IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

ELIZABETH ANN FIRIDIN, representative of the ESTATE OF RONALD W. SHOUP, and next friend to minor child SARAH ANN SHOUP, Plaintiffs, v. CORRECT CARE SOLUTIONS, LLC, JILL MOSSER, IRMA MOORE, MARY-JOY MONSALUD-WALLACE, BRITTANY JOHNSON-SMITH, ADAEZE UDEZUE, TERAH CHIPMAN, G. R. JOHNSON, DARRICK E. WEST, JAMES CHANDLER, CLAUDE T. MASSEY III, JASON T. COPELAND, DAVID R. SEYMORE, DAVID COLLISON, BENJAMIN R. HUMES, MICHAEL MAANS, DION J. STEPHENS, DARRIAN POLK, BRIAN BEEBE, JOHN E. DITTMAN and RICHARD DOWNS, Defendants.	C.A. No.: N16C-02-028 (VLM) JURY TRIAL DEMANDED

AMENDED COMPLAINT

1. Correctional officers at Sussex Correctional Institution in Georgetown Delaware, repeatedly used physical force to subdue and restrain Ronald W. Shoup, until the resulting blunt force injuries killed him on February 27, 2014. The fatal blunt force injuries included bilateral hemothoraces, multiple fractures, multiple contusions, and a crushed chest. The medical staff had four times requested assistance from the correctional officers to subdue and restrain Ronald Shoup, be-

cause he was suffering hallucinations from his untreated alcohol withdrawal and could not cooperate with them.

2. On June 6, 2014, the Register of Wills in Kent County appointed Elizabeth Ann Firidin (Beth) as the Administrator of the Estate of Ronald W. Shoup (Ron).

3. Ron was the natural father of Sarah Ann Shoup, (Sarah) a minor, who was born on 8/20/1998 ~~8/31/98~~.

4. Beth is the natural mother of Sarah and brings this wrongful death and survival action as next friend to Sarah Ann Shoup.

5. At all times pertinent to these proceedings, Ron was in the custody of the Delaware Department of Correction (DOC) in the pretrial unit or infirmary at Sussex Correctional Institution (SCI).

6. At all times pertinent to these proceedings, Correct Care Solutions (CCS) was a corporation that had contracted with DOC to provide medical services to inmates incarcerated in Delaware including those being held at SCI.

7. Ron entered SCI on 2/20/14, was not given any adequate care for his withdrawal symptoms by CCS employees, and on 2/27/14, correctional officers (C/O's) killed him.

8. At all times pertinent, Jill Mosser (Mosser), was employed by, and acting on behalf of, CCS, as Health Service Administrator (HSA). At all times per-

tinent she was working within the space and time limits of her job as HSA, and was the CCS administrator in charge of the entire medical department at SCI. She now is the equivalent of a HSA for Connections, the current medical vender to DOC. Mosser began working at SCI as a staff nurse for a predecessor to CCS in 2003. Mosser continued to work as a staff nurse at SCI until October 2005 when she became the HSA for Correctional Medical Services (CMS), the medical care provider to inmates at SCI in October 2005. When CCS replaced CMS on July 1, 2010, Mosser continued to work as HSA at SCI for CCS. As HSA at CCS at SCI, Mosser had oversight over all of the medical care providers including those who were supposed to be providing medical care to Ron.

9. At all times pertinent to these proceedings, Defendants Brittany Johnson-Smith; Irma Moore; Mary-joy Monsalud-Wallace, Adaeze Udezue and Terah Chipman were employed by and acting on behalf of CCS.

10. All defendants employed by CCS were also acting on behalf of the state and were legally obligated to observe the civil rights of inmates like Ron on by providing them reasonable medical care for all of their serious medical needs. All employees of CCS were obligated to provide medical care to inmates that met applicable standards of care and the DOC policy manual. CCS is responsible for all of the actions of its employees and agents that breached applicable standards, or

violated Ron's civil rights in the course of providing him health care for his serious medical needs.

11. Defendant G. R, Johnson (Johnson) is the warden at SCI and was so in 2013. He had been an employee of DOC for nearly 23 years with most of them spent at SCI at various ranks until promoted to warden.

12. At all times pertinent to these proceedings, Defendants Darrick E. West; James Chandler; Claude T. Massey III; Jason T. Copeland; David R. Seymore; David Collison; Benjamin R. Humes; Michael Maans; Dion J. Stephens; Darrian Polk; Brian Beebe; and John E Dittman were employed by DOC as correctional officers. All defendants employed by DOC were acting on behalf of the State of Delaware and were legally obligated to observe the civil rights of inmates like Ron.

13. Defendants Mosser, Moore, Monsalud-Wallace, Johnson-Smith, Udezue, Chipman, Johnson, West, Chandler, Massey, Copeland, Seymore, Collison, Humes, Maans, Stephens, Polk, Beebe, Dittman and Downs are being sued in their individual capacities for damages arising out of the violations of the civil rights of Ronald Shoup.

CCS PROCEDURES AND PRACTICES

14. As part of the contractual obligation to DOC to provide medical care in Delaware prisons, CCS provides doctors, nurse practitioners, nurses and other

medical staff to DOC institutions, including SCI. Unfortunately CCS was perpetually short staffed at SCI, and regularly had their employees perform tasks for which they were not sufficiently trained or qualified, due to the lack of adequate skilled help. The lack of adequate staffing caused the medical services being provided to the inmates to frequently fall below the applicable standards.

15. A CCS medical staff member, usually a LPN, initially evaluated all inmates for obvious medical and mental impairments when they arrived at SCI. The LPN's employed at SCI and CCS were not adequately trained or qualified to evaluate inmates for signs of withdrawal from drugs or alcohol. If an LPN thought an inmate had no serious medical conditions after they evaluated him, he was placed into the general population.

16. Inmates housed in general population, must submit a "sick call request" form to the medical staff if they want to be seen by a care provider. Members of the correctional staff sometimes refer inmates for medical care when the inmate is not capable of making the request.

17. Initially a nurse reviews the request and meets with the inmate to determine if the request can be handled without a medical visit with a doctor or nurse practitioner. The nurse puts the names of inmates who need medical visits on the sick call list for a doctor or nurse practitioner to see at sick call. However, if an in-

mate has an obvious urgent need for medical care, they are supposed to be seen immediately.

18. Inmates have no choice about which medical providers treat them, and may not insist on being taken out of the prison for medical care. Inmates are completely dependent on the medical provider and DOC to provide for their serious medical conditions.

FACTUAL CHRONOLOGY

19. Ron was remanded to SCI by a Sussex County Court of Common Pleas judge on February 20 as a result of DUI related charges.

20. According to medical records signed by Toccara Goodwin LPN, Ron was admitted to SCI on **2/20/14** at **1118.**

21. LPN Goodwin noted that Ron had been incarcerated at SCI on 2/5/2014, had cataract surgery on 2/17/2014 and had an eye patch on his right eye. He had hypertension, GERD and cirrhosis of the liver. He was taking Inderal, Aldactone and Lasix. He had been a daily drinker for over 30 years and had 2 pints tonight but did not appear to be under the influence of alcohol or drugs. His vital signs were: BP 102/62; pulse 92; respiration 18, and temperature 97.8.

22. LPN Goodwin placed Ron in general population and at **1300** she noted him to be an "Intoxicated white male…CIWA (Clinical Institute Withdrawal Assessment) protocol initiated…." The plan was to monitor his BP with CIWA.

23. The next morning, **2/21/14**, Ron requested his "medicine for liver and eye." At **0810** he was ordered omeprazole, lasix, propenolol, and spironolactone, all to be taken at least once a day. But according to the medication administration records, he received propanalol once on the 21st and once on the 22nd, and spironolactone once on the 22nd and 23rd, and then not again. Nothing was ordered for his eye. An EKG was ordered and Ron was enrolled in Chronic Care Clinics (CCC) for HTN, GERD, and cirrhosis. Ron asked about his eye drops when he was getting his EKG at **1200**.

24. When Ron was seen at sick call at **0900** on **2/23/14**, he was still asking for the eye drops he was supposed to be using for 30 days after his 2/17/2014 cataract surgery. At **1230** on **2/23/14** there was a telephone order noted from Elizabeth Stewart Jones RN, MS, ANPC (NP Jones) for: Ketorolac 0.5% opth solution; and prednisolone AC eye drop; to be used four times a day for 30 days.

25. Nevertheless, Ron filed a request dated 2/26/14, in which he asked for his eye medicine, blood work, and to talk to mental health. The triage by mental health took place on **2/25/14** at **1520**, meaning that Ron filed his request no later than 2/25/14. Not surprisingly, five days after being admitted to SCI Ron was still not getting all of the eye drops he was supposed to be taking every day.

26. Ron had cataract surgery on 2/17/14 and the doctor had given his parents a letter that they took to the prison to verify that he needed his medica-

tion. Ron C. spoke with Ron every day from Thursday 2/21/14 to Wednesday, 2/26/14, and Ron told him that up until Sunday 2/23/14 he did not receive his drops for his eye or his medicine for his liver.

27. Nurse Practitioner Elizabeth Stewart Jones (NP Jones), completed Ron's physical, and first CCC evaluation around **1000** on **2/25/2014**. She noted that he suffered from GERD, cirrhosis, hypertension, and was an alcoholic. His pulse was 54, B/P 107/74 and respiration 12. He had been to Beebe Hospital on 12/21/2013 with chest pain but did not have a MI. She ordered labs: DP II, AFP, VA, PSA, and ammonia level.

28. At **1020** on 2/25/14 NP Jones noted confusion over the eye medications Ron was supposed to be taking and claimed that she just became aware of his recent cataract surgery and his scheduled outside visit on 2/27/2014 with Delaware Eye Institute. At **1130** on **2/25/14** NP Jones ordered a seven-day bridge order of Ketosolve and Vigamox for Ron's eyes until he could be seen at Delaware Eye Institute.

29. At **1039** on **2/25/14** Ron's EKG was read as abnormal.

30. Marie – Lisa Francis, Master of Social Work, (MSW Francis), evaluated Ron on **2/25/14**, at **1917** because Nurse Charles (Charles Collins, LPN) asked mental health to see (him). Correctional Ofc. stated "never seen someone so out of it in long while" Sgt. Bradley stated the cellmates said inmate made threats against

correctional officers and others, and he was up all night making plots and threatening statements.

31. Ron told MSW Francis: "I'm having problems. I don't know how to handle these guys because I'm new. I have not laughed in a while. I'm frustrated with medical department. I had cataract surgery on 2/17/14. I have 8 DUI's."(Not true) "The inmates are breaking me in, playing tricks on the new the guy." "I want someone to talk to, someone to listen to me."

32. MSW Francis noted that some of Ron's issues were; insomnia, social withdrawal, affective instability or liability, signs of withdrawal, and chronic, serious or terminal illness. He last had alcohol a week ago, was drunk. He has cataracts, and cirrhosis of the liver. Her findings about Ron include that he; was disoriented to time, appeared disheveled and bizarre, was depressed, had no hallucinations, but had delusions about "Inmates just breaking me in."

33. MSW Francis believed that Ron was a moderate threat to his own safety or the safety of others. At **1946** she noted Staff Interventions: Placed on "PCO Level II" due to reported depression, poor coping skills, poor supports, chronic alcohol abuse, ability to handle life stresses, delusions about other inmates "breaking him in."

34. Physician's Orders written around 1946, taken off at 2030: Vistaril 100 mg PO 1 dose, now. Admit to infirmary for Level II dos. 24 hr. chart. Lisa Dick LPN. TVO Janet Snowdons RN/Ronda Montgomery RN.

35. The DOC MENTAL HEALTH/PSYCHIATRY OBSERVATION SHEET for Ron was signed by MSW Francis and by Janet Snowdens RN. Level II was circled meaning inmate is considered a moderate risk to harm himself or others. 15-minute checks. (staggered intervals no greater than 15 minutes)

36. Mental health observation.

2028: (Initial entry in the observation log book) I/M arrived in infirmary, being assessed and given meds by nurse Erin and nurse Beth, then placed in cell # 81, stripped of DOC--orange C/O's. Sitting and quiet.

