IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND

HARFORD COUNTY BRANCH of the NAACP
Post Office Box 525
Aberdeen, Maryland 21001

and

CHARLES MORRIS
c/o Mayer Brown LLP
1999 K Street N.W.
Washington, DC 20037

Plaintiffs,

v.

SHERIFF JEFFREY GAHLER, individually, and in his official capacity as Harford County Sheriff,
45 South Main Street
Bel Air, Maryland 21014

WARDEN DANIEL J. GALBRAITH, individually, and in his official capacity as Warden of the Harford County Detention Center,
1030 Rock Spring Road
Bel Air, Maryland 21014

HARFORD COUNTY, MD,
Serve On:
County Executive Robert G. Cassilly
220 South Main Street
Bel Air, Maryland 21014

STATE OF MARYLAND,
Serve On:
Attorney General Anthony Brown
200 St. Paul Place
Baltimore, Maryland 21202

Defendants.

Civil Action No.: 1:26-cv-239

JURY TRIAL DEMANDED

COMPLAINT AND JURY DEMAND

INTRODUCTION

1. Perhaps the most fundamental constitutional duty of jail officials is to keep people in their care alive and safe. Tragically, this is something the Harford County Detention Center ("HCDC") has failed to do.

2. HCDC's suicide rate is more than five times the national average. Worse still, HCDC's egregious death rate is compounded by dozens of recent, preventable suicide attempts. As a result, Plaintiffs, their members, and their loved ones have suffered terribly and needlessly.

3. Defendants improperly dismiss this deadly crisis as beyond their control. According to HCDC's warden, Daniel J Galbraith, "[i]f somebody wants to kill themselves, they're determined and they've made their mind up, they're going to find a way."[1]

4. The medical community categorically rejects Defendants' fatalism. As HCDC's own Suicide Prevention and Crisis Manual recognizes, it is a "myth" that "[s]omeone who is really intent on committing suicide cannot be stopped," and a "fact" that "most suicidal people want to be rescued."[2] People contemplating suicide "are ambivalent about living, not intent on dying."[3]

5. Plaintiff Charles Morris illustrates that point. Today, he is glad to be alive. But for a few dark hours in August 2024, Defendants' misconduct robbed him of all hope. HCDC staff ignored red flags noted in their own written policies, including Mr. Morris's tearful confession that he did not see a reason for living, his diagnoses of major depression and bipolar disorder, and his seizure disorder. They locked Mr. Morris in a solitary cell for 23 hours a day, with a bunk bed

[1] Ben Conarck, *Why is the suicide rate so high at this Maryland jail?*, THE BALT. BANNER, Feb. 15, 2024, https://www.thebanner.com/community/criminal-justice/after-a-spate-of-suicides-in-the-harford-county-jail-was-anybody-watching-NKNDBS4B3ZCWJDKSQ6JOMVBD5A/.
[2] HARFORD COUNTY DETENTION CENTER SUICIDE PREVENTION AND CRISIS INTERVENTION MANUAL, 4.
[3] *Id.*

practically purpose-built for suicide attempts. Predictably, like others before him, he hung himself. When jail staff found him, he had apparently been hanging for several minutes and was not breathing. He was rushed to Bayview Hospital in Baltimore, where he spent a week fighting for his life.

6. Defendants then sought to cover up the incident to prevent Mr. Morris's family from discovering HCDC's malfeasance, insisting *no family be notified* and that Mr. Morris remain alone with no loved ones to support him or assist in any medical decision-making as he lay near death, hospitalized in a coma. Defendants directed hospital staff that Mr. Morris's family would *only* be notified of his devastating injuries if he became brain dead.

7. Mr. Morris was the latest victim of HCDC's lethal pattern and practice of deliberate indifference, including Defendants' malign insistence on maintaining practices that exacerbate—and even encourage—the risk of suicide attempts, their refusal to take rudimentary precautions, and their *de facto* punishment of survivors. Among other things:

a. HCDC routinely fails to adequately assess suicide risk, regularly failing to identify people in significant jeopardy, *e.g.*, people experiencing severe withdrawal or with well-documented serious mental health needs.

b. Although isolation severely aggravates the risk of distress and self-harm, the jail defaults to locking people in 23-hour-per-day solitary confinement upon arrival.

c. Flouting basic standards of care, HCDC keeps people in solitary even after determining they are suicidal, without anything remotely adequate by way of monitoring, therapeutic care, or re-evaluation.

d. Although hanging is the leading cause of death in jails, including HCDC, the jail uses cells with superfluous bunks that serve as makeshift gallows.

e. HCDC's responses to suicide attempts often are unnecessarily punitive and involve excessive force, effectively punishing people for attempting suicide.

f. To cover up their wrongdoing, Defendants falsify records, withhold information from families, and preclude families from accessing and supporting their loved ones, while publicly proclaiming the jail blameless.

g. HCDC's "suicide watch" is so deficient that people have been able to rehearse their suicide attempts or even die while supposedly under observation.

8. In short, HCDC receives people like Mr. Morris who are vulnerable to self-harm, often presenting with psychiatric or other disabilities. It conducts blatantly deficient screenings that miss obvious warning signs. It puts people vulnerable to self harm in cells by themselves, often for 23 hours per day, with implements to hurt themselves. It then fails to monitor them or provide anything remotely resembling proper mental health care. And as a result, people deteriorate until they seek to end their lives, leading to a pattern of anguish, self-harm, and death far surpassing that of any other Maryland jail.

9. For years, Plaintiff Harford County Branch of the National Association for the Advancement of Colored People ("NAACP") has sought lifesaving reforms at HCDC for itself and its members. Its efforts have been fruitless. Despite deadly tragedies, extensive media coverage spreading the alarm, and many warnings from Plaintiffs and others urging action, Defendants maintain callous and deliberate indifference to the risks and needs of those in their care, often putting more effort into defending their track record and minimizing the harms.

10. Plaintiffs NAACP and Charles Morris now bring this action to finally end this pattern of cruelty, needless suffering, and death.

JURISDICTION AND VENUE

11. This Court has jurisdiction pursuant to 28 U.S.C. § 1331, as a civil action under the United States Constitution and federal laws, including 42 U.S.C. § 1983.

12. The Court has supplemental jurisdiction over Plaintiffs' state-law claims pursuant to 28 U.S.C. § 1367 because those claims form part of the same case or controversy and arise from

the same nucleus of operative facts as Plaintiffs' claims under federal law.

13. Venue is properly in this District pursuant to 28 U.S.C. § 1391 because all the events giving rise to Plaintiffs' claims occurred in Harford County, Maryland.

14. Plaintiff Charles Morris provided timely notice of the facts and circumstances giving rise to his state law damages claims against the State of Maryland ("Maryland") and Harford County. He has received final denials from Maryland's Treasurer and Harford County, satisfying his obligations under Md. Code, State Gov't § 12-106 and Md. Code, Cts. & Jud. Proc. § 5-304.

PARTIES

15. **Plaintiff NAACP** is a non-profit, non-partisan membership organization with more than 300,000 members and two million supporters. The NAACP is the nation's largest and oldest grassroots-based civil rights organization. The Harford County branch was started in 1920. It has 330 members who play an active role in deciding its leadership every two years in November by voting to elect the branch's president and other members of its executive committee. It sues on behalf of itself and its members, for declaratory and prospective equitable relief, as well as nominal damages in the amount of $1.

16. This lawsuit is central to the NAACP's mission and purpose, which includes "*securing the political, educational, social and economic equality of rights in order to eliminate race-based discrimination and ensure the health and well-being of all persons.*" Addressing health and incarceration-related disparities, especially for Black and other communities of color or other marginalized groups, is a hallmark of the NAACP locally and nationally. In 2022, nationally, the NAACP adopted a resolution titled "In-Custody Deaths – Incarcerated Residents Constitutional Protections Recovery," focused on remedying process failures and neglect in prisons and jails. Such shortcomings "result in the unnecessary and preventable loss of life" that disproportionately

harm persons of color. The resolution reflects growing local, state, and national NAACP efforts to redress the lack of adequate healthcare and risk of death facing incarcerated NAACP members and their loved ones.

17. The Harford branch of the NAACP has organizational standing to sue for equitable relief on behalf of itself and its members because, following decades of advocating for police accountability, it has had to shift significant time and resources to ameliorate the harms that HCDC's deadly pattern of misconduct poses to NAACP members. This includes time and resources for direct engagement, such as: (a) participating on the Harford County Sheriff's Office ("HCSO" or "Sheriff's Department") Community Board, (b) attending Harford County Police Accountability Board meetings, and (c) participating on the Maryland Commission on Hate Crime Response and Prevention. In addition, the NAACP (a) investigates complaints about HCDC and monitors Defendants' management of the jail; (b) meets with Defendants to resolve the complaints, tour the jail, and urge remedial measures to avert further harm; (c) conducts community education and engagement to enhance awareness and build support for jail reform; and (d) pursues and publicizes public information about Defendants' practices, including but not limited to a May 2024 request for the racial demographics of stops and searches by the Sheriff's Department and a November 2024 request for records detailing suicides and suicide attempts at HCDC.

18. The Harford NAACP further enjoys associational standing to pursue relief on behalf of its members because its members include, among others, persons directly injured by the misconduct set forth herein, such as: (a) Charles Morris, who attempted suicide at the jail and suffered punishing treatment both before and after his suicide attempt; (b) his sister, DeVora Jones; (c) Nathaniel Powell Sr., who is independently engaged in legal action related to the suicide of his son, Nathaniel Powell Jr. at HCDC; and (d) others who themselves have been incarcerated at

HCDC, or have loved ones incarcerated there, some experiencing addiction disorders and/or mental health disabilities. In bringing suit on behalf of these members, the NAACP seeks to ensure the future health and safety of those who are incarcerated at HCDC and the ability of their loved ones to obtain reliable, timely information in the event of emergencies.

19. **Plaintiff Charles Morris** is and was, at the time of the events complained of herein, a resident of Harford County, Maryland. On August 2, 2024, Defendants' abuses drove Mr. Morris to attempt suicide at HCDC, where he nearly died. Mr. Morris is a member of the NAACP and a qualified individual with a disability as defined by the Americans with Disabilities Act (the "ADA") and the Rehabilitation Act of 1973 (the "Rehabilitation Act"). Specifically, Mr. Morris is diagnosed with both major depressive and bipolar disorders, as well as a serious seizure disorder. Defendants' acts and omissions harmed Mr. Morris as set forth below.

