYNN; and
LAURA HAMMETT — PLAINTIFFS

vs. Case No.:

BOARD OF TRUSTEES of the UNIVERSITY of ARKANSAS, in their official capacity;
Karrar Aljiboori; Natalie J. Applebaum;
Timothy J. Baer; Jarred M. Baxter;
Alexis Beavers; Rebekah Danielle Beene;
Britney M. Beumeler; Kristy Bienvenu;
Jennings R. Boyette; Carol Brizzolara;
Cejae Brown; Elizabeth Brown;
Nolan R. Bruce; Amber Bryant; Elizabeth Cate;
Christopher S. Cathcart;
Shannon Cobb; Benjamin L. Davis;
Prashanth Reddy Damalcheruvu;
Rebekah Davis; Joseph P. Deloach;
Amanda Diehl; Jaicey Dowd; Nathan Ernst;
James Fitsimones; Chrystal T. Fullen;
Macall Gilmartin;Tyler Gray; Emily Gray;
Jordan W. Greer; Shannon Hankins;
Brandon Hearn; Rachel Hill; Mi-Ran Kim;
Mary K. “Katie” Kimbrough;
Alyssa Kirkpatrick; Jacob Langston; Eric Lambert;
Payton D. Lea; Ariana Limon; Noah Lloyd;
Joseph F. Margolick; Sarah E. Martin;
Tyree McClure; Zachary A. McConnell;
Elizabeth McNulty; Jordan Millsapps; Anna G. Morris;
Sriram Navuluri; Derrick C. Nichols; Mason Noble;
Kristina Ong; Na’Kika Perkins; Erika A. Petersen;
Brittany Presson; Nathan Redding; Edward Reece;
— DEFENDANTS

Arthur Rezayev; Brenda Roberts; Tyler K. Rose;
Christian Rosenbaum; Kristen Rosenbaum;
Tonya R. Sanders; Jackson Sargent;
Hannah Sclimenti; Carmen Shaw; Christian Spallino;
Caroline Steele; Krista J. Stephenson; Jordan M. Takasugi;
Evelyn Tipton; Marisa D. Tran; Julien P. Vinas;
Charles Waters; Adam S. Watkins; Derrick Wilkes;
Edward Williams; Lyrex Williams; Kesley M. Winn;
Leslie Witt; Susan Zaleski; Clinician Doe Defendants 1–5;
Security and Police Doe Defendants 1-5

**COMPLAINT FOR DAMAGES - MEDICAL MALPRACTICE**

COME NOW the Plaintiffs SEAN LYNN ("Lynn"), Pro se, and LAURA HAMMETT ("Hammett"), Pro se, whose claims all arise from the same nucleus of conduct, join to state as follows:

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Pg. 40: UAMS Police Department and Security Doe Defendants breached their duty to provide custodial protection to Lynn and Hammett.

Pg. 42: The defendants gave Hammett distressful misinformation and false promises to enlist her support.

Pg. 46: The defendants released Lynn "against medical advice" without prescribing drugs for agitation and in far worse condition than when he entered UAMS Medical Center.

Pg. 49: The defendants kept an inadequate medical record.

Pg. 54: The defendants prohibited Hammett from recording video of the alleged criminal conduct, based upon a UAMS policy.

Pg. 55: Lynn was left with hospital acquired disabilities and did not have an optimum recovery from the initial injury.

Pg. 57: Count I –Medical Injury Pursuant to Ark. Code Ann. § 16-114-201 et. seq.

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Pg. 72: Count V—Sean Lynn and Laura Hammett assert equitable claims against University of Arkansas through its Board of Trustees.

**The Parties, Including Credentials for Each Named Clinician Defendant**

1. Plaintiff Sean Lynn is a resident of Pulaski County. Plaintiff Laura Hammett is a student at a University of Arkansas campus in Pulaski County, is Lynn's mother and accommodator for Lynn's communication disabilities.

2. Defendant University of Arkansas, acting through its Board of Trustees, a state agency, is named solely for purposes of equitable relief. Referral to "the defendants" collectively does not include University of Arkansas.

3. The following defendants are named as individuals. They are referred to as clinician defendants to distinguish them from the state and from the security and police department defendants. In the body of the complaint, each is named by only their last name, unless there are two defendants with the same last name. Credentials are rarely used because the conduct complained of falls below the standard of reasonable prudence expected of any ordinary adult. All individual defendants are adults. Each was an active participant in the negligent or unlawful conduct that occurred at UAMS Medical Center on January 13 to 27, 2024 from which this complaint arose. Each was on the payroll for the UAMS unit of University of Arkansas:

Karrar Aljiboori, MD; Natalie J. Applebaum, MD; Timothy J. Baer, MA; Jarred M. Baxter, PCT; Alexis Beavers, PCT; Rebekah Danielle Beene, RN; Britney M. Beumeler, APRN, CNP; Jennings R. Boyette, MD; Carol Brizzolara, RN; Cejae Brown, RN; Elizabeth Brown, MD; Nolan R. Bruce, MD; Amber Bryant, OT; Elizabeth Cate, RD; Christopher S. Cathcart, PT; Shannon Cobb, RN; Benjamin L. Davis, MD; Prashanth Reddy Damalcheruvu, MD; Rebekah Davis, RN; Joseph P. Deloach, MD; Amanda Diehl, LCSW; Jaicey Dowd, RN; Nathan Ernst, RN; James Fitsimones, RN; Chrystal T. Fullen, PsyD; Macall Gilmartin, RN; Tyler Gray, RN;

Emily Gray, CCC-SLP; Jordan W. Greer, MD; Shannon Hankins, APRN, CNP; Brandon Hearn, RN; Rachel Hill, RN; Mi-Ran Kim, RN; Mary Katherine "Katie" Kimbrough, M.D.; Alyssa Kirkpatrick, RN; Jacob Langston, RN; Eric Lambert, PCT; Payton D. Lea, M.D; Ariana Limon, RN; Noah Lloyd, RN; Joseph F. Margolick, MD; Sarah E. Martin, MD; Jordan Millsapps, PCT; Tyree McClure, RN; Zachary A. McConnell, MD; Elizabeth McNulty, PCT; Anna G. Morris, MD; Sriram Navuluri, M.D.; Derrick C. Nichols, RN; Mason Noble, PCT; Kristina Ong, RN; Na'Kika Perkins, PCT; Erika A. Petersen, MD; Brittany Presson, RN; Nathan Redding, MD; Edward Reece, RN; Arthur Rezayev, MD; Brenda Roberts, RN; Tyler K. Rose, MD; Christian Rosenbaum, RN; Kristen Rosenbaum, PCT; Tonya R. Sanders, PCT; Jackson Sargent, RN; Hannah Sclimenti, RN; Carmen Shaw, RD; Christian Spallino, MD; Caroline Steele, RN; Krista J. Stephenson, MD; Jordan M. Takasugi, MD; Evelyn Tipton, RN; Marisa D. Tran, MD; Julien P. Vinas, RN; Charles Waters, RN; Adam S. Watkins, MD; Derrick Wilkes, PCT; Edward Williams, RN; Lyrex Williams, RN; Kesley M. Winn, MD; Leslie Witt, RN; Susan Zaleski, RN.; Clinician Doe Defendants 1-5.

4. Kristy Bienvenu, a Patient Relations Coordinator.

5. Security and Police Doe Defendants 1-5 were employees of University of Arkansas who worked on the UAMS Medical Center complex between January 13 and January 27, 2024. Their job duties included monitoring the campus for suspicious, unsafe and illegal activities and to protect staff, students, and the general public.

6. Security and Police Doe Defendants 1-5 had a heightened duty of care toward persons who were held against their will, such as Lynn.

**Venue and Jurisdiction**

7. Venue is proper under Ark. Code Ann. § 16-60-104 because this action involves multiple Defendants, and a substantial part of the events and omissions giving rise to the claims occurred in Pulaski County.

8. Venue is additionally proper under Ark. Code Ann. § 16-60-103(2) because Defendants, while acting under color of their positions as employees and agents of a state agency, University of Arkansas, committed the acts and omissions complained of herein in Pulaski County.

9. This Court has subject matter jurisdiction over this action pursuant to Article 80, § 6 of the Arkansas Constitution and Ark. Code Ann. § 16-13-201, because this is a civil action seeking legal relief for torts committed in Arkansas, including ordinary negligence and medical injury pursuant to Ark. Code Ann. § 16-114-201 et seq. This Court also has jurisdiction to decide the equitable claim for permanent injunction pursuant to Ark. Code Ann. § 16-111-101.

10. This Court shall have personal jurisdiction of all parties to this action, and all causes of action or claims for relief, because all parties purposefully availed themselves of Arkansas law and protections by working for or contracting with UAMS and had minimum contacts such that maintenance of the suit does not offend traditional notions of fair play and substantial justice. Ark. Code Ann. § 16-4-101.

**The clinician defendants unlawfully violated Lynn's right to refuse treatment after mistakenly adopting an erroneous report of how an injury occurred.**

11. Lynn sustained a head injury when he jumped approximately 10 feet from a falling ladder, on January 13, 2024.

12. Lynn remembers exactly where he was standing and what he thought as he abandoned the falling ladder.

13. Lynn knew that if he stayed on the ladder, it and he would fall down a steep slope behind the house. He jumped and landed close to the house, but "forgot to account for inertia" and flipped backwards.

14. Lynn thought about his daughter on the way down. It was her life that flashed before his eyes.

15. Lynn landed on his head approximately three feet from the house. Impact was excruciating.

16. According to the recording made by the 911 call center, the homeowner called at 4:27 p.m.

17. The homeowner said he was sleeping when the accident occurred; Lynn was on the ground and "it look[ed] like he fell about three stories off of the ladder."

18. The homeowner said "I'm standing right here close to him. I just can't go too close or I'll lose cell phone signal." There was no screaming heard. The owner sounded calm, also.

19. The owner said Lynn was moving and it looked like he was in "quite a bit of pain."

20. In response to the 911 operator's questions, the owner said, "he's got some bleeding from his face it looks like."

21. The 911 operator asked if it was "spurting or pouring?"

22. The homeowner answered, "It looks like…He knows his name. My roommate's talking to him, um, it's, it's, he's bleeding. I can't tell if it's pouring or not, but there's some serious blood from his nose area."

23. When the 911 operator asked if Lynn was having difficulty breathing, the owner responded, “mmmm, he’s having a lot of difficulty in general.” The 911 operator gave instructions, including not moving Lynn and said an ambulance was on the way.

24. According to the MEMS Patient Care Record and the 911 recording, the dispatch call was made at 4:28 p.m.

25. Little Rock Fire Department personnel arrived at the scene first. Metropolitan Emergency Medical Services personnel arrived at the scene at 4:38 p.m.

26. Lynn told Fire Department personnel that he was standing partway up the ladder when he jumped. A fire department employee said he can’t remember exactly how far Lynn said, but it was less than 20 feet.

27. MEMS employee Ogle wrote that Lynn fell 30 to 35 feet, with no attribution.

28. Ogle also erroneously wrote that the injury was at “Home.” Lynn’s home address was on his driver’s license, which was apparently reviewed to find Lynn’s date of birth.

29. Ogle also referred to the ladder falling across the powerlines and wrote, “No signs of electric involvement.”

30. During transport to the UAMS Medical Center, the EMT recorded a Glasgo Coma Scale of greater than or equal to 13 and a Revised Trauma Scale of 12. These scores indicate mild injury. The only intervention by the EMTs was supplemental oxygen and inserting an IV with fluid. Ogle’s report said, "IV therapy: 18 ga; forearm left; saline lock; total fluid:10; Patient response: Unchanged; Successful; Complication: None"

31. Plaintiffs did not name MEMS or the EMT as defendants because the care rendered by MEMS was appropriate and timely. The EMT did not attribute his erroneous

statement about the height of the fall. Therefore, the clinician defendants should have inquired from the only witness, Lynn, or wrote "unknown" as to how the blunt force trauma occurred.

32. Upon evaluation at UAMS Medical Center, imaging revealed fractures and intracranial findings that did not require surgical intervention. Medical staff informed Lynn that no surgery was planned and that observation was the primary course of care.

33. Initial test results showed healthy vitals. Of note, on January 13[1] at 5:16 p.m., Lynn's sodium level was 139. A juror of ordinary intelligence can comprehend that this score is not in a dangerous range without expert testimony, because the test results indicate any abnormalities with an exclamation point, red font or other obvious communication, and this score was not flagged.

34. An initial toxicology screening verified that at entry to UAMS Medical Center, Lynn was negative for all tested substances, including: THC, opiate, methadone, cocaine, labbenz (benzodiazepines), barbiturate, labamph, (amphetamines), and ethanolpl (blood alcohol).

35. Upon entry to the ED, according to notes by Triage Nurse Nathan Ernst, Lynn had blood pressure 120/70, heart rate 60, Glasgow Coma Scale 14, where 13 – 15 is a "mild" TBI. GCS evaluates three key responses: Eye Opening- Spontaneous, to voice, to pain, or none; Verbal Response- Oriented, confused, inappropriate words, incomprehensible sounds, or none; and Motor Response- Obeys commands, localizes pain, withdraws, abnormal flexion, extension, or none. According to Ernst, Lynn had top score on all metrics but one, and that one was second best.

[1] All dates are in 2024, unless specified. All times are best approximations, using timestamps when available.