37. Infirmary Admission Record at **2030**: Vital Signs: **2035**; BP 104/70; Pulse 61; Respiration 18; Temperature 97.2. Emotional Status: Cooperative. Alcohol abuse history. Elizabeth Hitchens RN.

38. Mental health observation.

2040: Lying awake, quiet

2050: Lying awake, quiet, relaxed

2100: Laying down, quiet, relaxed

39. Progress note at **2100**: Ron--"I'm good". Alert and oriented to self and time, but not oriented to place. Denies suicidal or homicidal ideation. Brought to

infirmary PCO2 status. Vital signs stable. Cooperative with care. Altered thought process. Will continue to monitor. RN Hitchens.

40. CARE PLAN: Ambulate PRN. OOB ad lib. **Vital Signs**: BP, Pulse, Resp., Temp. Every shift. RN Hitchens

41. The night shift nursing assessment: BP 114/76, temperature 99.2, pulse 66, and respiration 16. Alert to person and time, not place. Hallucinating.

42. Mental health observation:

2115: Laying down, quiet, relaxed

2130: Sitting, quiet on bed

2145: Sitting, quiet on bed

2155: Toileted

2205: Toileted, urinating

2215: Sitting, on edge of bed staring at floor

2230, 2245, 2300, 2315, 2330: Sitting, quiet

2345: Standing at door

43. Mental health observation continued on **2/26/2014:**

0000, **0010, 0025**: Sitting, quiet.

0040: Standing at door

0050, 0100: Sitting, quiet

44. Progress note at **0100**: Alert and oriented to self and time, not oriented to place…. Inmate hallucinating talking to people and thinks he is at Beebe hospital: good eye contact. A: altered thought process P: continue to monitor. Lisa Dick, LPN.

45. Mental health observation:

0107: Cuffed, out for vitals, C/O Terry shook down cell

0110: Back in cell, uncuffed.

0125: Sitting, quiet

0140: Trying to bust out of cell, asking for tools to take door apart

0155: Sitting, quiet

0210: Standing in cell talking

0225: Trying to open door

0240: Sitting, quiet

0250: Sitting, playing with door

0300: Still messing with door

0315: Messing with door, yelling

0320: Being told again to stop messing with door

0330: Sitting, yelling for tools

0345: Sitting, talking about busing a hole in wall, hitting door

0400: Sitting, on floor, talking

0415: Standing at door, quiet

0430: Standing at door

0445: Sitting, quiet

0500: Trying to get out

0515: Sitting, talking

FIRST DOCUMENTED USE OF FORCE BY C/O'S

0521: I/M being brought out and I/M fighting back; Attempted to take handcuffs; Observers out of area. (For nine minutes only the correctional officers witnessed what they did to Ron)

0530: Observers back in area; I/M lying down, quiet

0545: Chow, fluids rejected, meal rejected

0600: Sitting, mumbling

46. Progress note at **0610**: Inmate brought out of cell for medication and eyedrops. Inmate calm and cooperative but refused breakfast. Inmate awake all night, hallucinating, talking to people, occasionally banging on door, off and on. LPN Dick.

47. Mental health observation:

0615: Standing, yelling, mumbling

0630: Sitting, quiet

0645: Sitting, yelling we better open door

0700: Again messing with door, yelling

0715, 0730: Sitting, yelling

0745: At door looking out

0800: Sitting, yelling

0810: Out to see Dr. Potter (Actually out to see Tracy Coleman, LPC)

48. The day shift nursing assessment: BP 92/58, temperature 98.8, pulse 78, and respiration 15.

49. Initial Psychiatric Evaluation at **0815**: Ron denied ever being in a psychiatric hospital, and denied ever taking psychiatric medications. Ron stated that he was "frustrated – stuck behind refrigerator – have to go in front of it". LPC Coleman found it difficult to continue the interview because Ron was unable to cooperate with the assessment. Ron was disoriented to time and place and was having delusions. He believed he was at his parent's home. "Refer to medical to rule out psychosis." Tracy Coleman, LPC.

50. LPC Coleman tried to conduct Ron's initial comprehensive mental health evaluation at the same time as the initial psychiatric observation, but she was unable to do so because the inmate was uncooperative. She believed Ron's condition was possibly medically induced and referred him to medical ASAP.

51. Mental health observation:

0821: Returned to cell, got vitals and assessed by nurse (There is no progress note for this assessment)

0830: Returned to cell

52. Brittany Johnson-Smith RN made entries on the CIWA and Neurological Assessment documents at **0830,** but did not write a corresponding progress note.

53. Ron's CIWA scores were charted from 2/20/14 through 2/24/14, and every time the total score was zero. There are ten different symptoms that make up the CIWA scale, and all but one are evaluated on a scale from zero to seven, with zero being normal and seven extremely severe symptoms. The other symptom is evaluated on a scale from zero to four. Symptoms evaluated on scale of zero to seven include Agitation, Anxiety and Orientation.

54. Ron apparently had no CIWA evaluation on 2/25/14, as no CIWA scores were recorded again until **0830** on 2/26/14 when RN Johnson-Smith gave Ron a total score of 18. (Tremor: 7 out of 7. Agitation: 4 out of 7. Anxiety: 4 out of 7. Orientation: 3 out of 7.) The scores for Agitation, Anxiety and Orientation were low considering the descriptions of Ron's behavior as recorded in the progress and observation notes including those of LPC Coleman made just 15 minutes prior. BP was 92/58; Temp 98.8; Pulse; 78.

55. Mental health observation:

0845: Meals given

0858: Down to doctor office.

56. Provider Infirmary Admission note: around **0900**: S: 65-year-old man (actually 49 year-old man) with history of hypertension and alcohol abuse, GERD, cirrhosis; recent cataract surgery; hallucinating and delusional; reddened and blotchy face – rosacea; A: alcohol withdrawal in patient with chronic liver disease. Vitals: 92/58; 98.8; 78. Adaeze Udezue MD

57. Physician's Order from around **0900:** Librium (chlordiazepoxide) with various options to give as needed for 5 days, according to DOC protocol; phenergen 25 mg TID x 5 days; IVF 5 ½ NS at 200 cc/hr. x 24 hours. Blood work: DP3 and NH3 --Mgt. Adaeze Udezue MD

0910: Returned at nurse station to get IV

0915: Returned to cell

58. Peripheral IV maintenance record started at **0918**.

59. Mental health observation:

0930, 0945, 1000, 1015: Lying down, quiet

1030: Sitting, on bed, quiet

60. Progress note at **1030**: Ron was: Alert and oriented only to self, vital signs stable. Patient very confused, trembles, I and O started, CIWA's #18 neuro v

started #14 GCS. Spoke with mother, no history of mental health problems. Only history of alcohol abuse. Altered mental status. RN Johnson-Smith.

61. On Wednesday 2/26/14 Ron called Ron C. and said "Dad go on your internet and look up ABC Action News, I was told that I was naked and two millionaire woman were chasing me up the stairs and wanted to give $150,000. They are making fun of me in here." Ron C. thought that Ron was hallucinating and going into detox.

62. Mental health observation:

1045, 1100: Sitting, on bed, quiet

1115: Lying down, quiet

1130: Standing in cell

1135: Chow, fluids accepted, meal accepted

1145: Sitting, eating

1200, **1215**: Sitting, on bed, quiet

1230: Nurse in cell to fix IV

1245, 1300, 1315: Sitting, on bed, quiet

1320: Nurse into cell to fix IV

1330: Lying down, quiet

1345: Sitting, on bed, quiet

1355: Nurse in cell to administer eye drops

1400: Given water

1415, 1430, 1445, 1500: Sitting, on bed, quiet

1508: Toileted, urine

1515, 1530: Sitting, quiet, on bed

1545, 1600, 1615, 1630: Laying down, quiet

63. The evening shift nursing assessment: BP 100/60, pulse 84, temperature 96.8, and respiration 16.

64. Initial infirmary progress note at **1630** on **2/26/14**. S: "verbal" but not making sense: I have to go home and celebrate my birthday" O: oriented to name only. Not to place and time. Very agitated. IVE 200 cc/hr., to right FA. Keeps picking at tubing; unable to carry a conversation with patient due to his inappropriate conversation. Bangs at door at times. A: risk for W/D; altered thought process and risk for injury, risk for dehydration. P: continue with CIWA and alcohol W/D protocol. Try to maintain safe environment. Given increased fluids by mouth. Continue IVF and I and O. Continue with PCO2 with observer on site. Follow up with on-call provider PRN. Irma Moore, RN.

65. Mental health observation:

1635: Chow, fluids accepted, meal accepted.

66. The entry on the CIWA score sheet at **1640** revealed: Agitation: 4 out of 10. Auditory disturbances: 3 out of 10. Visual disturbances: 3 out of 10. Anxie-

ty: 4 out of 10. Orientation: 4 out of 10. Total score 18. BP 100/60; Temp 96.8; Pulse 84. RN Moore. (According to RN Moore Ron's CIWA score was slightly under severe, yet less than an hour later she was calling the QRT team to restrain Ron so that she could give him a shot to calm him down).

67. Mental health observation:

1645: Sitting, still eating

1653: At the flap saying he wants to leave now, trying to come through the flap

1658: Asked for and was given toilet paper. (C/O Smoot), sitting on toilet, toileted

68. According to the Order Record History, Ron was not administered some of his regular medications at **1700** because he was "too agitated"**,** and not given any medications but Ativan after that.

69. Mental Health Observation:

1712: Sitting, quiet, looking out of flap, mumbling every once in a while

1726: I/M was twisting and pulling on IV; nurse Beverly was alerted and went and spoke to him

1731: Tampering with IV; threatened to rip it if we don't open the door; Nurse Bev at door with him

1732: Officer Barmore call for backup from Sgt. Koontz

1734: I/M pulled tubing out of contact before Sgt. got to area

SECOND DOCUMENTED USE OF FORCE BY C/O'S

1738: 3 officers are trying to get him down to cuff him and shackle him so they can get him out to start the IV back again

70. Infirmary progress note at **1740**: Attempted to change IV tubing. Patient says "oh no you don't" he then grabbed IV tubing and tried to pull the system through the door port. I held onto the tubing. It snapped. Fortunately he still had the dial-a-flow on and blood backed up to that and slowed enough for CO to get assistance. He became extremely agitated when the door was opened and he saw the cuff. He began trying to kick and yell at the CO. Took 4 to subdue him and calm him down enough to come out to nurses station for assessment, vitals signs and remove the IV. Talked nonstop. Noted: patient is too agitated to put IV back in. Also his skin is reddish and dry in texture, especially his face. No open areas noted. RN Moore.

71. Mental health observation:

1742: Nurse Irma trying to get the IV started back up

1750: I/M returned to cell, uncuffed and unshackled; nurse unable to restart I/V; I/M standing at door demanding to see someone because "he's been kidnapped," yelling, struggling, banging, mumbling

72. 4 to 12 evening shift note: Peripheral IV was “on hold” due to agitation and confusion.