20. **Defendant Jeffrey Gahler** is the Sheriff for Harford County and, in this capacity, is an agent of Harford County and the state of Maryland. As sued in his official and individual capacities, Defendant Gahler is a "person" acting at all times under color of state law under the federal and state constitutions and 42 U.S.C. § 1983. At all relevant times, Sheriff Gahler was an official with final decision-making authority and control over HCDC and the Sheriff's Department. He is directly responsible for (a) HCDC and Sheriff's Department policies; (b) the care and custody of persons detained at HCDC; and (c) the appointment, retention, supervision, training, and conduct of his officers, deputies, employees, and agents. Plaintiff Charles Morris also sues Defendant Gahler in his individual capacity for monetary damages.

21. **Defendant Daniel Galbraith** is the Warden of HCDC and, as such, is an agent of Harford County and the state of Maryland. As sued in his official and individual capacities, Warden Galbraith is a "person" acting at all times under color of state law within the meaning of

the federal and state constitutions and 42 U.S.C. § 1983. At all relevant times, Warden Galbraith was an official with final decision-making authority and control over HCDC, including its policies and personnel. He is directly responsible for the appointment, retention, supervision, training, and conduct of his officers, deputies, employees, and agents, and for the care and custody of persons confined at HCDC. Plaintiff Charles Morris also sues Defendant Galbraith in his individual capacity for monetary damages.

22. **Defendant Harford County**, the County where the events alleged herein occurred, is a local government and a "person" within the meaning of the federal and state constitutions and 42 U.S.C. §1983. Employees of the Harford County Sheriff's Office, including the Individual Defendants, are jointly employed by Harford County and the state of Maryland, making the County jointly and severally liable for their legal violations. Harford County and Maryland likewise share responsibility for operation of HCDC, which is a division of the HCSO, managed primarily by Sheriff's Office personnel. Harford County is a "public entity" under Title II of the ADA, 42 U.S.C. § 12131, and qualifies as a program or activity receiving federal financial assistance, covered by the Rehabilitation Act.

23. **Defendant State of Maryland** is a "public entity" under Title II of the ADA, 42 U.S.C. §12131, and further, is a program or activity receiving federal financial assistance, covered by the Rehabilitation Act. The State is jointly liable with Harford County for conduct of HCSO employees in violation of Title II of the ADA, 42 U.S.C. § 12010 et seq., and Section 504 of the Rehabilitation Act ("Section 504"), 29 U.S.C. § 794(a). Maryland is named as a Defendant (a) on Plaintiffs' claims seeking declaratory and prospective injunctive relief as a covered entity under the ADA and the Rehabilitation Act, and (b) as a responsible entity for state constitutional violations and torts committed by its agents under the Maryland Tort Claims Act.

FACTUAL ALLEGATIONS

I. DEFENDANTS ARE ENGAGED IN AN UNLAWFUL AND CONTINUING PATTERN AND PRACTICE OF DELIBERATE INDIFFERENCE TO THE SAFETY OF PEOPLE IN THEIR CARE

A. HCDC Officials and Staff Knowingly Disregard Established Legal and Medical Standards, Exacerbating Risks of Suicide-Related Harm to Vulnerable Detainees

24. Jails assume responsibility for the safety of the people they take into their care—people who come to them not having been convicted of any crime, often in crisis. That responsibility includes protecting against the leading cause of death in jails: suicide. As HCDC's own written policies expressly acknowledge: "*Correctional officers* ***are responsible for preventing suicides****–both legally and morally... Management and prevention of suicide is a critical area in which the correctional officer can be the difference between life and death.*"[4] Yet, as detailed below, Defendants have engaged in a reckless and deliberate pattern and practice of misconduct, violating their own policies and well-established correctional standards.

25. ***Deficient screening, monitoring and treatment.*** Because the vast majority of suicides and attempts in jails are committed by pretrial detainees within the first seven days of their booking, effective initial screenings and monitoring are vital. Frequently, people arrive at jail in crisis, facing new and acute stressors, including profound shame, frightening criminal charges, loss of freedom, and sudden isolation from friends, family, and support systems. They are disproportionately likely to be intoxicated or experiencing withdrawal from narcotics or alcohol, to have histories of mental illness or psychiatric disabilities, and to have missed their prescribed medications for mental health and other ailments, all of which increase suicide risk. Rather than engaging in any kind of meaningful evaluation, monitoring or treatment, HCDC officials regularly

[4] *Supra* note 2, at 1 (emphasis added).

wait until a person is either actively self-harming, or announces a specific intent to commit self-harm, before flagging the person as at-risk, flouting basic standards of care and their own policies.

26. ***Excessive reliance on isolation and solitary confinement.*** Solitary confinement significantly increases feelings of hopelessness and suicide risk. The National Study of Jail Suicides shows that two out of every three people who committed suicide in jail were being held in isolation.[5] Indeed, HCDC's Suicide Prevention and Crisis Intervention Manual dictates that "if a correctional officer believes an inmate is suicidal," the C.O. should ***not*** "[p]lace the inmate in isolation, even if the inmate is unruly or abusive, unless a special watch of continuous staff observation is initiated."[6] Yet, Defendants routinely violate this command. Further, HCDC (a) routinely places newly detained individuals in solitary confinement, confined to cells for 23 hours a day, precisely when they are at the greatest risk for suicide and (b) utilizes housing policies that invite solitary confinement as a knee-jerk response to nearly every kind of medical, mental health or other special need. Placing people already at increased risk of suicide or with mental health issues in solitary exacerbates those issues and increases suicide risk. Defendants know this.

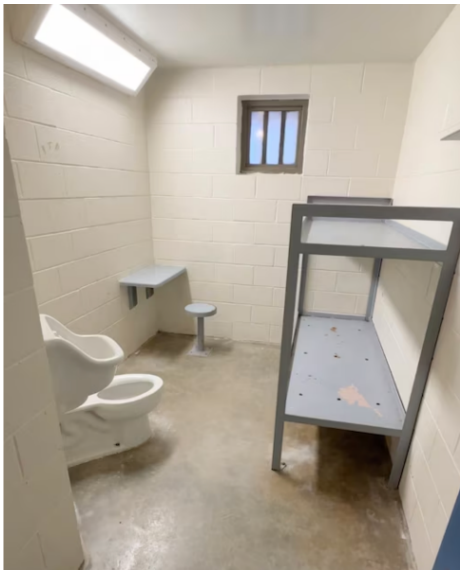
27. ***Deficient monitoring even for those identified as needing suicide or medical observation.*** Even when the jail *does* place people on suicide watch (or other medical observation), any monitoring and mental health care has often been so egregiously inadequate that people end up hurting themselves or dying anyway. Experts recognize that—in part because of the importance of communication and therapeutic engagement in mitigating feelings of hopelessness—remote surveillance alone is not enough for monitoring people who are suicidal. Cameras may supplement,

[5] Lindsay M. Hayes and Joseph R. Rowan, *National Study of Jail Suicides: Seven Years Later*, JAIL SUICIDE PREVENTION INFORMATION TASK FORCE: NATIONAL CENTER ON INSTITUTIONS AND ALTERNATIVES, 2 (Feb. 1988), https://www.prisonlegalnews.org/media/publications/hayes_and_rowan_jail_suicide_prevention_information_task_force_national_study_of_jail_suicides_1988.pdf.
[6] *Supra* note 2, at 12-13.

but do not substitute for, human contact, connection, and direct observation. As explained by Lindsay Hayes, a leading expert on preventing jail suicides, use of "[video surveillance] as an alternative to staff observation is not supported by national correctional standards … Despite its intended use, [video surveillance] does not prevent a suicide, it only records a suicide attempt in progress."[7] This too, Defendants know. Yet HCDC routinely relies on cameras instead of human monitoring. In fact, HCDC's reliance on video as a substitute for actual observation has been so deficient that individuals on "suicide watch" or other medical observation are essentially left unmonitored. Consequently, many of the jail's failures—including an individual rehearsing his suicide—were captured *on video*. In these types of emergencies, every moment of response time counts, but HCDC's excessive reliance on remote surveillance impedes their ability to intervene with people who are actively suicidal.

28. ***Protrusions easily used for hanging.*** Hanging is the top risk for jail suicide (93% of such deaths)[8], and of grave concern because serious brain damage and death can occur within a few minutes of oxygen deprivation. Given hanging risk, experts and common-sense counsel that, whenever possible, cells should be free of obvious, unnecessary protrusions that can be used for hanging, and that this is most crucial in cells housing people at risk of suicide. Yet HCDC routinely houses at-risk individuals in cells that have unnecessary bunks even after repeat incidents of bunks being used in suicides and suicide attempts.[9]

[7] Lindsay Hayes, *Report On Suicide Prevention Practices Within The Sacramento County Jail System: Sacramento, California*, Nov. 22, 2016, https://www.disabilityrightsca.org/system/files/file-attachments/%5B001-4%5D_Exhibit_D-Hayes_Report_2018-07-31.pdf; *See also* https://www.apt.ch/sites/default/files/publications/factsheet-2_using-cctv-en_0.pdf ("CCTV recording of cells to purposely prevent suicide attempts should not replace staff physically checking the situation of the persons concerned on a regular basis.").
[8] Morris L. Thigpen, et al., *National Study of Jail Suicide: 20 Years Later*, U.S. DEPT. OF JUST.: NAT'L INST. OF CORR., Apr. 2010, https://static.prisonpolicy.org/scans/SuicideStudy-20YearsLater.pdf.
[9] *Supra* note 1.



29. ***Degrading, isolative and punitive responses to suicidality.*** Rather than anything remotely responsive to the needs of those contemplating suicide, HCDC's version of "suicide watch" often involves putting people in solitary confinement cells on the restrictive housing unit or so-called "medical" cells in the detention center basement, removing all their property and clothing, and then putting them on some form of camera surveillance. HCDC's suicide manual stresses that people at risk of suicide should *never* be isolated or left alone. Neither should they be subjected to traumatic and unnecessary force, restraints, or otherwise punished for their suicidality or other mental health symptoms with degrading conditions. Yet HCDC routinely imposes inhumane conditions upon people who are in such anguish that they are contemplating or have attempted to take their own lives, causing egregious additional pain and suffering.

30. At HCDC, conditions of "suicide watch" are so extreme and unmitigated by any therapeutic response that they are more punitive even than *disciplinary* segregation. Among other things, Defendants routinely strip people of their clothing, pinning them down and literally cutting the clothing from their bodies or forcing them to undress in front of multiple officials; strip them of all personal possessions, denuding their cells and leaving some with nothing but a mattress;

deny them any human contact, confining them in solitary monitored by video (rather than face-to-face), and often precluding family members from seeing or contacting them; and in some instances, handcuff or even strap suicidal people into restraint chairs that completely immobilize them. Sometimes, HCDC's responses violate its own written policies governing suicide watch, which require that those in special confinement have access to normal activities, "clothing which is not degrading,"[10] and access to their personal items unless those items pose a risk of imminent danger.