36. The only one of 37 Primary Scene Trauma Level 1, 2 and 3 Activation criteria Lynn met was “fall greater than 20 feet” – which was based on an error written by the EMT, who was not a witness to the accident, and who may have been quoting the homeowner, also not a witness to the accident.

37. Neither “Emergency Physician Discretion” nor “MD/Charge RN discretion” were checked off on the chart. Objectively, no clinician defendant recorded a condition that warranted trauma scene activation.

38. Ernst noted on the Behavior & Suicide Screen that Lynn said that over the past two weeks he had not felt down, depressed, hopeless, nor had thoughts of killing himself, and, in fact, never had thoughts of killing himself.

39. There was no indication that Lynn “refused” to answer, was “unable to complete” or “was not assessed due to severity of illness.”

40. Prior to the administration of levetiracetam (Keppra) and fentanyl, Lynn was alert, oriented, communicative, and capable of understanding and expressing his wishes, including his desire to refuse treatment and leave the hospital.

41. Ernst noted that Lynn’s sensory, motor, and circulatory systems were intact.

42. iSTAT blood test results at 17:22 showed:

sodium: 141 mmol/L [Ref Range: 135 - 145];
potassium: 3.8 mmol/L [Ref Range: 3.5 - 5.0];
chloride: 106 mmol/L [Ref Range: 98 - 109];
CO2: 23 mmol/L [Ref Range: 22 - 31];
BUN: 13 mg/dL [Ref Range: 6 - 20];
Glucose: 155 mg/dL [Ref Range: 70-105];
Hct: 47 % [Ref Range: 40 - 52];
Hb: 16.0 g/dL [Ref Range: 14.0 - 18.0];
pH: 7.34 [Ref Range: 7.31 - 7.41];
PCO2: 41.2 mmHg [Ref Range: 41.0 - 51.0];
HCO3: 22.2 mmol/L [Ref Range: 23.0 - 28.0];
BE: -4 mmol/L [Ref Range: -2 - 3]

43. Rose noted “no lacerations” and “no acute surgical intervention” required in electronic notes made at 5:54 p.m.

44. Lynn had fractures in his skull. No surgical intervention was required, and no emergent hemorrhage was documented requiring operative control.

45. Petersen and Aljiboori noted “No neurosurgical intervention is warranted at this time.” 5:54 p.m.

46. Rose documented that gastrointestinal prophylaxis was “not indicated” and that anticoagulation could safely be delayed until after a follow-up CT scan confirmed stability. Deep Vein Thrombosis prophylaxis (blood clot prevention) would be started on January 15 at 10:21 a.m., indicating both that the medical defendants found the brain bleeds were stable and acknowledging that DVT problems are often caused by confinement to an ICU bed.

47. In general, Dr. Rose said Lynn was in “NAD,” meaning no acute distress.

48. The medical record created by the emergency room clinicians contains the following notes, though sometimes in shorthand.

49. Pain Assessment using the Wong-Baker FACES Pain Rating: Hurts little bit.

50. Mental Status: Alert to 2 spheres: person, place, time and situation. There was no indication on the record to which spheres Lynn was oriented. Lynn remembers and told Hammett several times since leaving the hospital that he knew who he was and that he was at a hospital, but he didn’t know where the hospital was or the time, unless he could see a clock.

51. Lynn had never been to UAMS. As Lynn got just a mile from the hospital on January 27, he said “I knew I was in a hospital, but I thought it was in the middle of nowhere.”

52. Ernst reported:

Behavior: Calm

Chronic Deficits: None
Living Situation: Home with family/friends
Speech: Clear
Nutrition: Well Developed, Well Nourished
Skin: Warm; Dry
Mucous Membranes: Moist; Pink
Height and Weight
Height: 182.9 cm (6')
Height Method: Estimated
Weight: 99.8 kg (220 lb)
Weight Method: Estimated
Mobility: No Limitations
Behavior: No Issues
ED HDS Fall Risk: No Fall Risk
CAM (Confusion Assessment Method)
Feature 1: Acute Onset and Fluctuating Course: No
Feature 2: Inattention: No
Feature 3: Disorganized Thinking: No
Feature 4: Altered Level of Consciousness: Normal
CAM-Short Result:
CAM negative: Delirium NOT suggested
CAM-S Short Notification
CAM-S Short Provider Notification: No
Education Assessment
Learner: Patient
Learning Style: Audiovisual
Motivation: Motivated
Barriers to Patient Learning: None
Domestic Issues D.V. Screen
Are you in a relationship which causes you fear, pain or injury?: No
Do you need information on how to get help if you have been abused either physically, emotionally, and/or sexually?: No
Nursing Diagnoses
Nursing Diagnoses: Knowledge Deficit; Altered Comfort; Impaired Mobility
Cardiac
Cardiac Rhythm: Sinus rhythm
Cardiac Regularity: Regular
Other flowsheet entries
How confident are you filling out medical forms by yourself?: Extremely

53. Lynn had no broken bones, other than skull fractures. Some of the skull fractures, as defendants admit, might be pre-existing, as Lynn has hit his head during falls on other occasions.

54. At 6:43 p.m., Damalcheruvu noted no evidence of ossicular disruption. Ossicles are tiny middle-ear bones.

55. The claim that Lynn fell 30 to 35 feet was unattributed and bore no logical relationship to Lynn's condition on arrival. Reasonable triage and emergency department staff therefore should have relied on their own independent assessment, rather than defaulting to an unsupported assumption made by an EMT and the homeowner.

56. At 10:16 p.m., Bruce acknowledged that "CT looks worse than his exam with SDH and sizeable IPH. Suspect his exam will get worse - ICU for close monitoring and low threshold to intubate if declines." A suspicion that a patient's condition will deteriorate is not imminent threat of death or loss of limb. No one petitioned a court for permission to treat Lynn without his consent.

**Clinicians deemed Lynn's refusal of treatment to be evidence of incapacity and violated UAMS policy by designating themselves as surrogate decision-makers.**

57. Under Arkansas law, where a patient refuses care and no valid surrogate exists, treatment may proceed only upon a court granting a petition supported by medical certification of necessity. Ark. Code Ann. § 20-9-604. No such petition was sought or obtained for the clinician defendants to treat Lynn. Instead, Defendants disregarded Lynn's refusal and proceeded without lawful consent.

58. UAMS requires all residents to pass a course on patient autonomy on Workday; therefore, a resident who fails to maintain a simple understanding of the law involved does not follow the standard of care.

59. UAMS did not administer sedating medication prior to Lynn's initial imaging, and Lynn did not resist or interfere with that assessment. He later described the CT scan as lying still while a machine rotated around him, consistent with routine imaging.

60. After clinicians determined that no surgery was required and that there was no imminent threat of death, Lynn refused further treatment and sought to leave the hospital. Clinician defendants including, but not limited to, Ernst, Rose, Peterson, Aljiboori, Applebaum, Takasugi, Redding, Arensberg, and Benjamin Davis deemed Lynn's decision to leave as agitation and, on that basis, unlawfully assumed decision-making authority over him.

61. No valid consent was ever obtained. Lynn does not recall signing any consent form. The only document purporting to be consent is dated January 14 at 4:09 p.m. and lists the signatory as "significant," with a signature resembling Lynn's.

62. In the approximately twenty-three hours preceding the 4:09 p.m. signature, Defendants administered multiple sedating and psychoactive medications without consent, including:

- 1,000 mg levetiracetam at 5:46 p.m. on January 13 (Ernst, ordered by Martin);
- 50 mcg fentanyl at 5:51 p.m. on January 13 (Ernst, ordered by Applebaum);
- 0.5 mg lorazepam at 2:40 a.m. on January 14 (Williams, ordered by Stephenson), not documented until January 19;
- 5 mg intramuscular haloperidol at 8:40 a.m. on January 14 (Langston, ordered by Kindy);
- 1,000 mg levetiracetam at 9:02 a.m. on January 14 (Langston, ordered by Martin);
- Continuous dexmedetomidine infusion from 11:02 a.m. to 3:15 p.m. on January 14 (Langston, ordered by Kindy); and
- 5 mg olanzapine at 3:58 p.m. on January 14 (Williams, ordered by Rose).

63. These medications substantially impaired Lynn's ability to communicate and were administered without consent.

64. At approximately 4:09 p.m., while Lynn was aphasic and documented as being in "non-violent, non-self-destructive restraints," from 9:28 a.m. to 7:09 p.m., Doe Defendants directed him to sign two electronic documents—a privacy notice and a purported consent form. The medical record does not identify who presented the documents, what explanation was given, or whether Lynn demonstrated comprehension. During proceedings before the Arkansas Claims Commission, UAMS admitted it could not identify whose signature appears on the form and could not produce a valid consent.

65. Throughout this period, Lynn repeatedly stated that he wished to leave the hospital. These statements were made directly to nurses, physicians, and staff.

66. Hammett arrived at UAMS Medical Center at approximately 12:29 p.m. on January 14, less than two hours after Lynn's significant other notified her. She explicitly told the clinician defendants that Lynn wanted to leave. The clinician defendants were dismissive of Hammett and treated themselves or other UAMS employees as surrogate decision-makers, in direct violation of UAMS Policy PS.2.06, which prohibits treating providers or employees from serving in that role.

67. From the moment Hammett arrived on January 14, she consistently communicated Lynn's refusal of further treatment and his longstanding aversion to institutional medical care. Health Information Exchange data to which UAMS has access confirmed that Lynn had avoided institutional care for nearly a decade, reinforcing that his refusal was consistent with his history and values. Defendants nevertheless proceeded as if consent were present.

68. When Lynn attempted to leave, Defendants characterized his actions as "elopement," a term repeatedly used to pathologize his attempts to exercise autonomy. Multiple clinicians documented this characterization, including:

> Beumeler: "Continues to attempt to elope."
> Gilmartin: "elopement"
> Greer: "Patient lacks capacity and continues to try and elope. Will give zyprexa, phenobarb, and ativan PRN. Will add precedex as needed for safety of patient and staff. Placed on 72 hour hold due to lack of capacity and potential elopement with mother."
> Hankins: "non-cooperative over the last few days trying to elope"
> Rezayev: "attempts to elope when off sedation"
> Winn: "readmission to SICU on 1/21 d/t sustained agitation, attempted elopements"
> Sargent: "elopement"
> Rebekah Davis: "Patient was de-escalated to the floor but required readmission to SICU on 1/21 d/t sustained agitation, attempted elopements, pulling out lines."

69. These entries framed Lynn's resistance as pathology rather than as refusal of unwanted treatment, and Hammett's assistance as interference rather than lawful patient advocacy.

70. Clinician defendants, including Zaleski, further misrepresented the cause of Lynn's distress to Hammett, falsely stating that benzodiazepines and opioids were "never" administered to TBI patients, despite having administered both. They attributed his agitation to brain injury while concealing that the actual cause was medication effects.

71. Lynn's agitation was caused in part by his desire to leave and his concern for being "broke" or "robbed." On January 24, Baer documented that Hammett was concerned about the financial burden. On January 25, Diehl recorded that Hammett would not consent to further treatment for that reason. The defendants ignored Lynn's expressed values regarding cost, ultimately generating charges exceeding $115,000.

72. Cobb, Beumeler and doe clinician defendants further misled Hammett regarding law enforcement involvement, suggesting police would intervene to prevent Lynn's departure. In reality, no such authority existed. Officer Clifton Moore later stated that police had not been called. Further, on January 27, ethicist Micah Hester wrote that police would not have intervened absent a true emergency. Nevertheless, Defendants used the specter of law enforcement to coerce compliance.

73. UAMS, through Hester, finally acknowledged that Lynn wanted to leave, that Hammett could be a surrogate and agreed, and that no alternate surrogate was identified. There was no material change in Hammett between January 13 and January 27. Hammett was a viable surrogate all along.

74. Despite all of this, Defendants later represented to Lynn—through their insurer—that Hammett agreed to Lynn's treatment. That assertion is contradicted by the contemporaneous record and evidences a post hoc effort to manufacture consent where none existed and induce discord between Lynn and Hammett.

75. This course of conduct demonstrates conscious disregard for Lynn's autonomy, deliberate misrepresentation of material facts, and intentional misuse of institutional authority to impose confinement and treatment without lawful consent.

**The defendants confined Lynn without lawful authority.**

76. Lynn refused treatment for several articulated reasons, including that his pain was minimal and he wished to recover at home.

77. Second, Lynn did not want to use pharmaceuticals that have the potential for abuse and high risk of dependency, and that are indicated only to mask pain or alter moods.

78. Third, Lynn did not want the defendants to bankrupt him.

79. Fourth, when Lynn dies, he does not want to die in a hospital. The clinician defendants kept telling Lynn death was imminent.

80. Finally, the clinician defendants conduct at UAMS hurt Lynn more than the TBI hurt him.

81. Despite Lynn's reasonable refusal of treatment, all Defendants imprisoned him in UAMS Medical Center for two weeks. He was confined to a room, half the time with no shower and no bed for his visitors, with no refrigerator nor cooking facilities, and with annoying noises.

82. All Defendants denied visitation from Lynn's then eight-year-old daughter, even though one of the staff noted the positive effect just speaking to his daughter on the telephone had on Lynn.

83. The defendants kept Lynn naked for several days at a time. There was no medical purpose. Much of this time he was bound to the bed rails.

84. The defendants denied Lynn access to fresh air and unfiltered sunlight throughout the confinement.

85. On January 13 at 6:06 p.m., Doe Defendants reviewed the contents of Lynn's wallet and scanned an expired insurance card, demonstrating awareness of his identity and access to personal information. Nevertheless, no Defendants attempted to contact Lynn's family, notify next of kin, or request a welfare notification.

86. Defendants took possession of Lynn's phone and did not permit Lynn access to it, thereby preventing him from contacting family members, seeking outside assistance, or arranging transportation home.

87. Doe Defendants attempted to determine if Lynn had valid insurance, by having someone named James Rhodes run Lynn's full name in six inquiries on January 14 at 2:05 a.m.

The Doe Defendants put effort into collecting revenue to pay their salaries but put no effort into finding Lynn's family.

88. On January 14 at 7:15 am, while Lynn was physically and chemically restrained, according to a note by Aljiboori, Lynn "Intermittently asks for family members." Yet Aljiboori, Ernst, Nolan, Bruce, Lyrex Williams, Stephenson, Waters, Takasugi, Redding, Kim and Doe defendants failed to make any documented effort to contact family.

89. This conduct violated UAMS written policy. To wit:

90. A patient has a right "to have a family member or other person of [his] choosing to be notified promptly upon [his] admission to UAMS Medical Center."

91. A patient has a right "to refuse treatment[.]"

92. A patient has the right "to leave UAMS against the advice of [his] health care providers, to the extent permitted *by law*." (Emphasis added.) Only a legal order to the contrary overrides autonomy.

93. UAMS is a primary source of authority for defining the standard of care applicable to its clinicians. A violation of those policies is prima facie evidence of a breach of the applicable standard of care.

94. UAMS admitted on the record generated by UAMS staff:

> "Arkansas has no law (and UAMS, no policy) that covers so-called 'medical holds,' which means that the ability to hold a patient who wants to leave AMA can only happen in a very limited set of conditions where the team can show a significant risk of imminent harm could befall the incapacitated patient should they leave the hospital."

95. The only criteria "the team" relied on to activate trauma care was a mistaken assumption of an EMT who did not witness the purported 35-foot fall.

96. The defendants took mutually incompatible positions: they treated Lynn as incapacitated enough to justify extended confinement and rehabilitation, while also concluding that Lynn "made too much money" to qualify for Medicaid.

97. Bryant, an occupational therapist, evaluated Lynn during the period of confinement and documented "Questionable functionally participation from pt." (sic). The following day, Bryant recommended "Acute Rehab for TBI," a recommendation that signaled prolonged impairment and inability to function independently.

98. Doe Social Workers decided Lynn would not qualify for Medicaid, without speaking to Hammett—despite Hammett making several requests to speak with a social worker or case manager.

99. Case Manager Beene concurred with the Social Worker(s)' assessment of earning capacity on January 19 but continued to hold Lynn against his will. Her conclusions were inconsistent because Medicaid is an income-based program, and people facing imminent death or who have newly acquired hearing loss have diminished earning capacity.

100. According to billing documents and the medical record, defendants ordered or carried out only one CT angio head combo imaging and two CT scans of the brain on January 13 and early January 14. No surgery was suggested, according to the Medical Record. The concern for further bleeding or lack thereof was not documented again.

101. On January 15, physical therapist Cathcart spent 13 minutes assessing Lynn. Cathcart's "Summary Assessment: TBI consistent with RLA IV." Cathcart failed to mention the drug cocktail inflicted on Lynn the previous 40 hours.

102. Further, Cathcart failed to notice the incongruity between the expected condition of a 33-year-old man's limbs and torso after a 35-foot freefall and Lynn's condition. There was no

mention that Lynn escaped four-point restraints several times and had to be restrained so he could not escape. Cathcart thereby failed to consider evidence that an ordinary person who was reasonably prudent would consider.

103. On January 16, 2024, Defendant Sriram Navuluri, M.D., an otolaryngology resident, evaluated Lynn and documented that he was awake, alert, in no acute distress, with intact cranial nerve function and no gross neurologic deficits. Navuluri noted that a right ear wick was removed (which was four days before the scheduled removal) and that the ear was dry with no visible drainage. The examination found no evidence of active otorrhea or cerebrospinal fluid leak, and the assessment concluded that **no acute ENT intervention was required**. Defendant Jennings R. Boyette, M.D., attending, cosigned and approved these findings. Despite the absence of any documented ENT emergency,  and no petition filed by Navuluri, Boyette or any clinician defendant, Lynn remained confined and subject to ongoing restraint and sedation.

104. During Lynn's confinement, multiple Patient Care Technicians ("PCTs") acted as custodians and guards, assisting in the enforcement of restraints, restricting his access to food, and facilitating his continued detention. The following PCTs affirmatively documented their involvement in these custodial acts: Baxter, Beavers, Noble, Sanders, McNulty, Lambert, Perkins, and Kristen Rosenbaum. In addition, Millsaps and Wilkes were present during periods of Lynn's confinement, with limited documentation, and were therefore substantially certain to have participated in or facilitated the custodial restraint of Lynn, even though their specific actions were not fully recorded in the PCT flowsheets. Each of these individuals acted under color of their employment and in concert with other Defendants to maintain Lynn's confinement without lawful consent.

105. Lynn, when not in a drug-induced stupor, continually tried to escape or convince the clinician defendants to allow him safe passage. Jaliyah Rucker, PCT, not made a defendant, wrote "pt has been asking 'why can't I just go' pt becoming agitated." Rucker made the reasonable connection between Lynn's desire to leave and his agitation. She did not attribute his agitation to the effects of a fictionalized fall from three stories high.

106. No one initiated psychiatric commitment proceedings, sought judicial authorization for confinement, or complied with any statutory procedures governing involuntary detention, which includes appointment of counsel to the detainee.

107. Despite repeatedly referring to Lynn as being on a "72-hour hold," Defendants failed to produce, serve, or document any lawful hold order. Instead, defendants including but not limited to Greer, Elizabeth Brown, and Benjamin Davis, repeatedly "restarted" or extended purported holds without notice, process, or legal authority, subjecting Lynn to continuous confinement.

108. Jordan W. Greer, MD, put Lynn on a "72 hour hold" on the claim "Patient lacks capacity, is hyponatremic, is at high risk of seizures and medical decline. He is requiring IV medication." Medical holds allowed by court petition have no standard time limitation, because there is no way to predict when the medical emergency will dissolve. The 72 hours allowed specifically for a psychiatric hold is time in which the required evaluations, documentation and hearing with appointed counsel for the patient must take place.

109. The first UAMS employee to agree Lynn was allowed to leave despite the unsolicited advice from the defendants was an admissions officer Hammett complained to on January 24. It took another 72 hours for Hammett to get Lynn out.

110. Two psychiatrist defendants, Winn and Lea, evaluated Lynn for the first time during his confinement on January 24. Lynn was heavily sedated and unable to rouse, so Winn spoke to Hammett.

111. In conclusion, Winn and Lea noted that they were unable to assess suicide risk. Despite the lack of reasonable information indicating a suicide risk, and no legal process, Winn and Lea continued to confine Lynn and batter him, in concert with the other clinician defendants. Still, there were never any court proceedings initiated.

112. Kimbrough was documented as "attending" physician from January 26 to 27. Kimbrough made no electronic signature in the record until January 31. Kimbrough authorized a "72-hour hold" for Lynn on January 27. Kimbrough was not present at discharge and neither Lynn nor Hammett recall meeting Kimbrough. It is more probable than not that Kimbrough did not make a visual assessment of Lynn.

113. (Dr. Mary K. Kimbrough uses the alias "Katie Kimbrough" in several places including for her entry in Open Checkbook.)

114. On January 27, Elizabeth Brown and two male doe defendants blocked the door to the room in which they were imprisoning Lynn. Hammett invoked 42 USC 1983, Deprivation of rights under color of law. Then Hammett asked Deloach if the men would tackle Lynn again if he tried to leave. Deloach said yes, but he would try to speak to higher ups. A few hours later, Lynn was allowed to leave.

**The clinician and doe defendants battered Lynn continuously and included Hammett in physical struggles during the two-week period.**

115. Intent for purposes of battery is established where a defendant knowingly administers medication, applies restraint, or directs others to do so, knowing the patient has refused consent. Each act listed below constitutes a separate harmful or offensive contact.

116. Where supervisory defendants ordered, authorized, or knowingly permitted nonconsensual physical or chemical contact with Lynn, they acted with the intent required for battery and were complicit in causing the harmful or offensive contact.

117. Clinician defendants physically restrained Lynn, including the prolonged use of four-point restraints. These restraints were applied not in response to imminent threat of death or loss of limb, but to prevent Lynn from purposefully removing medical devices and leaving.

118. "Justification" for the restraints was marked with template values on a flowsheet, including, "Attempt(s) to remove/tamper with tubes/lines; Removal of dressing; Removal of medical equipment; Disorient ed/Confused with risk for self harm." Lynn removed medical devices to refuse treatment so he could leave. Rather than let him leave, the defendants restrained him.

119. Defendants used intimidation to confine Lynn by placing guards at the door.

120. All clinician defendants deprived Lynn of sleep by both physical contact and nuisance. Lynn moves frequently in sleep and the restraints used by the clinician defendants did not allow for Lynn to move. There was also noise from the television and the monitoring equipment. Damalcheruvu wrote that Lynn "will sleep for short periods at a time (10 mins) and wake up frequently throughout the night."

121. The preponderance of the harmful and offensive contacts were not documented by the defendants. Lynn has extreme athletic ability. After jumping 10 feet and hitting his head, then being forced to take medications to which he had a bad reaction, Lynn could still escape from four-point restraints and outrun the college student defendants. It took at least three people to tackle Lynn to the surface they intended to bind him onto. Each specific contact listed here likely also had doe defendants involved but not documented.

122. There were several times Hammett witnessed doe defendants slam Lynn's head into hard surfaces. One was on January 21. Greer ordered Hammett to leave Lynn's room and go to the central waiting room out by the elevator bank. While in the waiting area, Cobb walked past and made a disturbing face and gesture, waving her fingers with a contemptuous grin. Apparently, she knew that Lynn was going to be physically restrained again and denied food and use of a toilet.

123. Soon after, Lynn came running down the hall carrying two grocery bags full of his personal belongings.

124. There were several men and women chasing Lynn. He got into the closest elevator and was followed by the others who surrounded and tugged at Lynn.

125. Hammett was by the elevators then and Lynn managed to hand the bags to Hammett, still with the Defendants trying to capture Lynn. While Lynn was in the elevator kitty-corner to the first, Hammett witnessed one defendant slam Lynn's head into the wall of the elevator.

126. The only meaningful documentation of this event made by defendants was the surveillance video. Doe defendants destroyed that.

127. On January 14 at 12:32 a.m., Lynn was transferred from the Emergency Department to H4. In a contemporaneous "Head-to-Toe" nursing assessment, Lyrex Williams, RN

documented the left ear as "intact." Although the assessment allowed for notation of impaired hearing, bleeding, or drainage, none were recorded for the left ear, while blood and clear drainage were documented on the right. This entry reflects that, at the time of transfer, no abnormality of the left ear was observed or recorded.

128. The Nursing Head-to-Toe flow sheets document Lynn's left ear as intact and without hearing impairment through January 17 at 6:59 a.m., the final entry by McClure. At 7:31 a.m. that morning, Reece recorded "intact; impaired hearing" for the left ear and, for the first time, noted impaired hearing in the right ear as well. Every subsequent nursing entry repeated this finding for both ears, despite no documented intervening injury, event, or assessment explaining the sudden change.

129. Baer and McBain wrote "hearing difficulties" were noticed on January 17 just before 4:00 p.m.

130. One or more Doe Defendants disrupted the oscillator chain in Lynn's left ear during one of the struggles to restrain Lynn. "Ossicle dislocation" was noted on **February** 15, 2024, by a UAMS affiliated doctor Lynn was referred to by Hammett's Chiropractor. (Neither Lynn nor Hammett realized the doctor was affiliated with UAMS until May 2025, but thought he had a bad attitude, so went to someone else after the first visit.)

131. McConnell ordered the following clinician defendants to force Lynn to take a 975 Mg. tablet, close to the maximum recommended daily dosage (4,000 Mg.) of acetaminophen, despite Lynn's continued protests and slight pain at entry to UAMS Medical Center. Even though there was probably offensive or painful contact for those who tried but failed to administer the medicine, those 13 administrations are not included here. Those who administered the

acetaminophen: McClure X2, Christian Rosenbaum, Cejae Brown, Roberts X2, Sclimenti X2, Presson X4, Steele X3, Cobb. Total =16 doses.

132. Spallino ordered the following clinician defendants to force Lynn to take acetaminophen through a feeding tube, despite Lynn's continued protests and only slight pain at entry to UAMS Medical Center. The pain Lynn had during the confinement was all caused by the defendants and ironically, some of the pain was caused by insertion of a feeding tube without consent. Defendants who each administered 975 Mg. through the feeding tube include: Vinas, Christian Rosenbaum X4, Lloyd X4, Sargent X4, non-named nurse X2, Fitsimones. Total = 16.

133. Lynn had a documented history of substance abuse but was in recovery for approximately a decade. During that time, he was a devoted father, earned multiple associate degrees, qualified for a contractor's license, and sustained an excellent credit history. Hammett told numerous Doe Defendants about Lynn's history that made him particularly vulnerable to the administration of controlled substances.

134. Hammett repeatedly warned Defendants that Lynn's drug-induced behavior closely resembled his past substance use and was not representative of his baseline functioning.

135. On January 24 at approximately 8:40 a.m., Hammett raised these concerns directly to the ICU team, including residents, nurses, and a professor who were discussing Lynn's case in a group setting outside his room. Clinician Defendants nevertheless continued to administer sedating medications without consent.

136. In addition to the potential for causing Lynn to lose his sober lifestyle, the substances clinician defendants forced on him have known side effects and contraindications listed on FDA approved inserts that are required to be comprehensible to the ordinary adult. A

sampling of the drugs administered to Lynn is presented here, quoting from the FDA approved inserts.

137. On the Dosage Range Chart for fentanyl, 50 mcg, the dose administered to Lynn by Ernst, 50 mcg, is recommended for the following: “For open heart surgery and certain more complicated neurosurgical and orthopedic procedures where surgery is more prolonged, and the stress response to surgery would be detrimental to the well-being of the patient.” Further, “[e]xpect the need for postoperative ventilation and observation due to extended postoperative respiratory depression.” No surgery was recommended, planned or performed on Lynn.

138. Hypersensitivity to fentanyl is a contraindication. Lynn never took fentanyl before January 13, so it was an unknown risk. Lynn’s brother died from a single dose of pharmaceutical methadone, so the risk to Lynn was real.

139. For patients with evidence of increased intracranial pressure, including aphasia, fentanyl citrate is known to depress respiratory drive, with resultant $CO_2$ retention that can further increase intracranial pressure. This risk is set forth in the manufacturer’s warnings.

140. “Fentanyl may increase the frequency of seizures in patients with seizure disorders and may increase the risk of seizures occurring in other clinical setting associated with seizures.”

141. Amantadine is a psychoactive medication used to modify cognitive or behavioral symptoms and is not a treatment required to prevent imminent death or medical emergency. Amantadine can cause agitation, confusion, hallucinations, insomnia, orthostatic hypertension, and behavioral disinhibition. Administration of amantadine could confound assessments of capacity.

142. Zofran is used to treat or as a prophylactic for nausea. Nausea is not a life-threatening condition. Nausea is a known side effect of fentanyl, and this anti-nausea medication was administered shortly after the administration of fentanyl.

143. Propranolol is so dangerous that patients are admonished not to stop "cold turkey" but to wean off of it. Propranolol does not begin to work for pain control for approximately two weeks. It is not used to prevent an imminent threat of death from headache.

144. According to the FDA access data: toxicity of propranolol may be increased by co-administration with substrates or inhibitors of CYP1A2, such as ciprofloxacin, one drug administered to Lynn through his ear canal;

145. Propranolol can inhibit the metabolism of diazepam, resulting in increased concentrations of diazepam and its metabolites. The defendants administered diazepam to Lynn during his confinement;

146. The following adverse events were observed and have been reported in patients using propranolol. Central Nervous System: Light-headedness, *mental depression manifested by insomnia*, lassitude, weakness, *fatigue;* catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by *disorientation for time and place, short-term memory loss*, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate-release formulations, fatigue, lethargy, and vivid dreams appear dose-related.

147. On January 21, Gilmartin held the Proponolol ordered by Elizabeth Brown because he wrote "pt not cooperating." According to various defendant nurses, the next five doses were not given due to contraindication, order parameters not met, NPO without meds, and MD notified.

148. Propranolol is a heart medication, primarily, but indicated for “migraines” as a prophylactic. It is not approved for treatment of TBIs, according to the FDA approved insert.

149. Lynn did not have significant headaches after weaning off propranolol after the defendants released him, showing its nonconsensual use was wholly unnecessary.

150. OLANZapine zydis (ZyPREXA) disintegrating tablet 5 mg is indicated for treatment of schizophrenia and bipolar disorder. This was ordered by Elizabeth Brown (who specializes in orthopedics) and administered by Cobb, Limon and Presson before any psychiatric evaluation was made.

151. As discussed in detail above, during the first twenty-three hours of confinement, Clinician Defendants forced Lynn to use FentaNYL, levetiracetam, lorazepam, haloperidol, dexmedetomidine, and olanzapine—some multiple doses.

152. Blood draws involved intentional physical contact and penetration of Lynn’s body. The blood drawn was owned by Lynn because it was still in his possession.

153. A non-exclusive list of offensive or harmful contacts with Lynn, specifying the defendants involved follows. There were often doe defendants working with the named defendants to impose their concerted will on Lynn.

154. January 13 at 6:20 p.m. Waters forced Lynn to have a blood pressure test.

155. January 13 at 6:20 p.m., Redding ordered a blood draw for a High Sensitivity Troponin I timed blood series, which was authorized by Watkins and electronically released at approximately 6:00 p.m. The blood draw was physically performed by Ernst.

156. January 13 at 6:26 pm. Takasugi ordered and Ernst placed EKG 12 Lead. Lynn expressed that wires and the sticky pads on him was offensive. Lynn wanted and needed sleep in a comfortable bed and Takasugi and Ernst forbid it.

157. January 13 at 6:46 p.m. Redding ordered hypertonic infusion.

158. January 13 at 7:00, 7:02 p.m. Takasugi ordered and Witt forced Lynn to be injected with ondansetron (Zofran).

159. January 13 at 7:06 p.m. Doe Defendants drew blood. This contact was offensive to Lynn, who wanted to be sleeping comfortably at home.

160. January 13 at 7:45 p.m., Waters drew blood for cardiac enzyme testing and serum sodium measurement, reflecting routine monitoring rather than an emergent deterioration.

161. January 13 at 9:55 p.m. Kim administered substances intravenously into Lynn without consent. Brizzolara made a dual signoff.

**162. January 14 about 4 a.m. to January 15 about 7 p.m. continuous physical restraints**. Authorization by Bruce.

163. January 15 at 4:46 a..m..: Hammett took picture of Lynn in hand restraints with blood at IV. He was naked before she covered him.

164. January 15, Tran ordered the following RNs to force Lynn to ingest propranolol (Inderal) tablet 10 mg every six hours.: Roberts X2; Cejae Brown; Christian Rosenbaum; McClure X2; Reece X2.

165. January 16 at 6:00 a.m. Rose ordered and Reece drew blood from Lynn's body without Lynn's consent.

166. January 16 at 8:00 a.m., QUEtiapine (SEROquel) tablet 100 mg ordered by Greer was administered by Reece.

167. January 16 at 1:04 p.m. and 4:59 p.m. Reece drew blood from Lynn's body without Lynn's consent.

168. January 16 at 1000 p.m. QUEtiapine (SEROquel) tablet 200 mg ordered by Hanson was administered by McClure.

169. January 17, Arensberg ordered and Cejae Brown forced Lynn to swallow amantadine HCl (Symmetrel) capsule 100 mg.

170. January 17 at 9:11 am., QUEtiapine (SEROquel) tablet 100 mg ordered by Greer was administered by Rosenbaum.

171. January 17 at 931 p.m., QUEtiapine (SEROquel) tablet 200 mg ordered by Hanson was administered by Roberts.

172. January 18, Elizabeth Brown ordered defendant nurses to force Lynn to ingest propranolol (Inderal) tablet 20 mg and to hold if heart rate dropped below 60. This was double the dose ordered by Tran on January 15. Elizabeth Brown's orders were carried out by: Cobb; Limon X2; Steele X4; Presson X4; Sclimenti.

173. January 18 at 8:13 a.m., QUEtiapine (SEROquel) tablet 50 mg ordered by Margolick was administered by Sclimenti.

**174. January 18 from 4 p.m. to January 19 at 6:15 p.m. Physical Restraints. Discrepancy between PCT Beaver notes and RN Presson notes. Presson wrote that restraints were discontinued from January 18 at 7:39 p.m.to 939 p.m. Beaver marked restraints from 6:46 p.m. to 9 pm. (**More discrepancies in the record will be discussed later in the complaint and during discovery.) **January 18 restraints ordered by Elizabeth Brown and Morris. Authorized by Margolick. January 19, restraints ordered by Morris, authorized by Margolick.**

175. January 19 at 8:52 a.m., QUEtiapine (SEROquel) tablet 100 mg ordered by Elizabeth Brown was administered by Steele.

176. January 20 at 8:23 a.m., QUEtiapine (SEROquel) tablet 100 mg ordered by Elizabeth Brown was administered by Steele.

177. January 20, Beumeler ordered Lynn to be force fed divalproex (Depakote) enteric coated tablet 500 mg. This order was carried out by Cobb, Sargent, Limon, and Steele.

178. January 21 at 10:25 a.m., QUEtiapine (SEROquel) tablet 100 mg ordered by Elizabeth Brown was administered by Cobb immediately after Lynn escaped to the lobby and Hammett talked him on the phone to convince him into returning to the room.

179. January 21 at 10:03 p.m.: Hearn, Spallino and Greer inserted a catheter in Lynn's penis. Lynn pulled it out, communicating that he did not consent.

180. January 21: Limon documented repeated refusals to take medication, then drugged Lynn anyhow.

**181. January 22 at 10:30 a.m. Tyler Gray started restraints, continuous until January 25 at 1123 a.m. Primarily Christian Rosenbaum and Noah Lloyd were enforcing them.**

182. January 22: Benjamin Davis ordered dexMEDEtomidine (Precedex) 400 mcg/NaCl 0.9 % 100 mL (4 mcg/mL) infusion into Lynn's body without consent. The following clinicians participated in the nonconsensual harmful and offensive contact: Christian Rosenbaum, Vinas, and Tyler Gray.

183. January 22 at 4:30 p.m.: Hankins documented catheter placement, Lynn pulling it out and catheter being inserted in his penis again. Hankins documented that Lynn was chemically sedated and in physical **restraints** following the third urethra catheterization in two days.

184. January 22 at about 800 p.m. Spallino ordered and Vinas administered LORazepam (Ativan) 2 mg/mL (injection) and PHENobarbital 130 mg/mL (injection).

185. January 23 at 12:37 a.m.: Spallino ordered various nurses to administer propranolol and Trazodone by feeding tube. Nurses documented the administration by "feeding tube" of propranolol until 10:32 a.m. on January 27, though Hammett saw that the feeding tube was removed on January 26.

186. January 23: Benjamin Davis ordered dexMEDEtomidine (Precedex) 400 mcg/NaCl 0.9 % 100 mL (4 mcg/mL) infusion into Lynn's body without consent. The following clinicians participated in the nonconsensual harmful and offensive contact: Christian Rosenbaum, Zaleski, Lloyd, Langston, and Ong.

187. January 23: Christian Rosenbaum and Doe Defendants made Lynn defecate in a bedpan, wiped Lynn's anus, but left some feces and left dried blood on his penis. Hammett arrived at the hospital after taking the LSAT and cleaned Lynn better. Then two male defendants came into the room and took over. (Likely Doe Defendants for this conduct include, but are not limited to, Ong, Lloyd, and Zaleski.)

188. January 23: Benjamin Davis ordered and Christian Rosenbaum drew blood from Lynn without consent.

189. January 23: Lloyd injected substances including Lorazepam into Lynn intravenously with Kim approving.

190. January 23 at 5:30 p.m. Hammett recorded Lynn who was physically **restrained**, with feeding tube and catheterized without consent.

191. January 24 at 12:10 a.m., PHENobarbital 130 mg/mL (injection) ordered by Spallino was administered by Lloyd.

192. January 24 at 7:31 a.m. LORazepam (Ativan) 2 mg/mL (injection) (Completed) by Rosenbaum, ordered by Rezayev.

193. January 24: Shaw, Margolick and Lloyd ordered or installed a feeding tube.

194. January 24 at 8:08 a.m.: ciprofloxacin-dexAMETHasone in right ear canal ordered by Stephenson. If prescribed for home use, this medication would be appreciated by Lynn. But the FDA access data states that ciprofloxacin increases the toxicity of propranolol, which was routinely administered by feeding tube on this date.

195. January 24 at 948 a.m.: DiazePAM by feeding tube ordered by Rose.

196. January 24 at 2:02 p.m.: dexMEDEtomidine (Precedex) IV ordered by Benjamin Davis. Administered throughout the day by Lloyd, Zaleski, Rosenbaum and Langston.

197. January 24 at 8:17 p.m.:: LorazePAM drip administered by Lloyd.

198. January 24 at 10:15 p.m. traZODone (Desyrel) tablet 100 mg administered by Lloyd.

199. January 25 at 9:25 a.m.: “Urine still a little pink tinged from trauma of pulling foley out this morning”

200. January 25 at 1050 a.m.: “right upper arm PIV is reddened, swollen and warm to the touch.”

201. January 25, Tran ordered a nurse to draw blood using venipuncture.

202. January 25 at 8:05 p.m. traZODone (Desyrel) tablet 100 mg ordered by Spallino was administered by Sargent.

203. January 26: Kimbrough and Arensberg authorized and ordered urine collection which entails offensive contact with Lynn’s genitals. Kimbrough imposed the continuation of a forced liquid diet until Lynn was discharged on January 27.

204. January 26: Spallino and Margolick ordered and authorized drawing blood to test for a culture that came back negative. The intent was not to hurt Lynn, but there was the requisite intent to make the harmful and offensive contact. No beneficent testing would be required if the clinician defendants had not caused previous harm that might lead to infection.

205. January 27: Sargent inspected Lynn's genitalia.

206. During several attempts by the clinician defendants to apply physical restraints or capture Lynn who was running down hallways trying to escape, there was transference of the battery to Hammett. For example, during the elevator incident on January 21, Hammett was taking the bags out of Lynn's arms and the doe defendants pulled Lynn back. Once Hammett was exceedingly aware of her head and Lynn's hitting each other's.