73. RN Moore filed an incident report concerning Ron around **1800**. “Disorderly or Threatening Behavior”:

> MR. RONALD SHOUP IS A PATIENT IN THE INFIRMARY AS LEVEL II. HE IS VERY AGITATED AND CONFUSED. HE KNOWS HIS NAME, BUT GETS CONFUSED TO TIME & PLACE. WHEN TRYING TO RE-ORIENT HIM, HE DOESN'T ACCEPT THE INFO. HE HAD AN IV INFUSING INTO HIS RT ARM. HE HAD BEEN PICKING AT THE TUBING FREQENTLY DURING THE DAY. WHEN I ATTEMPTED TO HANG ANOTHER BAG, HE SAID "NO YOU DON'T!!" HE THEN TRIED TO PULL THE IV TUBING OUT OF MY HANDS. NOTED THE IV SET UP WAS OUTSIDE THE DOOR WTIH THE TUBING GOING THRU THE FLAP TO THE PATIENT. SO HE'S ON THE INSIDE PULLING THE TUBING. I'M ON THE OUSIDE HOLDING ONTO THE TUBING, TRYING TO KEEP HIM FROM PULLING THE WHOLE SET-UP INTO HIS ROOM. HE'S YELLING AT ME THRU THE WHOLE EPISODE. THE TUBING SNAPPED. I HURRIED THE C.O. TO GET ASSIST THRU THIS. NOW BLOOD WAS BACKING INTO THE TUBING. TOOK TOTAL OF 4 C.O.'S TO CONTROL HIM & CALM HIM ENOUGH TO HAVE HIM RESTRAINED SO I COULD SAFELY TIE OFF THE TUBING, REMOVE THE REST OF THE IV TUBING AND THE ANGIOCATH FROM THE PATIENT. SINCE THIS, HE'S VERBALLY HOSTILE AND YELLING. I DID CALL THE DOCTOR TO GIVE STATUS REPORT. DID GET AN ORDER TO GIVE HIM SOMETHING TO TRY TO CALM HIM DOWN. IRMA MOORE, RN

74. Mental health observation:

> **1800**: Lying down screaming, yelling, mumbling

75. Infirmary progress note at **1810**: Becoming extremely agitated. Pulling molding off the floor board and started lifting tiles off the floor. Called provider to give status report. New orders noted. QRT team will have to be called to assist. He is too aggressive to attempt without them, RN Moore

76. **1810** Mary-Joy Monsalud-Wallace MD gave a telephone order to RN Moore for Ativan 2 mg IM x1, for Ron.

77. The 12/15/15 **DELAWARE DEPARTMENT OF JUSTICE REPORT ON THE DEATH OF RONALD W. SHOUP** noted this about the QRT at SCI:

> All correctional officers receive QRT training as part of the Correctional Officer Basic Course and then again annually by Correctional Emergency Response Team ("CERT") Headquarters and its institutional QRT instructors. Officers are assigned to the QRT at the beginning of each shift and consist of one supervisor defined as a Lieutenant or above and five correctional officers.

78. Mental health observation:

1815: Standing at door still screaming, yelling, mumbling, threatening to kill everyone who doesn't open the door; banging on door and toilet

1830: Standing at door yelling and making random statements about protecting the kids from all of us; making random threats

THIRD DOCUMENTED USE OF FORCE BY C/O'S

79. Lt. Chandler filed an incident report concerning Ron around **1815**:

On the above date and approximate time I Lt. Chandler was called by the watch commander Captain Atallian who informed me that I needed to report to the infirmary to check on an unruly inmate. Upon arriving in the infirmary I found inmate Ronald Shoup #00431647 yelling and screaming from level cell # 81. I Lt. Chandler attempted to talk to inmate Shoup but he kept yelling at this writer telling me to (take my coat off and come in the room like a man.) Nurse Irma Moore advised this writer that the inmate had tussled with her when she went in to change his IV bag, inmate Shoup had also ripped out his IV line from his arm. Nurse Irma further advised that the doctor had been contacted and a shot had been ordered for inmate Shoup. I Lt. Chandler then proceeded to the captains office to brief then oncoming Captain West of the situation. At approximately 18:35 hours team members arrived to the QRT room where they received there briefing from this writer. Once dressed myself and the team proceeded to the infirmary where the team was staged. I Lt. Chandler approached the door of cell # 81 upon arriving I observed that inmate Shoup had torn the molding off from the cell wall and was shoving in under the door. I Lt. Chandler informed inmate Shoup that he would be receiving a shot, and for him to turn around face the wall. Inmate was further instructed to kneel down cross his legs and place his hands behind his back of his neck. Inmate was asked by this writer if he would comply to which he said no come and get me. I Lt. Chandler then brought up the team from the staging area, the door was then opened and the team went into cell# 81 and secured inmate Shoup with handcuffs and leg shackles. Once secured Nurse Irma came in and administered the shot to inmate Shoup. Inmate was then taken by the team from cell l# 81 to cell # 80 once in cell the handcuffs and leg shackles were removed and the team exited the cell and the door was secured. The team then departed the infirmary and proceeded back to the QRT room, watch commander Captain West was notified that everything was 10-1 in the infirmary at this time Qrt muster was 10-1 at 1919 hours E.O.R.

80. Cpl Massey filed an incident report concerning Ron around **1830**:

On the above date and approximate time I, Cpl Claude Massey was called by the Watch Commander and instructed to report to the Muster Room to suit up in QRT gear as the #3 man for an unruley inmate in the Infirmary. I arrived at the Muster Room and was instructed by Lt Chandler that I/M Ronald Shoup (#00431647) needed to be given a needle by the medical staff and that we were needed for this procedure. The team suited up and I reported to the Infirmary where I/M Shoup was given orders to lay down by Lt Chandler and he refused. The team was then ordered to FIRE, after a brief struggle the inmate was handcuffed and secured, a nurse entered the room and gave I/M Shoup a needle after which the team moved him to Cell #80, we unsecured the inmate and exited the cell with no further action needed.

81. C/O Copeland filed an incident report concerning Ron around **1835**:

On the above date and time I C/O Copeland was called along with the rest of the team one members to the muster room. Upon arrival team one was instructed to gear up and head to the infirmary to help medical staff administer a shot to I/M Shoup, Ronald #00431647. When team one reached the informary Lt. Chandler wen to the door of cell #81 and talked with the inmate trying to get him to comply. When the inmate was noncompliant Lt. Chandler instructed team one members to line up in front of the door in this order 1. C/O Seymore, 2. C/O Collison (handcuffs), 3. Cpl. Massey, 4. C/O Humes, and myself as the 5 man (shackles). Team one entered the cell and secured the inmate. I secured the inmate's legs with the shackles. A nurse then administered a shot to the inmate's buttocks. Team one then moved I/M Shoup from cell #81 to cell #80. I/M Shoup was placed on the floor and unsecured. Team one exited the cell with no further incident. EOR.

82. C/O Seymore filed an incident report concerning Ron around **1835**:

On the above date and approximate time I C/O Seymore was on duty at the pretrial programs counter when team one was called to the muster room. I C/O Seymore responded to the muster and was told by Lt. Chandler to suit up for a cell extraction. I C/O

Seymore and the rest of the team were suited up and we received our assignments and were briefed on the situation that we were going to medical to assist the medical staff to give inmate Shoup, Ronald #00431647 a shot. I C/O Seymore was assigned the number one man the initial contact man and the team had received their assignments and then moved out en route to the infirmary at 1945. The team arrived at the infirmary and Lt. Chandler went to cell 81 to try and talk to inmate Shoup, Ronald #00431647 to get him to comply. The inmate did not comply with any of Lt. Chandlers orders. The team was called to medical cell door 81 and the order was given to fire at 1950.I C/O Seymore did fire and pinned the inmate to the bed while the rest the team secured the arms and legs. I C/O Seymore did give this inmate verbal commands through the whole process. The inmate was secured and the nurse did come in to give this inmate a shot in the buttocks area. The nurse exited the cell I C/O seymore gave the command team lift and the team did lift the inmate and move him to cell 80.The team placed the inmate in the floor of cell 80 and the command was given to unsecure the legs and arms. The inmate was given commands by me to place his hands on his head when unsecured and to not make any sudden movements or get up until the team was out of the cell and the door was secured. The team did exit the cell and the door to cell 80 was secured without further incident. The team then returned to the muster room to return the gear and debriefing by Lt. Chandler. I C/O Seymore then returned to my post at the pretrial programs counter. E.O.R

83. C/O David Collison filed an incident report concerning Ron around **1835**:

On the above date and approximate time, I C/O David Collison (Team 1) was directed by Capt D. West to report to the Muster Room along with responding Team 1 officers. Lt. J Chandler (Team 1 Leader) briefed Team 1 Officers and gave assignments. Inmate Ronald Shoup SBI #431647 was to be administered a shot by the Infirmary Nurse. After refusing to comply with Lt. Chandlers orders, Team 1 was called to Cell 81 door and gave the directive to fire. I officer D. Collison was number

> 2 man and secured I/M Shoup with handcuffs. Once I/M Shoup was secure, the Nurse was called in and administered the shot to I/M Shoups' buttocks. I/M Shoup was then moved to Cell 80 and secured in Cell 80 without further incident.

84. C/O Ben Humes filed an incident report concerning Ron around **1835**:

> On February 26, 2014 at approx. 1835 hours, I C/O Ben Humes (team 1 member #4) was summoned to the muster room to suit up! At approximately 1845 we arrived in medical and were ordered to fire on I/M Shoupe, Ronald (sbi 431647). Upon a successful deployment we then moved such inmate from cell 81 to cell 80. Said inmate was administered a shot and we safely backed out of the cell! E.O.R

85. Mental health observation:

1839: I/M talking/yelling at officer through door threatening to kill officer; tampering with toilet, trying to unscrew it, asking for tool; I/M was able to remove piece of baseboard; C/O Smoot waiting for back up to take it from him and to let nurse in to administer shot.

86. Infirmary progress note at **1840**: QRT team here. Patient subdued without much exertion. Ativan 2 mg IM given. Patient then moved to room 80. Mattress removed since he is trying to tear it up. Is allowed to keep suicide gown but picks at it and tries to tear it apart unsuccessfully. RN Moore.

87. Mental Health Observation:

1843: I/M is continuing to rip the trim up from the floor, has pulled quite a bit of it up now

88. C/O Scott Smoot Jr. filed an incident report concerning Ron around **1845**:

> On the above date and approximate time RP, CO Scott Smoot, was on duty in the infirmary. IM Shoup, Ronald, housed in cell 81 on a level 2 was becoming beligerant towards staff, saying he was going to kill staff and cursing at all staff security and medical. IM Shoup was able to remove the black rubber moulding from the bottom of the wall as well as remove some of the tile from the floor and peeled some paint off the walls in cell 81. IM Shoup eventually had a shot ordered by the doctor and QRT and k-9 was needed to administer the shot. IM Shoup calmed down for a few hours after the shot but as off 2223 is starting to push and bang against the door and become disruptive once again. RP will advise 12x8 of the situation.(It is unclear why the report time recorded by C/O Smoot is 1845 yet his report mentions things that happened at 2223)

89. Mental Health Observation:

1845: QRT team has been called; nurse Irma got a order for a shot to be given

1850: I/M at door, yelling and shaking the door

1853: QRT team has arrived

1854: Observers out of area

1856: Team entered cell got I/M down

1858: Nurse gave shot

1903: QRT team finished and leaving the area

90. The **DOJ's REPORT** contained the following about the first QRT team:

The QRT is Summoned for the First Time on the evening of February 26, 2014

Because of the deterioration in Mr. Shoup's condition, at 18:45 hours, an infirmary nurse phoned an on-call doctor, and received approval to administer a shot of Ativan to calm Mr. Shoup. The Ativan was prescribed by a doctor who had not personally examined Mr. Shoup, but who instead relied upon the observations of the nurse. Prior to requesting permission to administer Ativan, a nurse had already summoned the Quick Response Team ("QRT") to restrain Mr. Shoup for purposes of administering the Ativan.

The members of the QRT were assembled and briefed prior to arriving in the infirmary. The QRT arrived in the infirmary at 18:53 hours on February 26, 2014. Prior to entering Mr. Shoup's cell, the supervisor attempted to make contact with Mr. Shoup through the cell door but Mr. Shoup was unresponsive to his commands. The QRT entered Mr. Shoup's cell where he was handcuffed and shackled. The nurse then entered the cell to administer the shot of Ativan in Mr. Shoup's right buttock. The QRT then moved Mr. Shoup from the cell he was in to the cell next door due to the destruction he had caused in the first cell. This entire episode took less than ten minutes, and there is no indication that Mr. Shoup suffered any serious physical injuries from his interaction with the first QRT team.