* * *

31. In sum, HCDC's suicide rate of more than five times its peers is no accident, given the cascading impact of its deficient practices. Jail officials' reckless conduct and deliberate indifference create the perfect storm for self-harm: HCDC routinely isolates new admittees 23 hours a day in cells with the means to hang themselves, without adequate mental health screening, monitoring, or human contact, even after they have been identified as needing observation.

32. That HCDC officials frequently call upon their staff to intervene only after people are found hanging in their cells, and without *ever* assessing what could be done differently, fails the people in their care and staff alike.

B. Defendants Disregard or Exacerbate Obvious Red Flags for Suicide, Respond to Suicidal Ideation with Punishment, and Violate Their Own Written Policies, Resulting in a Devastating Pattern of Needless Human Suffering

33. Below, Plaintiffs trace in chronological order the disturbing record of pain and suffering wrought by Defendants' pattern of unlawful actions and omissions, beginning in 2019, as the NAACP began to amplify its previous calls for accountability and reform. The examples below largely recite facts from HCDC's own incident reports, obtained by the NAACP. Sadly, these are merely illustrative; there are many others.

[10] HARFORD COUNTY SHERIFF'S OFFICE DETENTION CENTER POLICY: SPECIAL CONFINEMENT, 9 (2024).

34. **On April 10, 2019**, Mr. Marlyn Barnes, a 30-year-old father of five, died after using a sheet from his bunk to hang himself within a day of arriving at HCDC. According to news reports in the *Afro*, HCDC investigators acknowledged that he had disclosed wanting to take his own life.[11] He was reportedly extremely distressed. HCDC failed to inform Mr. Barnes's family of the details of his death, leading them to suspect foul play. They heard only months later that the Medical Examiner issued a report classifying the death as a suicide, doing little to quell the family's suspicions and pain. At the time, his mother told reporters that she just wanted to know the truth about what happened to her son. His death was the subject of protests led by activists in the Black community outside the jail.

35. **Less than a month later, on May 1, 2019**, Thomas "Tommy" Pardew took his life by hanging. Mr. Pardew had been at the jail less than a week. According to news reports, footage captured Mr. Pardew practicing how he would hang himself—without interruption by HCDC staff—while supposedly on "suicide watch."[12] HCDC personnel, in violation of their own policy, failed to observe Mr. Pardew on an ongoing basis, or even at 15-minute increments. Indeed, after Mr. Pardew tied his jail-issued pants around his neck and then to the cell bars, more than 30 minutes passed before his limp body was discovered by correctional staff.

36. According to news reports, the nurse watching Mr. Pardew on video the day he died logged a ***false*** entry claiming he was lying on his bunk alive after he had already been hanging for more than 20 minutes.[13] Critically, jail officials' own reports acknowledged both the falsification of crucial records and the potential cause: The nurse told detectives she was responsible for

[11] Special to the AFRO, *Suspicious Deah Raises Questions*, AFRO, Aug. 30, 2019, https://afro.com/suspicious-death-raises-questions/.
[12] *See* Ben Conarck, *System Failure: How a Man Killed Himself on Suicide Watch in the Harford County Jail*, THE BALT. BANNER, Feb. 15, 2024, https://tinyurl.com/ywvtzjmz.
[13] *Id.*

monitoring more than five detainees on her third day of employment. Despite this egregious failure that cost Mr. Pardew his life, jail officials took no remedial action. When asked by a reporter how the jail addressed the matter, Defendant Gahler said he couldn't remember the details, while disclaiming any responsibility.

37. Defendants' failures led to another tragic and preventable death the following year. On **April 24, 2020**, deputies found Randy Gisiner hanging from a sheet tied to the top bunk in his cell. Mr. Gisiner had previously been on suicide watch with drug detoxification protocols, but he was moved off suicide watch into another cell, where he was improperly subjected to isolated confinement without adequate monitoring or medical treatment. Within 48 hours, he had deteriorated so severely that he hung himself using the plainly unnecessary upper bunk. His lifeless body was only discovered accidentally, because officers preparing to do shakedowns happened upon him. HCSO assigned its own detectives to investigate the incident, and no reforms came of it.

38. As in Mr. Gisiner's case, HCDC staff routinely miss signs that people are deteriorating to the point of no return. For example, on **October 17, 2020**, HCDC staff discovered a detainee, "Mr. A," lying in a pool of his own blood and moaning after slashing himself with razors that HCDC staff provided him. According to incident reports, when officers responded, they saw the entire cell floor, walls and toilet bathed in blood. The victim's shirt was drenched in his own blood, and he had written a message in blood on the cell wall. Despite repeated radio calls for tourniquets and other assistance, medical staff were slow to respond. One staffer stated that medical needed to "step up." Mr. A was taken to a hospital by ambulance.

39. The tragic deaths of Mr. Pardew and Mr. Gisiner are not the only instances where Defendants' excessive reliance on remote surveillance as a substitute for suicide watch,

particularly combined with excessively punitive conditions on suicide watch, exacerbated the risk of self-harm. On **February 11, 2021**, "Mr. B" was ostensibly being monitored on continuous "suicide watch" via camera, subjected to withholding of all of his personal property, and expressing frustration with his continued isolation. Despite these escalating red flags, Mr. B was left in solitary confinement, where he was able to climb the bars of his cell, tie one end of his blanket to the bars, the other around his neck, and hang himself—all before a nurse purportedly providing continuous monitoring noticed, radioed correctional officers, and HCDC officers were able to untie the blanket. Only after being restrained in handcuffs and leg irons was he taken to the hospital.

40. Less than a week later, on **February 16, 2021**, "Mr. C" was ostensibly on suicide watch in HCDC's T dorm. Despite being on suicide watch, Mr. C managed to attach his shirt to the top corner of his bunk and hang himself before an officer touring the dorm found him. HCDC's response was to put him on remote surveillance in the restrictive housing unit.

41. A few months later, on **July 3, 2021**, Jack Lazar was admitted to the jail on minor trespassing and "criminal mischief" charges. At his intake, he disclosed his medical and psychological history. Because he was in drug withdrawal, staff placed him on medical observation requiring 15-minute checks, reduced to 30 minutes on July 6. After an incident requiring overnight hospitalization, Mr. Lazar confided to medical staff that he was struggling with his first-ever incarceration and was unable to reach his family. Despite displaying worsening mental health symptoms based on his isolation, he was sent back to solitary without adequate monitoring. His cell had an unnecessary bunk bed. The next day, July 10, correctional staff found Mr. Lazar unconscious and hanging from the top bunk with a sheet tied around his neck. He never recovered, dying four days later.

42. In some particularly horrifying instances, HCDC staff respond to suicidal persons with handcuffing and shackling, threats of force, tasing, forcible undressing, or traumatic "restraint chairs"—all under the guise of protecting detainees from themselves. For example, on **June 20, 2022**, "Mr. D" was seen attempting to tie a blanket to the bars, in apparent preparation for suicide. Mental health staff apparently decided to place Mr. D on suicide watch. In response, jail staff sought to remove Mr. D's property from his cell. When he objected, instead of attempting to de-escalate or involve mental health staff, multiple deputies violently entered the cell, struck Mr. D with a shield, pinned him to the wall, and forcibly handcuffed him to the bed before cutting off his pants with shears and stripping all his clothing. Defendants then removed all property from Mr. D's cell, and threatened to tase him if he moved after they removed the cuffs.

43. It is sometimes hard to fathom what more HCDC staff need to recognize that someone in their charge desperately needs help. For example, "Mr. E," a veteran, repeatedly asked to speak with mental health staff. According to an incident report, Mr. E "had been drawing several graphic pictures of a figure being hung from a tree and posted them on his cell door." **On June 27, 2022**, staff found Mr. E hanging in his cell. After they cut him down, he was choking and unable to control his extremities. Staff found a suicide note in his pocket and multiple notes and drawings relating to suicidal thoughts in his cell. Yet, somehow, HCDC staff had failed to adequately identify Mr. E as at risk—despite the many warning signs, mental health staff claimed to investigators that he "showed no signs" of suicide risk. This was yet another lost opportunity for HCDC officials to examine how their screening practices were routinely missing suicidal patients.

44. HCDC staff regularly appear to assume that people who are disruptive, confrontational, or even those who simply make requests of staff, cannot ***also*** be suicidal, let alone at ***increased*** risk. As a result, staff improperly dismiss real risks of harm as feigned attempts to

secure some benefit, particularly for people with mental health disabilities. This violates well-established standards and HCDC's own suicide manual, which explains the dangers of dismissing suicide risks: First, of course, is that such dismissals of suicidality may be factually wrong. Second, is that, regardless of motivation, people engaging in self-harm are at risk of injury or death, even if accidental.

45. For example, "Mr. F" displayed symptoms strongly suggestive of serious mental health issues, including throwing feces. On **September 28, 2022**, after other detainees called for help, HCDC staff found Mr. F with a string tied tightly around his neck. Although Mr. F "had started to turn purple," and despite medical staff determining that Mr. F needed urgent hospital treatment, jail officials expressed that he was not "actually" suicidal, but merely trying to manipulate them. Perhaps because of this disbelief, less than two weeks later, while on "suicide watch," Mr. F was able to make a second, very serious attempt on his own life.

46. On **January 21, 2023**, Defendants' failures led to another death, when Nathaniel Powell, Jr., son of NAACP member Nathaniel Powell, Sr., was found hanging in his cell. Jail officials missed obvious warnings that he was suffering from serious symptoms of depression and drug withdrawal, leaving him to deteriorate into such anguish that he took his life. At his initial screening on January 18, Mr. Powell worried about the serious losses he was facing and confessed that other family members had attempted suicide. The screening also indicated that Mr. Powell was an extremely heavy user of opiates and had previously experienced withdrawal symptoms. He was flagged for an "urgent" mental health visit, but received only a flyby intake screening at his cell door with an HCDC staffer nearly 12 hours later. Even with just this cursory review, the staffer noted that Mr. Powell presented symptoms of depression and was "detoxing heavily and requested to remain in cell area for assessment." Although medical information available to her indicated

that Mr. Powell had been hospitalized as a child for "emotional, mental health, and/or psychiatric problems," this staffer did not seek any clarification or elaboration.