**The defendants failed to accommodate Lynn's aphasia and hearing loss, communication disabilities they caused or exacerbated.**

207. The clinician defendants caused Lynn to experience exacerbated aphasia and auditory impairment that affected his ability to express himself verbally, though he retained comprehension and reasoning.

208. The defendants mischaracterized these communication impairments as lack of capacity and failed to provide reasonable accommodations. Instead of adjusting communication methods, the defendants used Lynn's impaired speech as rationalization to override Lynn's expressed refusal of their involvement.

209. For example, Speech Language Pathologist Emily Gray wrote, "Pt repeatedly reported that he could not hear." She took off her PPE mask to allow Lynn to try to read her lips. That was the extent of Gray's recommended investigation or accommodation for Lynn's sudden hearing loss.

On January 17, Emily Gray wrote:

> Pt deferred nearly everything on his tray but was agreeable to consuming applesauce for ongoing swallow eval. SLP placed spoon in applesauce. Pt utilized spoon x1 without issue but then removed spook (sic) and drank applesauce from container until fully consumed. No s/s of aspiration. Pt did not want to drink any liquids.
>
> Recommendations: Continue full liquid diet; per ENT, no chew diet is recommended. Pt technically can upgrade to puree, however, SLP was unable to fully educate him on his options today due to language comprehension and hearing impairments. It is likely pt will not enjoy a pureed tray, and therefore consume less PO intake.

210. As a result, Lynn was denied pureed food despite demonstrated tolerance and eagerness to gulp the applesauce down. Emily Gray observed clear non-verbal communication of Lynn's desire for food and inexplicably recommended withholding food—a recommendation that was adopted by all the clinician defendants.

211. Aljiboori either feigned lack of comprehension of what "Stope. What are you dong?" meant, or he is negligent to try to treat patients who speak a language he does not comprehend.

212. Rather than taking time to decipher what Lynn was saying, as Hammett did, the "one-on-one" care team members usually had Lynn physically restrained in his room while the defendant sat at a desk out in the hallway. The team appeared to be using the "let-them cry-it-out" theory used to try to make children fall asleep without external soothing. The defendants ignored Lynn's clear communication.

213. Rather than accommodating Lynn's documented communication and hearing impairments, defendants treated those impairments as a reason to deny him adequate nutrition and lose autonomy over his body.

**The defendants breached their custodial duty to provide adequate nutrition.**

214. While Lynn was held against his will, Doe Defendants, Cate, Shaw, Emily Gray, Beavers, Cobb, Lambert, Millsapps, McNulty, Noble, Perkins, Sanders, and Wilkes, and each other individual defendant breached their nondelegable duty, as custodians, to provide adequate nutrition sufficient to sustain health, promote healing, and prevent foreseeable harm.

215. Despite this duty, Cate and Shaw, registered dietitians, never consulted with Lynn or with Hammett regarding Lynn's known dietary preferences, food aversions, or his long-standing preference for salty, protein-rich foods.

216. There is a single note in the medical record in which clinicians might have asked Lynn's then significant other about Lynn's diet and learned that he was lactose intolerant and had purposefully lost significant weight recently. Lynn was still fed cow milk products.

217. Had Lynn been permitted to return home—or had Defendants made accommodations for Hammett to prepare Food—Lynn's nutrition would have been individualized, adequate, and healing. Hammett was prepared to provide nourishing liquid and soft foods consistent with the hospital's stated dietary restrictions, including broths, blended soups, mashed vegetables, smoothies, and high-protein foods adapted to protect Lynn's jaw, but was denied a cooking area and refrigeration. These foods were consistent with Lynn's normal diet and are commonly known to impart health.

218. Hammett brought high sodium bottled soup and the clinician defendants left it unopened. Hammett brought shelf safe pureed fruits and vegetables, and the clinician defendants did not offer them to Lynn when he was physically restrained—which was a high percentage of the time.

219. Instead, Defendants provided Lynn with meals that were grossly inadequate in calories, protein, and essential nutrients. During his confinement from January 13 to January 27, 2024, Lynn lost approximately seventeen pounds in fourteen days. There is no documentation that this weight loss was meaningfully addressed or mitigated.

220. The food provided consisted of small portions of highly processed, high-sugar items with minimal protein or sodium. When Lynn's sodium levels declined precipitously, the clinician defendants did not respond with targeted nutritional support. Instead, Cobb offered a popsicle.

221. This approach disregarded Lynn's increased metabolic needs and foreseeable risk of harm.

222. On January 22, Shaw, R.D., documented that a "decision was made to start tube feeding as the patient is sedated now." Shaw did not identify any medical inability to eat, aspiration event, or refusal of food that was not caused by forced sedation. Instead, nutrition support was initiated solely because Lynn had been chemically sedated by the clinician defendants.

223. Shaw did not consult Lynn or his next-of-kin surrogate, did not assess his food preferences or prior intake, and did not consider less restrictive alternatives such as assisted oral feeding or family-provided nutrition.

224. Lynn became severely hyponatremic during the confinement.

225. Lynn was often unable to feed himself due to restraints and sedation imposed by the defendants. Shaw's conduct contributed to the deprivation of adequate, individualized nutrition during Lynn's involuntary confinement.

226. When Lynn was finally unrestrained and permitted by Jason Patterson, RN, not a defendant, to eat freely on January 26, he consumed a full sushi meal eagerly, demonstrating that

prior under-nutrition was the result of the clinician defendants' control and restrictions, not Lynn's unwillingness or inability to eat.

227. The failure to nourish Lynn adequately was not the result of medical necessity. It reflected a custodial environment in which restraint, control, and institutional convenience were prioritized over basic care. Cobb's statement that most of the UAMS SICU patients usually eat out of trashcans and are grateful for the food the clinician defendants provided, further reflects an attitude of indifference and disregard.

228. By denying Lynn adequate nutrition while preventing his family from caring for him, the clinician defendants acted with malice—consciously disregarding their custodial obligations and exposing Lynn to foreseeable physical and psychological harm during a period of forced confinement.

**UAMS Police Department and Security Doe Defendants breached their duty to provide custodial protection to Lynn and Hammett.**

229. At all relevant times, the UAMS Police Department and unidentified Security Doe Defendants were acting within the scope of their employment and were responsible for maintaining safety, order, and lawful conduct within UAMS facilities. Their duties included protecting patients and visitors, preventing unlawful restraint or confinement, and intervening when individuals were subjected to force or detention without lawful authority.

230. Once Lynn was prevented from leaving and subjected to physical restraint and sedation, he became a person in involuntary custody. Rather than safeguarding Lynn's liberty, UAMS security personnel facilitated and enforced his continued confinement by standing watch, monitoring his movements, and failing to intervene when he was restrained, chemically subdued, or prevented from leaving.

231. Security personnel observed—or reasonably should have observed—Lynn attempting to leave the unit, being physically restrained, and being forcibly returned to his room. These events imposed a duty to inquire whether his detention was lawful and consensual. Instead, security personnel took no steps to verify consent, to question the legality of the confinement, or to document objections raised by Lynn or his mother. Their inaction functioned as affirmative participation in Lynn's false imprisonment.

232 The UAMS Police Department and Security Doe Defendants also owed an independent duty to protect Hammett, a business invitee lawfully present in the hospital. Hammett was repeatedly placed in volatile and dangerous situations as she attempted to protect her son from unlawful restraint. On multiple occasions, she was pulled away, blocked, or forced into physical proximity with staff during their efforts to restrain Lynn, exposing Hammett to physical contact that was harmful. Security personnel failed to intervene to protect Hammett from foreseeable and actual harmful contacts.

233. Further, security personnel had access to surveillance systems that recorded Lynn's movements, restraint events, and interactions with staff. These recordings would have provided objective evidence of whether Lynn was voluntarily present or being detained against his will. The failure to preserve or produce such recordings reflects a breach of custodial responsibility, malice, and supports an inference that the evidence would have corroborated unlawful confinement.

**The defendants gave Hammett distressful misinformation and false promises to enlist her support.**

234. Beginning on January 14, the doe clinician defendants told Hammett that Lynn's intoxicated behavior was caused by the traumatic brain injury. They adamantly said the clinicians at UAMS never give opioids or benzodiazepines to TBIs.

235. On January 18, Hammett documented that she felt devastated and anticipated caring for a grown man who acted intoxicated indefinitely.

236. On January 19, Case Manager Beene told Hammett that Lynn could be released on January 23. Clinician Defendants were still lying to Hammett about the cause of Lynn's intoxicated behavior. Hammett still agreed she would care for Lynn at home "24/7." Because Hammett was scheduled and paid in full for the LSAT on January 23, and the clinician defendants defrauded her into thinking Lynn would need constant attention, Hammett settled for the contractual agreement. Beene agreed to release Lynn on January 23 in consideration of Hammett's promise to convince Lynn that interim escape attempts were too dangerous.

237. On January 21, Beumeler told Hammett by telephone that there were police approaching. Hammett feared it might end up like the fatal shooting of Tyrone Washington by a UAMS police officer. Hammett won some concessions if she would talk Lynn into going upstairs. Beumeler agreed to let Lynn wear clothes, eat soft foods, and use a comfortable pillow that Hammett would bring that day. Hammett talked Lynn into going back upstairs.

238. Cobb later bragged to Hammett that Cobb lured Lynn with a popsicle to sit in a wheelchair as the police approached.

239. After Lynn returned to the "floor", Nurse Beumeler called Hammett again and informed her that Lynn was being transferred to the ICU and that restraints and sedation would

likely be used. Hammett expressly objected, warned that restraint would exacerbate Lynn's trauma, and offered reasonable alternatives, including remaining at bedside to assist with care and oral intake. These offers were rejected.

240. Hammett took video of Lynn On January 21 at 1:45 p.m. His language was confused, but he was wearing a shirt Hammett brought that day and did not appear to be in any physical distress. He clearly wanted to leave.

241. When Hammett discovered the truth about some of the drugs and demanded Lynn's release on January 21, Hammett was excluded from Lynn's room. Hammett spoke to a doctor, she thinks it was Greer. She told the doctor that she would be taking Lynn out on January 23, after she took the LSAT.

242. On January 23, Lynn looked worse than ever. He was restrained, catheterized with his bloody penis exposed, groggy, with other tubes and wires attached.

243. The promise of releasing Lynn on January 23 was broken.

244. It took Hammett four more days to get him out.

245. On January 24, Lynn was in four-point restraints, no clothes on, sedated, tube in his nose, the pillow Hammett brought was not on his bed, the healthful soft foods Hammett brought on January 21 were on a table out of reach of Lynn and untouched. The bananas were turning with black spots. Nolan R. Bruce, MD was the attending physician.

246. Hammett went downstairs and spoke to Latisha in admissions. Latisha agreed that if what Hammett told her was accurate, Lynn should be released against medical advice. This employee made an effort to help by making a phone call.

247. Hammett went upstairs and spoke to Rebekah Davis and Charge Nurse Zaleski. Zaleski said to Hammett again, "we don't give benzos to TBIs."

248. Lorazepam and diazepam, both benzodiazepines had already been administered that morning.

249. The UAMS Police Department, to this day, refuses to pursue charges against any of the people who held Lynn against his will and battered him continually for two weeks. On June 20, 2024, Police Corporal "Detective" Clifton Moore told Lynn that there was no police report or documentation of any incident concerning Lynn.

250. Moore verified that frequently officers respond to patient control, "when a patient is behaving in a violent manner toward staff … or could be a danger to themselves or others, patients and visitors ... then officers could be called to assist." The defendants never made a report of this kind, according to Moore.

251. Numerous defendants told Hammett that police would stop Lynn and her from leaving. Dr. Benjamin L. Davis, M.D. noted on January 27 in contradiction. "It was made clear to me the police would be no help without a 72 hour psych hold, which, as stated above, was impossible."

252. On January 27, Benjamin Davis wrote:

> On morning rounds Mr. Lynn appeared physically robust but asked the same question (when can I go home?) repeatedly, despite repeated exhortations that he needs eunatremia and TBI rehab. He was told by his nurse and at least THREE physicians today, on multiple occasions that going home isn't safe. As was his mother, as this was in her presence every single time. She stated her intention to leave with him. We attempted to place a 72 hour hold but then learned he'd already had one this admission, and a second one isn't possible. We asked psych to weigh in but ultimately, it is clear that the patient himself does not have capacity, but determination about his mother's decision making capabilty [sic] was outside their realm of expertise since she is not a patient.

253. At no time during Lynn's two-week confinement did Defendants request or obtain consent from Hammett for treatment, restraint, sedation, nor invasive procedures.

254. Nevertheless, on December 23, 2025, Steve Hillis, Vice President of Health Care Claims for A.J. Gallagher Risk Management Services LLC—acting on behalf of the professional liability insurer for the Individual Defendants, The Doctors Company—wrote to Lynn that, "the medical records indicate that Mrs. Hammett was fully informed of the treatment plans and agreed with the doctors until the end of your admission, which you and she ended prematurely, against the advice of multiple physicians."

255. That statement is demonstrably false. The medical records indicate that Defendants misinformed Hammett. Further that Hammett was helping Lynn "elope." The record reflects repeated objections, persistent efforts to secure Lynn's release, and the absence of any lawful surrogate authorization.

256. The assertion that consent existed, when no such documentation exists and when Defendants were fully aware of its absence, evidences bad faith. It further supports a reasonable inference that the defendants understood consent was legally required, knew it had not been obtained, and later attempted to retroactively manufacture or imply consent through mischaracterization of the record.

257. This post hoc narrative is inconsistent with the contemporaneous medical documentation and supports an adverse inference that material facts were omitted, altered, or obscured to shield Defendants from liability. Such conduct demonstrates consciousness of wrongdoing and an effort to reframe unlawful confinement as voluntary medical care after the fact.

**The defendants released Lynn "against medical advice" without prescribing drugs for agitation and in far worse condition than when he entered UAMS Medical Center.**

258. On January 27, at about 1123 a.m., Brown stood outside Lynn's room with two male staff members positioned to prevent Lynn from leaving. In response to Hammett's request for an immediate capacity assessment, Brown stated that Lynn would be reassessed "on Monday" and that Lynn was "on a 72-hour hold," which had been "restarted." Brown further stated that Lynn lacked capacity and that Hammett could not authorize Lynn's departure because the "72-hour hold" required Lynn to remain confined until a future assessment. When Hammett asked for the criteria supporting confinement, Brown stated that Lynn was being held to prevent danger to himself or society, while simultaneously acknowledging that staff "didn't know" what danger existed because Lynn "didn't have capacity." Hammett then expressly told Brown to read 42 U.S.C. § 1983 so that Brown would understand that she and the other defendants were depriving Lynn of his Constitutional rights under color of law.

259. The first and only clinical medical ethics consult documented in the medical record was made at 1:50 pm on January 27. Ethicist Micah D. Hester, PhD. Wrote that the time he spent on this matter was 45 minutes. He did not speak to Lynn or Hammett. Hester marked, "Decision Making Capacity: Unknown." In his narrative, he wrote that, "Mr. Lynn's capacity is questionable, at best, and thus his decision to leave may not be a capacitated decision. His mother, however, also believed he should be allowed to leave, and not [sic] other persons were sought out to be a potential surrogate."

260. Hester did not document any objective evidence of incapacity.

261. Hester made this admission:

> "Arkansas has no law (and UAMS, no policy) that covers so-called 'medical holds,' which means that the ability to hold a patient who wants to leave AMA can

> only happen in a very limited set of conditions where the team can show a significant risk of imminent harm could befall the incapacitated patient should they leave the hospital. The team is unable to make such a claim, and thus, while it is understandably disturbing to the team, there are few options other than to let Mr. Lynn go, after signing AMA paperwork. As of the writing of this note, it is indicated in the social work and resident notes that that paperwork has been signed and Mr. Lynn will be leaving this afternoon."

262. Deloach required Hammett to sign a document that said she understood that Lynn was leaving against medical advice. Hammett asked Lynn to sign and he did with no hesitancy. Hammett wrote on the document that Lynn wanted a prescription for the medications that the Defendants thought he needed. Dr. Deloach left the room, saying he needed to check if he could give Lynn a prescription. He returned with a prescription for only propranolol and sodium tablets. Because it is dangerous to quit Propranolol suddenly, Lynn had to buy it and wean off of it at home.

263. Defendants issued no discharge prescriptions for benzodiazepines, opioids, dexmedetomidine, or barbiturates, confirming that these drugs were not medically indicated beyond their use to suppress Lynn during confinement. Despite labeling his departure as "against medical advice," Defendants prescribed no treatment for agitation or psychiatric instability, underscoring that Lynn's distress was situational and induced by restraint, not a medical pathology.

264. Lynn's treating physicians after discharge—whom he continues to see as medically indicated—did not prescribe any additional medications until he experienced his first seizure eight months later.

265. The discharge instructions issued by Deloach, and Kimbrough who was not present, imposed no restrictions beyond those routinely given to patients discharged after minor injury.

266. The lack of instructions tailored to a patient who needs intensive care exposes the absence of any genuine medical justification for advice to keep Lynn in ICU. If Lynn were truly unsafe for discharge, issuing routine outpatient instructions would have been reckless. Instead, the discharge documentation confirms that Defendants' assertions of incapacity and need for intensive care were pretextual and unsupported by their own contemporaneous clinical conclusions.

267. Lynn left the hospital with new and permanent injuries that did not exist at admission, including hyponatremia, disruption of the left ossicular chain with resulting hearing loss, suffering with tinnitus, acute aphasia, recurrent nightmares, and lasting psychological trauma caused by prolonged restraint, sedation, and loss of autonomy, as well as possible urethral scarring from nonconsensual catheterization.

268. Lynn was denied the ability to heal in the manner he chose and had repeatedly requested. Instead of being permitted to recover in a calm, familiar environment, he was confined in a hospital setting that stripped him of control over his body, surroundings, and daily rhythms. He was denied access to the foods, hydration, and electrolytes he preferred and relied upon. He was prevented from spending time outdoors, from experiencing natural light, and from engaging in restorative rest. He was restrained for significant periods, limiting movement of his limbs and preventing self-soothing or physical regulation. He was deprived of meaningful contact with loved ones and of the simple activities he used to maintain emotional equilibrium. Rather than allowing him to heal in his own way, Defendants imposed conditions that foreseeably caused agitation and undermined Lynn's recovery.

269. Through its standard adhesion consent form, UAMS expressly acknowledges that "the practice of medicine and surgery is not an exact science," that "no guarantees or assurances

have been made as to the results," and that patients retain the right "to consent to or refuse any recommended or proposed care, procedure, or treatment."

270. Despite these express representations, Defendants disregarded those terms. Any purported consent obtained from Lynn was void or voidable, having been extracted while he was sedated, restrained, and under coercive conditions. By continuing treatment after Lynn repeatedly refused care, Defendants breached the very conditions under which consent could lawfully exist.

**The Defendants kept an inadequate medical record.**

271. It is easy to comprehend that medical providers must keep an accurate and complete record of patient treatment, especially as here, where the patient refused consent.

272. In the related action pending before the Arkansas Claims Commission, counsel for UAMS certified under Rule 11 that the medical record produced on April 29, 2025 constitutes the complete record of written communications concerning Lynn's hospitalization and that it "speaks for itself."

273. It does not.

274. The medical record omits material facts and fails to account for clear and documented deterioration in Lynn's condition during his confinement. Most notably, the final diagnosis summary omits any designation of hospital-acquired conditions, despite objective evidence of new and worsening injuries that arose during hospitalization.

275. The final diagnosis summary lists "contusion of lung, bilateral, initial encounter" as a condition present on admission. However, on January 13, radiologist Joe Jose, M.D. reported "airspace opacities and ground-glass opacities in the dependent portions of the bilateral lungs, may be secondary to aspiration," and further stated, "Cannot exclude contusions in the setting of trauma." This language reflects diagnostic uncertainty, not a confirmed finding. Dr. Jordan

concurred on January 13. “Multiple airspace opacities in the lung apices may represent pulmonary contusions in the setting of trauma.” This also shows possibility or suspicion. No subsequent imaging documented progression or resolution of pulmonary contusions. In fact, there was no mention of a possible or actual pulmonary contusion after January 13. Nevertheless, the provisional possibility of contusion was later treated as an established diagnosis.

276. On January 13, there seems to be automated recording of the administration of Fentanyl. Frida Ruiz Rivera, RRT was present, according to the record. Then there is no further record of Rivera, no notes or diagnosis. This is odd, since Fentanyl is a known respiratory depressant and Lynn’s condition deteriorated significantly after the administration.

277. On January 18 to 19 the PCT notes and nurses flowsheet for restraints have clear discrepancies, where one says restraints were discontinued for a two-hour break and the other marked restraints as in use during that same two hours. Plaintiffs continue to find further discrepancies.

278. On January 21, Rezayev documented, “Patient attempted to elope, was redirected by mother and hospital staff and guided back to hospital room.” Rezayev failed to mention that Hammett (mother) redirected Lynn by speaking to him on the telephone from her home. That information would contradict the narrative that Hammett would not be able to “control” Lynn at home.

279. On January 23, Case Manager Rebekah Davis, RN, wrote that Lynn had SIADH, without mentioning that SIADH was acquired during his confinement. Davis failed to mention the disruption of Lynn’s oscillator chain and loss of hearing that the defendants caused.

280. Davis wrote that Lynn showed “increasing agitation and has been non cooperative.” Davis failed to record the cause of Lynn’s agitation—that the defendants were restraining him

physically and by giving him strong and dangerous drugs, and that they bashed his head against hard surfaces several times in their attempts to force him to "cooperate."

281. Davis acknowledged that Lynn was "admitted to SICU for close monitoring." Anticipation that a patient will suddenly become unstable is not imminent death or loss of limb.

282. Davis acknowledged Lynn "pulled foley for a second time," and [doe defendants] replaced it. Davis acknowledged that doe defendants forced placement of a Dobhoff tube with feeds. But Davis did not acknowledge that this confinement and forced drugs and procedures violated UAMS policies that adopted Arkansas constitutional and statutory law.

283. Davis said Lynn was "over the income limit for Medicaid." Davis did not ask Hammett what Lynn's income was. Nor did any other defendant. Davis and all other defendants who might have capability of arranging for Medicaid failed to use common sense. The defendants were all grossly negligent not to deduce that if Lynn fell from the height of a third story roof and required six months of inpatient rehab, as they told Hammett, that Lynn was not going to be able to work during at least those six months. Further, due to the defendants' negligence, Lynn kept saying he could not hear, and he had exacerbated aphasia. Any adult of ordinary intelligence would know that Lynn was going to have a hard time earning money with a newly acquired hearing loss.

284. Defendants failed to preserve surveillance footage from the emergency department, hospital halls, and stairwells where Lynn was confined and pursued. UAMS asserted in the Claims Commission proceedings that such footage was routinely overwritten after 21 days, but acknowledged that notice of potential litigation raises a duty to preserve the potential evidence.

285. The defendants should have known that Lynn would potentially sue them for holding him, drugging him and battering him without consent.

286. Explicitly, Hammett said loudly and clearly to Lynn that “they will pay you.” On January 27, Hammett told Elizabeth Brown to look up “42 USC 1983, deprivation of rights under color of law.” On January 29, Edward Williams documented that Hammett told him that she and Lynn “had a bad experience at UAMS and she used the terms such as assault, battery, holding him against his will, abuse, etc.”

287. On February 5, Hammett, as accommodator for Lynn, told Kathy Flores, Senior Manager of Patient Relations, that Lynn and she intended to sue UAMS. Ms. Flores told Hammett the claims would need to be filed in the Arkansas Claims Commission.

288. On February 6, Hammett and Lynn sent a settlement demand letter to Kristy Bienvenu, Patient Relations Coordinator.

289. It was apparent that the medical record would be needed and the surveillance videos taken in the ED and hallways would provide valuable insight that can not be captured by the written word.

290. Doe Defendants also produced medical records in multiple iterations, omitting material information in earlier productions that later appeared in subsequent versions. These failures impeded Plaintiffs’ ability to fully reconstruct events and assess individual responsibility.

291. Several Defendants asserted that they believed Lisette Reyes to be Lynn’s spouse. That assertion was contradicted in the record. Lynn repeatedly referred to Reyes as his “girlfriend” and “other mom.” The consent form has legal representative as “significant,” not “spouse.” Nurse Patterson wrote about the “pt girlfriend” in the record. Winn called Reyes “girlfriend” in a note on January 25. Cobb wrote “girlfriend at bedside” on January 21. Although Defendants eventually amended the medical record to correct misidentifying Reyes as “spouse”

after a formal request, they refused to amend other known inaccuracies in the record, including the erroneous cause of injury.

292. Defendants seemed to use scripts. For example, on January 13 at 10:16 pm., Bruce documented “75 minutes discontinuously providing consultative services.” He included in that time “time spent obtaining consent for any planned procedures.” There was no consent obtained and no planned procedures.

293. On January 23 at 2:21 p.m., Benjamin Davis wrote that he spent 35 minutes of discontinuous critical care time with Lynn that was “exclusive of procedures or educational activities.” Lynn’s entire hospitalization was for educational activities that benefited the professors, such as Assistant Professor Benjamin Davis who was paid $571,750.96 in fiscal year 2024, and the residents and trainees who used Lynn as an unwilling educational tool.

294. Until about May 5, 2025, none of the three medical records given to Lynn mentioned the administration of Fentanyl. The billing showed a dose. This incongruity made Plaintiffs conclude that doe defendants charged for Fentanyl but kept it for personal use or resale. The omission of the administration of Fentanyl and the triage report was either a grossly negligent mistake or a fraudulent act to mislead Plaintiffs about what caused Lynn’s intoxicated behavior.

295. The limited video recordings Hammett was able to make—despite UAMS policies prohibiting recording even during nonconsensual hospitalization—provide a far more accurate depiction of Lynn’s condition than the medical record. The videos show prolonged crying, repeated pleas to leave, visible distress, and embarrassment caused by unnecessary exposure of his body during periods when no examination or procedure was occurring. In contrast, the medical record repeatedly characterizes this behavior as “agitation,” without acknowledging the context or describing the underlying conduct. The chart contains no meaningful documentation

of Lynn's crying, pleading, or distress, nor of the circumstances in which his body was exposed. By reducing these observable human reactions to the single label of "agitation," the record obscures the reality of what was occurring and transforms visible fear, distress, and humiliation into a neutralized clinical label that conceals the true conditions under which Lynn was restrained and medicated.

296. Further, Doe Defendants and Zaleski failed to record that they told Hammett that they had not given Lynn benzodiazepines, which was clearly recorded in one of Hammett's videos.

297. The record is inconsistent with Hammett's eyewitness testimony, including that doe defendants told Hammett that Lynn was given no drugs other than a pain reliever.

298. UAMS counsel told Hammett that because the surveillance videos were deleted, it was going to be Lynn and Hammett's word against the defendants' word.

**The defendants prohibited Hammett from recording video of the alleged criminal conduct, based upon a UAMS policy.**

299. Cobb, Rosenbaum and the doe defendant who guarded the door on January 27 told Hammett there was a policy against video recording the staff to deter Hammett from making a video record of the conduct that appears to violate criminal code, as well as standard of care and civil law. Hammett discovered the policy number through a FOIA request answered by Leslie Taylor, MA, Vice Chancelor, Communications and Marketing, after Lynn and Hammett filed a claim in the Arkansas Claims Commission.

300. NR.AD.1.23 states in pertinent part:

> b. [] UAMS Staff may not be included in photographs or audio/visual recordings without their permission.
> c. UAMS does not provide permission for its equipment and facilities to be photographed or filmed.

d. UAMS staff may ask that the photography or filming/recording be stopped at any time. If a family member or friend refuses to stop and the activity is disrupting patient care or hospital operations, the person may be asked to leave the premises. Security may be contacted for assistance as necessary.

If a patient is taking photos or videos of staff members and refuses to stop, the healthcare team should attempt to explore the reasons for the photos/video and try to determine if there are concerns about treatment that can be addressed.

The Patient Advocate or Patient and Family Centered Care may be consulted for assistance as needed.

11. Photography by Attorneys - These pictures may often be used in a legal proceeding.

a. The attorney must provide proof of written patient consent.

b. If the patient lacks capacity, then the patient's legal next of kin must provide written consent.

c. A staff member shall be present while the attorney takes pictures of the patient.

d. No photographs of UAMS personnel, UAMS equipment, patients, visitors or other patient care areas is permitted.

e. UAMS staff or the patient may ask that the photography or film/recording be stopped at any time.

301. While Cobb, Rosenbaum and a doe defendant demanded Hammett stop recording, none addressed Hammett's concerns about the treatment. Patient advocacy was not sought, nor did the defendants inform Hammett that such advocacy was available until January 24.

**Lynn was left with hospital acquired disabilities and did not have an optimum recovery from the initial injury.**

302. Lynn left UAMS Medical Center after the two most traumatic weeks of his life. That day he said that the experience would "make a good horror movie" and "they treated me like one side in a war treats their prisoners."

303. Lynn entered UAMS Medical Center on January 13 with sodium levels recorded at 139 and 141 mmol/L. He left on January 27 with a sodium level of 128 mmol/L, after reaching a nadir of 121 mmol/L on January 18. UAMS refused Lynn's request for outpatient sodium

monitoring until February 1, when his insurance would become effective. When tested on February 2, his sodium level had returned to the normal range and has remained normal since.

304. But for Defendants' conduct, Lynn had an approximately eighty-percent chance of full recovery. Instead, Defendants caused injuries unrelated to the initial trauma and left Lynn with post-traumatic epilepsy, lingering aphasia, permanent hearing loss, tinnitus, and symptoms consistent with post-traumatic stress disorder.

305. Lynn entered UAMS Medical Center with his left ear intact and functioning and his right ear bloody but without ossicular disruption. By January 17, multiple Defendants documented impaired hearing. After Lynn's insurance became effective, the first physician he saw documented disruption of the left ossicular chain and tinnitus. Lynn did not sustain any head injury or ear trauma after leaving UAMS, and no hearing test was performed during his confinement.

306. Lynn visits a chiropractor and massage therapist about 30 times per year since the imprisonment. He uses writing and exercising for stress relief.

307. On August 2, 2024, Lynn experienced his first post-traumatic epileptic seizure. He was later evaluated in an emergency department, where imaging was described as similar to the CT performed at UAMS. He was discharged without being required to sign an against-medical-advice form.

308. Lynn began taking levetiracetam (Keppra) and has since reduced to the lowest effective dose. During the tapering process, he experienced one additional seizure and one episode of prodromal symptoms that required him to abandon driving and walk home from a job site.

309. Lynn now depends indefinitely on anticonvulsant medication and ongoing medical care. Had he been allowed to leave UAMS on January 13 and recover at home as he had successfully done after prior injuries, Lynn had a realistic prospect of full recovery.

**Count I –Medical Injury Pursuant to Ark. Code Ann. § 16-114-201 et. seq.– Sean Lynn asserts claims against each individually named Clinician Defendant and each Doe Defendant.**

310. Plaintiff Sean Lynn re-alleges and incorporates by reference all preceding paragraphs as if fully set forth herein.

311. From on or about January 13, 2024, through approximately 12:45 p.m. on January 27, 2024, the individually named clinician defendants and Doe Defendants owed Lynn a duty to act in accordance with the applicable standard of care for their respective credentials, applicable institutional policies, and Lynn's established legal rights as a patient.

312. During this period, Defendants breached those duties in multiple, interrelated ways that are readily comprehensible to laypersons and do not require specialized medical knowledge. The conduct alleged falls below the standard of reasonable prudence expected of any ordinary adult, independent of medical training.

313. As a direct and proximate result of Defendants' unlawful confinement, forced medication, and restraint, Lynn suffered physical, neurological, and psychological injuries as described herein.

314. Each trainee employed by UAMS had contractually agreed to understand and adhere to ethical, legal, and professional obligations, including the duty to report wrongdoing or unsafe practices. Discovery responses in the related matter confirm that no such reporting occurred,

despite Defendants' awareness that Lynn refused treatment through his words, his conduct, and the repeated objections of his mother.

315. Each supervising physician and attending clinician was responsible not only for his or her own acts and omissions, but also for the supervision and conduct of trainees acting under their orders and authority.

316. At all relevant times, Defendants failed to exercise the degree of care, skill, and learning ordinarily possessed and exercised by reasonably careful medical providers of similar training and experience under like circumstances. Defendants relied upon the unwitnessed assumptions of an EMT regarding the mechanism of Lynn's injury as the sole basis for a Level 2 trauma activation, without reconciling that narrative with their own clinical observations.

317. The following causes of action are subsumed within this medical negligence claim, whether sounding in negligence or intentional tort, and may be found individually or in the alternative as to each Defendant. Under Arkansas law, the two-year statute of limitations applicable to medical injury claims applies to all such subsumed causes of action, whether those causes would otherwise be subject to longer or shorter limitation periods.

**A. False Imprisonment**

318. Each individual defendant, by acts or omissions, directly restrained Lynn, confining him with no reasonable means of escape.

319. Defendants acted in utter disregard of Lynn's legal rights, knowing they denied Lynn due process as required for a 72-hour psychiatric hold or a medical hold to treat an imminent life-threatening condition.

320. Each Defendant was required to be familiar with UAMS policy, derived from Constitutional law, that patients, barring a legal order, have the right to refuse treatment.

321. False imprisonment does not require a malicious motive. It is immaterial whether the defendants thought they had a cure for TBI; or if they were trying to generate revenue for their employer.

322. It was illegal to force Lynn to stay inside UAMS Medical Center.

**B. Battery**

323. Each Individual Defendant took part in or facilitated harmful physical contact with Lynn. Some administered medication or restraints; others chased and tackled Lynn or stood by while it occurred, despite having a duty to intervene. Together, their actions included administering sedatives, antipsychotics, benzodiazepines, and opioids; physically restraining Lynn; and performing invasive procedures.

324. The Individual Defendants knew or should have known that Lynn did not consent to such contact. Indeed, his repeated verbal objections, attempts to leave, and physical resistance made the absence of consent unmistakable. The use of sedation or restraint to overcome that refusal did not restore consent and instead constituted battery.

325. Each Defendant is liable for his or her own acts in intentionally causing or participating in such contact or enabling such contact by others. Those acts were done though, in context of a continuing course.

326. The harmful and offensive nature of the contact was especially egregious because the defendants claimed to be helping Lynn, while causing hearing loss, exacerbated aphasia, confusion, agitation, infections, bloodletting, tinnitus, dehydration, rapid weight loss, hyponatremia, nausea, pain in his esophagus, and severe emotional distress.

327. As a direct and proximate result of these batteries, Lynn suffered physical injury, pain, emotional distress, loss of dignity, and lasting psychological harm. Here, each clinician

defendant knew or should have known that being bound, being punctured, inserted with tubes and drugged was potentially harmful and offensive to a reasonable sense of personal dignity. That is why the right to refuse that class of contact is supposed to be strictly protected.

328. In instances such as forced catheterization, when Lynn pulled the medical device out, it was the clinician defendant who ordered, authorized or inserted the device that caused the harm. Each was substantially certain that Lynn would pull the device out. Especially after the first and second time a catheter was reinserted.

329. Even where harm is unforeseeable, defendants are often held liable. An example in this case is that some of the defendants, particularly PCTs, may not have known the drugs they forced or coerced Lynn to take were contraindicated with other drugs he was administered in an inappropriate timeframe. The PCT who collaborated in the administration of the drugs is liable for the harm done, anyways. They need only understand that they had no legal authority to override Lynn's refusal.

330. Damages for mental suffering are recoverable without the necessity for showing actual physical injury in a case of willful battery because the basis of that action is the unpermitted and intentional invasion of the plaintiff's person and not the actual harm done to the plaintiff's body. Restatement (second) of Torts § 18. There was obvious physical harm done to Lynn, such as disruption of the tiny bones in his left ear and blood dried around punctures in his skin, but no expert is required to support the negative physical effects on Lynn from the forced use of prescription only medications and physical restraints.

**C. Negligence**

331. UAMS is a primary source of authority for defining the standard of care applicable to its clinicians, including through its published Patient Rights and Responsibilities. A violation of those policies constitutes prima facie evidence of a breach of the applicable standard of care.

332. Defendants failed to notify Lynn's next of kin promptly upon admission. On January 14, Reyes called Lynn, and a nurse answered and informed her that Lynn was hospitalized. Reyes then notified Hammett. Had Hammett been notified on January 13, she would have arrived within 20 minutes, as she was at Lynn's home at the time of admission. Earlier notification would have materially altered Lynn's care and confinement.

333. Defendants failed to respect Lynn's repeated refusal of treatment and continued medical intervention without consent.

334. Defendants administered pain management that was inappropriate to Lynn's expressed condition and wishes. Lynn stated that he was experiencing minimal pain, yet Defendants administered fentanyl, maximum-dose acetaminophen, and propranolol—despite his refusal and without medical necessity proportionate to his complaints.

335. Defendants caused or exacerbated Lynn's agitation through confinement, forced medication, and restraint, and then mismanaged that agitation. Lynn's two-week period of distress and resistance resolved immediately upon his release, supporting the inference that the agitation was situational rather than pathological.

336. Defendants conflated aphasia, hearing loss, and communication disabilities with decisional incapacity. Despite their specialized training, Defendants failed to distinguish expressive language impairment from cognitive function, resulting in erroneous determinations of incapacity.

337. Defendants failed to explain to Lynn why he was prohibited from using his cellphone or leaving the hospital when he asked, including prior to the administration of fentanyl.

338. Defendants failed to provide effective communication accommodations for Lynn's newly acquired aphasia and hearing loss. Speech-language pathology involvement was minimal and insufficient. Although Hammett attempted to facilitate communication, she was periodically excluded, misinformed about the causes of Lynn's impairments, and prevented from assisting meaningfully. Had Defendants accurately disclosed the effects of the medications being administered, communication strategies would have differed materially.

339. Defendants denied Lynn his right to leave against medical advice and denied him the opportunity to receive care in the safe setting of his home.

340. Defendants subjected Lynn to physical restraints used for coercion, convenience, and retaliation rather than medical necessity.

341. Defendants violated Lynn's right to personal privacy. Lynn was repeatedly left unclothed without medical justification and exposed to unnecessary observation and physical contact while restrained. These conditions caused ongoing humiliation and distress.

342. Doe Defendants, Jordan, Rezayev, Jordon, and Cobb denied Lynn access to Hammett on multiple occasions, including during preparations to transfer him to a more restrictive setting on January 21, immediately preceding an attempted escape and physical struggle near the elevators.

343. Defendants failed to provide Lynn access to judicial review, a public defender, or court process for any purported seventy-two-hour hold, and continued to deny such access throughout his confinement.

344. Defendants excluded Hammett from meaningful participation in care decisions, repeatedly misinformed her, restricted her access to records, labeled her as disruptive for advocating for Lynn, and threatened expulsion for attempting to assist him.

345. When Lynn asserted concerns and grievances and reiterated his desire to leave, Defendants escalated the use of physical and chemical restraints as tools of confinement rather than treatment. Periods of reduced resistance caused by sedation were falsely characterized as consent.

346. In addition to policy violations, Defendants violated Arkansas penal statutes enacted to protect individuals in Lynn's position, including Ark. Code Ann. §§ 5-11-103, 5-13-201, and 5-13-202, and Article 2 of the Arkansas Constitution. Violations of such statutes constitute evidence of duty and breach.

347. Defendants restrained Lynn without consent or lawful authority, exposing him to a substantial risk of serious physical injury and causing actual injury.

348. It was reckless to administer fentanyl and other controlled substances to Lynn against his will. Such medications are known to depress respiration, exacerbate aphasia, and contribute to hyponatremia—conditions that pose serious risks to patients with traumatic brain injury. Lynn's sodium levels declined during forced medication and normalized after discharge.

349. While engaging in false imprisonment, Defendants caused serious physical injury to Lynn. During Hammett's attempts to intervene, physical contact occurred that resulted in additional head impact to Lynn, increasing the risk of post-traumatic epilepsy, which later manifested.

350. By failing to intervene, preserve evidence, or protect Lynn from unlawful detention, the UAMS Police Department and Security Doe Defendants acted in concert with clinical staff and breached duties owed to both Lynn and Hammett.

351. These claims arise not from a single discrete error, but from a prolonged, interdependent course of conduct in which multiple clinicians acted in concert, each relying upon and reinforcing the assumptions of others. When professionals uncritically adopt unfounded conclusions—such as authority to deny bodily autonomy—responsibility does not dissipate; it multiplies.

352. For those clinicians who evaluated Lynn prior to fentanyl administration, reliance on a narrative of a thirty-five-foot fall was unreasonable. Their own documented observations did not support high-level trauma activation. The narrative originated from an EMT who did not witness the incident. It did not reflect the medical providers' documentation of Lynn's presentation.

353. When Lynn later clarified that he jumped approximately ten feet, Defendants refused to amend the record, supporting an inference that contrary information was disregarded or concealed.

354. But for Defendants' negligent and unlawful conduct, Lynn would have healed at home according to his wishes. Instead, he sustained permanent hearing loss, neurological injury, psychological trauma, and diminished professional capacity.

355. The burden of preventing the injuries described herein was minimal when compared to the foreseeable risk of harm and the gravity of the resulting injuries. Basic safeguards—such as verifying the patient's account of how the injury occurred, accurately documenting refusal of care, and invoking the statutory procedure for judicial review when a patient refuses treatment

that a clinician believes is urgently necessary—would have imposed little cost and prevented substantial harm.

356. The Arkansas legislature has already determined that requiring court involvement before overriding a competent patient's refusal is a reasonable and necessary safeguard, reflecting a policy judgment that the cost of compliance is outweighed by the benefit of protecting patient autonomy and preventing unlawful detention and injury.

**D. Conversion**

357. Lynn was billed for two 7.5 mL bottles of Ciprofloxacin–Dexamethasone 0.3%–0.1% ear drops at a cost of $1,272.25 per bottle. A single 7.5 mL bottle contains approximately 150 drops, for a total of approximately 300 drops billed to Lynn.

358. Medication administration records created by Defendants are internally inconsistent and reflect administration totals ranging from approximately 20 drops to 72 drops to 108 drops. No record supports use approaching the full contents of a single bottle before a second bottle was dispensed. Only one instance of documented waste appears in the record, when Lynn refused administration.

359. These records support the inference that the second bottle was dispensed and charged to Lynn before the first bottle was exhausted, and that the unused medication was retained by a clinician Doe Defendant or otherwise diverted, despite having been paid for on Lynn's behalf by Medicaid. The retention or diversion of medication paid for by Lynn constitutes conversion.

360. Additionally, Defendants removed Lynn's blood without consent and used it for training and practice. The unauthorized taking and use of Lynn's blood and bodily materials constitutes conversion of personal property under Arkansas law.

E. **Trespass to Chattels**

361. Lynn owned his cell phone.

362. It is well settled that due process is required before depriving one of a "significant" property interest.

363. On January 13 to 27, 2024, there was no published policy at UAMS that would allow Ernst and Doe Defendants to confiscate or make Lynn's cellphone inaccessible to him.

364. Had there been such a policy, it would not be effective as Lynn did not agree to follow UAMS policies. He did not want to be on the campus.

365. Ernst and the doe defendants knew or should have known that UAMS acknowledges the patient's right to have family members of their choosing be notified promptly upon their admission to UAMS Medical Center. Where, as here, the clinicians make no attempt to locate the family, it is especially harmful to deprive the patient of his ability to contact family by failing to relinquish control of the patient's phone.

Further, UAMS acknowledges the patient's right to have any restrictions on communication discussed with him. See Exhibit "A" attached. Ernst and the doe defendants failed to discuss the restriction of using his phone with Lynn.

366. Lynn is entitled to damages for the loss of use of his cell phone caused by Ernst and the doe defendants. This includes his inability to call Hammett for help before the clinician defendants began drugging him and retraining him physically.

F. **Outrage**

367. The defendants knew or should have known that emotional distress was the likely result of their conduct. If each defendant was required to stay in a room in ICU for two weeks, take each drug that Lynn was forced to take, consume the same food and water he consumed, be

restrained for the periods he was restrained, be naked for two three-day periods during the confinement and not have visitation with their children and, even though they are not already injured and know they will be able to leave in two weeks, they would be outraged.

368. The defendants' conduct was so extreme and outrageous, beyond all possible bounds of decency, and utterly intolerable in a civilized community that there are laws against that conduct. They are felonies that can carry many years of incarceration. The law recognizes the conduct as criminal, but the criminal system alone does not reliably deter it—making civil enforcement essential.

369. As a direct and proximate result of Defendants' acts and omissions, Lynn suffered substantial injury and damages, including but not limited to:

a. Interference with and delay of his chosen course of treatment and recovery at home;
b. Increased risk of long-term neurological injury, including post-traumatic epilepsy diagnosed in August 2024;
c. Pain and suffering resulting from prolonged nonconsensual physical restraint, chemical sedation, and confinement;
d. Severe hearing loss;
e. Tinnitus;
f. Ongoing aphasia and communication impairment;
g. Psychological trauma consistent with post-traumatic stress disorder, including intrusive memories, nightmares, hypervigilance, emotional numbing, and relational impairment;
h. A substantial diminution in Lynn's ability to pursue his professional and personal life.

370. The acts and omissions of Defendants were a substantial factor in causing Lynn's injuries and damages.

371. The Plaintiff  Sean Lynn individually, claims monetary damages against the individual defendants in an amount that exceeds the jurisdiction of the Circuit Court of Arkansas, to be determined at trial, plus costs, and for any further relief that this Honorable Court determines necessary and appropriate.

**Count II – Negligence – Laura Hammett asserts claims against each individually named defendant.**

372. Paragraphs 1 to 371 are incorporated by reference as if fully set forth herein.

373. Defendants owed Laura Hammett a duty of reasonable care as a business invitee on hospital premises and under the rescuer doctrine, as she was attempting to protect and assist her son while he was unlawfully confined and subjected to nonconsensual restraint and medication.

374. While Hammett attempted to extricate Lynn from a situation that reasonably appeared life-threatening and harmful to his neurological recovery, Defendants repeatedly engaged in chaotic and forceful restraint efforts that resulted in Hammett being pushed, pulled, or struck. These encounters occurred during multiple restraint episodes and in circumstances created and controlled by Defendants.

375. Due to the destruction and non-preservation of surveillance video, the precise identity of each individual who made physical contact with Hammett may not be ascertainable at this stage. Nevertheless, Hammett asserts her claim against all clinician defendants, as each participated in, authorized, or failed to intervene in conduct that created a foreseeable risk of harm. Discovery will further identify the specific acts and actors involved.

376. At the time of these events, Hammett was a sixty-one-year-old woman with Hashimoto's disease and chronic insomnia, both of which were controlled prior to Lynn's confinement. As a result of Defendants' negligence, Hammett's sleep was severely disrupted, her medically necessary dietary restrictions were abandoned, and her physical recovery regressed.

377. Defendants' conduct also interfered with Hammett's daily functioning and obligations, including her ability to study for the LSAT, attend her own medical appointments without undue burden, and provide transportation for Lynn's minor child.

378. The burden of preventing Hammett's injuries was minimal compared to the foreseeable risk and severity of harm. In addition to the personal injuries suffered by Hammett, Defendants' negligence imposed substantial and unnecessary costs on the State of Arkansas, including medical expenses exceeding $115,000, litigation costs, and the expense of remedial care required to make Lynn whole.

379. Laura Hammett individually seeks compensatory damages against the individual defendants in an amount exceeding the jurisdictional minimum of this Court, together with costs and such other relief as the Court deems just and proper.

**Count III—Outrage or alternatively, Fraud—Laura Hammett asserts outrage against the defendants alternatively Fraud against Susan Zaleski and Doe Defendants.**

380. Plaintiff Laura Hammett re-alleges and incorporates by reference paragraphs 1 to 379 as if fully set forth herein.

381. This claim is subject to the one-year statute of limitations applicable to the tort of outrage. The limitations period is tolled until May 5, 2025, when Hammett and Lynn first obtained the triage report and documentation revealing the administration of fentanyl and the triage report the defendants previously withheld.

382. During Lynn's confinement, Defendants knowingly made false and misleading statements to Hammett regarding Lynn's condition and the medications administered to him. Multiple Defendants represented that Lynn's agitated and intoxicated behavior was caused solely by a purported fall from a three-story height and denied the administration of opioids or benzodiazepines.

383. On January 24, 2024, Defendant Susan Zaleski, RN, stated to Hammett, “we don’t give benzos to TBIs,” despite the documented administration of benzodiazepines to Lynn. Defendants further represented that Lynn was receiving only Tylenol for pain and denied the use of opioids, including fentanyl, despite having administered them.

384. Defendants knew or should have known that these misrepresentations would cause Hammett extreme emotional distress by leading her to believe that her son’s apparent intoxication and exacerbated aphasia were permanent consequences of catastrophic brain injury, rather than drug-induced effects. Defendants further knew or should have known that portraying Lynn as having survived a “death-defying” fall and as neurologically devastated would discourage Hammett’s efforts to secure his release and assist him in exercising his right to leave.

385. As a direct result of Defendants’ conduct, Hammett experienced severe emotional distress. She feared that her son would either die suddenly in the hospital or survive with lifelong incapacity requiring constant care. While her efforts to secure Lynn’s release were impaired by Defendants’ misrepresentations, they were not extinguished. Until she learned that Lynn’s behavior was largely drug-induced, Hammett repeatedly stated that Lynn wished to leave and that it was his life and his decision.

386. Defendants knew or should have known that forcing a mother to struggle for two weeks to extricate her son from unlawful confinement, while withholding material facts and providing false assurances, would be profoundly disturbing. Hammett in fact suffered measurable harm, including severe emotional distress that contributed to a ten-point drop in her LSAT score on the January 23, 2024 examination compared to her prior practice performance.

387. Defendants’ conduct was extreme and outrageous, exceeding all bounds of decency tolerated in a civilized society. This is further evidenced by Defendants’ destruction of

surveillance video documenting the confinement and by their repeated demands that Hammett cease recording their illegal conduct.

388. In the alternative, Defendants Susan Zaleski and Doe Defendants committed fraud by knowingly making false representations of material fact with the intent to induce Hammett's reliance, which they knew would impede her efforts to protect her son. Hammett justifiably relied on these representations to her detriment, suffering emotional distress and other damages.

389. Plaintiff Laura Hammett seeks compensatory damages against the Individual Defendants in an amount to be determined at trial, costs, and all other relief to which she is entitled in law or equity.

**Count IV—Sean Lynn and Laura Hammett assert equitable claims against University of Arkansas through its Board of Trustees.**

390. Paragraphs 1 to 389 are incorporated by reference as if fully set forth herein.

391. The Board of Trustees of the University of Arkansas continues to enforce part of policy NR.AD.1.23, prohibiting the video recording of procedures and equipment in UAMS. In this case, UA and the other defendants did not comply or enforce the clause in the policy that requires employes to make a reasonable inquiry into why the videographer continues to attempt to record, as the reasonable assumption is that the patient or the patient's family are not satisfied with the care the patient is receiving.

392. Lynn and Hammett have substantial contacts in Pulaski County. Lynn controls six properties and works in Pulaski County. Hammett is a student on a UA campus and intends to work with Lynn.

393. The specter of having a medical emergency and being brought to UAMS is frightening. Hammett's husband was referred to UAMS for cancer treatment and asked to be referred to a different hospital.

394. Therefore, Lynn and Hammett ask this Court for injunctive relief, forbidding the UA campus from enforcing policy NR.AD.1.23 or any similar policy after a patient or surrogate qualified individual makes a minimum effort to leave, elope, escape, refuse treatment or is held in physical restraints.

395. Plaintiffs pray the Court orders the declaratory relief requested against University of Arkansas through its Board of Trustees as pled and any other relief the court finds just.

**Count V—Sean Lynn and Laura Hammett assert equitable claims against University of Arkansas through its Board of Trustees.**

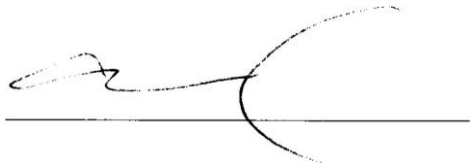
396. Paragraphs 11 to 395 are incorporated by reference as if fully set forth herein.

397. Because Lynn and Hammett should be able to rely on the state operated hospital and the doctors who are trained there, Lynn and Hammett ask this Court to give injunctive relief by ordering that each professor employed at UAMS who allowed for the false imprisonment of a patient, Lynn, between January 13, 2024 to January 27, 2024, be dismissed from any employment at UAMS.

398. Plaintiffs pray the Court orders the declaratory relief requested against University of Arkansas through its Board of Trustees as pled and any other relief that would be just.

**Jury Trial Demanded for Counts I, II and III.**

Respectfully Submitted,



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