91. Mental Health Observation:

1904: After QRT team, I/M was moved to cell 80 due to destruction of cell 81. The team moved him

1915: I/M picking at the paint peeling it off the wall

1930: I/M messing with the door trying to get out

92. Infirmary progress note at **1930**: Still agitated. Has periods of being quiet but doesn't last too long. Trying to pick at room but thus far not able to remove any tiles. Did get some caulking up only. RN Moore.

93. Mental health observation:

1945: Starting to quiet down a little, sitting on floor, fumbling with blanket

2000: Sitting on floor, mumbling

2015: Sitting on floor, naked, has picked up caulking from the floor

2030: Sitting on floor, naked, rocking, mumbling

2045: Banging, kicking door, hitting walls

2100: At door banging, yelling, mumbling

94. Infirmary progress note at **2100**: Continued to be hollering and knocking on door. Occasionally singing; sees own reflection and talks to it. Says this is not the SCI he knows and wants to go to the Georgetown he knows. Unable to carry on a conversation. RN Moore.

95. Mental health observation:

2115: Sitting on floor, picking at blanket, mumbling

2130: Sitting, quiet, on floor picking at gown

2145: Standing picking at blanket

2200: Pushing and banging door, yelling, mumbling; C/O Smoot at door talking to I/M

96. Physicians Orders at **2200**. Telephone order by Dr. Wallace to RN Moore. May repeat Ativan 2 mg IM x's 1.

97. Mental health observation:

2215: I/M at door banging on door wanting to get out, mumbling

2230: Knocking on door, talking to himself

2245: Pacing, banging on the door, mumbling; also nurse Irma called and got another order for a shot.

98. Infirmary progress note at **2245:** Called Dr. Wallace. New orders noted. Spoke with watch commander. Due to shift change, QRT team will be available around midnight? Patient is guarded but stable at this time even though he's chattering, kicking at the door and picking at the tiles. RN Moore.

99. Mental health observation continued on **2/27/2014**:

0000: At door picking at window

0015: At door, mumbling, banging on door

0030: Sitting on toilet, quiet

FOURTH DOCUMENTED USE OF FORCE BY C/O'S

100. C/O Dion J Stephens filed an incident report concerning Ron around **0030**:

On above date and approximate time main control made an announcement that team 1 report to the muster room. After arriving at the muster room team 1 was briefed by team leader Lt. Michael Maans on the situation. After suiting up in our QRT gear we reported to MSB infirmary cell #80 that was housing inmate Ronald Shoup SBI #00431647. Medical personnel needed to see inmate Ronald Shoup as he needed a shot. Lt. Michael Maans gave inmate Ronald Shoup 3 direct orders to turn around and be handcuffed and inmate Ronald Shoup refused and team leader Lt. Michael Maans had team 1 assemble and fire in on inmate Ronald Shoup. Team 1 consisted of the following C/O's Darrian Polk, Brian Beebe, John Dittman, Richard Downs and myself Dion Stephens the number 2 man. After firing in on inmate Ronald Shoup, I as the number 2 man handcuffed inmate Ronald Shoup. After inmate Ronald Shoup was properly secured, medical personnel gave inmate Ronald Shoup his shot and team 1 then unsecured inmate Ronald Shoup without further incident. After inmate was properly secured and the situation 10-1, team 1 reported back to the muster room for a debriefing and back to our assigned post.

101. Mental health observation:

0040 (2440): Sitting on toilet, mumbling

102. Lt. Michael Maans filed an incident report concerning Ron around **0050**:

On Thursday, February 27, 2014 at 0050 hours I, Lt. Michael Maans (Team 1) assembled Team 1 at the Muster Room per Capt. West. Capt. West informed myself that Inmate Ronald Shoup SBI#00431647 was ordered to receive a shot by medical and that the team needed to assist so the shot could be administrated. The team was suited up and briefed about the situation. The Team consisted of 1.) Officer Darian Polk, 2.) Officer Dion Stephens, 3.) Officer Brian Beebe, 4.) Officer Richard Downs, and 5.) Cpl. John Dittman. The team departed Pre-Trial building and reported to MSB Infirmary where Inmate Shoup is currently housed in cell 80. The team was placed against the wall

and I assessed and attempted to make contact with Inmate Shoup. Inmate Shoup ignored all attempts and commands without acknowledging my presence. The QRT team was then lined up outside of cell 80 and I attempted again to make verbal or noise contact with inmate Shoup. I was shouting trying to get inmates attention and beating on the door. I gave Inmate Shoup 3 orders to face the back wall and all attempts were ignored. The inmate was at the back of the cell walking around. At this time I gave Team 1 the order to fire. The QRT team entered the cell and secured Inmate Shoup in handcuffs and shackles. The nurse then entered the room and administered a shot in the left buttocks area. The nurse then departed the cell. I told Inmate Shoup that the restraints were going to be removed and that he was not to move until the door was secured and I gave him the OK to do so. Inmate Shoup stated that he understood. The restraints were removed and the team back out of the cell. Cell 80 door was secured by myself and Inmate Shoup was given the OK to move in the cell. The QRT team then departed the area and headed back to the muster room where equipment was cleaned and the team was debriefed of the situation. Watch Commander was notified of what had taken place with no further incident.

103. C/O Darian L. Polk filed an incident report concerning Ron around **0050**:

Entered By: Polk, Darian L (Correctional Officer)

On the above date and approximate time Team 1 was called to report to the Muster Room to suit up for QRT. Once the team was suited up we responded to the Infirmary, Upon arriving to the infirmary LT Maans gave I/M Ronald Shoup 00431647 3 direct orders to give up which I/M Shoup did not comply with. At this time LT Maans ordered the team to fire I C/O Polk made the initial contact with the shield, Once the I/M was secure the nurse administered at shot to I/M Shoup, At this time I ordered the team to unsecure I/M Shoup and then I ordered the team to back out. Once the Qrt team backed out the cell door was secure and there was no further incident

104. C/O Richard F. Downs filed an incident report concerning Ron around **0050**:

> Downs, Richard F (Correctional Officer)
>
> On the above date and approximate time team 1 was called to the muster room. C/O Darian Polk, C/O Dion Stephens, C/O Brian Beebe, Cpl John Dittman and myself C/O Richard Downs all responded. When I got there i was breifed by Lt Michael Maans, then suited up. When we got to the Infirmary cell 80 Lt Maans told inmate Ronald Shoup SBI # 00431647 to cuff up three times and he did not respond. At this time Lt Maans told Team 1 to fire so we did, we took inmate to the floor and cuffed and shakled the inmate. The nurse then came in to give him a shot and looked him over. We then took off handcuffs and shakles then exited the room one by one, all 10-1.

105. Cpl/Sgt John E Dittman filed an incident report concerning Ron around **0050**:

> Dittman, John E (Co Corporal/Sgt. - Large Inst.)
>
> On 27 February 2014 at approximately 0050 hours Team 1 was ordered muster to suit up and respond to MSB medical. I, Cpl John Dittman was assigned to the #5 position. Upon arrival to MSB Medical I observed team 1 leader Lt Mike Maans issue three direct orders to inmate Shoup, Ronald 00431647. Inmate refused to comply and Lt Manns gave the order for the team to fire. Team members were #1 C/O D Polk, #2 C/O D Stephens, #3 C/O B Beebe, #4 C/O R Downs and myself. Once inside the cell C/O Downs and Cpl Dittman secured secured the legs with schackles. After inmate was fully secured the nurse entered and administered a shot. After the nurse exited the cell the inmate was unsecured and the QRT exited the cell and secured the door with no further incident. EOR

106. C/O Brian Beebe filed an incident report concerning Ron around **0050**:

> On the above date and time I, Officer Brian Beebe, was assigned to Team #1 and ordered to the Muster Room to suit up for QRT. Once in the Muster Room we were briefed about the situation in the infirmary involving Inmate Shoup, Ronald SBI#00431647 by Team #1 Leader Lt. Manns. Once we arrived at the Infirmary the QRT team lined up along the wall while Lt. Manns gave Inmate Shoup three direct orders to face the back of the cell in which the inmate refused to comply. At this time Lt. Manns gave the team the command to fire. Once in the cell the team gained control of Inmate Shoup and secured his legs and hands. Once secured the nurse entered the cell and administered a shot. After the shot was administered the team unsecured the shackles and cuffs and backed out of the cell with no further incident. The team then returned to the Muster Room to debrief. EOR

107. It was more than a two hours between when the call was made to Dr. Wallace and the arrival of the QRT.

108. The **DOJ REPORT** contained the following about the second QRT team:

> **Second QRT Team is Summoned**
> **Just After Midnight on February 27, 2014**
>
> Although the shot of Ativan was administered at 18:58 hours, the shot seemed to have little effect on Mr. Shoup's agitation and aggression. At 19:15 hours, Mr. Shoup began to pick the paint off the wall. At 19:30 hours, Mr. Shoup was at the cell door trying to get out. By 21:00 hours, Mr. Shoup was observed talking to himself, and banging and yelling at his cell door. Between 22:00 hours and 22:45 hours, Mr. Shoup continued to push and bang on the cell door. At 22:45 hours, the nurse received doctor's approval for a second shot of Ativan – once

again without the doctor seeing Mr. Shoup – and called for the QRT's assistance in restraining Mr. Shoup. The supervisor from the first QRT declared that this second shot of Ativan would occur after his shift which ended at midnight.

In the early morning hours of February 27, 2014, a second QRT was assembled and briefed prior to arriving in the infirmary. The QRT arrived in the infirmary at 00:50 hours. Prior to entry, the supervisor attempted to make contact with Mr. Shoup through the cell door but Mr. Shoup was unresponsive to the supervisor's commands. Mr. Shoup was described as crouched in a ball, facing away from the door when the QRT team entered the cell.

The first QRT member who entered the cell hit Mr. Shoup with a shield, knocking him onto his right side. The four other QRT members restrained Mr. Shoup's arms and legs, and Mr. Shoup was rolled over to a prone position and handcuffed and shackled. Doctor Weedn has concluded, based on the factual evidence available to him and his examination of Mr. Shoup's medical records, that the weight of more than one correctional officer was placed on Mr. Shoup during at least part of this QRT intervention. Mr. Shoup was not combative or aggressive during this time. The nurse administered the second shot of Ativan at 00:50 hours. The QRT members then exited the cell; this entire episode took less than five minutes and the QRT left the infirmary at 00:55 hours. The intervention itself obviously did not unfold exactly as envisioned by the QRT training materials. Those training materials indicate that the mandated method of intervention is designed to avoid having correctional officers pile on inmates in the process of subduing them, yet the results of Dr. Weedn's medical examination suggest that in the process of attempting to restrain Mr. Shoup's arms and legs, other members of the second QRT team placed their weight on top of Mr. Shoup and that their combined weight caused the multiple fractures that ultimately led to his death.

109. Mental health observation:

0050: Observers out of area; team 1 in to admin meds

0055: Team out, I/M lying on floor, moaning

110. Terah Chipman LPN filed an incident report concerning Ron around **0055** on **2/27/2014**:

> **TEAM ONE RESPONDED TO INFIRMARY TO HELP SECURE INMATE RONALD SHOUP SO MEDICAL COULD ADMINISTER AN INJECTION. HE ONLY OBTAINED AN ABRAISON TO BOTTOM OF RIGHT FOOT.**

111. The nursing night shift was unable to assess vital signs.

112. CIWA score at **0100**: Agitation: 4 out of 10. Auditory disturbances: 3 out of 10. Anxiety: 4 out of 10. Orientation: 4 out of 10. Total score: 15. LPN Chipman

113. Infirmary progress note at **0100** on **2/27/2014**: Unable to assess vitals at this time. Inmate agitated; banging on door, picking at wall, talking to himself and the wall. At one point hollering for his mom. Order was received to give 1 more Ativan injection so per DOC arrangements made for QRT to come in and secure the patient. Injection given to the left gluteus maximus as ordered. After QRT left and patient secured in room noticed blood on the floor. Upon further research noted small abrasion to bottom of right foot. LPN Chipman.