47. HCDC thus improperly designated Mr. Powell as "low risk" for suicide, contrary to its own suicide prevention manual and its own staff's observation that Mr. Powell was in active withdrawal, showing symptoms of depression, and had a history of mental illness. Instead, HCDC designated Mr. Powell solely for periodic detox monitoring. Defendants then placed Mr. Powell in 23-hour-per-day solitary confinement in a cell with a dangerous bunk bed, without any treatment, and staff substituting cursory cell-side screenings for meaningful assessments of his plainly worsening condition. Indeed, staff acknowledged Mr. Powell's statement that he was in "excruciating pain." A *Baltimore Banner* article reports that detainees in nearby cells heard Mr. Powell "repeatedly calling for medical attention" and that "[w]hen those in cells near him feared he hanged himself, they called for deputies, who did not respond for at least fifteen minutes."[14] By the time Mr. Powell was found hanging in his cell, according to reports, he had no pulse. As explained in greater detail below, in the aftermath of Mr. Powell's tragic death, jail officials rebuffed efforts by his family and the NAACP to address the serious harms at the jail, and attempted to cover up their misconduct, even withholding his suicide note.

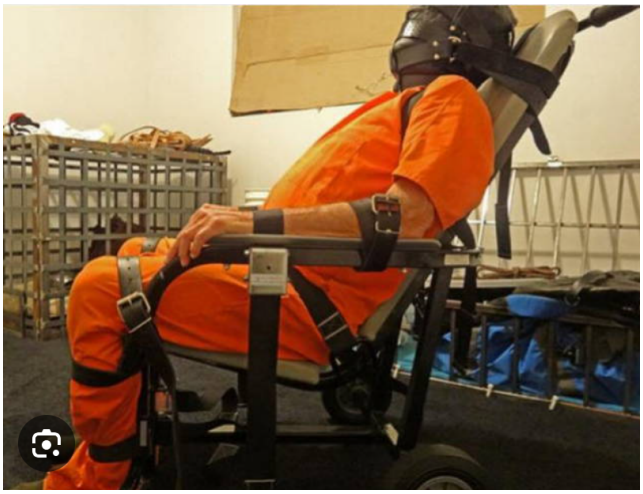
48. Less than two months later, the jail's perfect storm of deficient screening, deficient monitoring, and solitary confinement in cells with suicide-prone bunks led to another suicide attempt. **On March 9, 2023**, "Mr. G" was found unresponsive in his cell, hanging from a sheet attached to his bed frame. After the sheet was cut down, he was not breathing normally and was choking. He had been at the jail for five days on minor charges of an alleged violation of probation bench warrant for theft and acting as a contractor without a license. Although he had been referred

[14] *Supra* note 1.

to mental health staff and identified as having a special medical need, he did not receive the counseling or monitoring he needed. According to an incident report, he believed he would be bailed out shortly after arrival, given the minor nature of his charges. As the days passed and he remained in solitary confinement without any meaningful access to mental health treatment or basic social contact, he deteriorated and became so acutely distressed that he hung himself.

49. A **March 22, 2023** incident again illustrates HCDC's improper reliance on excessive force as a primary response to suicide attempts. "Mr. H" was already on suicide watch due to a prior suicide attempt, housed in HCDC's restrictive housing unit, and appeared to be experiencing symptoms of mental health disabilities. He again attempted to kill himself by hanging himself with a makeshift noose fashioned from his suicide smock and jumping from his bunk. Officers responded violently, with four officers pinning Mr. H onto his bunk, flipping him to his stomach, and handcuffing Mr. H—despite the fact that Mr. H offered what HCDC records describe as "passive" resistance to being handcuffed. Then, according to incident reports, corrections officers—not medical staff—ordered that Mr. H be placed in a restraint chair, to which he objected. His objection was not unfounded. The United Nations Committee Against Torture has urged the United States to abolish such chairs, which have straps that prohibit any movement, as in the example shown below from the Pennsylvania prison system.[15]

[15] Sehu Kessa Saa Tabansi, *From a Pennsylvania prison: The torture chair*, WORKERS' WORLD, Jan. 2, 2017, https://www.workers.org/2017/01/28411/.



Restraint chairs are an extreme response to be used only when there is no other way to protect someone under the supervision of medical staff, and for the shortest possible duration needed. Before confining him to a restraint chair, deputies had every opportunity to de-escalate, e.g., by engaging medical staff or merely waiting a few moments to allow a traumatized person to collect himself. Instead, *they* escalated, forcibly shackling him into the restraint chair while he, quite predictably, tried to resist. Correctional staff decided to keep him in the chair for two hours.

50. In yet another instance illustrating Defendants' punitive approach to mental health disabilities, on **June 11, 2023**, staff at the jail observed "Mr. I" banging his head against a wall while in solitary confinement. Correctional staff handcuffed him, and he struck his head against the wall one more time but was otherwise compliant. In lieu of, for example, moving him away from the wall and engaging medical staff in a de-escalating conversation, or providing Mr. I with medical services, several correctional officers responded with excessive force, strapping Mr. I into a restraint chair.

51. A few months after Mr. G almost succeeded in killing himself by hanging in solitary confinement, there was a nearly identical hanging attempt in the very same cell. **On June 21, 2023**, staff again found someone in their care, "Mr. J", hanging from the top bunk after being kept in

solitary. He had left a suicide note. Upon information and belief, Mr. J had not been adequately screened, monitored or treated by mental health staff, who again failed to identify someone plainly at risk of self-harm. According to an incident report, Mr. J was found only because he had covered his cell window, and staff went to the cell door to investigate. When they cut him down from the bunk, he was not responsive. He was taken to the hospital, where he told medical staff that he was going to keep trying to kill himself until he succeeded.

52. **On September 16, 2023**, "Mr. K", who was housed in a unit for persons identified as a danger to themselves or others, met with mental health staff. Although he was agitated, mental health staff failed to follow up. Later that day, he tried to kill himself. Mr. K had time to pen a suicide note, place a plastic bag over his head, fasten a noose of bedsheets around his neck, tie the other end to his bunk, and go limp. His serious suicide attempt was discovered by chance when a deputy collecting dinner plates noticed his suicide note and looked into the cell. Staff untied him. He fell to the ground and curled into a fetal position, moaning. He was taken by ambulance to the hospital, where officials acknowledged he was so gravely ill that they sought an involuntary emergency commitment.

53. The following month, **on October 28, 2023**, another suicidal person missed by HCDC screenings, "Mr. L," managed to tie a sheet around his neck and the bars of his cell near the top bunk, while in solitary confinement on HCDC's restrictive housing unit and monitored by camera. He was preparing to jump when officers cut him down and proceeded to pin him against the wall of his cell and handcuff him. Rather than providing counseling or mental health support, mental health staff put him on "suicide watch," in this instance simply returning him to the same cell without any possessions other than his mattress.

54. The trend of monitoring failures allowing suicidal people to injure themselves while purportedly under close observation continued on **April 16, 2024**. "Mr. M" had been at the jail since April 10 on a minor theft charge and was purportedly on "medical observation." HCDC staff saw him upset and crying, pleading for his medication, and aggrieved by the isolation of solitary confinement. A few minutes later, his attempts to hurt himself were caught on video, albeit unseen by his medical "observers". He was repeatedly punching, twisting, bending, and "assaulting" his left wrist, and positioning himself to find ways to smash, kick, or otherwise scrape it against his cell. After several minutes of this, he apparently realized he could use his sheet to hang himself, and he proceeded to spend several more minutes doing exactly that. It was only after staff saw "legs hanging in RHU 4" that they responded. According to HCDC records, most of Mr. M's wellness checks that day were "late." After the incident, Mr. M reiterated that his solitary confinement had driven him to self-harm.

55. Less than a month later, on **May 7, 2024**, another shocking death occurred at HCDC, this one involving a woman purportedly on suicide watch and in withdrawal from opioids. According to a report prepared by the Maryland Medical Examiner, Brittani Ugrotzi was on suicide watch when she died of respiratory failure associated with symptoms of her withdrawal from opioids, sepsis, and COVID. Despite being on suicide watch, and ostensibly subject to 15-minute checks for her well-being, *at least two hours* elapsed between Ms. Ugrotzi's last contact with staff and when she was found unresponsive. Equally horrifying, based on the information available, it is impossible to understand how Ms. Ugrotzi would have progressed to the point of death within two hours. She had been at the jail for four days. As her symptoms worsened, she should have received basic medical care and, if necessary, been taken to a hospital for emergency care. Defendants' grossly neglectful "monitoring" likely cost Ms. Ugrotzi her life.

C. Plaintiff Charles Morris Nearly Died as a Result of Defendants' Willful and Deliberate Indifference

56. On **August 2, 2024**, while in isolation, Charles Morris tied a noose from his pants and attached it to his upper bunk, stood on his lower bunk, and jumped off. The next time he opened his eyes, he was in the hospital and had been in a coma for three days. Every aspect of Mr. Morris's tragic suicide attempt—missed warning signs, inadequate monitoring and treatment, and solitary confinement in a dangerous cell—follow Defendants' unconscionable, longstanding and un-remediated pattern. Indeed, an HCDC nurse admitted that Mr. Morris should have been placed on suicide watch based on his comments and behavior.

57. During Mr. Morris's initial screening (with HCDC's Felina Talabert, at about 9:50 on the morning of his suicide attempt), Mr. Morris presented clear warnings of crisis, vulnerability to self-harm and psychiatric disabilities. To begin, he had recently been at a residential substance use program. His mother, with whom he lived and for whom he had been a long-term caregiver, recently died. He confided to staff that he was stressed about his ability to cope with all that emotionally, that he had diagnosed major depressive and bipolar disorders, and that he stopped taking his prescribed psychiatric medications prior to his arrest. He also disclosed that he had previously been prescribed medication for a seizure disorder, and that after he stopped taking that medication two to three months prior, he had suffered a recent seizure.

58. Although Ms. Talabert recorded all this and observed Mr. Morris was "anxious," "visibly depressed," and "tearful,"—notwithstanding that HCDC's own Suicide and Prevention Manual specifically enumerates red flags for suicide that are on all fours with Mr. Morris's screening—Mr. Morris was not flagged for special housing, monitoring, or medical attention necessary and appropriate to his circumstances, in direct violation of HCDC policies. Rather, he

was referred for a mental health visit and HCDC staff cruelly isolated him in a cell by himself 23 hours a day.

59. The purported mental health "visit" was just another flyby cell-side screening with Mackenzie Scarff who indicated in her written notes that Mr. Morris was "subdued," "unable to identify any reasons for living," and "overwhelmed." These were major red flags, but further assessment was nevertheless deferred.

60. Four hours later, a mental health staffer, Mercy Obeng, "attempted" to evaluate Mr. Morris by calling him out to a common area, where she observed that he "appeared depressed, and sad (tearful). He sat down with his head bowed down and was reluctant to talk." After answering a question about medication, Mr. Morris stopped answering questions. At that point, it should have been overwhelmingly obvious to the multiple jail staff who had interacted with Mr. Morris that he was in severe psychological distress and at serious risk of self-harm. According to HCDC's own suicide manual, he should have been put on suicide watch with continuous monitoring and offered more mental health support. Instead, like the many others failed by HCDC before him, he was sent back to his cell that Friday, with no plans for mental health contacts or treatment until Monday.

61. As the evening progressed, Mr. Morris was increasingly despondent. Like so many before him, Mr. Morris began to believe his only option was to end his life. Also, like so many before him, he turned to the obvious protrusion—the wholly unnecessary bunk bed in a cell where he was alone—as his means of doing so.

62. Because Mr. Morris had not been provided continuous monitoring, as HCDC's policies for suicidal detainees require, his suicide attempt was not discovered until a deputy (Deputy First Class Parker, Badge #1427) walked by and found him "hanging from detainee striped pants tied around his neck" with the other end "tied to the top corner of the top bunk." The

Deputy went in, called a Code Blue for help, and tried to hold Mr. Morris's weight. When other deputies arrived, they cut away the pants and lowered him to the floor. Mr. Morris was not responsive. They could not find any pulse and were forced to begin chest compressions, and then to use a defibrillator. Emergency personnel arrived and transported Plaintiff to Bayview Hospital.

63. Doctors confirmed that Mr. Morris very nearly died at HCDC. Prior to arriving at the hospital, he had a seizure from inadequate oxygen. He arrived at the ER suffering from cardiac arrest and acute hypoxic respiratory failure. He also suffered wounds to his neck, pains in his chest and leg, and other ailments. The hospital sedated him into a coma and intubated him for approximately three days. Mr. Morris remained in intensive care for nearly a week.

64. While Mr. Morris lay comatose shackled to a hospital bed, at risk of further emergent medical crises at any moment and under the guard of two Sheriff's deputies, Defendant Galbraith improperly tried to hide Mr. Morris's near-death from his sister and next-of-kin, DeVora Jones, a longtime NAACP member who is also a correctional nurse. Egregiously, the warden deliberately refused to contact Ms. Jones, repeatedly claiming to hospital staff, without any reasonable justification, that merely *notifying* the family of Mr. Morris's grave medical condition would somehow risk the safety of his staff. Callously, he told hospital staff that he would only notify the family in the event of Mr. Morris's brain death.

65. The warden's actions while Mr. Morris was hospitalized subjected Mr. Morris to unnecessary medical risks and violated the law. In addition to other constitutional imperatives relating to the rights of autonomy and close personal relationships, Maryland's Correctional Standards for Adult Detention Centers require the collection of next-of-kin information from detainees upon admission, so that "[i]n cases of death or serious illness/injury of an inmate, the

managing official or designee *will initiate contact* with the next of kin identified by the inmate a[t] admission *at the earliest opportunity*."[16]

66. These standards explicitly recognize the commonsense principle that close family members have an important interest in the health and safety of their loved ones, regardless of whether they have been arrested, and that next of kin are a crucial source of vital personal history and other information when someone is incapacitated—for example, deeply held personal wishes about end-of-life decisions. Health and medical decision-making are of vital constitutional significance, and recognized as strong interests that survive arrest and detention.

67. Anyone who has lived through a medical emergency knows that every moment matters, and that personal medical histories often affect which courses of treatment are appropriate. Defendant Galbraith's deliberate cover-up thus not only deprived Mr. Morris's family of any legal rights to exercise medical judgment on Mr. Morris's behalf when he was unable to do so for himself, but also needlessly exposed Mr. Morris to unwarranted medical risks. Of equal import to Mr. Morris and his family, and all NAACP members, Mr. Morris was on the verge of death. The warden's cover-up could have prevented them from saying goodbye.

68. Defendant Galbraith went so far in this effort to cover up Mr. Morris's suicide attempt as to unlawfully involve himself in medical consents. When the hospital asked who would make medical decisions for Mr. Morris, the warden falsely claimed that, instead of Mr. Morris's actual next of kin, *he* was the decision-maker for medical consents, flouting fundamental constitutional and Maryland law. Nowhere does federal or state law or any Maryland correctional standard authorize a jailer to insert himself as the medical decision-maker for anyone in his

[16] Department of Public Safety and Correctional Services: Maryland Commission On Correctional Standards, *Adult Detention Centers Standards Manual*, at 35, https://www.dpscs.state.md.us/publicinfo/publications/pdfs/MCCS/STANDARDS%20MANUAL%20-%20ADC-4-2020%20(Revised).pdf. (emphasis added).

custody. It is plainly unethical for jail officials to refuse to contact next of kin in a life-threatening emergency and then insert themselves as medical decision-makers on the grounds that next of kin are not available.

69. Even after his return to HCDC from his near-death hospitalization on August 11, 2024, Mr. Morris's ordeal continued through Defendants' use of excessively isolative and degrading conditions under the guise of HCDC's unnecessarily punitive "suicide watch." He was moved from his room at Bayview into an isolation cell at HCDC in handcuffs and shackles. Jail staff required him to remove all his clothing other than a single pair of thin shorts. It was degrading. He was left practically naked in a cold cell without bedding, except a single blanket. The jail had removed every single item of property from the cell—he was left with nothing to read or do except sit alone in the cell and feel miserable under the watch of a surveillance camera. In direct violation of HCDC policy, Mr. Morris was kept in this cell for 23 hours or more each day and cut off from any contact with his family.

70. Mr. Morris thought he was being punished for his suicide attempt, making him feel "more hopeless," and as if he were being condemned to failure.

71. Mental health nurses checked on Mr. Morris at the doors of his isolation cell, but he did not receive a mental health screening until a full day had passed. At that time, Mr. Morris told mental health staff that he was struggling to cope with the extreme isolation. Over several days, whenever he had an opportunity to speak with staff, Mr. Morris expressed his sense of profound physical discomfort, isolation, and anguish, begging for additional clothing and blankets and anything that could help him pass the time, such as books.

72. Mr. Morris was also isolated from his family, external support systems, and even other people being held at the jail. Other than a call immediately upon his return to the jail, at least three days passed before he was permitted to make any other call.

73. On August 15, 2024, mental health staff recommended that Mr. Morris be released from suicide watch and returned his personal property. Yet, he remained in solitary confinement until August 19, confined to a cell for 23 hours a day under camera surveillance. Plainly, HCDC knows that this type of solitary confinement is risky and harmful to mental health, given that when transferred to the general population, HCDC placed Mr. Morris on "Do not house alone" status.

74. Mr. Morris's traumatic near-death experience while awaiting his exoneration at trial was completely preventable and could have been mitigated in any number of ways. But Defendants, having failed to self-correct despite years of notice, failed to conduct adequate screening, failed to house him safely, and failed to afford Mr. Morris the monitoring his condition necessitated—all while repeatedly violating their own policies. Because of their failures, to this day, Mr. Morris suffers from the lingering psychological and physical impacts.

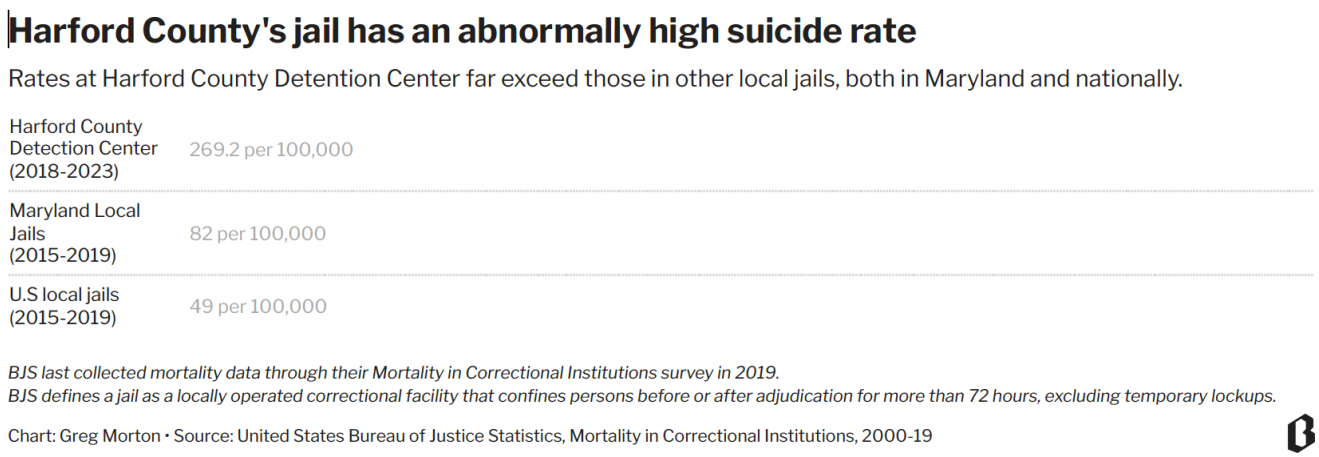
75. Shockingly, after Mr. Morris's near-fatal suicide attempt, instead of investigating why HCDC kept nearly killing people in its custody, Defendant Gahler issued a press release celebrating HCDC's success in "saving" Mr. Morris's life and falsely claiming that Mr. Morris "did not present any indications of trying to harm himself."[17]

[17] News Release, *Harford County Sheriff's Office releases Data on Suicide Rates at the Detention Center*, Aug. 16, 2024, https://harfordsheriff.org/news/releases/hcso-releases-data-on-suicide-rates-at-the-detention-center/.

D. HCDC Officials at the Highest Levels Ignore and Minimize the Overwhelming Evidence of Risk, Forcing NAACP Officials and Members to Intervene

76. Notwithstanding the devastating pattern of pain and death at HCDC catalogued above, Defendants shrug it off as business as usual at an American jail. They disclaim responsibility and contend nothing can stem this tide of killing and agony. Not so.

77. As the *Baltimore Banner* reported in February 2024, data show that deaths by suicide at HCDC far exceed those among local jails elsewhere in Maryland and across the country:



78. The foregoing data comes from one of two explosive *Baltimore Banner* articles published in February 2024, detailing the appalling pattern of suicides at the jail.[18] Among other things, the *Banner* investigation found that, in addition to HCDC's distressingly high suicide rate, the suicides were "eerily similar" to one another.[19]

79. But even in the face of media scrutiny, Defendants made no changes. The Sheriff's response to the *Banner*'s findings was to claim that other jails cover up suicides. The Sheriff also "declin[ed] to address questions and experts' concerns about [HCDC's] use of isolation in the first

[18] *Supra* notes 1, 12.
[19] *Supra* note 1.

few days of incarceration."[20] Similarly, Defendant Galbraith blithely rejected the suggestion of removing bunkbeds where newly admitted pretrial detainees are isolated to eliminate a key implement of suicide. He stated, "If I was to take off the top bunk, you'd be eliminating half the bedding space that I have in my jail,"[21] an excuse that defies logic, given that the bunkbeds at issue are in cells used for solitary confinement.