114. Mental health observation:

0105: Sitting down, quiet

0115: At door, real shaky, quiet

0120: Sitting on toilet backwards

0130: Lying on floor, quiet

0145: Lying on floor, quiet

115. Infirmary progress note at **0145**: Patient proceeded to take jacket and spread it on floor to lie down.

116. Mental health observation:

0200: Sitting, quiet, against door

0215: Sitting, quiet

117. Infirmary progress note at **0215**: Patient up walking around room picking at walls, then sitting down on floor, speaking or mumbling a flight of ideas. Sometimes he is asking to speak to the doctor so he can leave the hospital then back, talking to his mother. LPN Chipman

118. Mental health observation:

0230: Sitting, mumbling

0245: Lying down, mumbling

0300: Sitting, mumbling

0315: Lying down, mumbling

0330: Sitting, mumbling, on toilet

0345: Sitting, mumbling, floor

0400: Lying down, mumbling

0415: Sitting, mumbling

0430: Laying down, quiet

0445: Lying down, quiet

0455: Appears sleeping

119. LPN Chipman filed an incident report concerning Ron around **0556**:

> AT **0450** PYSCH TECH GRIFFITH WENT TO DO HIS 15 MINUTE CHECK ON INMATE RONALD SHOUP AND CALLED NURSE CHIPMAN TO DOOR IT APPEARED AT THIS TIME THAT INMATE WAS BREATHING BUT WOULD CHECK ON HIM AGAIN IN 5 MINUTES. AT **0506** PYSCH TECH BROWN DID CHECK AND NURSE CHIPMAN ALSO WENT TO CHECK ON HIM AGAIN AT THIS TIME HE DIDN'T APPEAR TO BE BREATHING. AT THIS POINT WE KNOCKED AND SHOOKED ON DOOR WITHOUT RESPONSE. OFFICER TERRY CALLED TO OPEN DOOR. NURSE CHIPMAN COULDN'T GET A PULSE WITH ASSISTANT FROM NURSE RICKETTS CPR WAS STARTED AND 911 CALLED. 0515 PARAMEDICS ARRIVED ON THE SCENE AND TOOK OVER. **0540** INMATE TRANSFERED TO BEEBE VIA 911 AND REPORT CALLED IN TO BEEBE ER CHARGE NURSE.

120. Richard Griffith, mental health observer filed an incident report concerning Ron around **0455**:

> On the above referenced time and date I, Richard Griffith; mental health observer, made a routine fifteen minute check on I/M Ronald Shoup, at which time I asked Nurse Terah Chipman to come to the door because I felt it hard to tell if I/M Shoup was breathing. Nurse Chipman felt as though she saw his chest

move and we agreed that we would check again in a few minutes. At **05:05** we checked again and began beating on the door and yelling his name with no response. I immediately went to get C/O William Terry from around the corner where he was doing compound diabetics. C/O Terry then came and opened the door to cell #80 and nudged the I/M and called his name with no response. Nurse Chipman then checked for a pulse and a heartbeat and yelled call 911. END OF REPORT.

121. The infirmary progress note at **0455**:

Psych tech Griffit did observation check and called me, nurse Chipman, to door. It appeared at this time it looked like he was breathing slow respirations. Advised I would recheck in five minutes. LPN Chipman.

122. C/O William Terry filed an incident report concerning Ron around **0500**:

On the above date and approximate time, I C/O William Terry was conducting am diabetic call for the compound. Psych Tech Rich Griffith came to me and asked me to check I/M Ronald Shoup cell 80. Mr Griffith stated that he couldn't tell if I/M Shoup was breathing. I immediately turned diabetic call over to Sgt Layton and responded to cell 80 and found nurse Terah Chipman beating on the door trying to get a response from I/M Shoup. I entered cell 80, shouted I/M Shoups name and nudged his leg and got no reponse. Nurse Chipman also entered the cell and checked his pulse and breathing and got nothing. Nurse Chipman said to call 911 and started CPR. I shouted for Sgt Layton and nurse Lakeischa Ricketts. Nurse Ricketts also entered the cell with the AED and assisted nurse Chipman. CPR was continued until Paramedics arrived at approximately **0520** and took over. At approximately **0535** a pulse was detected by Paramedics and CPR was stopped. I/M Shoup was transported to Beebe Hospital. End of report.

123. The infirmary progress note at **0506**: Went to the door while psych tech Brown was doing check couldn't tell at this time if he was still breathing according to the tinted glass so psych tech went to get the infirmary officer to open the door. Inmate was laying down not responding to anything, no pulse, noted; CPR started with another staff member calling 911; me and nurse Ricketts continued CPR until the paramedics arrived at **0515**. At **0540** inmate was transferred to Beebe ER via 911. LPN Chipman.

124. Mental health observation:

0505: Appears sleeping

0506: CO and nurse in cell to check on inmate

0507: Nurses in cell to administer CPR; inmate unresponsive

125. C/O Chaffinch filed an incident report concerning Ron around **0510**:

> On the above date, location, and approx. time I C/O Chaffinch responded back to Medical for assistance with an Inmate in Cardiac Arrest. I arrived in Medical to find 2 Nurses conducting CPR on Inmate Ronald Shoup in Cell # 80. I got Latex gloves and placed them on and by that time SCEMS(Paramedics) arrived and they pulled the Inmate out of the cell into Medical. I C/O Chaffinch then relieved Nurse Terah of Chest Compressions. I C/O Chaffinch continued with Chest Compression until I was relieved by Georgetown EMS provider. After the Medics were finished with their evaluation I assisted the EMS crew with loading the Inmate on to a backboard for transport. EMS personnel loaded Inmate into Ambulance for transport. I C/O Chaffinch then assisted the Nurse with clean-up of used Medical supplies. I then cleared Medical without further incident.

126. Lt Devern filed an incident report concerning Ron around **0515**:

> On the above date and time I, Lt Devern received a phone call from C/O Terry. He said I should report to the Infirmary. When I arrived in the infirmary I witnessed two nurses performing CPR on I/M Ronald Shoup. CPR continued until Paramedics arrived. I/M Shoup was then transported to Beebe Hospital.

127. Ron C. and his wife, Ron's mother, were driving to Florida on February 27, 2014 when their cell phone rang. They pulled over and a Delaware State Police Sargent put a Chaplin on the phone. He said "I am sorry to have to tell you this, your son Ron passed away this morning at Beebe hospital at 9:25." Mr. and Mrs. Shoup turned around and went directly back to Delaware.

128. On February 28, 2014, DOC spokesperson Nina Brown told Ron C that Ron had been acting up in his cell and was moved to the Infirmary Cell. At approximately 8:30 on February 26, 2014 the Quick Response Team was sent in to "quiet him down" so that he could be given him a shot of Ativan. Around 11:30 they had to send in the Quick Response Team again and give him another shot of Ativan. She claimed that Ron was breathing at 3:30 am on the 27th, but at 4:00 am he was not and he was dead before leaving the prison.

129. After Ron's death inmates who were being held near the infirmary heard C/O's joking about SCI having its first lethal injection. They also heard C/O's saying words to the effect, "now we can't touch anybody anymore or they will file a lawsuit".

130. Inmates remember a nurse who was a "tall" girl saying that Ron was not breathing and Sgt. Layton saying things like “he's faking” or “he's quiet now”. When the C/O’s were told that Ron might not be breathing they told the nurses to go look at him. The inmates could hear the Correctional Officers laughing when they were talking about going to check on Ron.

131. Randy Wagner in the Medical Examiner’s office subsequently informed Ron C. that Ron had a lot of bruises all over his body, more than he has ever seen, and they were conducting a homicide investigation.

132. Assistant Medical Examiner, Jennie Vershvovsky M.D., performed a medical autopsy on Ron, on February 28, 2014 in the Office of the Chief Medical Examiner. The cause of death listed on her autopsy report was "Multiple blunt force injuries” and the death was a “Homicide” that took place in "Sussex Correctional Institution in a (sic) isolated cell in the infirmary". Ron had "Sustained lethal trauma while being restrained multiple times by prison response team".

133. On March 11, 2014 plaintiff’s counsel received a letter from an anonymous source at SCI. The letter included the following statements:

> I understand you are looking for information on Ronald Shoup’s death. He died before 5:00 A.M. the day he passed. A code was called at 5:00 A.M after a nurse found him. He was already "cold" and "blue". He did not die at the hospital as reported. He may have been "pronounced" at the hospital! If you have the power to look at the medical report and the toxicology report, you may want to look for the amount of Thorazine he had been given! There were five different people (suit people)

> at SCI shortly after the death, early in the morning. (Mr. Coupe, Mr. Johnson, Ms. Valentino, two prosecutors that work with DOC) they reviewed video from the medical unit. His parents and family deserve the truth!

134. On May 2, 2014 plaintiff's counsel received another letter from an anonymous source at SCI that included the following statements:

> I was reading the article in the Cape Gazette and it was refreshing to see that someone was tracking prison beatings but it goes further than that. Since DOC was released from the MOA with the DOJ they are reverting back to their old ways. Vendors are being paid significantly large fees for lack luster services. Mr. Shoup was not giving the quality of care he deserved nor was he assessed properly for de-toxic protocol. Instead he was thrown in a cell with withdrawal symptoms that were not attended to by a psychiatrist because the vendor does not have psychiatrist coverage to accommodate all the institutions. Mr. Shoup may have had what is known as Delirium tremens which is brought on by withdrawal. There is appropriate treatment. Unfortunately, Mr. Shoup did not get it. Instead he was given a "cocktail" of Haldol, Ativan and Cogentin
>
> Dr. E resigned from working for DOC because he stated: "someday someone will die from withdrawal because they do not get the appropriate withdrawal care. Dr. E. as a psychiatrist could not work in such an unethical environment.
>
> If appropriate care was given he would not have need the CERT team. These types of unfortunate and unnecessary deaths, by officers, suicide or overdose can and should be prevented. Let's not forget 20 year old Eric…
>
> The young woman that died on her way to BWCI is another excellent example. She was received at SCI under the influence. She was held in a cell overnight with no evaluation. She was not referred her seen by mental health. The next morning she was being transferred to be WCI the DOC transport and had a

> seizure and died. What families need is for the DOJ to come back and take a look at where the DOC is now.
>
> Instead a 48 year old man, someone's son, is dead.

135. Detective Billy Porter from Delaware State Police Troop 5, told Ron C. that DSP had forwarded a report on Ron's homicide to the Attorney General's office in Georgetown Delaware in the summer of 2014. However, DOJ representatives continued to tell Ron C. and Beth, without explanation, that the investigation was not yet complete.

136. On or around August 18, 2015, Deputy Attorney General, David Hume IV, (DAG Hume) who works in the Georgetown DOJ office, told Ron's parents that there would be no criminal prosecution. He said he would send them a copy of Ron's autopsy report when he released his decision to the newspaper. However, on August 19, 2015, DAG Hume informed plaintiff's counsel, "This matter is still under review." Finally, on December 11, 2015, DAG Hume provided plaintiff's counsel a copy of the autopsy report dated February 28, 2014. The autopsy report confirmed that Ron was killed by C/O's as a result of the multiple times they used force against him.

137. The cover sheet summary of the findings included:

> A. CIRCUMSTANCES: Inmate found unresponsive in his cell after being restrained multiple times by prison response team. He was transported to Beebe Medical Center where he expired. Past history of chronic ethanol abuse

B. PATHOLOGICAL FINDINGS: Blunt force injury to the torso: cutaneous contusions; fracture, right clavicle; multiple bilateral rib fractures; bilateral hemothoraces; hemorrhage, soft tissue of the chest; hemorrhage, soft tissue of the back. Blunt force injury to the upper extremities. Blunt force injury to the lower extremities.