80. Ignoring reality, Defendant Gahler contended that "'We've never had an issue during my tenure with finding that one of our employees did not operate within our policies, or that there was any wrongdoing associated with it.'"[22] Gahler also disavowed responsibility for medical providers that he chooses. And while conceding "that there was 'concern' about a 'time check' in one of the five suicides on behalf of a medical staff member," he claimed ignorance and "contended that 'none of the issues with the checks or the timings' of any of the five suicide deaths 'had anything to do with Sheriff's Office personnel.'"[23]

81. Rather than genuinely investigating options to mitigate suicide risk, the HCSO's approach is to use criminal investigators who are themselves Sheriff's deputies to determine whether a ***crime*** occurred, rather than determining what could be done to prevent or limit further suffering and losses of life, or whether HCDC violated its constitutional obligations or its suicide prevention policies.

82. Given Defendants' recalcitrance, the NAACP has had to take a variety of actions over the course of many years, culminating in this suit. Among other things, the NAACP has repeatedly received and responded to ongoing complaints or other reports concerning suicide, lack

[20] *Id.*
[21] *Id.*
[22] *Supra* note 12.
[23] *Id.*

of medical and mental health services, and other poor conditions at the jail impacting the NAACP, its members, and the community the organization serves.

83. In January 2023, the NAACP learned that Nathaniel Powell Jr. lost his life at the jail due to Defendants' deliberate indifference to his medical needs while he languished in solitary confinement. Mr. Powell's father, Nathaniel Powell Sr., feared that his son had not, in fact, killed himself, but had been hurt by staff at the jail. Egregiously, HCDC never told Mr. Powell about his son's suicide note; he had to learn about it from a reporter and pursue an intensive administrative process before finally receiving it, with support from the NAACP.

84. Alarmed at the mounting death toll and fearful for their members' safety, the NAACP organized a February 3, 2023 meeting and tour of HCDC with members of its Legal Redress Committee and Defendants Gahler, Galbraith, and other jail staff. During the visit, it was noted that the cells for medical segregation were unused at that time, purportedly due to staffing shortages, highlighting the lack of protective options for medically vulnerable individuals.

85. Soon after, however, the NAACP received further complaints about Defendants' continued failure to provide needed medical and mental health services, including a July 29, 2023 complaint from a mother concerned that her daughter had been denied medication for four days while held at the jail; complaints on November 30 and December 1 of the same year from the loved one of a man who reported not receiving medical attention at the jail despite experiencing auditory hallucinations; and an April 23, 2024 complaint seeking support for the relative of an NAACP member, who shared that their requests for medical and mental health support were ignored among other mistreatment while detained at the jail.

86. In follow up, representatives from the NAACP again took action. Members of the organization's Legal Redress Committee toured the jail on June 14, 2024, where they again met

with Defendants Gahler, Galbraith, and other jail staff about how best to remedy deadly conditions at the jail. But NAACP members still left concerned that HCDC officials were responding performatively, while taking no real steps to mitigate the risks at the jail that posed threats to their members.

87. The NAACP received yet another complaint about HCDC on July 4, 2024, cementing their concerns about Defendants' failure to remedy risky conditions. This time, a relative sought help for a man suffering from being reportedly held in solitary confinement upon entry to the jail and denied needed medication. In an email response to outreach by the NAACP on the man's behalf, Defendant Galbraith dismissed the reality of the harmful and well-documented isolation imposed on those awaiting trial, curtly stating "[a]s I had shown you from your previous tour and visits to the Harford County Detention Center, we don't have solitary confinement cells or housing."

88. Less than a month later, NAACP member Charles Morris attempted to take his life at the jail. Even while Defendants tried to cover up his near-death from his family, Sheriff Gahler issued a press release misrepresenting Mr. Morris's suicide attempt and aiming to cast the jail as blameless in any suicide or suicide attempt.

89. In the ensuing months, the NAACP continued to strategize about how it could protect its members, eventually filing a November 2024 public records request seeking more information about suicide attempts that occurred at the jail. The incident reports obtained pursuant to this request confirmed their worst fears: the failures at the jail were even more widespread than they had previously known, and jail officials' claims that there was nothing else to be done were blatantly untrue.

CAUSES OF ACTION

COUNT I
Fourteenth Amendment to the U.S. Constitution, 42 U.S.C § 1983, and Articles 19 and 24 of the Maryland Declaration of Rights
Deliberate Indifference to Unconstitutional Conditions of Confinement Exacerbating Risk of Suicide and Serious Medical Needs
(All Plaintiffs Against All Defendants)

90. Plaintiffs incorporate and reallege the allegations of all preceding paragraphs.

91. By their policies and practices, acts, omissions and deliberate indifference to harms described above, Defendants have engaged in an unlawful pattern and practice of willfully subjecting Plaintiffs, their members, and loved ones to substantial risk of serious mental harm, physical injury, suffering and death through abusive conditions of confinement and constitutionally inadequate medical care.

92. Defendants have established and entrenched an unlawful policy, practice and custom of failing to adequately protect or provide adequate care for individuals at risk of suicide, primarily persons held pretrial, among those in their custody. Rather than protecting against risks or providing appropriate and necessary care to vulnerable detainees, Defendants instead knowingly engage in practices that together *heighten* risks of suicide and result in needless pain, suffering and death among people incarcerated at HCDC and their loved ones. This includes by:

a. Failing to properly screen individuals for risk of suicide;

b. Failing to properly monitor individuals at risk of suicide;

c. Placing individuals at risk of suicide in solitary or other isolated confinement, in violation of HCDC's own written policies;

d. Isolating individuals at risk of suicide in cells with superfluous upper bunk beds creating implements for suicide;

e. Responding to suicidal ideation with punishment rather than treatment, thereby exacerbating the risk of harm; and

f. Ignoring their own incident reports documenting repeated, similar suicide attempts while seeking to cover their failures and wrongdoing by falsifying records and denying information and access to family and loved ones of those harmed in their facilities, including Plaintiffs.

93. The cumulative effect of Defendants' failures, which serve no legitimate penological purpose, pose unacceptably high risks of, and have actually caused, significant mental and physical suffering.

94. Defendants know or should know of the grave risks their practices pose to people in pretrial detention, given the warnings inherent in the egregious record of suicides and self-harm among people in their care. In failing to heed these warnings by taking corrective measures, and by continuing to engage in a policy and custom in violation of detainees' due process rights and HCDC's own policies, Defendants directly caused harm to a long line of people in their care, including specifically Plaintiff Charles Morris, his loved ones, and other NAACP members.

95. Even after identifying people at risk in their care, Defendants fail to take adequate steps to protect against self-harm through deficient suicide protocols by subjecting those at risk to unnecessarily dangerous and harsh conditions in violation of their own policies and established correctional standards, putting them in punitive conditions more extreme than HCDC disciplinary segregation, and even using excessive force.

96. These policies and practices, acts and omissions have been, and continue to be, carried out by Defendants, their agents and employees under the color of law and are the proximate cause of Plaintiffs' ongoing deprivation of rights secured by the Fourteenth Amendment to the U.S. Constitution.

97. Defendants' failure to protect and denial of adequate care to people in their custody is the result of an objectively unreasonable response to substantial risks of suicide and pretrial detainees' serious medical needs, and causes the unnecessary, wanton infliction of pain and

suffering, and denial of substantive due process to Plaintiffs, in violation of the Fourteenth Amendment to the U.S. Constitution, as enforced through 42 U.S.C. §1983, and Articles 19 and 24 of the Maryland Declaration of Rights.

98. Plaintiff NAACP's members have suffered and will continue to suffer irreparable injury, including physical injury, mental and emotional distress, and even death.

COUNT II
Americans with Disabilities Act Title II
(All Plaintiffs Against State of Maryland and Harford County)

99. Plaintiffs incorporate by reference the allegations of all preceding paragraphs.

100. Defendants State of Maryland and Harford County each qualify as a "public entity" as defined under Title II of the ADA. *See* 42 U.S.C. §12131, 28 C.F.R. 35.104. As such, these Defendants jointly share responsibilities for compliance with the ADA and its implementing regulations, including by establishing adequate practices and procedures to accommodate people with disabilities in their custody and ensuring compliance.

101. Plaintiff Charles Morris and other NAACP members, past and present, qualify as individuals with a disability as defined by the ADA, including during the time of their incarceration at the Harford County Detention Center.

102. Although Harford County and the State of Maryland are responsible for safely accommodating people with disabilities in their custody, they routinely fail to meet these obligations at the Harford County Detention Center. That is, Defendants:

a. have failed to properly care for and accommodate people with disabilities in their custody at HCDC;

b. have failed to establish and enforce adequate practices and procedures to accommodate people with disabilities safely, including effective communication in assessing suicide risk and accessing mental health treatment;

c. have failed to provide adequate education or training to leadership and personnel staffing the Harford County Detention Center in how to keep individuals with disabilities in their custody safe from self-harm; and

d. have responded to distress expressed by people with disabilities punitively, resulting in exacerbation of the suffering and risks of self-harm experienced by those in Defendants' custody.

103. Specifically, Defendants State of Maryland and Harford County have discriminated against, punished, and failed to safely accommodate people in their custody and care–including Plaintiff Charles Morris and other NAACP members–because those individuals have disabilities, including but not limited to physical disabilities, cognitive disabilities, mental health or psychiatric disabilities, substance use disabilities, and/or suicidality associated with mental health crises and/or addiction withdrawal. Instead, Defendants operate HCDC in a manner that has and continues to exacerbate those risks of harm to and the *lack* of safe accommodations for people with disabilities who are detained there, in violation of Title II of the ADA.

104. Defendants' failure to safely accommodate HCDC detainees with disabilities in violation of the ADA has caused grave harm to Plaintiff Morris and to NAACP members.

COUNT III:

Section 504 of the Rehabilitation Act of 1973

(All Plaintiffs Against State of Maryland and Harford County)

105. Plaintiffs incorporate and reallege the foregoing paragraphs.

106. Due to mental health conditions, Plaintiff Charles Morris and other NAACP members qualify as individuals with a "disability" as protected by Section 504 of the Rehabilitation Act. *See* 29 U.S.C. § 794(a); 45 C.F.R. § 84.3(j).

107. The Rehabilitation Act dictates that no otherwise qualified individual with a disability be excluded from the participation in, be denied the benefits of, or be subjected to

discrimination under any program or activity receiving Federal financial assistance because of her disability. *See* 29 U.S.C. § 794(a).