C. CAUSE OF DEATH: MULTIPLE BLUNT FORCE INJURIES.

D. MANNER OF DEATH: HOMICIDE.

138. The report section of the autopsy described some of the injuries as follows:

> Blunt force injury to the neck and torso: On both shoulders, extending from the anterior to the posterior aspect of the body, there are two large areas of contusion variegating from purple to red-purple to blue-green-purple; measuring approximately 8" by 5" in greatest dimension. Slightly below the left breast, there is a small 1/4" area of purple contusion. A purple area of contusion is also noted on the lateral aspect of the left chest, close to the armpit. On the lateral aspect of the body, left side, there is a 3" dark red-purple fan-shaped patterned injury. The borders of this injury are deeper in color than the central area. When looking at the injury, on the right side, above and contentious with the injury, there is a half-circular contusion. On the left side of the injury at the 12 o'clock position, there is an additional horizontal contusion measuring 1/2". Examination of the back reveals a somewhat curvilinear 3" purple contusion in the area below the left scapula resembling the letter "S" in shape. There is a red-purple contusion on the left buttock which measures 1/2". On the lateral aspect of the lower torso, right side, there are two contusions, one is dark blue-purple and the other is red-purple measuring 1" and 1 1/2" respectively. Above them there are two circular yellow impressions, one of which is faint. Reflection of the skin of the chest reveals marked hemorrhage in the soft tissue of the chest wall and shoulders. Examination of the back reveals marked soft tissue hemorrhage involving the entire posterior aspect of the body where soft tissue is permeated with blood. There is a fracture of the distal clavicle on the right side.

Multiple bilateral rib fractures are identified: anteriorly, on the right side, ribs #2, 3 and 5 are fractured; on the left side, ribs #2 and 6 are fractured. There are also multiple fractures in the posterior ribs. On the right side, all ribs are fractured except ribs #10, 11 and 12. On the left side, all ribs are fractured except #9 through #12. Anterior-lateraily, on the left side, ribs #2, 3, 4 and 5 are also fractured and crushed (corresponding to the location of the patterned injury). The soft tissue of the intercostal spaces is hemorrhagic. There are bilateral hemothoraces with 100 ml of blood in the left chest cavity and 350 ml of blood in the right chest cavity (status post chest tube placement). There is also hemorrhage in the soft tissue of the posterior neck. Subpleural contusions are noted in both lungs.

Blunt force injury to the upper extremities: On the right elbow there is a 3 1/2" by 2" area of red contusion. The right forearm, mostly on the posterior aspect, shows green-red discoloration and slight swelling. A purple contusion is noted on the right wrist. Further dissection of the area of the right wrist reveals hemorrhage in the underlying soft tissue. There is a large purple contusion on the proximal knuckle of the index finger of the right hand. On the anterior aspect of the left upper arm there are three contusions measuring 1 1/2", 2" and 2", respectively. One of these contusions occupies the area of the antecubital fossa (may represent medical intervention). In the area of the left elbow there is a 3" by 1" red-purple contusion. Two purple contusions are noted on the posterior aspect of the left upper arm, each measuring 1/2" in greatest dimension. There are several contusions in the area of the left forearm. There is an area of blue-purple discoloration on the dorsal surface of the left hand and a purple-blue contusion on the index and fifth fingers. Further dissection of the left wrist reveals hemorrhage in the underlying soft tissue.

Blunt force injury to the lower extremities: On the medial aspect of the left thigh, there is a linear blue-purple contusion which measures 8" in greatest dimension. On the anterior-lateral aspect of the left thigh, there is a 3 1/2" linear abrasion surrounded by blue contusion. On the lateral-posterior aspect of the left thigh there is a 1" red contusion. Numerous red purple

> contusions are present below, above and on both knees ranging in size from 1" to 2" in greatest dimension. There are purple-red contusions on both ankles (areas of the medial malleolus). Numerous contusions are noted on the right and left feet. On the right foot, they are small and scattered ranging in size from 1/4" to 1/2" and on the left foot the largest purple contusion is noted in the area of the great toe measuring 1 1/2" in greatest dimension. There is a 1" laceration on the sole of the right foot. Lateral aspect of the right ankle shows green discoloration and several purple contusions. Dissection of the skin in the area of both ankles reveals underlying soft tissue hemorrhage.

139. Under the heading **Additional Observations and Recommendations** in the DOJ final report DOJ noted the following:

> DOJ does not have any independent expertise in either medicine or tactics for restraint of inmates. Nevertheless, there are three areas involving Mr. Shoup's death where DOJ believes it is not only qualified but compelled to comment on DOC policies and/or procedures in place at the time of the incident, even though that commentary is from the perspective of laypersons.
>
> **Propriety of Using QRT.**
>
> The QRT team, based on the materials made available to DOJ, appears to be specifically chosen, trained, and equipped to deal with dangerous situations involving violent or affirmatively resistant inmates. Not all situations in correctional facilities that require the use of force require correctional officers with this type of background and training – indeed, it appears that the first correctional officer intervention with Mr. Shoup was not conducted by the QRT team, and resolved without apparent injury to Mr. Shoup. It does not appear to DOJ that every planned use of force by correctional officers in DOC facilities should be performed by a QRT team.
>
> **Tactics Used by QRT Team.**
>
> Even if a QRT team must be used, the training provided for such QRT teams did not at the time of Mr. Shoup's death allow

> for any divergence from the tactics described above. Specifically, they did not allow for the fact that (a) the inmate against whom force should be used might not be affirmatively resisting correctional officers, and/or (b) be in a medically or physically fragile state. If a QRT team must be used against an inmate who is passive and/or in a fragile physical condition, DOJ believes that QRT team should not use the same tactics that it would use against a physically robust inmate who is affirmatively resisting the QRT team's efforts.
>
> **Direct Medical Attention.**
>
> Alcohol withdrawal is a potentially dangerous condition, and even at the levels demonstrated by Mr. Shoup can result in significant medical emergencies if not properly monitored. Yet, no doctor ever examined Mr. Shoup in spite of his significant and spiraling symptoms. Both of his Ativan injections were prescribed by a doctor over telephone, without any actual observation of Mr. Shoup. While this type of long-distance care may not have caused Mr. Shoup's death in this instance, it should not be the norm for patients in Mr. Shoup's condition.

140. The QRT consists of five correctional officers who are issued helmets, vests, body armor, and a "pinning" shield to use when extracting combative inmates from a cell against their wishes. The shield is hand held, and concave or convex depending on how you look at it. It is made of clear polycarbonate with two handles on the back of it. The shield is approximately 24 inches wide and 48 inches high, and weighs about 9 or 10 pounds. The concave nature of the shield is supposed to allow C/O's to "surround" the inmate with the shield and pin them against the wall. It is intended for use with belligerent, combative inmates who are intentionally disregarding orders, but at SCI it also gets used on inmates who are

incapable of following instruction because of mental impairment of some type. In fact it was the policy of DOC to use the QRT and shield on inmates with mental impairments, despite their inability to respond to verbal commands.

141. People suffering from delusions and hallucinations wander into the ER's in Delaware on a regular basis, and are not brutalized because they are hallucinating and cannot follow verbal commands. Instead, they are met with a few trained medical staff members, who without a hand held shield or other riot gear, quickly get the person strapped to a gurney so that a doctor can examine them and prescribe a drug to calm them down. In Ron's case we know that QRT member C/O Polk slammed his shield against Ron during the second QRT use of force on Ron, even though Ron was not responsive, combative, or aggressive, and was curled in a ball facing away from the door when the QRT entered the cell. Then, while Polk had Ron pinned down with the shield, additional QRT members piled on top of Ron crushing him. A result that does not occur when local hospitals deal with people in Ron's condition.

PRIOR INSTANCES OF LACK OF CARE FOR INMATES WITH WITHDRAWAL SYMPTOMS AT SCI

142. At SCI there is a long history of failing to provide medical treatment to inmates who are going through alcohol withdrawal and instead treating their hallucinations as disciplinary matters. G.R. Johnson is familiar with these cases and participated in most if not all of them. Mosser was employed at SCI during all of

these cases, most of the time as HSA or the equivalent. She would have been informed when an inmate going through withdrawal was having hallucinations and becoming belligerent, and she provided care in some of these cases.

143. Typically, an inmate begins to hallucinate or become delusional because they are going through withdrawal and the medical employees have not treated them for withdrawal. The medical employees are usually ill equipped to handle such situations. Frequently, like in Ron's case, nurses and social workers make treatment decisions, because doctors, nurse practitioners and psychiatrists are usually not on duty in the infirmary evenings and weekends, and frequently just call in orders for patients based on what the nurse tells them. The nurses have authority it appears, to ask C/O's to subdue an inmate who is hallucinating so they can give the inmate an injection of whatever the doctor has ordered to calm them down.

PRIOR CASE ONE

144. SB, a slender man in his 50's began to have alcohol withdrawal with hallucinations about four days after being incarcerated at SCI pretrial in August 2005. His symptoms were documented by a C/O, but there was no treatment given and SB scratched C/O Kevin Braswell with an ink pen, because he thought someone was going to kill him. In the subsequent struggle, C/O Braswell, who weighed about 300 pounds at the time, landed with both knees on SB's back while SB was

face down on some stairs. Defendant Johnson was a lieutenant and a supervisor of the C/O's involved in the incident. He was on duty but for undisclosed reasons he was not at SCI when the incident occurred. He learned about it after he returned to SCI and talked to the C/O's gathered around the soda machine. A disciplinary report was filed against SB, and Johnson served him with the papers for a disciplinary hearing. Johnson made no inquiry as to SB's mental competency to understand the papers he had just given him. Hearing officer Melvin Hennessy conducted the disciplinary hearing in an open area of SCI, by. No witnesses testified at the hearing that took about five minutes. Hennessy gave no consideration to SB's mental status, and he found him guilty of assault on an officer. Despite his obvious mental breakdown SB was immediately placed in disciplinary segregation, and it took about 10 days before he could get another inmate to file a request for him to be seen at sick call. The C/O's were unwilling to give him a sick call slip directly. The x-ray ordered by the sick call nurse showed all ribs on one side were broken but SB did not receive pain medication for another day or two. In September 2008, Johnson admitted that DOC had not given him any training on dealing with inmates who were suffering from drug or alcohol withdrawal during his almost 18 year career with DOC. There is no evidence that any DOC employee was disciplined for what happened to SB and no evidence that any remedial measures were taken as a result of what happened to SB. Mosser participated in the medical care

of SB. She started as a nurse at SCI in 2003 and was appointed HSA in October 2005 (December 2005 according to a later testimony). When SB was at SCI there was no protocol in the SCI procedures manual for dealing with inmates who were having withdrawal problems. The SCI vendors did not start using the CIWA scale until sometime later.

PRIOR CASE TWO

145. DK, a slender man in his 50's, while incarcerated at SCI pretrial in September 2006, was not treated for his obvious withdrawal symptoms. While under the delusion that the other inmates were going to kill him, he resisted C/O's trying to drag him back to his bunk. In the struggle, he accidentally pulled a computer monitor off of a desk and it struck a C/O in the head causing a small cut. Johnson was the SCI watch commander on this shift and had been informed that DK was acting paranoid and anxious, hours before the incident, but did not request any medical intervention. After the altercation, DK was taken to medical and seen by an LPN, not an RN or MD. DK was then placed in disciplinary segregation and sometime later was heard making noise and asking to see a supervisor. Johnson claims he looked in the cell for "a second" and saw DK banging his head against the bars. He did nothing personally but told two C/O's to get him down. Johnson's shift was over about that time and he made no follow up attempts to see how the matter with DK was resolved before he went home. He came back about 8 hours

later as SCI watch commander. By this time DK couldn't stand up and had somehow sustained a torn esophagus, multiple broken bones, bruises, lacerations, and swelling, especially on his head. He was finally transferred to the hospital and placed in a medically induced coma for a few days. Johnson was now a major having been a lieutenant for 9 years, but progressing to staff lieutenant, captain and then major in less than 2 years. He still had received no training on how to deal with inmates who were suffering from withdrawal and he never made any inquiry to find out how DK sustained his injuries. The SCI warden in September 2006 was Rich Kearney, and he testified under oath about conditions at SCI:

He said:

a) Force was used frequently at SCI by C/O's;

b) A detoxing inmate was a fairly common occurrence at SCI;

c) C/O's could use force to restrain inmates having psychotic episodes because that was the only way they were trained to handle such inmates.

146. Mosser gave care to DK on the day he was sent to the hospital and was aware of everything that happened to him were in the context of medical or mental health care. There is no evidence that she or Defendant Johnson were instrumental in bringing about any changes in the way withdrawing inmates were to be treated at SCI after DK suffered his injuries.

147. There is no evidence that any DOC or medical employee was disciplined for what happened to DK, nor is there any evidence that any remedial measures were taken to keep such a thing from happening again.

PRIOR CASE THREE

148. In May 2007 a young man, MN, was taken to SCI so highly intoxicated that he could hardly keep his eyes open for a booking picture. He was not cooperative with the booking process and despite his obvious intoxication the C/O's did not ask for medical help for MN. Instead, one of them punched MN in the face knocking him unconscious. The C/O's allowed the prison K-9 dog to bite MN on his buttocks and legs. Johnson and Mosser were working at SCI during the time this occurred. An Internal Affairs investigator found that the C/O who punched MN lied about it, but there was no discipline for that officer or anyone else involved in the incident. Johnson was a captain at this time and was watch commander of SCI at least four shifts per week and would have been aware of this case that was investigated by Internal Affairs. Mosser was HSA and would have been informed about what happened to MN.

PRIOR CASE FOUR

149. In May 2010, a 57 year old woman, ND was taken to SCI where she was held for about 24 hours. She was unable to sleep because a woman in a nearby cell was going through withdrawal and yelling all night long, apparently without

receiving medical attention. ND had her vital signs taken, but did not receive any actual medical care at SCI despite extremely high blood pressure, Johnson, who became acting warden at SCI in April 2010, before being named warden in July 2010, was deposed in the case and fully aware of the allegations of inadequate medical care for women inmates at SCI. Mosser remained as HSA and was aware of the care being given to female inmates.

PRIOR CASE FIVE

150. In 2009, 18-year-old ES had three DOC incarcerations during which his substance abuse and mental health issues were well documented. He was highly intoxicated when he was arrested again in August of 2010, but after evaluation at a hospital, he was released, still highly intoxicated, and taken to SCI. At the time of the initial intake he had an altercation with some C/O's, but because of the level of his intoxication at the time, he could not remember the altercation when he was placed in solitary confinement as punishment several weeks later. Several days into the solitary confinement, he wrote a mental health sick call request asking for medications and stating that his anxiety and depression were making him crazy in solitary. The first response to his request, was by Charles Collins LPN who reviewed the request and marked it "routine" about six hours after ES attempted suicide alone in his cell. ES was taken to the hospital where he died a few days later. John-

son was warden at SCI and as such was fully informed about this case. As HSA Mosser would have been informed of the details of a case involving suicide.

PRIOR CASE SIX

151. In July 2013, RB had a VOP hearing in the Court of Common Pleas during which she appeared to be under the influence. She was taken to SCI and the intake LPN wrote that RB had no past history of substance abuse, when the DOC records from a prior stay recorded such a history in great detail. RB received no treatment for withdrawal and the next morning, while waiting for the van to BWCI, she went to the bathroom several times and told the C/O's she felt nauseous. She became unresponsive on the way to BWCI and died a day later from a condition related to withdrawal. RB was mentioned in the May 2, 2014 anonymous letter:

> The young woman that died on her way to BWCI is another excellent example. She was received at SCI under the influence. She was held in a cell overnight with no evaluation. She was not referred her seen by mental health. The next morning she was being transferred to (B)WCI the DOC transport and had a seizure and died.

As warden, Johnson would have been made aware of the details of this case. As HSA Mosser also would have been informed of details of this case

THIS CASE

152. The inevitable happened in February 2014 when Ron was going through withdrawal at SCI and his withdrawal delusions and hallucinations were not treated before he lost touch with reality. His grasp on reality was already com-

promised when he stayed up all night from 2/24 to 2/25 making plots and threats. The C/O who requested that someone from mental health see Ron said he had not seen anybody that out of it in a long time. However, the CCS Medical employees allowed Ron to continue mentally decompensating without seeking proper care for his condition, until he was no longer able to cooperate with them. Then, they called on C/O's to repeatedly force Ron to let them give him medical attention, including injections to calm him down. The repeated use of force by the C/O's killed Ron. There is no evidence that any discipline was taken against any DOC or CCS employee as a result of this homicide.

CAUSES OF ACTION: JOHNSON

153. The cruel and unusual punishments clause of the Eighth Amendment, incorporated by virtue of the Fourteenth, obliges States to provide adequate medical care for inmates like Ron who have lost the means to provide for themselves, and prison officials such as Johnson, are constitutionally bound to provide such inmates adequate physical and mental health care for any serious medical condition.

154. The medical care given to inmates such as Ron, for their serious medical needs, is subject to local standards of care must respect the DOJ Bureau of Correctional Healthcare Services (BCHS) standards and must respect inmates' civil rights. See DOC policies 11 A-05 (E)(3) and 5.1 V.

155. Johnson was aware that he had a duty to ensure that DOC, CCS, and employees of both complied with all laws, regulations and rules, as well as the United States Constitution, when providing medical care to inmates, including Ron.

156. Johnson was also personally aware of the following:

a) There were many previous cases at SCI in which inmates going through withdrawal, or suffering a mental breakdown received inadequate care or no care for their withdrawal.

b) The failure of CCS, and previous medical vendors, to provide adequate care to inmates going through withdrawal, sometimes resulted in hallucinating or delusional inmates acting out resulting in the use of force by C/O's and physical injury to the inmate.

c) Force was used frequently at SCI by C/O's;

d) A detoxing inmate was a fairly common occurrence at SCI;

e) C/O's use force to restrain inmates having psychotic episodes because that is the only way they are trained to handle such inmates.

f) Prior to the C/O's killing Ron, he had done nothing to try to reduce the use of force by C/O's on inmates who were suffering withdrawal symptoms.

g) Prior to the C/O's killing Ron, he had done nothing to improve medical and mental health care for inmates going through withdrawal, or suffering a mental breakdown at SCI.

h) Withdrawal is a serious medical condition and left untreated it can cause death.

i) Inmates at SCI like Ron, who were suffering from withdrawal symptoms including hallucinations and delusions, were being treated by C/O's as if their inability to follow instructions was a control or disciplinary matter. As a result, behavior of the inmate caused by hallucinations and delusions, often resulted in repeated physical confrontations with correctional staff, including the QRT, and the inmate is often charged with a disciplinary infraction and placed in disciplinary segregation.

j) He had the authority to compel CCS to properly treat inmates suffering from withdrawal, but did nothing to compel CCS to do so.

k) SB, DK, MN, ND, ES and RB were former inmates at SCI and he had participated in their cases, or been made aware of them.

l) He had no training on dealing with inmates who were suffering from drug or alcohol withdrawal, despite a 23-year career with DOC.

m) No records are being kept by him or anyone else at SCI about the frequency of the use of force by individual C/O's on inmates who were hallucinating,

and actually, no records are being kept by anyone concerning how often C/O's are using force against inmates at SCI.

157. Johnson breached his known duty to make sure that inmates received reasonable medical care for serious medical conditions, and breached his duty by failing to exercise reasonable and ordinary care, and by being negligent and deliberately indifferent when overseeing the actions of CCS, and DOC employees. He could not have reasonably believed that inmates being physically manhandled because they were suffering from untreated withdrawal symptoms and hallucinating, were receiving reasonable medical care for their serious medical conditions.

158. Johnson, with deliberate indifference to the dysfunction of medical vendor CCS at SCI, and to the practice of C/O's using physical force on hallucinating inmates, exposed Ron to a sufficiently substantial risk of serious damage to his health. In fact Johnson's deliberate indifference allowed CCS and SCI employees to ignore the applicable standards of care, and to substitute physical force against Ron for the medical care he needed.

159. The fact that Johnson has a senior position at SCI for the DOC did not make him free to ignore substantial dangers to Ron's health and safety, and even though DOC had contracted with CCS to provide medical care to inmates, Johnson remains subject to a § 1983 claim because he knew that inmates had not been receiving reasonable medical care at SCI for withdrawal symptoms, for many years.

160. Warden Johnson's deliberate indifference to the ongoing failure of CCS to provide healthcare to inmates at SCI and his deliberate indifference to the ongoing failure of CCS was a cause of Ron receiving no medical care for his serious medical needs and ultimately was a cause of his death.

CAUSES OF ACTION: DARRICK E. WEST; JAMES CHANDLER; CLAUDE T. MASSEY III; JASON T. COPELAND; DAVID R. SEYMORE; DAVID COLLISON; BENJAMIN R. HUMES; MICHAEL MAANS; DION J STEPHENS; DARRIAN POLK; BRIAN BEEBE; JOHN E DITTMAN; and RICHARD DOWNS

161. Because Ron was not cooperative with the SCI nurses, West and C/O's whom he supervised, responded to the request of the nurses to force Ron to get an injection to calm him down by using two QRT's and a K-9 attack dog to force Ron to get the shot. Ron was not cooperative with the nurses or the C/O's, because his untreated withdrawal was causing him to hallucinate and become agitated.

162. West twice sent a QRT, dressed in riot gear and carrying a heavy shield, to pin Ron to the bed so a nurse could give him a shot to calm him down. As a longtime employee at SCI, West knew that when a QRT uses force to subdue an inmate having delusions or hallucinations, the result is often physical injury to the inmate. As watch commander West had authority to tell the medical staff to call for an ambulance to transfer Ron to a facility that could properly treat him. Ordering the QRT to use riot control force against Ron was not West's only option.

163. James Chandler; Claude T. Massey III; Jason T. Copeland; David R. Seymore; David Collison; and Benjamin R. Humes, were members of the first QRT that went into Ron's cell and C/O Seymore was the initial contact man for the QRT and was carrying the shield. He used it to pin Ron to the bed while the other QRT team members cuffed and shackled Ron. The hard shield and the weight of the correctional officer's on top of the shield was the cause of Ron's broken ribs and other injuries that proved to be lethal. The lethal injuries might have been caused by the combined use of excessive force by the first and second QRT, but whether or not the first QRT contributed to the lethal injuries, their use of force was unnecessary, excessive, and a violation of Ron's civil rights. Infirmary C/O Smoot noted that.... QRT and k-9 was needed to administer the shot. He does not explain why the k-9 (attack dog) was needed in addition to the QRT. In fact, a note at **1839** by RN Moore reflects that Ron had been "subdued without much exertion."

164. Michael Maans; Dion J. Stephens; Darrian Polk; Brian Beebe; Richard Downes; and John E Dittman were members of the second QRT that went into Ron's cell. Lt. Maans claims to have tried shouting and beating on the door to get Ron's attention, but Ron didn't even acknowledge his presence. After Maans gave the order to fire C/O Polk entered the cell first and hit Ron, who was crouched in a ball facing away from the door, with a shield, knocking him onto his right side.

The four other QRT members restrained Mr. Shoup's arms and legs, and Mr. Shoup was rolled over to a prone position and handcuffed and shackled. During this process the weight of multiple correctional officers was placed on Ron and crushed his rib cage. Mr. Shoup was not combative or aggressive at this time and the QRT intervention, especially as this one was carried out, was not justified by his actions. The nurse administered the second shot of Ativan at 00:50 hours and the entire episode took less than five minutes. The post QRT note confirms that the shot was give to Ron "without resistance". All QRT members and Chipman had to have been aware that the other team members had piled on top of Ron, but they did not include that information in their incident reports. The QRT team went to the muster room and had their equipment cleaned after this event. The observation log records that after QRT team left the area, around 0055, Ron was on the floor moaning.