108. Upon information and belief, the State of Maryland and Harford County receive federal financial assistance and are, therefore, covered by the Rehabilitation Act.

109. Although Harford County and the State of Maryland are responsible for safely accommodating people with disabilities in their custody, they routinely fail to meet these obligations at the HCDC. That is, Defendants have failed and continue to fail to properly care for and accommodate people with disabilities in their custody at HCDC, have failed to establish and enforce adequate practices and procedures to accommodate people with disabilities safely, have failed to provide adequate education or training to leadership and personnel staffing the Harford County Detention Center in how to keep individuals with disabilities in their custody safe from self-harm, and have responded to distress expressed by people with disabilities punitively, resulting in exacerbation of the suffering and risks of self-harm experienced by those in Defendants' custody.

110. Specifically, Defendants State of Maryland and Harford County have discriminated against, punished, and failed to safely accommodate people in their custody and care–including Plaintiff Charles Morris and other NAACP members–because those individuals have disabilities, including but not limited to physical disabilities, cognitive disabilities, mental health or psychiatric disabilities, substance use disabilities, and/or suicidality associated with mental health crises and/or addiction withdrawal. Instead, Defendants operate HCDC in a manner that has and continues to exacerbate those risks of harm to and the *lack* of safe accommodations for people with disabilities who are detained there, in violation of Section 504 of the Rehabilitation Act.

111. Defendants' failure to safely accommodate HCDC detainees with disabilities in violation of the Rehabilitation Act has caused grave harm to Plaintiffs Charles Morris and to other NAACP members.

PRAYER FOR RELIEF

A. WHEREFORE, Plaintiffs respectfully request that this Court enter judgment in favor of Plaintiffs and grant the following:

B. Declare, pursuant to 28 U.S.C. § 2201, that through their acts and omissions, Defendants have failed and continue to fail to protect Plaintiffs and their members against the serious risk of substantial harm of suicide at HCDC, as guaranteed by the Fourteenth Amendment to the Constitution of the United States and Articles 19 and 24 of the Maryland Declaration of Rights;

C. Declare, pursuant to 28 U.S.C. § 2201, that through their acts and omissions, Defendants have violated and continue to violate the Americans with Disabilities Act and the Rehabilitation Act of 1973;

D. Grant such equitable relief as is proper and just to ensure compliance with the U.S. and Maryland Constitutions and ADA and Rehabilitation Act, including but not limited to, requiring Defendants to immediately take steps to remedy the practices noted in this Complaint;

E. Award compensatory damages to Plaintiff Charles Morris in an amount to be determined by the jury, jointly and severally, against all Defendants;

F. Award nominal damages of $1 to Plaintiff NAACP;

G. Award all Plaintiffs reasonable attorneys' fees, expert witness fees and costs under 42 U.S.C § 1988 and 12205; and

H. Award such other and further relief in any form that this Court deems just and proper under the facts and circumstances as proved at trial.

JURY DEMAND

Plaintiffs request a trial by jury on any and all issues raised by this Complaint which are triable by right of a jury.

Dated: January 20, 2026

Respectfully submitted,

/s/ Katherine M. Bleicher

Sonia Kumar (Bar No. 07196)
Deborah A. Jeon (Bar No. 06905)
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Dara Johnson (Bar No. 31478)
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**pro hac vice application forthcoming*

JS 44 (Rev. 04/21)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. *(SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)*

I. (a) PLAINTIFFS

Harford County Branch of the NAACP and Charles Morris

(b) County of Residence of First Listed Plaintiff Harford County
(EXCEPT IN U.S. PLAINTIFF CASES)

(c) Attorneys *(Firm Name, Address, and Telephone Number)*
(1) American Civil Liberties Union of Maryland, 3600 Clipper Mill Road, Suite 200, Baltimore, Maryland 21211; Phone: 410-889-8555
(2) MayerBrown LLP, 1999 K Street NW, Washington, D.C. 20006; Phone: 202-262-3000
(3) Washington Lawyers; Committee for Civil Rights and Urban Affairs, 700 14th Street NW, Suite 400, Washington, D.C. 20005; Phone: 202-319-1000

DEFENDANTS

Sheriff Jeffrey Gahler; Warden Daniel J. Galbraith; Harford County, MD; State of Maryland

County of Residence of First Listed Defendant Harford County
(IN U.S. PLAINTIFF CASES ONLY)

NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.

Attorneys *(If Known)*

II. BASIS OF JURISDICTION *(Place an "X" in One Box Only)*

- ☐ 1 U.S. Government Plaintiff
- ☒ 3 Federal Question *(U.S. Government Not a Party)*
- ☐ 2 U.S. Government Defendant
- ☐ 4 Diversity *(Indicate Citizenship of Parties in Item III)*

III. CITIZENSHIP OF PRINCIPAL PARTIES *(Place an "X" in One Box for Plaintiff and One Box for Defendant)*

(For Diversity Cases Only)

	PTF	DEF		PTF	DEF
Citizen of This State	☐ 1	☐ 1	Incorporated *or* Principal Place of Business In This State	☐ 4	☐ 4
Citizen of Another State	☐ 2	☐ 2	Incorporated *and* Principal Place of Business In Another State	☐ 5	☐ 5
Citizen or Subject of a Foreign Country	☐ 3	☐ 3	Foreign Nation	☐ 6	☐ 6

IV. NATURE OF SUIT *(Place an "X" in One Box Only)*

Click here for: Nature of Suit Code Descriptions.

CONTRACT
- ☐ 110 Insurance
- ☐ 120 Marine
- ☐ 130 Miller Act
- ☐ 140 Negotiable Instrument
- ☐ 150 Recovery of Overpayment & Enforcement of Judgment
- ☐ 151 Medicare Act
- ☐ 152 Recovery of Defaulted Student Loans (Excludes Veterans)
- ☐ 153 Recovery of Overpayment of Veteran's Benefits
- ☐ 160 Stockholders' Suits
- ☐ 190 Other Contract
- ☐ 195 Contract Product Liability
- ☐ 196 Franchise

TORTS

PERSONAL INJURY
- ☐ 310 Airplane
- ☐ 315 Airplane Product Liability
- ☐ 320 Assault, Libel & Slander
- ☐ 330 Federal Employers' Liability
- ☐ 340 Marine
- ☐ 345 Marine Product Liability
- ☐ 350 Motor Vehicle
- ☐ 355 Motor Vehicle Product Liability
- ☐ 360 Other Personal Injury
- ☐ 362 Personal Injury - Medical Malpractice

PERSONAL INJURY
- ☐ 365 Personal Injury - Product Liability
- ☐ 367 Health Care/ Pharmaceutical Personal Injury Product Liability
- ☐ 368 Asbestos Personal Injury Product Liability

PERSONAL PROPERTY
- ☐ 370 Other Fraud
- ☐ 371 Truth in Lending
- ☐ 380 Other Personal Property Damage
- ☐ 385 Property Damage Product Liability

FORFEITURE/PENALTY
- ☐ 625 Drug Related Seizure of Property 21 USC 881
- ☐ 690 Other

LABOR
- ☐ 710 Fair Labor Standards Act
- ☐ 720 Labor/Management Relations
- ☐ 740 Railway Labor Act
- ☐ 751 Family and Medical Leave Act
- ☐ 790 Other Labor Litigation
- ☐ 791 Employee Retirement Income Security Act

IMMIGRATION
- ☐ 462 Naturalization Application
- ☐ 465 Other Immigration Actions

BANKRUPTCY
- ☐ 422 Appeal 28 USC 158
- ☐ 423 Withdrawal 28 USC 157

INTELLECTUAL PROPERTY RIGHTS
- ☐ 820 Copyrights
- ☐ 830 Patent
- ☐ 835 Patent - Abbreviated New Drug Application
- ☐ 840 Trademark
- ☐ 880 Defend Trade Secrets Act of 2016

SOCIAL SECURITY
- ☐ 861 HIA (1395ff)
- ☐ 862 Black Lung (923)
- ☐ 863 DIWC/DIWW (405(g))
- ☐ 864 SSID Title XVI
- ☐ 865 RSI (405(g))

FEDERAL TAX SUITS
- ☐ 870 Taxes (U.S. Plaintiff or Defendant)
- ☐ 871 IRS—Third Party 26 USC 7609

OTHER STATUTES
- ☐ 375 False Claims Act
- ☐ 376 Qui Tam (31 USC 3729(a))
- ☐ 400 State Reapportionment
- ☐ 410 Antitrust
- ☐ 430 Banks and Banking
- ☐ 450 Commerce
- ☐ 460 Deportation
- ☐ 470 Racketeer Influenced and Corrupt Organizations
- ☐ 480 Consumer Credit (15 USC 1681 or 1692)
- ☐ 485 Telephone Consumer Protection Act
- ☐ 490 Cable/Sat TV
- ☐ 850 Securities/Commodities/ Exchange
- ☐ 890 Other Statutory Actions
- ☐ 891 Agricultural Acts
- ☐ 893 Environmental Matters
- ☐ 895 Freedom of Information Act
- ☐ 896 Arbitration
- ☐ 899 Administrative Procedure Act/Review or Appeal of Agency Decision
- ☐ 950 Constitutionality of State Statutes

REAL PROPERTY
- ☐ 210 Land Condemnation
- ☐ 220 Foreclosure
- ☐ 230 Rent Lease & Ejectment
- ☐ 240 Torts to Land
- ☐ 245 Tort Product Liability
- ☐ 290 All Other Real Property

CIVIL RIGHTS
- ☒ 440 Other Civil Rights
- ☐ 441 Voting
- ☐ 442 Employment
- ☐ 443 Housing/ Accommodations
- ☐ 445 Amer. w/Disabilities - Employment
- ☐ 446 Amer. w/Disabilities - Other
- ☐ 448 Education

PRISONER PETITIONS

Habeas Corpus:
- ☐ 463 Alien Detainee
- ☐ 510 Motions to Vacate Sentence
- ☐ 530 General
- ☐ 535 Death Penalty

Other:
- ☐ 540 Mandamus & Other
- ☐ 550 Civil Rights
- ☐ 555 Prison Condition
- ☐ 560 Civil Detainee - Conditions of Confinement

V. ORIGIN *(Place an "X" in One Box Only)*

☒ 1 Original Proceeding ☐ 2 Removed from State Court ☐ 3 Remanded from Appellate Court ☐ 4 Reinstated or Reopened ☐ 5 Transferred from Another District *(specify)* ☐ 6 Multidistrict Litigation - Transfer ☐ 8 Multidistrict Litigation - Direct File

VI. CAUSE OF ACTION

Cite the U.S. Civil Statute under which you are filing ***(Do not cite jurisdictional statutes unless diversity)***:
42 U.S.C. § 1983; American With Disabilities Act; §504 of the Rehabilitation Act

Brief description of cause:
Civil rights lawsuit for Harford County Detention Center's failures in providing adequate treatment and care for inmates suffering from mental health issues

VII. REQUESTED IN COMPLAINT:

☐ CHECK IF THIS IS A **CLASS ACTION** UNDER RULE 23, F.R.Cv.P.