165. Ron was going through withdrawal, and proper treatment for it was not for the initial contact man to hit him with a large, heavy polycarbonate shield when he was offering no resistance nor was it proper treatment for four other correctional officers dressed in riot gear to pile on top of him and crush his rib cage.

166. The repeated use of QRT's in this case was unnecessary and unjustified. The actions of West and both QRT teams violated acceptable prison stand-

ards, medical and mental health standards and violated Ron's civil rights. It was corporal punishment instead of medical treatment, and it killed him.

CAUSES OF ACTION: CCS and JILL MOSSER

167. At all times pertinent to these proceedings, the medical and mental health care providers working at SCI, including defendant Mosser were employed by and were agents and/or employees of CCS. CCS is legally responsible for all of the actions of its employees and agents that breached applicable standards or violated Ron's rights in the course of providing him health care for his serious medical needs.

168. CCS and all of its employees were always obligated by the contract with DOC and by law to provide medical health care to inmates such as Ron, for their serious medical needs, that met local and the DOJ Bureau of Correctional Healthcare Services (BCHS) standards, and which did not violate inmates' civil rights. See DOC policies 11 A-05 (E)(3) and 5.1 V.

169. Many CCS employees, including Mosser, LPN Dick, and LPN Collins, had worked for years for previous medical vendors at SCI. These employees knew for years before the C/O's killed Ron that care for inmates going through withdrawal at SCI, often did not meet applicable standards of care, no matter which vendor was in place.

170. HSA Mosser was personally aware that:

a) The medical staffing level at SCI was always below that authorized by the contract with DOC, and never included enough employees skilled in caring for inmates suffering from withdrawal, thus many inmates did not receive adequate care for withdrawal;

b) Withdrawal is a serious medical condition that left untreated can cause death and Ron suffered from withdrawal when at SCI.

c) SCI C/O's treated inmates who were suffering from withdrawal symptoms, including hallucinations and delusions as if their inability to follow orders was a security or disciplinary matter. As a result, because inmates with hallucinations and delusions usually cannot follow orders from C/O's or medical staff, they end up having repeated physical confrontations with correctional staff, including the QRT, after which the inmate usually gets charged with a disciplinary infraction and placed in disciplinary segregation.

d) Adhering to the applicable DOC procedures, including the CIWA scale, and meting all other applicable standards is essential to the care of inmates going through withdrawal but CCS employees often failed to meet these standards of care.

e) Ron had serious withdrawal symptoms including hallucinations beginning on February 24, 2014, and continuing through February 27, 2014, when C/O's killed him.

f) She refused to send Ron to the hospital for his severe uncontrolled withdrawal symptoms, because sending him out for care would cost more than if he was treated in the SCI infirmary.

g) She had participated in or been made aware of the cases of former SCI inmates, SB, DK, MN, ND, ES and RB.

171. Standards in the DOC Policy Manual that are binding on all CCS employees, and are relevant to the failure to provide healthcare to Ron at SCI, include the following:

a) "The Intake Screening identifies items that require immediate consideration such as … the potential for drug and alcohol withdrawal." See DOC Policy 11 E-02 (VII)(C)(1).

b) "Nursing staff completing initial medical and mental health screening for purposes of medical continuity will immediately contact the on-call physician for… symptoms consistent with…withdrawal symptoms and/or specific acute symptoms of an emergent nature…."DOC Policy 11 E-02(V)(13).

c) "Offenders experiencing severe, life-threatening intoxication or withdrawal will be transferred to an acute care facility." See DOC Policy 11 G-06(V)(1). Furthermore:

d) A qualified member of the health care staff will assess an offender at risk for progression to a more serious level of withdrawal. The following condi-

tions would indicate the potential for such progression: (a) Nausea and/or vomiting; (b) Tremors, tremulousness or agitation; and (c) Known drug abuser. See DOC Policy 11 G-06(V)(2).

e) "The entire offender medical record is available during the infirmary stay." See DOC Policy G-03(V)(12).

f) Between 2/20/14 and 2/27/14, while Ron was under the care of the CCS medical staff at SCI, Defendants Moore, Johnson-Smith, Udezue, Monsalad-Wallace, and Chipman breached the applicable standards of care by failing to screen, diagnose and treat Ron in a reasonable, timely, appropriate manner for his serious medical conditions, including withdrawal from alcohol.

172. From July 1, 2010 through February 2014, HSA Mosser and thus CCS, negligently, with deliberate indifference, and as a matter of custom and practice;

a) Knowingly failed to maintain adequate staffing levels of competent nurses, physicians, and mental health clinicians at SCI to provide necessary and minimally adequate mental and physical health care for inmates who were suffering from intoxication or withdrawal.

b) Knew that inadequate staffing levels made it impossible for the staff to provide medical care to inmates like Ron, including screening them in a manner

consistent with applicable standards of care; and that some inmates were receiving almost no medical care for their withdrawal symptoms.

c) Failed to adequately discipline, train, and supervise the day-to-day activities of the health providers working under Mosser's supervision, in regard to evaluating and treating inmates suffering from withdrawal and mental breakdowns associated with withdrawal.

d) Violated the applicable standards for treating inmates like Ron, by refusing to transfer him to a hospital for treatment of serious medical needs that could not be adequately treated at the SCI infirmary.

e) Failed to provide adequate medical and mental health care to Ron and others like him because of the desire to maximize its profits.

173. Defendant Mosser acted negligently, indifferently, or intentionally by failing to make sure that inmates suffering from withdrawal and hallucinations were evaluated and treated by SCI medical staff in accordance with applicable standards of care. Her failures were a cause of Ron's premature death.

174. Mosser violated Ron's Eighth Amendment right to be free of cruel and unusual punishment, including homicide, by her indifference to his lack of adequate medical care for an obvious serious medical condition,

CAUSES OF ACTION: CCS; IRMA MOORE; BRITTANY JOHNSON-SMITH; ADAEZE UDEZUE; MARY-JOY MONSALUD-WALLACE AND TERAH CHIPMAN

175. Defendants Moore, Johnson-Smith, Udezue, Monsalad-Wallace, and Chipman were employed by, and were agents and/or employees of CCS, and all such CCS agents and employees at SCI, were obligated to adhere to all applicable standards of care when treating an inmate's serious medical problem such as withdrawal.

176. Moore, Johnson-Smith, Udezue, Monsalad-Wallace, and Chipman had ample notice that Ron was agitated, hallucinating and delusional as follows:

a) He was reported as being awake all night from February 24th to the 25th plotting and threatening C/O's and inmates.

b) At 1917 on the 25th MSW Francis noted that a C/O had not seen anyone "so out of it" in a long time. She thought Ron was exhibiting signs of withdrawal, was disoriented to time, and delusional. She put Ron on PCO Level II to be monitored.

c) The night shift nurse noted that Ron was hallucinating.

d) At 0100 on the 26th, LPN Dick confirmed that Ron was hallucinating and thought he was at Beebe hospital.

e) At 0521 Ron struggled with the C/O's when being brought out of his cell, and "Attempted to take handcuffs".

f) At 0610, LPN Dick noted that Ron had been awake all night, hallucinating, talking to people, occasionally banging on the door.

g) LPC Coleman tried to evaluate Ron at 0815, but found him unable to cooperate with her evaluation, and referred him to medical ASAP to rule out psychosis.

h) At 0858 Dr. Udezue, noted that Ron was hallucinating, delusional, suffering from alcohol withdrawal, and had chronic liver disease. She ordered Librium and told the nurse to start an IV.

i) At 1030 RN Johnson-Smith noted that Ron was alert, but oriented only to self, was very confused, and trembles. She called Ron's mother who told her that Ron had no history of mental health problems, just a history of alcohol abuse.

j) Ron was picking at his IV during the day, and by 1700 Ron was "too agitated" to be administered his eye drops. He received no other medications except the Ativan injections. Around 1726 Ron was pulling on his IV tubing, and after a tussle with RN Moore, it snapped. Moore got 4 C/O's to subdue him so she could take the IV out. She did not restart it but around 1810 got a telephone order from Dr. Wallace for Ativan, because Ron was becoming extremely agitated. Moore then decided the QRT team had to be called because Ron was too aggressive to attempt a shot without them.

k) Around 1840 the QRT team subdued Ron without much exertion and Ativan 2 mg IM was given. Ron remained unable to carry on a conversation and spent the next several hours naked and sitting, rocking, standing, mumbling, banging, yelling, singing, picking at his blanket or gown, talking to his own reflection, pacing, and banging on door wanting to get out.

l) Moore called Dr. Wallace for another order for Ativan around 2200, but no attempt was made to administer it until after midnight. By then, Ron was crouched on the floor offering no resistance, but because Moore and Chipman wanted the QRT to subdue him again, the second QRT came in and killed him by crushing his chest.

177. Moore, Johnson-Smith, Udezue, Monsalad-Wallace, and Chipman:

a) Between 2/25/14 and 2/27/14 breached the applicable standards of care by failing to screen, diagnose and treat Ron in a reasonable, timely, appropriate manner for his serious medical conditions, including withdrawal from alcohol.

b) Failed to act as an advocate for a patient who was unable to speak on his own behalf, instead watching him mentally and physically deteriorate in front of their eyes without making any effort to get him proper medical care. Their duty was not fulfilled by calling in a QRT multiple times to subject an agitated, halluci-

nating, delusional patient, to repeated physical assaults to give him shots to calm him down.

ALL DEFENDANTS

178. All individual defendants, and CCS, through the actions of its employees, and through its corporate policies and customs, are liable to plaintiff for all of their own constitutional violations as well as for the known constitutional violations of others that they ratified or to which they acquiesced.

179. But for the negligent, wanton, willful, and intentional actions of the defendants, Ron would not have suffered severe physical injury and intense pain for several days and would not have died on February 27, 2014. Had any defendant shown compassion for the man suffering in front of them, and made sure he got the care he needed, he would not have been killed by C/O's on February 27, 2014.

DAMAGES: WRONGFUL DEATH

180. Sarah Shoup, is the minor daughter of Ronald Shoup and is his heir.

181. As a result of the wanton and willful, negligent, intentional, and reckless actions of defendants, Sarah Shoup has suffered the following injuries:

a) The loss of the expectation of monetary benefits that would have resulted from the continued life of Ronald Shoup;

b) The loss of contributions for support;

c) The loss of parental services;

d) The loss of a relationship with her father;

e) Funeral expenses; and

f) The mental anguish which has been suffered and will be suffered by Sarah as a result of the death of Ronald Shoup.

WHEREFORE, Plaintiff Elizabeth Firidin, as Next Friend of Sarah Shoup, demands judgment against all Defendants, such special damages as she can prove, general compensatory damages, punitive damages, attorney's fees pursuant to 42 U.S.C. §1988, costs and such other relief as the Court deems appropriate.

DAMAGES: SURVIVAL ACTION

182. As a result of the wanton and willful, negligent, intentional and reckless actions of Defendants, Ronald Shoup received woefully inadequate medical care for a serious medical condition from February 20, 2014, to February 27, 2014. Instead of the care he needed, C/O's were repeatedly called to physically force him to cooperate with the nurses on duty because he was hallucinating and could not cooperate on his own. Because he did not receive proper care and was subjected to repeated uses of force by the C/O's, Ron suffered the following injuries:

a) Severe physical, mental, and emotional pain, distress and suffering;

b) Cruel and unusual punishment and a depravation of his civil rights;

WHEREFORE, Plaintiff Elizabeth, as Administratrix of the Estate of Ronald Shoup, demands judgment against all Defendants, such special damages as she can

prove, general damages, punitive damages, attorney's fees pursuant to 42 U.S.C. §1988, costs and such other relief as the Court deems appropriate.

GRADY & HAMPTON, LLC

/s/ Stephen A. Hampton
Stephen A. Hampton (#2451)
6 North Bradford Street
Dover, DE 19904
(302) 678-1265
shampton@gradyhampton.com

Attorney for Plaintiffs

Dated: February 4, 2016