DEMAND $

CHECK YES only if demanded in complaint:
JURY DEMAND: ☒ Yes ☐ No

VIII. RELATED CASE(S) IF ANY

(See instructions): JUDGE _____ DOCKET NUMBER _____

DATE SIGNATURE OF ATTORNEY OF RECORD

FOR OFFICE USE ONLY

RECEIPT # _____ AMOUNT _____ APPLYING IFP _____ JUDGE _____ MAG. JUDGE _____

INSTRUCTIONS FOR ATTORNEYS COMPLETING CIVIL COVER SHEET FORM JS 44

Authority For Civil Cover Sheet

The JS 44 civil cover sheet and the information contained herein neither replaces nor supplements the filings and service of pleading or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. Consequently, a civil cover sheet is submitted to the Clerk of Court for each civil complaint filed. The attorney filing a case should complete the form as follows:

I.(a) Plaintiffs-Defendants. Enter names (last, first, middle initial) of plaintiff and defendant. If the plaintiff or defendant is a government agency, use only the full name or standard abbreviations. If the plaintiff or defendant is an official within a government agency, identify first the agency and then the official, giving both name and title.

(b) County of Residence. For each civil case filed, except U.S. plaintiff cases, enter the name of the county where the first listed plaintiff resides at the time of filing. In U.S. plaintiff cases, enter the name of the county in which the first listed defendant resides at the time of filing. (NOTE: In land condemnation cases, the county of residence of the "defendant" is the location of the tract of land involved.)

(c) Attorneys. Enter the firm name, address, telephone number, and attorney of record. If there are several attorneys, list them on an attachment, noting in this section "(see attachment)".

II. Jurisdiction. The basis of jurisdiction is set forth under Rule 8(a), F.R.Cv.P., which requires that jurisdictions be shown in pleadings. Place an "X" in one of the boxes. If there is more than one basis of jurisdiction, precedence is given in the order shown below.
United States plaintiff. (1) Jurisdiction based on 28 U.S.C. 1345 and 1348. Suits by agencies and officers of the United States are included here.
United States defendant. (2) When the plaintiff is suing the United States, its officers or agencies, place an "X" in this box.
Federal question. (3) This refers to suits under 28 U.S.C. 1331, where jurisdiction arises under the Constitution of the United States, an amendment to the Constitution, an act of Congress or a treaty of the United States. In cases where the U.S. is a party, the U.S. plaintiff or defendant code takes precedence, and box 1 or 2 should be marked.
Diversity of citizenship. (4) This refers to suits under 28 U.S.C. 1332, where parties are citizens of different states. When Box 4 is checked, the citizenship of the different parties must be checked. (See Section III below**; NOTE: federal question actions take precedence over diversity cases.**)

III. Residence (citizenship) of Principal Parties. This section of the JS 44 is to be completed if diversity of citizenship was indicated above. Mark this section for each principal party.

IV. Nature of Suit. Place an "X" in the appropriate box. If there are multiple nature of suit codes associated with the case, pick the nature of suit code that is most applicable. Click here for: Nature of Suit Code Descriptions.

V. Origin. Place an "X" in one of the seven boxes.
Original Proceedings. (1) Cases which originate in the United States district courts.
Removed from State Court. (2) Proceedings initiated in state courts may be removed to the district courts under Title 28 U.S.C., Section 1441.
Remanded from Appellate Court. (3) Check this box for cases remanded to the district court for further action. Use the date of remand as the filing date.
Reinstated or Reopened. (4) Check this box for cases reinstated or reopened in the district court. Use the reopening date as the filing date.
Transferred from Another District. (5) For cases transferred under Title 28 U.S.C. Section 1404(a). Do not use this for within district transfers or multidistrict litigation transfers.
Multidistrict Litigation – Transfer. (6) Check this box when a multidistrict case is transferred into the district under authority of Title 28 U.S.C. Section 1407.
Multidistrict Litigation – Direct File. (8) Check this box when a multidistrict case is filed in the same district as the Master MDL docket.
PLEASE NOTE THAT THERE IS NOT AN ORIGIN CODE 7. Origin Code 7 was used for historical records and is no longer relevant due to changes in statute.

VI. Cause of Action. Report the civil statute directly related to the cause of action and give a brief description of the cause. **Do not cite jurisdictional statutes unless diversity.** Example: U.S. Civil Statute: 47 USC 553 Brief Description: Unauthorized reception of cable service.

VII. Requested in Complaint. Class Action. Place an "X" in this box if you are filing a class action under Rule 23, F.R.Cv.P.
Demand. In this space enter the actual dollar amount being demanded or indicate other demand, such as a preliminary injunction.
Jury Demand. Check the appropriate box to indicate whether or not a jury is being demanded.

VIII. Related Cases. This section of the JS 44 is used to reference related pending cases, if any. If there are related pending cases, insert the docket numbers and the corresponding judge names for such cases.

Date and Attorney Signature. Date and sign the civil cover sheet.

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Maryland

Harford County Branch of the NAACP and Charles Morris

Plaintiff(s)

v.

Sheriff Jeffrey Gahler, Warden Daniel J. Galbraith, Harford County, MD, State of Maryland

Defendant(s)

Civil Action No. 1:26-cv-239

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Sheriff Jeffrey Gahler
45 South Main Street
Bel Air, Maryland 21014

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: (1) American Civil Liberties Union of Maryland, 3600 Clipper Mill Road, Suite 200, Baltimore, Maryland 21211; Phone: 410-889-8555
(2) Mayer Brown LLP, 1999 K Street NW, Washington, D.C. 20006; Phone: 202-263-5282
(3) Washington Lawyers; Committee for Civil Rights and Urban Affairs, 700 14th Street NW, Suite 400, Washington, D.C. 20005; Phone: 202-319-1000

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No. 1:26-cv-239

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Maryland

Harford County Branch of the NAACP and Charles Morris

Plaintiff(s)

v.

Sheriff Jeffrey Gahler, Warden Daniel J. Galbraith, Harford County, MD, State of Maryland

Defendant(s)

Civil Action No. 1:26-cv-239

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Warden Daniel J. Galbraith
1030 Rock Spring Road
Bel Air, Maryland 21014

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: (1) American Civil Liberties Union of Maryland, 3600 Clipper Mill Road, Suite 200, Baltimore, Maryland 21211; Phone: 410-889-8555
(2) Mayer Brown LLP, 1999 K Street NW, Washington, D.C. 20006; Phone: 202-263-5282
(3) Washington Lawyers; Committee for Civil Rights and Urban Affairs, 700 14th Street NW, Suite 400, Washington, D.C. 20005; Phone: 202-319-1000

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No. 1:26-cv-239

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

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❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Maryland

Harford County Branch of the NAACP and Charles Morris

Plaintiff(s)

v.

Sheriff Jeffrey Gahler, Warden Daniel J. Galbraith, Harford County, MD, State of Maryland

Defendant(s)

Civil Action No. 1:26-cv-239

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* Harford County, MD
County Executive Robert G. Cassilly
220 South Main Street
Bel Air, Maryland 21014

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: (1) American Civil Liberties Union of Maryland, 3600 Clipper Mill Road, Suite 200, Baltimore, Maryland 21211; Phone: 410-889-8555
(2) Mayer Brown LLP, 1999 K Street NW, Washington, D.C. 20006; Phone: 202-263-5282
(3) Washington Lawyers; Committee for Civil Rights and Urban Affairs, 700 14th Street NW, Suite 400, Washington, D.C. 20005; Phone: 202-319-1000

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No. 1:26-cv-239

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

This summons for *(name of individual and title, if any)* _____ was received by me on *(date)* _____ .

❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc:

AO 440 (Rev. 06/12) Summons in a Civil Action

UNITED STATES DISTRICT COURT

for the

District of Maryland

Harford County Branch of the NAACP and Charles Morris

Plaintiff(s)

v.

Sheriff Jeffrey Gahler, Warden Daniel J. Galbraith, Harford County, MD, State of Maryland

Defendant(s)

Civil Action No. 1:26-cv-239

SUMMONS IN A CIVIL ACTION

To: *(Defendant's name and address)* State of Maryland
Attorney General Anthony Brown
200 St. Paul Place
Baltimore, Maryland 21202

A lawsuit has been filed against you.

Within 21 days after service of this summons on you (not counting the day you received it) — or 60 days if you are the United States or a United States agency, or an officer or employee of the United States described in Fed. R. Civ. P. 12 (a)(2) or (3) — you must serve on the plaintiff an answer to the attached complaint or a motion under Rule 12 of the Federal Rules of Civil Procedure. The answer or motion must be served on the plaintiff or plaintiff's attorney, whose name and address are: (1) American Civil Liberties Union of Maryland, 3600 Clipper Mill Road, Suite 200, Baltimore, Maryland 21211; Phone: 410-889-8555
(2) Mayer Brown LLP, 1999 K Street NW, Washington, D.C. 20006; Phone: 202-263-5282
(3) Washington Lawyers; Committee for Civil Rights and Urban Affairs, 700 14th Street NW, Suite 400, Washington, D.C. 20005; Phone: 202-319-1000

If you fail to respond, judgment by default will be entered against you for the relief demanded in the complaint. You also must file your answer or motion with the court.

CLERK OF COURT

Date: _____

_____
Signature of Clerk or Deputy Clerk

Civil Action No. 1:26-cv-239

PROOF OF SERVICE

(This section should not be filed with the court unless required by Fed. R. Civ. P. 4 (l))

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❒ I personally served the summons on the individual at *(place)* _____ on *(date)* _____ ; or

❒ I left the summons at the individual's residence or usual place of abode with *(name)* _____ , a person of suitable age and discretion who resides there, on *(date)* _____ , and mailed a copy to the individual's last known address; or

❒ I served the summons on *(name of individual)* _____ , who is designated by law to accept service of process on behalf of *(name of organization)* _____ on *(date)* _____ ; or

❒ I returned the summons unexecuted because _____ ; or

❒ Other *(specify):*

My fees are $ _____ for travel and $ _____ for services, for a total of $ 0.00 .

I declare under penalty of perjury that this information is true.

Date: _____

_____
Server's signature

_____
Printed name and title

_____
Server's address

Additional information regarding attempted service, etc: