IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION AT MEMPHIS

NICOLE FREEMAN, as wrongful death representative of Gershun Freeman and next friend of minor child T.F., *Plaintiff*, v. SHERIFF FLOYD BONNER, Jr., in his individual capacity; CHIEF JAILER KIRK FIELDS, in his individual capacity; and the GOVERNMENT OF SHELBY COUNTY, TENNESSEE, *Defendants*.	)	**Case No. 23-cv-02193-MSN-tmp** **COMPLAINT FOR VIOLATIONS OF THE CIVIL RIGHTS ACT OF 1871, 42 U.S.C. § 1983, and THE AMERICANS WITH DISABILITIES ACT OF 1990** **JURY DEMAND**

SECOND AMENDED COMPLAINT

TO THE HONORABLE DISTRICT COURT JUDGE:

Plaintiff Nicole Freeman, by and through her designated attorneys, for her Second Amended Complaint alleges as follows:

I.

INTRODUCTION

A. *Nature of Action*

On October 5, 2022, Gershun Richandre Freeman died face down on the floor of the Shelby County Men's Jail (the "Jail"). He died handcuffed and naked, with a correctional officer's knee

in his back and hand around his neck. Minutes earlier, ten or more employees of the Shelby County Sheriff's Office (the "SCSO"), including members of the Jail's infamous Detention Response Team (the "Blackshirts"), had brutally stomped Mr. Freeman, bathed him in chemical irritant, and struck him repeatedly with implements including mace cans, handcuffs, and heavy rings of jailer's keys. Those events give rise to this action.

Mr. Freeman's killing did not happen in a vacuum. It resulted from certain policies and customs of the Shelby County government (the "County") and the pronounced dereliction of Shelby County Sheriff Floyd Bonner and Chief Jailer Kirk Fields. The County's practices, and Sheriff Bonner and Chief Fields' derelict leadership, made a scene like what unfolded on October 5, 2022, all but inevitable.

Plaintiff Nicole Freeman brings this action as Mr. Freeman's surviving spouse, on behalf of all wrongful-death beneficiaries. Her federal claims sound in the Americans with Disabilities Act of 1990, the Civil Rights Act of 1871, and *Monell v. Department of Social Services of New York City*, 436 U.S. 658 (1978). She also pleads common-law negligence claims, under this Court's pendant jurisdiction, which sound in Tennessee's Governmental Tort Liability Act (the "GTLA").

B. *Relevant History of the Shelby County Jail*

While not itself a basis for Defendants' liability here, the history of civil-rights violations at the Jail is relevant to this action because that history demonstrates the County's awareness of the sorts of policies, customs, and practices likely to deprive inmates of their constitutional rights. The Civil Rights Division of the United States Department of Justice (the "DOJ") investigated the Jail in 2000 and summarized its observations in a letter to Shelby County then-Mayor, Jim Rout.[1] The DOJ directly linked the constitutional violations in the Jail to "a lack of effective oversight…and

[1] **Exhibit A**.

the lack of supervision to prevent the staffs' use of force exceeding the limitations of policy."[2] The DOJ recommended ways to fix the problems it saw and gave the County a reasonable time to redress these issues.

When the County failed to fix Jail conditions, the DOJ sued the County to enjoin it "from depriving persons incarcerated at the Jail . . . of rights, privileges or immunities secured and protected by the Constitution of the United States." *United States v. Shelby County, et. al.*, No. 2:02-CV-02633. Shelby County and the DOJ reached a Settlement Agreement to remedy the Jail's deficiencies in "inmate on inmate violence," "inmate classification," "staffing," and "security," through improved policies and customs.[3] Conditions at the Jail improved for several years. Recently, policies and customs—accompanied by increased violations of inmates' constitutional rights—have returned to pre-Settlement-Agreement norms.

By entering into the Settlement Agreement, Shelby County recognized the Jail's custom of violating inmates' constitutional rights and addressed those violations in its Standard Operating Procedure guidelines which, if adhered to, reasonably protected the safety of inmates in their care and custody. Among the most basic terms of the Agreement, the Jail agreed to implement an effective system for the prompt discipline of staff who violate its use-of-force policies.[4] These specifics mean that, in the time since the County agreed to it, the County has known of the constitutional magnitude of the risk posed by certain customs and patterns of conduct by Jail staff, as well as the sorts of remedial measures required to mitigate that risk. Those customs and patterns of conduct, including those that Plaintiff alleges below, resulted in the brutalization and death of

[2] *Id.* at 6.

[3] **Exhibit B**.

[4] *See id.* at 4.

Mr. Freeman. The County's history with the DOJ means that it knew the risk posed by the customs and patterns of conduct alleged below, and it knew exactly how to fix these risks, well before its employees killed Mr. Freeman.

II.

SUBJECT MATTER JURISDICTION AND VENUE

1. This Court has original subject-matter jurisdiction, under 28 U.S.C. §§ 1331 and 1343(a), to hear and adjudicate Plaintiff's federal claims under 42 U.S.C. §§ 1983 and 12132.

2. This Court has supplemental jurisdiction, under 28 U.S.C. §§ 1331 and 1343(3), (4), to adjudicate all state-law claims pendent to the federal claims that are the thrust and gravamen of this action.

3. This Court provides proper venue for this action under 28 U.S.C. § 1391(b) because the action arises from events that occurred in the Western District of Tennessee.

III.

PARTIES AND JURISDICTION

4. Plaintiff Nicole Freeman ("Ms. Freeman" or "Plaintiff") is the widow of Mr. Freeman, a resident of Shelby County, and the mother of Mr. Freeman's minor child, T.F. As surviving spouse, Ms. Freeman holds first right under Tennessee's wrongful-death statutes to prosecute this action. Tenn. Code Ann. § 20-5-107. She brings this suit on behalf of herself, the minor child T. F., and all other wrongful-death beneficiaries.

5. Defendant Floyd Bonner, Jr. ("Sheriff Bonner") is the County Sheriff. Technically also a County employee, Sheriff Bonner holds an elected office statutorily vested with responsibility for the safe and constitutional operation of the Jail. Sheriff Bonner was elected and

sworn into office as the 47th Sheriff of Shelby County in 2018 and can be served with process at 201 Poplar Avenue, 9th Floor, Memphis, Tennessee 38103. He is sued in his individual capacity.

6. Defendant Kirk Fields ("Chief Fields") is the director of the Jail and a Shelby County employee. Through Sheriff Bonner, the County has vested Chief Fields with responsibility for the safe and constitutional operation of the Jail. Chief Fields was appointed as the Chief Jailer by Sheriff Bonner in 2018. He can be served with process at 201 Poplar Ave., 9th Floor, Memphis, Tennessee, 38103. He is sued in his individual capacity.

7. The County is a party Defendant to this matter in its capacity as a local-government body and political subdivision of the State of Tennessee. The County is subject to service of process through the office of the County Attorney, Marlinee Iverson, at 160 North Main Street, 9th Floor, Memphis, Tennessee 38103. Among other functions, the County operates and maintains the SCSO and the Jail. The County and its agents acted under color of state law at all pertinent times.

8. Below, the "Defendants" shall refer collectively to the County, Sheriff Bonner, and Chief Fields.

IV.

FACTUAL ALLEGATIONS

A. *The Death of Gershun Freeman*

9. Cameras the County installed in the Jail captured much of what transpired on October 5, 2022. Plaintiff's attorneys have possession of a single thirteen (13) minute and eight (8) second compilation of camera footage of the incident released by the Davidson County District Attorney's Office (the "DCDAG"), which is investigating the incident for possible criminal charges. Plaintiff has previously moved for leave of this Court to file the camera-footage

compilation as **Exhibit C** to her first complaint (ECF No. 2). This Court granted Plaintiff's motion (ECF No. 11) and a copy of the video has been placed on file with the Clerk. Plaintiff incorporates the previously filed video here as Exhibit C.

10. Mr. Freeman entered the Jail on October 1, 2022, following charges brought against him by officers of the Memphis Police Department.

11. Mr. Freeman's reported behavior leading to his arrest was uncharacteristic of him. His family believes that he was suffering from a mental health crisis at the time of his arrest.

12. In accordance with County policy, the Jail provided Mr. Freeman with a perfunctory mental-health screening upon his arrival. The "evaluation" process consisted of a brief oral interview conducted by a licensed practical nurse or medical assistant. The Jail contracts with Wellpath, LLC, its medical services provider, for limited mental health services. The Jail has no formal structure for the provision of mental or behavioral health services, even though it houses approximately 200 inmates with specifically identified behavioral-health issues on the second floor and approximately another 150 such inmates scattered throughout other parts of the facility. This means that, at any given time, fifteen to twenty percent of the Jail population requires mental or behavioral health services of some kind. Despite those numbers, the County provides only an LPN with a checklist to screen for even the most severe mental health issues. The perfunctory screening process all but ensures a high rate of mis- or missed diagnoses for inmates' psychiatric disabilities or acute psychiatric conditions. This failure to diagnose results in a failure to route inmates in need to an alternate facility capable of providing adequate psychiatric or other behavioral-health care or the provision of psychiatric care on-site. Upon information and belief, the Jail's perfunctory screening process failed to diagnose Mr. Freeman upon his arrival.

13. On October 5, 2022, just before 8:00 A.M., a Licensed Master Social Worker ("LMSW") was called to address mental health issues that Mr. Freeman was having. She had difficulty obtaining information because he was selectively mute.

14. "Selective mutism" is a term of art in psychiatry and psychology that refers to a condition in which severe anxiety, sensory integration dysfunction, and post-traumatic stress disorder, among other conditions cause an individual to be unable to respond to questions, making accurate evaluation challenging.

15. Mr. Freeman was able to respond in a limited fashion to some questions, from which the LMSW determined that Mr. Freeman had suffered from, at a minimum, suicidal ideation since the time of his incarceration on October 1, 2022, and that he required a full psychiatric evaluation. She requested that Mr. Freeman be placed on suicide watch in Pod 4-J and that he be scheduled for evaluation by Dr. Ike, the jail psychiatrist then on duty.

16. Accordingly, Mr. Freeman had apparently been exhibiting symptoms of a mental health disorder for four days without referral to a psychiatrist or social worker, four days in which access to a mental health professional could have prevented his descent into a fully psychotic state.[5]

[5] He could not have been referred to a psychologist because the Jail does not employ one. Despite having been placed on repeated notice beginning on June 30, 2020, that employing a jail psychologist to screen for certain mental health and developmental disorders was necessary in a facility of this size, the Jail has made no effort to fill this gap in services that is necessary to address the needs of people with disabilities. County Defendants are well aware of this because the Jail was made subject to random inspection in another matter, *Busby v. Bonner,* 2:20-cv-02359-SHL-atc, and in the initial report of the inspector, Mike Brady, he advised the County of this deficiency. The County and Sherriff Bonner did not merely choose to ignore this finding, they actively fought against its implementation. This is further evidence that the County and Sherrif Bonner are wholly resistant to making even minor policy changes to protect individuals with mental and developmental disabilities who are in their custody.

17. In the suicide pod, Jail staff put Mr. Freeman in a cell, naked and alone, with only a paper-like orange "tarp" to cover himself. (It is possible that Mr. Freeman was issued an anti-suicide smock, but Plaintiff is aware of no evidence to support this contention.)

18. By that afternoon, Mr. Freeman's psychiatric condition had worsened severely. He was yelling and begging for medical personnel.

19. He was experiencing an obvious mental-health crisis that the medical examiner would later determine was a psychotic episode and a contributing factor in his death.

20. Despite this erratic behavior, Mr. Freeman was, at least, secure in his cell without the means to do himself harm. The only two reasonable responses under the circumstances would have been 1) do nothing, and 2) contact medical staff. The Jail staff had other ideas.

21. Typically, Jail staff feed detainees on the suicide pod by delivering food trays to their individual cells. The Jail community refers to these feedings as "tray time."

22. Shortly after 4:30 P.M. on October 5, 2022, and during "tray time," Mr. Freeman was exhibiting symptoms of active psychosis. Upon information and belief, Mr. Freeman's psychosis was a symptom of the psychiatric or psychological problems then afflicting him.

23. At evening tray time, correctional deputies Anthony Howell ("Officer Howell") and Antonio Williams ("Officer Williams") entered the 4-Juliet pod. Officer Howell carried a stack of trays. Officer Williams sauntered ahead of him, shaking a can of Freeze +P, the chemical irritant that SCSO issues its deputies. Freeze +P is a combination of CS gas and Oleoresin Capsicum (pepper spray), in the highest legally permissible concentrations. Is manufacturer advertises it as "the most intense incapacitating agent available today."[6] As discussed below, unconstitutional

[6] **Ex. C** 00:00–40. Plaintiff has previously requested permission and subsequently filed a copy of this video with the Court as ECF No. 39-3, and incorporates use of the previously authorized video by reference. A placeholder page will be submitted with the filing.

deployment of chemical weapons at the Shelby County Jail is not merely common, it is a custom and unwritten policy established at the highest levels of administration.

24. Because many of the individuals in 4-Juliet pod suffer from severe mental health disorders and therefore are more prone than average to erratic behavior, professional standards for the operation of jails and prisons require guards feed inmates such as those housed in 4-Juliet through security flaps on the cell doors. Fully opening the cell doors on this pod substantially increases the likelihood of confrontation with inmates suffering from acute psychosis or other destabilizing psychiatric conditions.

25. When the deputies reached Mr. Freeman's cell, just as they had for the other cells in 4-Juliet, the deputies directed a third staff member, correctional officer Lubria Henderson ("Officer Henderson"), who was operating the cell-pod doors from the far end of the hallway, to completely open Mr. Freeman's cell door. As the door rolled open, the deputy holding the can of mace raised and pointed it at Mr. Freeman without any provocation and without the need to open the cell door at all.[7]

26. Holding up his orange tarp to shield himself from the deputy's mace, Mr. Freeman attempted to swat away the mace can in the deputy's hand.[8] As he did so, Mr. Freeman exited his cell; he did not attempt to strike the deputy, but only to deflect the source of the chemical irritant.

[7] Sheriff Bonner, in a public statement criticizing release of the video, described the video as "out-of-context" and stated that Mr. Freeman was engaged in "erratic and violent behavior that led to the need to restrain Mr. Freeman." This is nonsensical. Mr. Freeman was confined alone in a cell. He posed no threat to anyone until deputies opened the door wielding a can of pepper spray to deploy upon Mr. Freeman. This is especially relevant given Mr. Freeman's psychotic state. No reasonable corrections officer nor facility compliant with the Americans with Disabilities Act would utilize pepper spray and a beating to subdue an already-secure individual suffering from acute psychosis.

[8] **Ex. C** 00:40.

27. As Mr. Freeman reached for the mace in Officer William's hand, Officer Howell stepped toward Mr. Freeman and struck him with an overhand "haymaker" punch, knocking Mr. Freeman to the floor.

28. Then, in tandem, the two deputies beat and stomped Mr. Freeman no fewer than eighteen (18) times in the seconds before other officers reached the scene.[9] Each of these deputies used excessive force. *See Coleman v. Oninku*¸ No. 1:17-cv-599, 2021 U.S. Dist. LEXIS 154422, at *25 (D.S. Ohio Aug. 17, 2021) (finding it unreasonable to use 20 punches to head, neck, and shoulder to restrain an inmate when the inmate's hands were visible to cuff.).

29. Watching the above unfold, the door operator Officer Henderson, who could at that point have closed the main door to the 4-Juliet cell pod, limiting Mr. Freeman's access to any other part of the Jail, and who could have called Jail medical staff immediately to respond to both the psychotic episode and Mr. Freeman's injuries, instead left the main cell-pod door open and unattended, and joined in the beating. The door operator sprayed enough chemical irritant toward Mr. Freeman that the caustic chemicals pooled on the floor, creating a hazard for everyone in the cell pod. Officer Henderson then beat Mr. Freeman with the metal cannister of mace.[10]

30. The above actions of the first two Jail deputies and the door operator—beating Mr. Freeman and dousing him with chemical irritant—subdued and incapacitated Mr. Freeman, rendered him non-violent and non-threatening for the rest of the encounter, and therefore made all subsequent applications of force to Mr. Freeman unwarranted and excessive. *See Young v. Kent Cty. Sheriff's Dep't*, No. 21-1222, 2022 U.S. App. LEXIS 740, at *14 (6th Cir. Jan. 10, 2022)

[9] *Id.* at 00:40–49.

[10] *Id.* at 00:50–58.

(denial of qualified immunity for correctional officers' use of force because inmate was partially incapacitated from the first pepper spray, subdued, non-violent, and non-threatening).

31. Within seconds, no fewer than seven (7) additional Jail staff members arrived on scene and joined in the melee. They included regular correctional deputies and members of the Blackshirts, a special Jail unit known for their physicality and rough treatment of detainees. According to multiple eyewitnesses, Ashley Harris ("Officer Harris"), Cedric Scott ("Officer Scott"), Antonio Buford ("Officer Bufford"), Ebonee Davis ("Officer Davis"), Courtney Parham ("Officer Parham"), K. Gray ("Officer Gray"), and Damian Cooper ("Officer Cooper") also joined in the assault.

32. Over the next minute, Blackshirts and other staff punched, kicked, and struck Mr. Freeman with various implements. Mr. Freeman tried to crawl down the hallway through pools of oil-based irritant. He twice tried to cling to his assailants' feet.[11]

33. On camera, Officer Davis strikes Mr. Freeman with a mace cannister multiple times, kicks him, and douses him with chemical irritant; lying on the floor, he tries to cling to her feet.[12] Eyewitnesses recount that Mr. Freeman begging for help at this time. A Shelby County grand jury indicted Officer Davis for aggravated assault in concert resulting in death.

34. While Officer Davis struck Mr. Freeman as he begged for help at her feet, Officer Cooper repeatedly kicked Mr. Freeman. Given Officer Cooper's well-documented history of excessive force, these actions are commonplace. A Shelby County grand jury indicted Officer Cooper for aggravated assault in concert resulting in death.

[11] *Id.* at 00:50–51.

[12] *Id.* at 00:55 – 01:14.

35. Next, a Blackshirt believed to be Officer Parham placed handcuffs around his fist and struck Mr. Freeman no fewer than three (3) times with these makeshift brass knuckles.[13] Jail staff has a history of using handcuffs as striking implements. A Shelby County grand jury indicted Officer Parham for second-degree murder and aggravated assault in concert resulting in death.

36. In addition to boots and fists, handcuffs, and mace cannisters, Jail staff struck Mr. Freeman with heavy rings of "door-roll keys" and sets of brass handcuff keys. Using such equipment contrary to the equipment's purpose, strictly to inflict pain and punishment, served no legitimate penological or custodial purpose.

37. After ten (10) or more Jail staff shoved him away from his cell and bulldozed him out of the suicide pod, Mr. Freeman—disoriented—stumbled down an adjacent hallway. Correctional officers doused him with more irritant. Then, Captain Michael Green ("Captain Green") grabbed Mr. Freeman and slammed him to the floor.[14]

38. As Mr. Freeman lay on the floor, other Jail staff kicked him and doused him in more chemical irritant. These included D___ Haywood ("Officer Haywood"), Lareko Elliott ("Officer Elliott"), Chelsey Duckett ("Officer Duckett"), Jeffrey Gibson ("Officer Gibson"), Charles Gatwood ("Officer Gatwood"), Stevon Jones ("Officer Jones"), James Perry ("Officer Perry"), Officer Davis, Officer Buford, and Officer Moore. Officers Elliott, Duckett, and Gibson were charged with and indicted for aggravated assault in concert resulting in death.[15] Additionally, Officer Jones was charged with and indicted for second-degree murder and aggravated assault in concert resulting in death.

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[13] *Id.* at 1:00–03.

[14] *Id.* at 2:46–56.

[15] *Id.* at 2:56 – 4:15.

39. Jail staff sprayed so much chemical irritant that it formed a pool on the floor.[16]

40. After this second melee, Jail staff allowed or even encouraged Mr. Freeman to stumble past them and make his way up an escalator to the fifth floor.

41. After Mr. Freeman reached the fifth floor, several deputies—including Officers Jones, Perry and Lawson, who had followed Mr. Freeman up the escalator—cornered him upstairs. They punched, kicked, and slammed Mr. Freeman to the floor once again.[17]

42. Those same correctional deputies quickly gained control of Mr. Freeman, who was still naked and now drenched in mace. They handcuffed his hands behind his back, then pressed him, facedown, against the floor.

43. Deputies held Mr. Freeman in the facedown position for over five minutes, with Officer Jones kneeling on Mr. Freeman's back, neck, and head.[18]

44. Each of these deputies knew or should have known that placing substantial or significant pressure on Mr. Freeman's back while he was face down and subdued was excessive force. *See, e.g.*, *Champion v. Outlook Nashville, Inc.*, 380 F.3d 893, 903 (6th Cir. 2004) (It is "clearly established that putting substantial or significant pressure on a suspect's back while that suspect is in a face-down prone position after being subdued and/or incapacitated constitutes excessive force."); *Hopper v. Phil Plummer*, 887 F.3d 744, 754 (6th Cir. 2018) (holding that "forcibly restraining an individual in a prone position for a prolonged period of time when that individual pose[s] no material threat" is unconstitutional) (quotation omitted); *Jennings v. Fuller*, 659 F. App'x 867, 870 (6th Cir. 2016) ("Leaving a suspect in a situation where he will likely be

[16] *Id.* at 4:05–15.

[17] *Id.* at 4:50 – 5:10.

[18] *Id.* at 05:00 – 10:20.

asphyxiated may be objectively unreasonable."); *Sweatt v. Doxtader*, 986 F. Supp. 2d 886, 898 (E.D. Mich. 2013) (denying qualified immunity even though the plaintiff "did not suffer from asphyxia," because the plaintiff "was kneed after he surrendered and was . . . laying [sic] prone on the ground").

45. Until medical staff arrived, Jail staff largely milled about Mr. Freeman's body, stepping over and around it. At one point, a deputy carrying paperwork walked directly over Mr. Freeman's nearly lifeless form, glancing down as he passed.[19]

46. At 4:57 p.m. deputies finally called a "code white" (medical emergency), and medical personnel arrived in three minutes. Mr. Freeman was blinking with a faint pulse, but within moments his heart stopped. Jail medical personnel attempted emergency lifesaving measures until the arrival of Memphis Fire Department, who ultimately pronounced Mr. Freeman dead at 5:27 p.m.

47. When Nurse Rovelta Sain asked deputies about the incident for the purposes of completing an emergency response progress note in Mr. Freeman's medical chart, the deputies told not merely a lie, but a fish story of epic proportions. Her progress note, reviewed and approved by the Jail's medical director, Dr. Donna Randolph, states:

> Witness description of incident:
>
> Incident initially started as code blue. Pt attacked security staff. Security staff stated pt took big can of chemical spray and begin (sic) spraying staff.

48. Put succinctly, the deputies initiated the incident with Mr. Freeman by wantonly and unconstitutionally deploying pepper spray on him while he was completely secure and posed no threat to anyone and begging for medical attention. They then beat, stomped, kicked, and

[19] *Id.* at 11:13–23.

choked him to death. Then, when immediately faced with the necessity of providing an explanation for killing him, they lied and told Jail medical personnel that he had done to them what they, in fact, had done to him.

B. *No Accountability*

49. In the hours following the incident, agents from the Tennessee Bureau of Investigation (the "TBI"), at the request of the Shelby County District Attorney General (the "SCDAG"), began an investigation of the incident.

50. Upon information and belief, Jail staff and other SCSO employees interfered with the TBI's investigation in at least the following ways:

(a) Giving false narrative accounts of the incident;

(b) Telling the TBI that no Jail detainees witnessed the incident;

(c) Intimidating Jail detainees who did witness the incident from reporting what they saw to TBI agents; and

(d) Withholding pertinent camera footage from the TBI.

51. Upon information and belief, County leadership has not terminated or otherwise meaningfully disciplined any Jail staff members who participated or declined to intervene in the events described above.

52. In response to the release of the jail-camera footage by the Davidson County District Attorney General's office (the "DCDAG"),[20] Sheriff Bonner criticized the DCDAG for being transparent, falsely accused the DCDAG of releasing the video "out of context," and announced he would refrain "from taking further administrative action" against any SCSO

[20] The SCDAG transferred investigation of the incident and prosecution of any appropriate criminal charges to the DCDAG.

employees involved, pending the outside criminal investigation.[21]

53. Sheriff Bonner now maintains that he placed each of the deputies involved in Mr. Freeman's beating and murder either on "administrative leave" or "relieved of duty" status. This is false. In truth, at the time Sheriff Bonner made the statement above— that he would refrain from *further* action pending criminal investigation—had taken no administrative action whatsoever.[22] Thus, by saying he would refrain from taking further action, Bonner meant he would refrain from taking *any* action. Indeed, witnesses have observed several of Mr. Freeman's assailants working inside the Jail since the incident, and even in the time since the publication of the indictments. Sheriff Bonner's inaction means that criminal defendants indicted for murder, and criminal defendants indicted for aggravated assault, continue to work in the Jail, where they have authority and control of potential witnesses. Sheriff Bonner is—or had he conducted even a cursory inquiry would be—aware that his deputies lied about what initiated the altercation. Mr. Freeman clearly did not possess, obtain, or deploy chemical irritant. Bonner's glaring, willful inaction constitutes a ratification of his killer deputies' conduct, gives a green light to similar conduct in the future, and threatens the integrity of the criminal investigation and prosecution.

54. Sheriff Bonner and the County's inaction in the face of Mr. Freeman's death fits a preexisting pattern of *de minimis* response to inmate deaths and other use-of-force incidents in the

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[21] Lucas Finton, *Surveillance footage from jail shows officers kneeling on inmate's back for almost six minutes*, THE COMMERCIAL APPEAL (Mar. 2, 2023, 4:56 PM), https://www.commercialappeal.com/story/news/2023/03/02/video-released-of-shelby-county-jail-officers-beating-inmate/69964005007/ (updated Mar. 3, 2023, 6:28 AM).

[22] Sheriff Bonner told local news that he would take no action against his deputies until the completion of the independent criminal investigation. Jordan James and Stuart Rucker, *Gershun Freeman's family wants justice after death in Memphis jail*, WREG MEMPHIS (Mar. 17, 2023, 3:25 PM), https://wreg.com/news/local/gershun-freemans-family-wants-justice-after-death-in-memphis-jail/ (updated Mar. 17. 2023, 5:51 PM).

Jail, as discussed below.

C. *Pattern and History of Jail Problems*

55. Not only were the County's policies, as understood and applied by Jail staff, insufficient to protect the constitutional rights of pre-trial detainees. It was also the County's unwritten but affirmative policy and custom to tolerate and tacitly approve of Jail staff members' use of excessive and unwarranted force as a means of Jail population control.

The fact that at least fourteen (14) correctional officers committed the violent acts described above in front of one another, without fear of punishment or lowering of esteem, *by itself* reveals a custom of tolerance to the use of excessive force against prisoners.

56. Further evidence of a culture of tolerance lies in the recent "disciplinary" history of Jail staff, replete with substantiated findings of excessive or unwarranted force against inmates. Between June 2018 and September 2021, the County saw thirty-two (32) substantiated violations of the SCSO's excessive or unwarranted force policies in the Jail.[23] Only one (1) of these resulted in a Jail staff member's termination.[24] Sheriff Bonner and Chief Fields chose not to terminate their

[23] Plaintiff's Rule 1006 Summary of those violations is hereto attached as **Exhibit D.**

[24] This was the only instance Plaintiff's counselors are aware of from Shelby County in which a correctional officer from 201 Poplar was criminally charged for their battery of a citizen of Shelby County. Sheriff Bonner's Motion to Dismiss further supports this assertion when he claimed that of the forty-three officers who have been fired since 2018, only one was related to a use of force issue. (ECF No. 30-1, PageID 355). This case also did not involve mere excessive force, but rather a guard intentionally tracked an inmate down at the nurse's station and, in a premeditated fashion and without provocation, delivered a beating that resulted in the inmate's hospitalization. The guard was charged criminally, and only under those circumstances was he terminated. In other words, Plaintiff can identify no instance during the administration of Sheriff Bonner and Chief Fields in which violations of the use of force policy, no matter how frequently or severely an individual guard violates the use of force policy, has ever resulted in termination.

employees involved in the other incidents, despite these employees' serious and often repeated policy violations and criminal conduct.[25]

57. On October 12, 2020, the Shelby County Commission held its hearing and vote on an Ordinance to: 1) disqualify applicants from Public Safety positions if prior work history depicted termination for excessive force; 2) request that the SCSO seek revocation of Peace Officer Standards and Training (POST) Certification for deputies terminated or *disciplined* for excessive force; and 3) establish a tracking system of Public Safety Officers terminated or disciplined for excessive force. A copy of the transcript of the hearing was filed by Sheriff Bonner as ECF No. 30-3.

58. Sheriff Bonner has actively resisted policies intended to curb the SCSO employees' use of excessive force. Specifically, he testified before the County's legislative body in opposition to the above proposed ordinance stating "[W]e already have these things in place and I think there has been a misconception of the public, maybe some of the Commissioners, that we don't . . . [W]e have everything in place now that can safeguard for excessive force." (ECF No. 30-3, PageID 24).

59. Sheriff Bonner misrepresented how the SCSO responded to his deputies' use of excessive force. Through Chief Inspectors Bucker and Kellerhall, he represented to the Commission that the SCSO seeks de-certification from to State of Tennessee POST Commission any time a deputy is terminated for a determination of excessive force. (ECF No. 30-3, PageIDs 371-72). In fact, Sheriff Bonner has implemented a practice or custom of not terminating deputies for substantiated instances of excessive force.[26] Furthermore, Sheriff Bonner failed to address the

[25] **Ex. D**.

[26] Sheriff Bonner recently told the Shelby County Commission that the Jail is "a direct-supervision facility," which currently requires 112 more officers "[f]or us to operate in a direct-supervision model." Sydney Hawkins, *SCSO provides update on crime, conditions at 201 Poplar*, WMC ACTION NEWS 5 (May 10, 2023, 7:01 PM), https://www.actionnews5.com/2023/05/11/scso-provides-update-crime-

SCSO's lack of a centralized tracking system of instances of excessive force with the Commission and misrepresented that SCSO already had such a tracking system in place.

60. Adopting Sheriff Bonner's ostrich stance, the County has refused even to centralize information regarding use of excessive force in the Jail.

61. In stark contrast to the SCSO's testimony before the Commission, in response to a September 2020 request for records of all County public-safety officers' violations of the County's use-of-force policies in the preceding two years, the County said it did not maintain those records in a format that allowed identification or production, even to its own lawmakers. The decision to not maintain this data reveals the County's willful blindness to incidents of excessive force in the Jail. Almost by definition, willful blindness *to* excessive force permits the continued use *of* excessive force.[27]

62. The County nominally adopted a "duty to intervene" policy in June 2020. But it never trained Jail staff to implement the policy, never gave them written information about the policy, and never advised them of any consequences for violating the policy. The "duty to intervene" policy thus existed in name only. The County's de facto policies do *not* require officers to intervene in unwarranted or excessive force incidents.

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conditions-201-poplar/. It appears either that the demand dropped or the supply rose since last fall when, about a week before Mr. Freeman's death, Bonner said Jail staffing was "short by 334 correctional officers." Bria Bolden, *'We're losing employees to Amazon: Shelby County Sheriff talks retention at crime commission meeting*, WMC ACTION NEWS 5 (Sep. 29, 2022, 9:21 PM), https://www.actionnews5.com/2022/09/30/were-losing-employees-amazon-shelby-county-sheriff-talks-retention-crime-commission-meeting/.

[27] Plaintiff's counsel ultimately obtained evidence of the instances of substantiated excessive force through discovery in a case remarkably similar to this instance. Defendants now assert that this request was denied because it would have required sorting or compiling. (ECF No. 30-1, PageID 357). However, if Defendants kept these records in a single location, as they represented to the Commission, there would have been no need for sorting or compiling. Plaintiff avers that no such system exists, and that Defendants are indeed failing to properly track correctional officer misconduct at the Jail.

63. As noted above, Shelby County Jail guards, as a matter of custom and unwritten policy, use Freeze +P (pepper spray/CS gas) to punish inmates rather than for its intended purpose of incapacitating inmates that pose a direct threat or who are actively resisting. This punitive, unconstitutional use of Freeze +P goes all the way to Defendant Fields. During the worst part of the COVID-19 pandemic in 2020, inmates with COVID-19 symptoms were placed in a single housing unit on the sixth floor of the Jail. For reasons immaterial here, Chief Fields made the express decision to shut down the separate housing unit and return inmates, many of whom were still symptomatic, to general population. The inmates staged a peaceful sit-in with a single demand: test them for COVID-19 before returning them to general population. Chief Fields refused to test the inmates and, rather than employ lawful methods of restraint such as handcuffs and physically moving inmates, he instead personally ordered that his deputies deploy numerous cans of Freeze +P into the housing unit without regard for safety, quantity, targeting particular inmates or otherwise using any reason or restraint whatsoever as a punitive measure.[28]

64. The Sixth Circuit and district courts in this circuit have repeatedly held such wanton use of chemical weapons to violate the Fourteenth Amendment. *See Stoutamire v. Schmalz*, No. 1:16CV2840, 2022 U.S. Dist. LEXIS 16322, at *19 (N.D. Ohio Jan. 28, 2022) (collecting cases and stating that the "wanton use of pepper spray as punishment on a compliant, non-threatening inmate is a clearly established violation of an inmate's constitutional right to be free from excessive force.")

[28] This scene was recounted by Marcus Hunt, an inmate being held for an alleged violation of his misdemeanor probation for failure to pay an $80 probation fee. Mr. Hunt was one of the inmates sick with COVID-19. During the incident, he managed to use the phone in the housing unit to call the ACLU of Tennessee, where he recounted the ongoing incident to Stella Yarborough, the current legal director of ACLU-TN, as it happened. Mr. Hunt filed suit in *Hunt v. Shelby County et al.,* 2:21-cv-02186-JTF-cjc ECF-1, PageID 11-12 (W.D. Tenn. 2021), alleging these specific facts. That case was settled without an admission of liability.

65. Chief Fields personally established and/or ratified a practice of unconstitutionally using chemical agents in an unconstitutional fashion to punish inmates for behavior that posed no safety risk.

66. The decision by deputies to engage in that specific conduct, the unconstitutional use of a chemical weapon to punish Mr. Freeman for exhibiting symptoms of psychosis is what initiated the entire incident that lead to his death.

67. The Fourteenth Amendment to the United States Constitution requires Jail staff to maintain a reasonably safe and secure custodial environment, free from unwarranted or excessive force by Jail staff, even when doing so would require active restraint of fellow staff members. The County's choice not to train, discipline, or supervise Jail staff as to the "duty to intervene" policy amounted to a policy of acquiescence to the use of unwarranted or excessive force against inmates and reflected a deliberate indifference to their Fourteenth Amendment rights.

68. The Jail saw eight (8) prisoner deaths between January 1, 2022, and October 5, 2022, not including Mr. Freeman.[29] Most of these deaths occurred on the fourth floor of the Jail and considered independently or with the other violations alleged above, put the County on notice that its correctional officers were not receiving proper supervision.

69. This rate of inmate deaths is substantially higher than the national norm. Indeed, the Jail now stands among the most dangerous pre-trial detention facilities in the United States. The pattern of Jail deaths also put the County on notice that its current policies and customs do not protect the health and safety of Jail inmates.

70. The allegations above show that the SCSO, Sheriff Bonner, and Chief Fields have entirely failed to adequately train Jail staff at all levels that, *inter alia*:

[29] Two (2) more deaths occurred outside the Jail but in SCSO custody.

(a) Use of force against pre-trial detainees is consistent with the objective "excessive force" standard where officers apply force to a person who has been accused but not convicted of a crime, but who is free on bail. *See Kingsley v. Hendrickson*, 576 U.S. 389, 399 (2015); and

(b) Use of force requires that officers consider both the severity of a crime and the threat of harm posed by an individual before the application of force. *Coffey v. Carroll*, 933 F.3d 577, 588 (6th Cir. 2019).

71. The deprivation of Mr. Freeman's constitutional rights, in addition to his physical injuries, severe psychological and emotional trauma, and death, were direct and proximate results of the County's above policies and customs, as well as the dereliction and inadequate supervision by Sheriff Bonner and Chief Fields.

72. Plaintiff's loss of her husband, and the minor child T.F.'s loss of her father, were also direct and proximate results of the County's above policies and customs, as well as the dereliction and inadequate supervision by Sheriff Bonner and Chief Fields.

V.

FEDERAL CAUSES OF ACTION

73. Plaintiff incorporates and reiterates the allegations above as if set forth verbatim under the following counts.

74. The Defendants, acting under color of state law, violated the rights of Mr. Freeman secured by the Fourteenth Amendment.

A. *Count One - Violation of 42 U.S.C. § 1983 through Policies, Customs, Practices, and Ratification (Against the County)*

75. As a local government body and political subdivision of the State of Tennessee, the County is subject to liability under section 1983 for the official acts and omissions of its policymakers.

76. Sheriff Bonner, Chief Fields, the SCSO's Assistant Director of Jail Programs, and various other County policymakers enacted policies and tolerated practices and customs that were deliberately indifferent to, and caused the violation of Mr. Freeman's constitutional rights.

77. These policies, customs, and practices included, but were not limited to, the following:

(a) The County's official policy of providing detainees only perfunctory mental-health screenings upon arrival to the Jail;

(b) The County's official policy of confining the provision of emergency-medical care to outside medical staff;

(c) The County's unwritten custom and practice of tolerating instances of excessive force by Jail staff against inmates;

(d) The County's unwritten custom and practice of tolerating violations of mental-health and other Jail medical protocols;

(e) The County's tacit encouragement of Jail staff who inflicted pain and punishment on inmates experiencing mental-health crises as a means of compelling submission and compliance;

(f) The County's policy or custom of deploying chemical weapons for unconstitutional purposes;

(g) The County's refusal to promulgate appropriate policies or procedures, or to take other measures, to prevent the use of unwarranted or excessive force by Jail staff despite awareness of a clear and persistent pattern of such conduct;

(h) The County's decision not to adequately train and supervise subordinate correctional officers in the appropriate use of force in the Jail, despite a clear and persistent pattern of excessive-force violations;

(i) The County's decision not to promulgate appropriate policies or procedures,

or to take other measures, to ensure correctional officers' compliance with mental-health and other Jail medical protocols, despite a clear and persistent pattern of violations of these protocols by Jail staff;

(j) The County's failure to adequately train or supervise subordinate officers in the importance of following mental-health and other Jail medical protocols, despite a clear and persistent pattern of violations of these protocols by Jail staff; and

(k) The County's continued reliance on members of the Blackshirts to fill Jail staffing shortages, despite these officers' well-known and well-documented pattern of using unwarranted and excessive force against detainees.

78. Furthermore, the County ratified the actions of Jail staff that caused and contributed to Mr. Freeman's injuries and death by refusing, through policymakers Sheriff Bonner and Chief Fields, to investigate, or to take administrative action against, the officers involved.

79. Furthermore, the County's demonstrated pattern of inadequately investigating similar incidents supports the inference that the County inadequately investigated this incident.

80. The County's ratification of the subordinate officers' conduct supports the inference that Mr. Freeman's death resulted from policy decisions attributable to the County.

81. Sheriff Bonner and the Shelby County Sheriff's Office's command staff approved, tolerated, and ratified the acts and omissions of the SCSO's correctional officers, as described above, were approved, tolerated, and ratified by

82. On or about September 20, 2023, a Shelby County grand jury indicted nine (9) correctional officers on criminal charges in connection with the beating and murder of Mr. Freeman. Prior to the unsealing of those indictments, Bonner held a surprise press conference in his office, backed by the entire Shelby County Sheriff's Department's command staff. The few words he gave there arguably violated state law, certainly violated the State's instruction to keep the information confidential, and fundamentally violated his oath and honor as a career law-enforcement officer.

83. During that press conference, Sheriff Bonner said unequivocally that:

(a) no action of any correctional officer in this matter caused the death of Mr. Freeman;

(b) he stood by the actions of Mr. Freeman's killers;

(c) the Shelby County grand jury only indicted the officers because of Bonner's election campaign for Memphis Mayor;

(d) he found the decisions of those Shelby County grand jurors "despicable;"

(e) each of the criminal defendants "remain[ed]" on paid administrative leave;

(f) none of the officers had been punished; and

(g) if there were a fund to contribute money to the officers, he would be the first person to contribute.[30]

84. On September 27, 2023, Sheriff Bonner did in fact contribute $1,500.00 to what was established as the "Defend the 9" Go Fund Me campaign. This campaign appears to have been shut down by Go Fund Me at the time of the filing of this pleading. However, a screenshot of Sheriff Bonner's contribution is hereto attached as **Exhibit E.**

85. The official and *de facto* policies of the County were also direct and proximate causes of Mr. Freeman's injuries and death because Jail staff acted according to these official and *de facto* policies when they brutalized and killed Mr. Freeman.

[30] Joel Griffin Moore, *9 corrections deputies indicted over death of Gershun Freeman*, ACTION NEWS FIVE (September 20, 2023, 4:56 PM), https://www.actionnews5.com/2023/09/21/9-corrections-deputies-indicted-over-death-gershun-freeman/ (Updated Oct. 4, 2023 at 10:31 PM CDT); *see also WATCH: 'I stand with these officers': Sheriff Bonner speaks after deputy jailers are charged with murder*, FOX 13 (September 20, 2023), https://www.fox13memphis.com/news/watch-i-stand-with-these-officers-sheriff-bonner-speaks-after-deputy-jailers-are-charged-with/video_85c4b813-c6c7-5f15-adfe-d69ae68fc90f.html

B. *Count Two - Supervisory Liability under 42 U.S.C. § 1983 (Against Sheriff Bonner)*

86. As the head of the SCSO and the County's chief law-enforcement officer, Sheriff Bonner was at all pertinent times responsible for controlling and supervising the conduct of subordinate SCSO employees.

87. Sheriff Bonner owed a non-delegable duty and responsibility to formulate, oversee, and implement official policies, practices, customs, and procedures of and for the SCSO.

88. Long before and at all times pertinent to the events above, Sheriff Bonner knew that:

(a) The perfunctory mental health screenings provided to detainees upon arrival at the Jail were inadequate to identify inmates with psychological and psychiatric problems despite their outsize prevalence among the Jail population and that a more robust screening process would provide adequate protection;

(b) The County's official policy of confining the provision of emergency-medical care to outside medical staff, rather than SCSO Jail staff, was resulting in a failure to provide necessary medical care in the initial minutes of medical emergencies (i.e., before medical staff could arrive);

(c) In a clear and persistent pattern, the Blackshirts and other Jail staff regularly used excessive force against inmates;

(d) In a clear and persistent pattern, the Blackshirts and other Jail staff regularly violated mental-health and other Jail medical protocols;

(e) In a clear and persistent pattern, the Blackshirts and other Jail staff regularly inflicted pain and punishment on inmates experiencing mental-health crises as a means of compelling submission and compliance;

(f) The County's policy or custom of deploying chemical weapons for unconstitutional purposes;

(g) The Jail lacked appropriate policies, procedures, or training to prevent the use of excessive or unlawful force by correctional officers in the Jail despite awareness of a clear and persistent pattern of such conduct;

(h) The Jail lacked appropriate policies, procedures, or training to ensure correctional officers' compliance with mental-health and other Jail medical protocols, despite a clear and persistent pattern of violations of these protocols by

Jail staff; and

(i) The use of the Blackshirts to fill Jail staffing shortages, despite these officers' well-known and well-documented pattern of using excessive force against detainees was resulting in more excessive force incidents than would have occurred if regular correctional deputies staffed these positions.

89. Despite this knowledge, Sheriff Bonner failed to properly supervise the Blackshirts and other Jail staff to avoid the use of excessive force.

90. Sheriff Bonner at all times had the ability to order remedial use of force training for each deputy at the Shelby County training facility and chose not to send deputies to this training.

91. Furthermore, Sheriff Bonner failed to properly investigate all allegations of excessive force and to implement an unbiased use of force investigation procedure. Here, Sheriff Bonner utilizes a use of force investigation procedure that includes allowing front-line supervisors, sergeants, lieutenants, and captains that are working the floor with deputies to determine if their use of force was excessive. (*See* ECF No. 30-3, PageID 383). By allowing these immediate supervisors, who are facing critically short staffing on their shifts, to make these determinations and issue punishments, Sheriff Bonner is ensuring no meaningful corrective punishment will occur for instances of excessive force by deputies.

92. Additionally, Sheriff Bonner at all times had the ability to create new procedures requiring internal investigators to refer all confirmed cases of excessive force to prosecutors for review. Memphis Police Director Michael Rallings issued such a procedure in 2019. Sheriff Bonner failed to issue such procedure.

93. Finally, Sheriff Bonner has attempted to cover-up the unconstitutional conduct of his subordinates by making misrepresentations about the SCSO's abilities related to excessive force and by failing to take appropriate administrative action in this matter and others.

94. Sheriff Bonner has been the Sheriff since 2018. Sheriff Bonner is or should be

aware of each of the instances of excessive force at the Jail addressed in Plaintiff's Rule 1006 summary, as well as any new instances of substantiated uses of force which have occurred since September 2021.

95. Rather than terminating employees who have committed assault and battery on Shelby County citizens, Sheriff Bonner between 2018 and 2021 only issued six (6) oral reprimands, four (4) written reprimands, four (4) one-day suspensions, five (5) three-day suspensions, three (3) five-day suspensions, eight (8) ten-day suspensions, and one (1) thirty-day suspension through his designee, Chief Fields.

96. The continued allowance of excessive force by Sheriff Bonner and Chief Fields is shocking and encourages more excessive force to occur.

97. For example, in April of 2019, Lieutenant Todd Connolly stomped and kicked an inmate while he was being held on the floor (Ex. D., p. 3, Incident SI2019-303) and followed this assault less than a month later in May 2019 with spraying chemical agent multiple times in the face of a handcuffed inmate who posed no threat of harm. (Ex. D., p. 3, Incident SI2019-265). The result of these two substantiated instances of excessive force was a single day suspension without pay each time. A single day suspension is *not* actually a deterrent or punishment because, during the relevant time frame, overtime shifts have been consistently available to security staff, meaning that a one-day suspension would not typically be anything more than changing a deputy's day off, as they could make up the missed work on their next day off. No reasonable person would view rescheduling a day off as a practical deterrent to the use of excessive force. Thus, these "suspensions without pay" need only exist on paper and at the discretion of the supervisor approving overtime.

98. Not to be outdone, Officer Cooper previously committed three (3) separate,

substantiated instances of excessive or unwarranted force against three (3) separate citizens of Shelby County between 2019 and 2021. (*See* Ex. D, p. 3, Incident SI2019-151; p. 10, Incidents SI2020-456 and SI2020-089). Yet he maintained his employment.

99. Furthermore, Elvis Hester, a pretrial detainee at the Jail, alleged he was retaliated against by four deputies—including Officers Jones and Cooper—after he filed a grievance against Officer Jones under the Prison Rape Elimination Act. Shelby County and Sheriff Bonner determined the officers had used excessive force and fabricated their formal statements about the incident. Despite this, Shelby County and Sheriff Bonner failed to take any action against the officers involved, with the exception of Officer Jones, who received a brief suspension. The State is now prosecuting Officer Jones for the murder of Mr. Freeman.[31]

100. Sheriff Bonner's failure to take any meaningful action against Officers Jones or Cooper for their previous instances of excessive force directly contributed to the death of Mr. Freeman. Again, Officer Jones was one of two officers charged with second-degree murder in this matter.

101. The aforementioned substantiated instances of excessive force, including multiple instances by different deputies, gave Sheriff Bonner actual notice of a need to revise and improve Jail operations and the SCSO disciplinary process. No improvements have been made.

102. Sheriff Bonner has authorized and approved violations of the SCSO's excessive-force policy by choosing not to appropriately punish or terminate offenders.

103. The pre-trial detainees in the Jail had clearly established rights to receive basic mental-health and other medical care, and to be free from unwarranted or excessive force.

[31] This matter was litigated in *Elvis Hester v. Shelby County, Tennessee, Stevon Jones, Damian Cooper, James Perry, and Steveland Freeman*, Case No. 2:21-cv-02030-JTF-atc, filed Jan. 13, 2021, in the Western District of Tennessee where the parties reached a settlement without admission of liability.

104. The camera footage and incident records in this matter demonstrate Jail staff were either unaware of clearly established law or believed they would not face meaningful consequences for violating pre-trial detainees' rights. This level and degree of ignorance among SCSO employees demonstrates that Sheriff Bonner failed to properly train or supervise his subordinates on fundamental principles regarding use of force, mental-health and other medical protocols.

105. Properly trained and supervised public-safety officers and other personnel would not have engaged in the acts that preceded and caused Mr. Freeman's death.

106. Sheriff Bonner's failure to properly control or supervise his subordinates in the manner alleged under this Count directly and proximately caused Mr. Freeman's injuries and death, and Plaintiff and T.F.'s losses of their husband and father, respectively.

107. Sheriff Bonner's failure to provide adequate and proper training and supervision, as evidenced by the actions of so many officers in this matter amounted to deliberate indifference and disregard for the constitutional rights of detainees like Mr. Freeman.

C. *Count Three - Supervisory Liability under 42 U.S.C. § 1983 (Against Chief Fields)*

108. As the County's Chief Jailer, Chief Fields was at all pertinent times responsible for controlling and supervising the conduct of Jail staff and for the safety and wellbeing of the Jail's pre-trial detainees.

109. Chief Fields had a non-delegable duty and responsibility to formulate, oversee, and implement official policies, practices, customs, and procedures for Jail staff.

110. Long before and at all times pertinent to the events above, Chief Fields knew that:

(a) The perfunctory mental-health screenings provided to detainees upon arrival at the Jail was inadequate to identify inmates with psychological and psychiatric problems, and that a more robust screening process would provide adequate protection;

(b) The County's official policy of confining the provision of emergency-

medical care to outside medical staff, rather than SCSO Jail staff, was resulting in a failure to provide necessary medical care in the initial minutes of medical emergencies (i.e., before medical staff could arrive);

(c) In a clear and persistent pattern, the Blackshirts and other Jail staff regularly used excessive force against inmates;

(d) In a clear and persistent pattern, the Blackshirts and other Jail staff regularly violated mental-health and other Jail medical protocols;

(e) In a clear and persistent pattern, the Blackshirts and other Jail staff regularly inflicted pain and punishment on inmates experiencing mental-health crises as a means of compelling submission and compliance;

(f) The County's policy or custom of deploying chemical weapons for unconstitutional purposes;

(g) The Jail lacked appropriate policies, procedures, or training to prevent the use of excessive or unlawful force by correctional officers in the Jail despite awareness of a clear and persistent pattern of such conduct;

(h) The Jail lacked appropriate policies, procedures, or training to ensure correctional officers' compliance with mental-health and other Jail medical protocols, despite a clear and persistent pattern of violations of these protocols by Jail staff; and

(i) The use of the Blackshirts to fill Jail staffing shortages, despite these officers' well-known and well-documented pattern of using excessive force against detainees was resulting in more excessive force incidents than would have occurred if regular correctional deputies staffed these positions.

111. Despite this knowledge, Chief Fields failed to properly supervise the Blackshirts and other Jail staff to avoid the use of excessive force.

112. Chief Fields at all times had the ability to order remedial use of force training for each deputy at the Shelby County training facility and chose not to send deputies to this training.

113. Furthermore, Chief Fields failed to properly investigate all allegations of excessive force and to implement an unbiased use of force investigation procedure. Here, Chief Fields utilizes a use of force investigation procedure that includes allowing front-line supervisors, sergeants, lieutenants, and captains that are working the floor with deputies to determine if their use of force was excessive. (*See* ECF No. 30-3, PageID 383). By allowing these immediate

supervisors, who are frequently understaffed, to make these determinations and issue punishments, Chief Fields is ensuring no meaningful corrective punishment will occur for instances of excessive force by deputies.

114. Finally, Chief Fields at all times had the ability to create new procedures requiring internal investigators to refer all confirmed cases of excessive force to prosecutors for review. Memphis Police Director Michael Rallings issued such a procedure in 2019. Chief Fields failed to issue such procedures.

115. The Chief Jailer since 2018, Chief Fields has actual notice of each of the instances of excessive force at the Jail addressed in Plaintiff's Rule 1006 summary, as well as multiple other instances of substantiated excessive-force investigations since September 2021.

116. Rather than terminating the employees who physically assaulted Shelby County citizens in their care and then turning these criminal offenders over to the Shelby County District Attorney General for prosecution, Chief Fields between 2018 and 2021 issued six (6) oral reprimands, four (4) written reprimands, four (4) one-day suspensions, five (5) three-day suspensions, three (3) five-day suspensions, eight (8) ten-day suspensions, and one (1) thirty-day suspension. The continued allowance of excessive force by Chief Fields shocks the conscience and encourages more excessive force to occur.

117. Given his knowledge of the substantiated instances of excessive force above, and others, including multiple instances by different deputies, Chief Fields had actual notice of a need to revise and improve Jail operations and the SCSO disciplinary process. However, no improvements have been made. Chief Fields has failed to improve the Jail's operations and properly discipline his deputies.

118. Chief Fields has implicitly authorized and approved the conduct of his subordinates

by failing to appropriately punish violations of the SCSO's excessive-force policy.

119. The pre-trial detainees in the Jail had clearly established rights to receive basic mental-health and other medical care, and to be free from unwarranted or excessive force.

120. The camera footage and incident records in this matter demonstrate that Jail staff were either unaware of clearly established law or believed they would not face meaningful consequences for violating pre-trial detainees' civil and constitutional rights. This level and degree of ignorance demonstrates that Chief Fields failed to properly train or supervise subordinate Jail staff regarding use of force, mental-health and other medical protocols.

121. Properly trained and supervised public-safety officers and other personnel would not have engaged in the acts that preceded and caused Mr. Freeman's death.

122. Chief Fields' failure to properly control or supervise his subordinates as alleged under this Count directly and proximately caused Mr. Freeman's injuries and death, and Plaintiff and T.F.'s losses of their husband and father, respectively.

123. Chief Fields' failure to provide adequate and proper training and supervision, as evidenced by the actions of so many officers in this matter was so grossly negligent that it amounted to deliberate indifference and disregard for the civil and constitutional rights of detainees like Mr. Freeman.

124. Chief Fields personally established and/or ratified the custom or *de facto* policy for using chemical weapons for the unconstitutional purpose of punishing inmates who were already restrained and/or posed no threat, which is an act so reckless as to amount to deliberate indifference to the Eighth and Fourteenth amendment rights of detainees like Mr. Freeman.

D. *Count Four – Violation of the Americans with Disabilities Act (Against the County)*

125. "In the Americans with Disabilities Act [the "ADA"], Congress provided [a]

broad mandate" to "effectuate its sweeping purpose [to] . . . forbid[] discrimination against disabled individuals in major areas of public life, [including] . . . public services . . . ." *PGA Tour, Inc. v. Martin*, 532 U.S. 661, 675 (2001). It is "a milestone on the path to a more decent, tolerant, progressive society." *Id.* (quoting *Bd. of Trustees of Univ. of Ala. v. Garrett*, 531 U.S. 356, 375 (2001) (Kennedy, J., concurring)).

126. The ADA embodies a public policy committed to the removal of a broad range of impediments to the integration of people with disabilities into society and strengthening the federal government's role in enforcing the standards established by Congress.

127. The ADA requires that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132.

128. The ADA further prohibits any public entity from, either directly or through contractual or other arrangements, using any criteria or methods of administration that (a) have the effect of subjecting qualified individuals with disabilities to discrimination on the basis of their disability or (b) perpetuate the discrimination of another public entity if both public entities are subject to common administrative control or are agencies of the same State. 28 C.F.R. §§ 35.130 (b)(3)(i), (iii).

129. The ADA further forbids retaliation against individuals with disabilities on the basis of their disabilities.

130. Mr. Freeman was an individual with a medical condition that substantially limited one or more major life activity, and therefore, was considered to be a person with a disability under the ADA. *See* 29 U.S.C. § 705(9)(B), as amended by the ADA Amendments Act, Pub. L. 110-325,

Sec. 7, 122 Stat. 3553 (Sept. 25, 2008).

131. Shelby County is a public entity subject to the ADA.

132. At the time of the incident that forms the basis of this Complaint, Mr. Freeman was suffering from acute psychosis that derived from his disability.

133. Mr. Freeman was one of hundreds of detainees at the Jail with such mental health disabilities. At any given time, the Jail houses between 150 and 350 detainees with *diagnosed* mental health disorders. The Jail is well-aware of the need for mental health accommodations to be compliant with the ADA but provides totally inadequate resources to meet those needs.

134. Further, 4-Juliet pod was supervised by senior deputies with authority to provide reasonable modifications that would have accommodated Mr. Freeman's disability or otherwise remedy policies, practices, customs and procedures that violated the ADA.

135. The lack of training the senior deputies supervising the 4-Juliet pod received, along with the fundamental lack of investment in mental-health resources for the Jail, violated ADA requirements.

136. Jail staff discriminated against Mr. Freeman on the basis of his disability when they responded to his symptoms of acute psychosis, attributable to his disability, with gratuitous and punitive violence. This discrimination was a direct and proximate result of the County's failure to have adequate mental health policies and procedures in place to address the needs of the twenty percent of the Jail population suffering from mental health conditions.

137. The County subjected Mr. Freeman to discrimination on the basis of his disability in violation of 34 C.F.R. § 104.4(b)(4) by operating a mental-health pod that lacked adequate mental-health staff and utilized Jail staff with no medical training, who were ignorant of de-escalation techniques, to manage inmates experiencing acute psychosis and other mental health

conditions.

138. The County used methods of administration that had the effect or purpose of defeating or substantially impairing accomplishment of the objectives of the Jail's programs and services in violation of 34 C.F.R. § 104.4(b)(4) to the extent such programs and services existed.

VI.

PENDANT CAUSES OF ACTION

139. Plaintiff incorporates, re-alleges, and reiterates the allegations in Paragraphs 1-136 as if set forth verbatim under this Count.

140. In addition, Plaintiff avers that the County is liable under the Tennessee Governmental Tort Liability Act, Tennessee Code Annotated section 29-20-205 because certain County employees involved in Mr. Freeman's death, who either were not—or were not *exclusively*—deliberately indifferent to his constitutional rights, nonetheless did act with simple negligence. These negligent County employees included but were not limited to:

(a) The corrections deputies who struck, improperly restrained, and failed to intervene in the violent assault on Gershun Freeman;

(b) The deputies who opened Gershun Freeman's cell door while he was in a psychotic state;

(c) The Jail officials with responsibility for the supervision of the corrections deputies who killed Gershun Freeman; and

(d) Sheriff Bonner and Chief Fields (if and only if a finder of fact determines that their conduct was merely negligent and not deliberately indifferent).

141. Those County employees were negligent in that:

(a) They owed Mr. Freeman a duty of care;

(b) They breached that duty;

(c) That breach of duty contributed to Mr. Freeman's injuries and wrongful death; and

(d) It was foreseeable that the County employees' breach of duty would cause Mr. Freeman's injuries and wrongful death.

VII.

LOSS OF CONSORTIUM

142. Plaintiff incorporates, re-alleges, and reiterates all allegations above as if set forth verbatim under this Count.

143. Plaintiff was at all relevant times the wife of Mr. Freeman, and her minor child was the child of Mr. Freeman and, as such, they were entitled to the comfort, companionship, society, love, enjoyment, and support of Mr. Freeman.

144. As a direct and proximate result of the facts alleged above, the Plaintiff and her minor child were deprived of the comfort, companionship, society, love, enjoyment, and support that Mr. Freeman would otherwise have provided them.

145. Plaintiff and her minor child have suffered and will continue to suffer economic and emotional loss and injury.

146. Plaintiff's injuries and damages are permanent and will continue indefinitely. Plaintiff seeks actual and punitive damages from the Defendants alleged herein.

VIII.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully demands judgment against the Defendants on each Count of the Complaint and prays that this Court:

A. Empanel a jury of no fewer than eight to hear and try all jury-triable questions raised by the pleadings in this matter, or as may emerge over the course of discovery;

B. Award Plaintiff compensatory damages according to the proof, but in no event less than **ONE HUNDRED MILLION DOLLARS ($100,000,000)**;

C. Award Plaintiff punitive damages against the individual Defendants in an amount to be determined according to the proof;

D. Award Plaintiff taxable costs and expenses under 28 U.S.C. § 1920 and Federal Rule of Civil Procedure 54;

E. Award Plaintiff reasonable attorneys' fees and non-taxable expenses under 42 U.S.C. § 1988;

F. Award Plaintiff pre- and post-judgment interest under Tennessee Code Annotated section 47-14-123; and

G. Grant such other and further relief as the Court may deem appropriate under the circumstances.

§ § §

Dated October 27, 2023.

Respectfully submitted,

/s/ *Brice M. Timmons*
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IX.

CERTIFICATE OF SERVICE

I certify that a copy of the foregoing pleading is filed October 27, 2023 via the District Court's electronic-filing system and all counsel of record will be served automatically by operation of the same.

/s/ Sara Katherine McKinney

THE UNITED STATES DEPARTMENT of JUSTICE

DINGS LETTER RE INVESTIGATION OF SHELBY COUNTY JAIL

The Honorable Jim Rout
Mayor of Shelby County
160 North Main, Suite 805
Memphis, Tennessee 38103

Re: Investigation of Shelby County Jail Memphis, Tennessee

Dear Mayor Rout:

On August 24, 2000, we notified you of our intent to investigate conditions in the Shelby County Jail ("SCJ"), pursuant to the Civil Rights of Institutionalized Persons Act ("CRIPA"), 42 U.S.C. Section 1997 et seq. Our investigation focused on allegations of inadequate supervision of inmates and staff that lead to excessive levels of violence in the facility, inadequate mental health and medical care, and deficient sanitation and environmental health. I am writing to report the findings of our investigation, supporting facts, and recommended remedial measures, as required by CRIPA.

On October 4-6, and December 11-13, 2000, we toured the SCJ with expert consultants in prison security, correctional health care, mental health care and environmental health and safety. Our consultants subsequently prepared reports to us of their findings and recommendations. While at the SCJ, we interviewed administrators, staff, and inmates and reviewed documents, including policies and procedures, incident reports and medical records. In addition, we received and reviewed the documents provided to us before, during and following our on-site tours. We also reviewed the December 22, 2000 Opinion Finding Defendants in Contempt of Court, entered by the district court in Little v. Shelby County, No. 96-2520 (W.D. Tenn.) (the "Little Findings"), and the March 14, 2001 Technical Assistance Report from the National Institute of Corrections ("NIC"). At the end of our October visit, our expert consultants in corrections, medical care and environmental health conducted exit interviews in which they conveyed their preliminary findings.

We appreciate the assistance provided to us by the Shelby County Sheriff's office and representatives of the county government. In particular, staff at the Jail and in the office of the Sheriff's legal advisor extended every courtesy to us during our visits, and provided all documents we requested.

Based on our investigation, however, and as described more fully below, we conclude that certain conditions at the SCJ violate the constitutional rights of inmates. We find that persons confined in the SCJ risk serious injury from deficiencies in the following areas: security and protection from harm, mental health and medical care, and environmental health and safety. Crowding in the facility exacerbates these deficiencies.

I. Legal Framework

The constitutional law governing conditions of confinement for inmates has two sources, the Eighth and Fourteenth Amendments. Pre-trial detainees, individuals who have not been convicted of the criminal offenses with which they have been charged, comprise the majority of inmates at the SCJ. Under the Fourteenth Amendment, these inmates "retain at least those constitutional rights . . . enjoyed by convicted prisoners." Bell v. Wolfish, 441 U.S. 520, 545 (1979). Further, the Fourteenth Amendment prohibits punishment of pretrial detainees or the imposition of conditions or practices not reasonably related to the legitimate governmental objectives of safety, order and security. Id. at 535-37.

Under the Eighth Amendment, convicted inmates at the SCJ are entitled to "humane conditions of confinement; prison officials must ensure that inmates receive adequate food, clothing, shelter and medical care and must 'take reasonable measures to guarantee the safety of the inmates.'" Farmer v. Brennan, 511 U.S. 825, 832-833 (1994) (quoting Hudson v. Palmer, 468 U.S. 517, 526 (1984)). The Eight Amendment also forbids excessive physical force against prisoners. Hudson v. McMillian, 503 U.S. 1, 9 (1992). Likewise, prison officials have a duty to protect prisoners "from violence at

the hands of other prisoners." Farmer, 511 U.S. at 833. The Eighth Amendment protects prisoners not only from present and continuing harm, but from future harm as well. Helling v. McKinney, 509 U.S. 25, 33 (1993).

The SCJ must ensure that inmates receive adequate medical care, including mental health care. See Farmer v. Brennan, 511 U.S. 825, 832 (1994); Phillips v. Michigan Department of Corrections, 731 F. Supp 792 (W.D. Mich. 1990, aff'd 932 F.2d 969, 1991 WL 76205 (6th Cir. (Mich.)). Deliberate indifference to inmates' (including pretrial detainees) serious medical needs violates the Eighth Amendment because it constitutes the unnecessary and wanton infliction of pain contrary to contemporary standards of decency. Estelle v. Gamble, 429 U.S. 97, 104 (1976); Rich v. City of Mayfield Heights, 955 F.2d 1092, 1096 (6th Cir. 1992).

II. The Shelby County Jail Facilities

The Shelby County Sheriff's Office operates the SCJ, which consists of four physically separate facilities: the main Jail at 201 Poplar Street in downtown Memphis ("Jail"), the Jail East facility for women located in East Memphis, the prison ward at the University of Tennessee Medical Center (know as the Med), and leased dormitory-style space, known as P Dormitory, at the Shelby County Corrections Facility. We were informed that, by agreement with the City of Memphis, the SCJ also detains all inmates charged by the City, which has no separate jail of its own. Thus, the SCJ houses both men and women of minimum, medium, and maximum security custody, plus an average of more than 100 state-convicted inmates, and a varying number of juvenile detainees who have been remanded, under state law, to face criminal charges as adults.

The downtown Jail was opened in 1981, and had 2,789 beds at the time of our tours. Two floors of the Jail contain dormitory housing, a small number of single cells on the second floor are reserved for inmates with special needs, and the remaining Jail housing is in double-bunked cells. An addition to the Jail is currently under construction, and we are told it will contain space for as many as 250 inmates. The lower level of the Jail is used for intake, booking, classification and pretrial services. The Jail also contains a small medical area on the second floor, an indoor gymnasium, a secure roof-top recreation area, a chapel and a small room used as a law library.

The Sheriff's Office opened a facility known as Jail East in 1999, and moved all female inmates to that facility, which has a separate intake and booking area, a small medical area, and a capacity of 384. P Dormitory, space leased from the Department of Corrections, houses 200 low security male inmates.[(1)] Unless otherwise noted, our findings refer to the main Jail and to Jail East.

III. Findings and Supporting Facts

A. Deficient Security and Supervision and Protection from Harm

1. Inmate-on-Inmate Violence

Inmates at the SCJ face an unconstitutional threat of violence from attacks by other inmates. In November of 1997, the district court in the Little case found that:

Gang involvement is very prevalent in the Shelby County Jail. Gangs known as the Gansta Disciples and Vice Lords are present in the Shelby County Jail. Gang members are responsible for many violent acts, stabbings and rapes in the Shelby County Jail.

Little Findings of Fact and Conclusions of Law at 5 (November 12, 1997). On December 22, 2000, the court held, on plaintiffs' motion for contempt, that "[t]hose same conditions exist unchanged in the Shelby County Jail today."

Little Findings at

1. The court found that:

[T]here is no evidence to demonstrate that the guards are adequately supervising the inmates to ensure that the pods to which they are assigned are safe and compatible housing assignments. Rather, the evidence presented [at 5 days of testimony in November and December of 2000] demonstrates that gang members control the daily life of the inmates in 95% of the pods; that the gang members run organized brawls between gang members and non-gang members

[referred to as "Thunderdome"]; that the gang members post rules in the pods that are imposed on other inmates upon threat of physical violence . . . . The Court heard testimony from inmates who had been assaulted in the Jail, both in Thunderdome events and for failing to participate in them, that the guards responsible for supervising the pods to prevent the inmates from assaulting each other were either away from their assigned posts, aware of the assaults but failed to stop them, or asleep.

Little Findings at 38 - 39. The County stipulated that assaults by inmates on other inmates occur in the intake area of the Jail, and that the Gangsta Disciples are responsible for many violent acts towards other inmates in the Jail. Id. at 10-11. These facts concerning gang control and frequent assaults of inmates are consistent with the observations of our consultants.

2. Inmates Are Not Supervised Adequately.

The Jail is chronically short-staffed and plagued by high turnover and absenteeism. Interviews with SCJ officials and correctional officers, review of staffing rosters and the December 22, 2000, Little Findings confirm that the SCJ incurs substantial overtime in order to staff necessary posts. The ongoing personnel shortage compromises institutional security and the safety of inmates and staff.(2) Due to short staffing, the SCJ routinely requires officers to supervise more than one pod(3) of inmates at a time -- notwithstanding that officers have no line of sight supervision of the cells in these pods. Little Findings at 10, Stipulated Facts Nos. 6 - 9. Moreover, the significant crowding results in so many inmates congregating inside the dayrooms that an officer's view of the back of the dayroom is also obstructed. Officers do not make required rounds of the catwalks to observe conditions inside the cells, and even when they make infrequent rounds, their view into the cells is obstructed by poor lighting and various obstructions hung by the inmates. Thus, housing staff cannot, and do not, supervise inmates adequately.(4) The recent testimony in the Little contempt hearings was replete with examples of inmates who suffered harm at the hands of other inmates without interference from -- indeed, often without the knowledge of -- correctional officers. Little Findings at 17, 19-20, 38-39.

Staffing shortages also are blamed for consistently, dangerously low staffing in the intake area, where assaults by inmates upon other inmates frequently occur. The County admits that as many as 150 inmates may be awaiting classification in the intake area, and that only three officers per shift are regularly assigned to intake. Id., Stipulated Facts Nos. 4, 6.

3. SCJ Fails to Classify Inmates Effectively.

SCJ further compromises safety by classifying inmates with a system that has substantial deficiencies. First, a significant flaw with the current classification system is that an inmate's classification is not reviewed on a periodic basis, to take into account possible changes in charges and institutional behavior that might warrant an increase or a reduction in the inmate's classification level. Reviews are particularly important because many inmates remain in the SCJ for many months or years. Second, the system considers only prior convictions in assessing an inmate's criminal history, and does not consider prior assaultive charges for which an inmate currently may be on bond awaiting trial. Third, the SCJ routinely fails to discipline misbehavior while in the facility, and thus, routinely fails to incorporate information about disciplinary findings in its classification and re-classification decisions. Finally, the classification system does not take into account gang affiliation or participation in gang-related activity -- even activity that occurs in the Jail. These deficiencies substantially increase the likelihood of an inmate's classification not reflecting his or her true potential for violence, and increases the risk of serious harm to inmates.

In addition, the Jail's intake area consistently fails to separate and supervise inmates with a potential for violence, leaving inmates prone to attack during the hours -- and sometimes days -- that it takes to complete the booking and classification process. The Jail was designed with separate holding tanks on either side of a hallway of central offices used for booking, identification, preliminary classification, medical screening and pretrial services. The Jail separates inmates and processes them through either the assaultive or the non-assaultive corridor, based only on information available at arrest, primarily, their charges. Both sides of the intake area suffer from deficient staff supervision. In addition, these areas are grossly crowded, with as many as 100-150 inmates at peak times. The holding tanks, with a maximum total capacity of 75 inmates, are inadequate to contain this number of inmates, who often spill into the hallways. The identification unit and medical screening area can be accessed from either the assaultive or the non-

assaultive hallways, and basic security is consistently lax, permitting assaultive and non-assaultive inmates to mix in these areas.

4. SCJ Does Not Discipline Inmates Who Violate Jail Rules.

SCJ officials have not taken the necessary steps to control inmate misconduct through the disciplinary process. Disciplinary infractions routinely result in no formal discipline, both because mandated hearings are not held within 72 hours, after which the charges expire, and because staff, knowing that follow-up with a hearing and punishment is unlikely, frequently do not initiate the process by charging or "writing up" the inmate. One of the factors contributing to this problem is the lack of sufficient disciplinary segregation beds. "Waiting lists" are common as inmates determined to have violated institutional regulations must wait for a bed in disciplinary segregation to become available. The NIC report also highlighted this problem, calling the number of disciplinary segregation beds "seriously inadequate." NIC Technical Assistance Report at 20. Furthermore, even when disciplinary action is taken, that information is not incorporated into re-classification decisions. This failure substantially increases the likelihood of inmates' classification not reflecting their true potential for violence, and increases the risk of serious harm to inmates.

5. SCJ Does Not Control Dangerous Contraband, Tools or Keys.

The SCJ fails to conduct sufficient searches of inmate living areas to control inmates' accumulation of dangerous contraband. For example, the shakedown team conducted no shakedowns at Jail East between March and December 2000. During our visit in October, inmates at Jail East complained that other inmates had accumulated stocks of disposable razors from the commissary, a clear security concern. At the main Jail, the shakedown team's log included shanks, razor blades removed from their disposable handles and other forms of life-threatening contraband, as well as stockpiled medications and other items frequently used for barter and extortion among inmates.

Inadequate tool and key control at SCJ create a significant risk of harm to both institutional security and the health and safety of inmates and staff. SCJ staff members at both the Jail and Jail East were unable to identify emergency keys for unlocking doors,[(5)] and a lieutenant assigned to the key storage area could not identify any use for a number of keys under his control. The NIC team made similar observations in its tour of the SCJ in January 2001. We observed inmates with broad access to dangerous tools which could easily be used as weapons, for example, acetylene torches and heavy metal cutters used by unguarded workmen installing a railing in the lower level. We also observed the door to the DRT staging room left open to an adjoining hallway where unescorted inmates walked, despite the fact that chemical agent sprays, among other items, are stored in unlocked cabinets and file drawers in the room.

6. Excessive Use of Force Is Prevalent.

The level of force used by staff against inmates at the SCJ is excessive, and senior Jail management is aware of the problem. The Chief Jailer conceded that the use of force "may be bordering on high," the Commander of Security acknowledged that staff routinely use chemical agents before using hands-on control techniques (an express violation of SCJ policy), and a former commander of Internal Affairs confirmed the use of force outside the parameters of the staff's training. The use of pepper spray is particularly uncontrolled. The reasons include the lack of guidance in policies, the lack of inventory control for chemical agents, the lack of effective oversight or investigation of all incidents involving this type of force, and the lack of supervision to prevent the staff's use of force exceeding the limitations of policy.

a. Policies on the Use of Force Provide No Operational Guidance.

The SCJ's use of force policies and procedures are too vague to provide guidance to staff in identifying the limited appropriate circumstances for uses of force. The Constitution permits the use of force in correctional settings only to the extent that the force used by officials is reasonably necessary to respond to a threat to security or discipline reasonably perceived by officials. Hudson v. McMillian, 503 U.S. at 7 (discussing factors that courts evaluate in determining "whether the use of force could plausibly have been thought necessary in a particular situation"); Williams v. Browman, 981 F.2d 901, 905 (6th Cir. 1992) (same). The SCJ's policies, however, describe permissible uses of force more indiscriminately. For example, the SCJ "Use of Chemical Agents" policy permits the use of chemical agents when an inmate "shows no intention of complying" with a verbal order, no matter what the order or how insignificant its impact on security. Inmates complain of being sprayed by officers in the course of verbal disagreements, and numerous reports

indicate that inmates are sprayed with chemical agents on little provocation. However, if an officer states that the inmate refused a verbal order, the officer's behavior is safely within the bounds of SCJ policy. Less forceful alternatives to control inmate behavior, including a show of force through additional or supervising officers, hands-on control tactics, and discipline through the administrative process, are neither encouraged nor required by this policy.

SCJ policy also authorizes the use of force to prevent destruction of county property, no matter how insignificant its value. The exertion of force against inmates, including chemical sprays, to prevent insignificant property damage is excessive, yet is within the bounds of this policy. See Hudson v. McMillan, 503 U.S. at 7 (the need for force, the relationship between that need and the amount of force used, and any efforts made to temper the severity of a forceful response are among the factors properly used to evaluate whether the use of force was wanton and unnecessary); Lock v. Jenkins, 641 F.2d 488, 496 (7th Cir. 1981) (although the significant destruction of prison property might justify the use of tear gas, damage to a food tray does not rise to this level). This policy, in particular, should be amended to authorize force only in the face of destruction of valuable property. Sound use of force policies should provide guidance to staff so that staff's response to the threat posed by an inmate's behavior employs only the force reasonably necessary to control that behavior.

b. Chemical Agents Are Not Inventoried.

There is no inventory control of canisters of pepper spray. In fact, numerous canisters are held in unlocked file cabinets in the DRT staging room, and canisters are issued to each officer at the training academy. Depleted canisters are replaced upon application. A 1996 policy requiring canisters to be weighed upon issue and quarterly was revised in 1998 to eliminate the quarterly weighing. Monitoring the volume of chemicals used by staff is one way to identify heavy use -- and prevent excessive use -- of chemicals.

c. Uses of Chemical Agents Are Not Investigated.

There is no effective investigation of the use of chemical agents, the most routine use of force at the SCJ. Staff are required to fill out a form entitled "Use of Chemical Agent," but even the most blatantly inappropriate reasons for the use of chemicals stated on these reports -- indeed, even reports with no stated reasons -- are not investigated by the Internal Affairs Bureau.(6)

For example, staff spray inmates when they are verbally aggressive, as in the following report: "Inmate refused to remove his clothing after being placed on suicidal precaution and became verbally abusive and very hostile." Staff frequently spray inmates displaying behaviors characteristic of mental illness, as in the following examples: "Inmate was beating his head against tank door. He was sprayed to prevent him from hurting himself;" and "[Inmate] refused to talk sensible, he began to praise the devil pulling off all his clothes, walking naked . . . given several orders to go to his cell, but still refused."

None of these instances was investigated, as evidenced by the fact that none appeared in the Internal Affairs Bureau's investigation logbooks. Incidents where inmates were sprayed while lying prone on the floor or while locked in their cells were also not investigated. Indeed, the use of chemicals against an inmate is seldom reported on the separate forms designed for that purpose and is even more rarely investigated. To ensure the appropriate use of chemicals by staff, supervisors should provide oversight, feedback and discipline for misuse.

d. Examples of Excessive Force

A hearing-impaired, mentally ill inmate was pepper sprayed while laying quietly in his cell, then he was forcibly removed from the cell by five members of the Detention Response Team ("DRT") wearing riot gear and gas masks, strapped into a five-point restraint chair, and a solid hood placed over his head. He was then transported to and from a shower in the restraint chair. The stated justification for this extraordinary show of force was that the inmate, who was known to be hearing impaired, had refused a verbal order to take a shower. The use of this level of force in these circumstances, upon an inmate with known disabilities that would affect his ability to comply with staff orders, appears to us to be an example of wilful and wanton infliction of pain without justification.

The policy on use of the restraint chair requires the use of a "disposable spit cap." The policy states that the spit cap is used to "eliminate any potential health hazards." Staff proffered to us that it was used to reduce the possibility of

transmitting HIV. We are aware of no medical or scientific literature to suggest that HIV is transmitted by spitting. Moreover, the disposable mesh bag (i.e. spit cap) that was used in a demonstration on a member of the DOJ team is distinguishable from the opaque bag that was placed over the head of the deaf inmate described above. In the actual incident, as opposed to the demonstration, the inmate's eyes, ears, nose and mouth were completely covered by the "spit cap" that resembled a canvas pillow case. The canvas bag was placed back on the inmate's head after he complied with the DRT's instruction to shower and dress out. The use of the canvas hood is never appropriate. Moreover, because no valid penalogical purpose has been suggested for the disposable spit cap, its use is also inappropriate.

Inmates reported many additional examples of the use of excessive force, particularly involving pepper spray. Several inmates in one pod, independently and without collusion, told us that the DRT had sprayed gas into the dayroom of their pod during what the inmates described as a practice session, while inmates were locked in their cells. This appears to be confirmed by a DRT incident report stating that the team used two cans spray in one pod. The DRT report alleged that a number of inmates in the pod had refused a verbal order to lock down. Inmates report that pod officers routinely use pepper spray in the course of verbal altercations.

In summary, the vague policies on use of force, the admissions of senior management, the review of incident reports and complaints, and the lack of oversight on the use of chemical agents lead us to conclude that the SCJ violates the constitutional rights of inmates by permitting the excessive use of force by staff. We conclude that there is a pattern or practice of excessive use of force against inmates at the SCJ and that management has failed, in particular, to correct the clear misuse of chemical agents by staff.

B. Mental Health and Medical Care Is Constitutionally Deficient.

Shelby County contracts with Correctional Medical Services ("CMS") to provide mental health and medical care at the Jail and Jail East; critical care is provided by the University of Tennessee's Regional Medical Center. Medical and mental health services at the Jail and Jail East are critically deficient in several respects:

- initial evaluations are frequently deficient;
- access to both medical and mental health care through sick call is deficient because there are too few qualified professionals on staff to evaluate sick call requests and perform examinations in a timely manner;
- mental health diagnostic assessments are inadequate;
- prescription medication is not managed and administered reliably;
- chronic illnesses, including severe mental illnesses, are not managed effectively; and
- there is no screening for emergent mental health concerns in the general housing areas.

1. Deficient Access to Care

a. Intake Evaluations

There is a critical shortage of qualified health professionals to serve an inmate population the size of the SCJ. In the year 2000, the Jail booked more than 64,000 inmates, averaging more than 5,300 bookings per month. The staff is hard-pressed to provide complete intake evaluations for such large numbers of inmates, and we noted numerous lapses in medical intake evaluations, particularly in screening for transmissible infectious diseases, taking and recording vital signs, and assuring timely continuation of prescription medications.

The following examples illustrate lapses in providing minimally competent medical intake evaluations. Problems with screening for infectious diseases were evident from the files of two inmates with recorded histories of tuberculosis, neither of whom was screened for current signs of the disease, even though our review occurred almost two months after their admissions. We discovered many cases where previously-prescribed medication was not continued upon intake, including an inmate who required seizure medication that was not ordered by a physician until four days after intake. Another inmate, a renal dialysis patient with hypertension and diabetes, received no treatment for either

condition for three days, and no blood pressure or blood sugar monitoring. An inmate admitted on medications for HIV received no physician evaluation and no medication evaluation during five months of incarceration. These are all potentially life-threatening delays.

There is inadequate evaluation and treatment of substance abuse and the symptoms of withdrawal. Inmates are not asked directly about drug and alcohol use. A recently-implemented protocol to screen inmates for drug or alcohol withdrawal relies heavily upon reviewing vital signs for indications of withdrawal, yet vital signs are routinely not taken and recorded during intake evaluations. One inmate who admitted to drug and alcohol abuse at intake received no physical evaluation or physician appointment during two months of incarceration.

Failure to continue medication promptly and to monitor vital signs at intake also contributes to deficiencies in mental health care. One inmate was admitted and discharged within two days without receiving previously-prescribed medication for bipolar disorder, although the medications were identified on his intake forms. He was re-arrested a day later but his psychiatric medication again was delayed for two days. This inmate committed suicide five days after his first admission (on the third day of his second admission), having not received prescribed mood-stabilizing medication for four of his last five days. It took two weeks for another inmate to receive the psychotropic medication he had been taking at the time of his arrest.

Lack of privacy in the intake area may inhibit candid responses to the intake screening questions, increasing the chances of missing an inmate with a significant mental health or suicide concern.

Although national statistics suggest a higher prevalence of mental health concerns among female than male inmates, there is a disturbing shortage of qualified mental health professionals at Jail East. The mental health staffing for inmates at Jail East consists of a technician working two hours per day, five days per week, and a psychiatrist working three hours per week. There is no substitute staffing during staff vacations or other absences. This is insufficient to accomplish timely screening for mental health concerns, or to provide essential treatment for those with identified needs, including those on psychiatric medication. For example, the psychiatrist canceled his one-morning per week visit to Jail East during our December tour. In his absence, no new or altered prescriptions could be ordered, and inmates who required psychiatric services faced a longer wait for those services. During our October tour, a nurse at Jail East told us that an inmate who appeared to be depressed and in need of mental health treatment had not been seen by mental health staff in the four days since her admission, despite this nurse's phone calls to the main Jail's mental health staff requesting an evaluation.

b. Sick Call

Access to non-emergency care is deficient, both because it is not timely, and because it is not provided by appropriately-qualified professionals. For non-emergency care, both medical and mental health visits are initiated by submission of a sick call slip, which inmates complained were often unavailable. One inmate told us that he used his library time to make copies of the slips because they were so hard to come by. SCJ policy states that sick call will be scheduled at least once per week for all inmates. The Jail's policy does not meet accepted national standards for large jails, which require requests for medical care to be reviewed by a qualified medical professional within 24 hours, and the patient to be seen by a qualified professional within the following 24 hours (72 hours if a weekend). The Jail's actual practice, described below, deviates even further from accepted national standards. In practice, it appears that sick call requests are triaged by a nurse,[(7)] and inmates are scheduled for the next weekly sick call on their floor - which could be as much as a full week later. One inmate, known to have AIDS, submitted a sick call request complaining of sores and a burning sensation, but was not called for an evaluation until ten days later. If a case is deemed by correctional staff to be sufficiently urgent, an inmate instead might be escorted to the second floor medical area for an evaluation prior to the next weekly sick call on his floor. The NIC report found that the Jail's ad hoc sick call practice placed correctional staff in the untenable position of being gatekeepers for medical services. NIC Technical Assistance Report at 15.

In addition to its limited availability, sick call is constitutionally deficient because sick call examinations are conducted by staff not qualified to do so.[(8)] This has compromised the health of inmates and subjected them to unnecessary pain. For example, an inmate who had recently undergone surgery to repair a hernia in his groin area requested sick call in June and again in July, complaining of pain in his groin, particularly when urinating. He was examined by a registered

nurse ("RN") and then a licensed practical nurse ("LPN"), but did not see a doctor and did not receive antibiotics, despite indications of an infection. In August, two months after his first complaint to the Jail, the inmate's genitourinary infection was diagnosed during a surgery followup visit at a hospital clinic. Another inmate twice requested attention for a suspected broken finger and was twice seen by an LPN, but did not see a physician for a week. These delays unnecessarily prolonged the inmates' pain and/or illness, and could have resulted in significant medical complications.

c. Mental Health Diagnosis and Treatment

All mental health staff interviewed acknowledged significant difficulty in responding to the mental health needs of inmates.(9) The staff at the main Jail, but not Jail East, performs timely, cursory evaluations of all inmates with identified mental health concerns, primarily those identified at intake. Outreach is necessary to identify other inmates with mental health concerns before those concerns escalate to crises that require intensive intervention and threaten the health and safety of inmates and staff alike. However, no designated mental health staff persons review sick call requests to identify inmates with emerging mental health concerns. Moreover, despite CMS policy requiring mental health workers to make rounds to housing units, and national standards with the same recommendation, the only housing areas in which mental health workers conduct rounds to identify emergent needs are the pre-classification cells on the Jail's lower level. Outreach by mental health staff is particularly important because correctional staff at the SCJ demonstrate little training in or understanding of the needs of inmates with mental illness or suicidal tendencies.

Diagnostic evaluations of those inmates identified as needing mental health treatment are deficient, with only three of seventeen charts reviewed containing any diagnostic assessment at all. A diagnosis is critical to assessing the adequacy of the inmate's medication and any treatment. The SCJ employs no psychologists to assist the psychiatrists with diagnoses.

Because there is almost no outreach to identify inmates in need of mental health services who have not self-identified, large numbers of inmates at the SCJ receive little or no mental health care. There is no education or programming on important mental health topics, such as drug and alcohol dependance or medication compliance. Finally, as described in the context of medication administration, infra, the SCJ fails to administer prescription medication reliably. Because the dominant mental health intervention at the SCJ is medication, missed doses (both not administered and not taken) are unacceptably high and likely to have serious consequences for behavioral disorders within the Jail.

d. Care of Chronic Medical Conditions is Deficient.

Although the SCJ has a rudimentary computerized tracking system for chronic care patients, we found many significant lapses in the care of these patients. For example, one inmate who was receiving HIV medications prior to incarceration received no medication or evaluation during five months of incarceration at the SCJ. Another inmate had numerous serious medical conditions identified at intake, including diabetes,(10) high blood pressure, and mental illness. He received no physician evaluation for diabetes until five months after intake, and no physician evaluation during a two month period when he was experiencing dizziness and other symptoms of hypoglycemia. He was found dead in his cell one year after his initial intake, with the probable cause of death noted to be heart disease and diabetes. It is likely that poor control of these chronic and life-threatening conditions contributed to this death. The lack of sufficient qualified staff is a likely cause of the SCJ's failure to ensure that chronic care patients receive necessary care for their life-threatening conditions.

e. There is no Infirmary Care for Inmates Requiring Close Observation By Medical or Mental Health Staff.

There is no infirmary for observation and treatment of inmates with serious medical or mental health conditions requiring ongoing medical treatment, but not hospitalization. This is a significant deficiency. In addition to the examples of chronically ill inmates noted above, a 24-year-old inmate died at the Jail in December of pneumonia, a treatable illness. Although the inmate had visited the emergency room the day before his death, he was released and returned to general housing, where his condition deteriorated rapidly. In the day before his death, he was not observed by medical staff except for two brief encounters with a nurse (there is no indication if the nurse was an LPN or RN). Another inmate exhibited uncontrolled hypertension for nine months, during which time he suffered two strokes and possible heart injury. He was transferred to the hospital four times, and each time he was returned to general population housing. He should have been housed in an infirmary with the ability to monitor his blood pressure and medications to bring the hypertension under control, to lessen the chance of suffering the additional stroke and heart damage. A third inmate,

who died of heart failure in October 2000, went back and forth between general population housing and the hospital. On his last release from the hospital, he was placed in a cell with no running water because the hospital suggested that he would exacerbate his heart condition by drinking too much water. A far more appropriate placement would have been an infirmary, where fluid intake and output could have been monitored. In each of these instances, the inmates' care was compromised, and their pain or illness exacerbated, by the unavailability of close medical monitoring in an infirmary.

2. Medication Administration is Deficient.

Both medical and mental health care is compromised by significant lapses in administration of medications. Missed doses included medications essential for conditions such as serious mental illness, diabetes, asthma, and HIV. Of 17 charts reviewed, at least 10% of the prescribed doses of psychotropics on the second floor medical housing unit and 20% of the doses on the general housing units were never delivered. On occasion, no medications were distributed to an entire pod and quite possibly the entire floor. In many instances, contrary to the stated policy and procedure, there is no documentation in the medical charts explaining the missed doses.

Staff also fails to ensure that inmates take their prescribed medication. Our review of shake-down logs confirm that numerous pills are confiscated from hordes in inmates' cells. During our December tour, we observed inmates place medication in their mouth and then turn their backs to the staff to walk back to their cells, enabling them to spit out and save the medication unobserved by staff.

3. Suicide Precautions Are Inadequate.

The cells in the area of the Jail reserved for suicidal inmates are unsanitary, foul-smelling, contain bunks and plumbing fixtures from which an inmate could hang himself, and cannot all be seen and heard from the control room where staff are stationed. Inmates in these cells are required to strip completely, and are not given paper gowns or blankets, despite complaints that the cells are chilly. The condition of these cells is well-known among inmates, who told us that they are loathe to say anything to staff that could result in being placed in these cells.

In addition to the inmates' expressed reluctance to self-identify suicidal thoughts, our psychiatrist noted that correctional staff throughout the SCJ appeared untrained in identifying inmates with mental illness or those with suicidal or self-injurious tendencies. Mental health professionals do not visit general housing units, despite a policy requiring them to do so. The emergent mental health problems missed due to inadequate screening and outreach include suicidal tendencies.

4. Medical Safety and Related Security Concerns

Mental health staff do not communicate with security staff. This failure has significant consequences, particularly in crisis intervention and the use of restraints. We reviewed a video tape of a use of force incident involving the deaf inmate discussed under security concerns, supra. Mental health personnel had identified the inmate as having schizoaffective disorder. Either this information was unavailable to security staff, or, staff acted upon misinformation about mental illness in their approach to this inmate. Appropriate training by mental health professionals and consultation with the mental health providers at the Jail at the time of this incident could have prevented the excessive use of force in this case.

In addition, in our review of records provided to us by the SCJ we discovered many incidents where staff used force, including pepper spray, against inmates displaying self-injurious behavior characteristic of mental illness, without consulting with mental health staff about appropriate interventions.

At the time of our visits, there were numerous lapses in maintenance and inspection of essential medical equipment. For example, there was no documentation of weekly sterility checks for the autoclave, no inspection of the temperature of the medicine refrigerator in nearly a month, and no inspection of emergency medical kits (which lacked essential equipment, as we observed when a nurse at Jail East opened one to attend to an inmate in crisis during our October tour).

Finally, SCJ's policy for the control of blood borne pathogens was not communicated to line staff through training or policy. Lapses in basic medical sanitation and safety practices pose a significant threat to the well-being of all persons

confined or employed at SCJ.

C. The SCJ Does Not Provide Adequate Food, Clothing and Shelter.

Our inspection revealed deficient food service, basic sanitation and safety practices at the SCJ. Unsafe food handling and inadequate sanitization of kitchen utensils and cooking equipment present an unacceptably high risk of food contamination and food-borne disease. Similar risks of disease result from SCJ's inadequate level of overall sanitation and pest control. Our consultant concluded that these practices stem from a failure to train and supervise staff in rudimentary concepts of sanitation, food handling, and pest control. In addition, more maintenance and food service workers and supervisors are needed to prepare and serve food properly and to maintain food service equipment in a facility this large.

1. Unsafe Food Handling and Food Service

The freezers and food storage areas at the main Jail are filthy. There is evidence of roach infestation, gnats and rodents in the kitchen, dishwashing and food storage areas. During our tour in October, we observed servers without hair coverings, gloves or serving utensils. Personal articles of clothing were stored on a shelf in the kitchen next to clean pots and pans. In the laundry area, food service trays are stored on a shelf next to mop heads. There is a practice of serving food to inmates working in the laundry area, and washing serving trays and utensils in the mop sink in this area. There is no attempt to sanitize these items. Each of these practices violates basic tenets of sanitation and safe food handling, and should be stopped immediately.

Pots and pans and serving pieces are neither fully cleaned nor sanitized because the dishwashing equipment does not reach sanitizing temperatures. Of four units tested by our consultant, none functioned to sanitize cooking and eating utensils. The dishwashing area had a putrid smell, and food residue was visible on pots and pans after they had been "cleaned." Inmates complained of being given a single utensil, often of disposable plastic, and having to reuse this utensil and clean it in their cells, although sanitizing agents are not available in the cells for this purpose.

Foods on the serving line and in holding ovens and refrigerators and freezers on the day of our visit deviated significantly from temperatures recommended for safe food handling. The NIC report also found food served at improper temperatures. Food held at improper temperatures invites contamination that can sicken inmates through food poisoning.

2. Pest Control and Sanitation is Inadequate.

Roaches, rodents and spiders are present in inmate housing and the medical area at both the main Jail and Jail East. Both inmates and staff showed evidence of bites from brown recluse spiders.

3. Lighting, Ventilation, Sanitation and Laundry Service in Housing Units Is Inadequate.

Proper sanitation is hampered by the lack of hot water in some inmate cells and shower areas. Our consultant noted numerous examples of broken plumbing fixtures and inmate cells without access to hot water or to water at all. Both staff and inmates told us that such conditions are longstanding. The lack of a preventative maintenance plan or a system for scheduling and prioritizing work orders for repairs contributes to a backlog of essential repairs.

The current policy regarding access to laundry must be reviewed and updated. The laundry service is neither frequent enough nor reliable. We heard many reports from inmates of clothing and bedding not being returned from the laundry, or coming back stained and ripped. As a result, many inmates wash clothing and bedding in sinks and toilets. This contributes to poor sanitation and threatens security, because items left hanging to dry impede staff's ability to observe and supervise inmates.

Finally, our consultant identified numerous areas where there was virtually no ventilation and where the lighting was not adequate to maintain hygiene, allow individuals to move around safely and prevent eyestrain.

4. Improper Storage and Handling of Hazardous Materials

We observed numerous examples of unacceptable storage of hazardous materials during our tours. Unless properly labeled, stored, and disposed, these materials can cause a variety of serious health problems. Bio-hazardous waste containers in the medical area used gray liners without bio-hazard markings, making inadvertent exposure or improper disposal likely. Caustic chemicals in the laundry and storage areas were labeled only with a marker, which can be rubbed off and contains no information about the contents, effects of exposure or appropriate first aid, or other important labeling information. In storage areas, some of these containers were "sealed" by placing latex gloves over their openings, which is inadequate. There must be an accessible eye wash fountain and training in the use of personal protective equipment for inmates who work with these caustic chemicals, yet neither appeared to be provided.

5. Fire Safety and Prevention Is Deficient.

In correctional facilities, the safety of inmates in the event of an emergency depends upon the rapid unlocking of doors. In October, two officers stationed near an exit door at Jail East had no idea how that door could be opened in the event of an emergency. During our December tour, deputy jailers on the second floor administrative segregation/deadlock unit (P and Q pods) were unable to comply with our request to manually unlock the sally port doors because the manual override was broken.(11) This is indicative of a lack of a regular preventive maintenance program and is also a serious safety lapse in the event of a fire emergency. In the event of a power outage or smoke buildup, visual examination of keys is generally impossible, and keys should be notched for easy identification under such conditions. Yet, as noted above and in the security section, staff at both locations were unable to identify keys even after several minutes of visual examination.

Improperly controlled combustibles and highly flammable materials throughout the institution and inmate living areas dramatically increase the risk of harm to inmates. Because inmates are locked in their cells, the amount of combustible material should be limited. Yet, in many of the cells, inmates used paper bags as trash receptacles. We saw numerous examples of ripped fire-retardant mattress covers and, as mentioned earlier, improperly stored and labeled flammable liquids and other chemicals, all of which presented serious fire hazards. Sprinkler heads in the food storage units in the kitchen were rendered ineffective because cartons were stacked too close to the ceiling and sprinkler heads.

We observed serious deficiencies in fire or emergency safety training and planning. Available documentation suggests that fire drills happen infrequently, and do not occur on all shifts. Correctional officers we spoke to were unable to explain their roles in the event of an emergency. Our consultant also noted numerous examples of electrical problems that could be fire hazards throughout the Jail and Jail East.

D. Insufficient Access to the Courts

As presently constituted, the law library offers little effective assistance to most inmates. Legal materials, including the single copy of the Tennessee Code Annotated, are not up to date. A not-yet-certified paralegal is available for limited hours during weekday daytime shifts. Inmates reported that the one-hour time slots they may request to visit the legal room are often shortened because pod officers may not release them or arrange an escort for them in a timely way. One inmate complained that his legal mail had been opened, and that staff delayed mailing court papers. Our review of inmates' access to legal services at the SCJ was limited, and we did not identify any inmate whose ability to pursue a claim was impaired because of the deficiencies in services. Nonetheless, we are concerned that such an injury is likely to occur.

E. Insufficient Access to Exercise

The Sixth Circuit has not defined a constitutionally required amount of exercise, however, it has recognized that one hour per day, five days per week every thirty days is unconstitutional, even as a punitive sanction. Rodgers v. Jabe, 43 F. 3d 1082, 1088 (6th Cir. 1995). Inmates at SCJ receive far less opportunity for exercise, averaging less than two trips to recreation per inmate per month in the year 2000 (the Jail's records do not specify whether the recreation period was indoors or outdoors). In the winter months of 2000, it appears from the Jail Monthly Summary Reports that inmates each received slightly more than one trip to recreation per month.(12)

Lack of exercise opportunities, which may create a constitutional violation standing alone, may also exacerbate other constitutional violations. In Gilland v. Owens, 718 F. Supp. 665, 689 (W.D. Tenn. 1989), involving the SCJ, the district court found that a monthly average of 1.35 trips to recreation per inmate was a "near-total deprivation" of opportunities

for exercise that violated the constitutional rights of inmates. 718 F. Supp. at 688. The court also held that lack of exercise opportunities was a factor contributing to unconstitutional violence at the SCJ. Id.[13] In many respects, conditions at the SCJ today seem little improved from those found unconstitutional in 1989.

IV. Recommended Remedial Measures

To rectify the identified deficiencies and to ensure that the Shelby County Jail complies with federal constitutional requirements, the following minimum remedial measures must be implemented.

A. Security, Supervision and Protection From Harm

1. To reduce inmate-on-inmate violence, the County must increase direct sight and sound supervision of inmates in their housing units. If the current configuration of the Jail, in which staff have limited direct sight and sound supervision of inmates, is maintained, then the County must significantly reduce double celling, or hire significantly more staff to supervise housing units. The County must increase the frequency of shakedowns and provide timely and sufficient escort of inmates to other areas of the Jail and for essential programming and services.

2. The County must improve the quality of staff through hiring and enhanced training. Well-trained and knowledgeable supervisory personnel must be available to supervise line staff.

3. The County must take steps to implement basic security procedures, including but not limited to key control, tool control, and the control of dangerous contraband (such as razor blades fused to toothbrush handles). Staff should be aware of these procedures, including the use of emergency keys. The County also must ensure that security inspections occur on a regular basis and must provide ongoing maintenance to security devices such as door locks and manual unlocking mechanisms.

4. The County must revise its inmate classification system to take into account gang-related information. The County must review inmates periodically for possible reclassification. Any new or revised classification system must be validated in advance of its final implementation.

5. The County must implement an effective and timely system of inmate discipline and provide an adequate number of single-occupancy cells for the immediate segregation of all inmates sentenced to the disciplinary segregation unit. Closely related, the County must implement procedures for assigning otherwise unmanageable inmates to administrative segregation and must provide an adequate number of single-occupancy cells for these inmates.

6. The County must take more effective steps to separate assaultive from non-assaultive prisoners during the intake process.

7. The County must revise its policies on the use of force, including the use of chemical agents and the use of mechanical restraints, to provide clearer guidance to staff and to ensure that physical force is limited to clearly identified situations, such as threatened escape, harm to persons, or damage to valuable property. Security staff should receive special training on all the new policies.

8. The County must ensure appropriate use of the restraint chair, by restricting its use to tightly prescribed circumstances, and requiring pre-authorization and supervision by mental health staff for any use of the restraint chair involving mentally ill inmates. The chair must not be used for punishment and no hoods or disposable spit caps should be used under any circumstances.

9. Staff must report all uses of force (including chemical agents and mechanical devices). Trained investigators should investigate all such reports. These investigators must also thoroughly investigate all allegations of failure to report a use of force. The County must implement an effective system for the prompt discipline of staff who violate policies in this area.

10. The members of the Detention Response Team must be dedicated to that purpose and must not fill other posts. In addition to responding to emergencies, including necessary cell extractions, the DRT must provide additional back-up security for officers in housing units and enhance pod officers' capability to conduct housing unit shakedowns and security inspections.

11. The County must adopt an aggressive program to identify and control inmates who are members of organized gangs. While such membership itself is not unlawful, staff at the jail must eliminate all forms of control currently exercised by gangs and their leaders and must be vigilant in detecting and punishing gang-related misconduct of all forms. Illicit gang-related behavior should be an important factor in increasing an inmate's classification status.

B. Mental Health and Medical Care

1. The County must comply with SCJ's stated policies for providing timely medical and mental health intake screening of all inmates. In particular, increase timeliness of mental health evaluations at Jail East.

2. The County must ensure SCJ's continuation of prescription medication promptly upon admission.

3. The County must ensure SCJ's compliance with stated policies for screening of infectious diseases, particularly tuberculosis.

4. The County must provide access to sick call to all inmates five days per week. Increase professional staff so that all sick call examinations are conducted by appropriately licensed professionals.

5. The County must ensure compliance with SCJ's policy that mental health professionals make regular rounds to all housing units.

6. The County must provide accurate diagnoses, or differential diagnoses, for all inmates identified as requiring mental health services at SCJ.

7. The County must improve monitoring and treatment of chronically ill inmates, including those with serious mental illness, through regularly scheduled visits to Jail medical (or mental health) professionals.

8. The County must establish an on-site infirmary at the SCJ to provide more intensive medical and mental health monitoring for inmates who are unstable or otherwise medically inappropriate for general population housing.

9. The County must comply with stated policy for medication administration, including documentation of missed doses. Ensure that oral medications dispensed to inmates are ingested.

10. The County must provide disposable paper gowns to inmates in suicide precaution cells.

11. The County must remove suicide hazards from suicide precaution cells.

12. The County must provide proper sanitation and lighting for cells in suicide precaution areas.

13. The County must provide direct line of sight supervision to all inmates on suicide precautions. Increase the number of suicide precaution beds to include sufficient beds for constant observation, and for "close" observation (meaning frequent, but not constant observation).

14. The County must train all SCJ staff in policies for the control of blood borne pathogens. Provide adequate personal protective equipment to all staff.

C. Environmental Health and Safety

1. The County must ensure that officers who supervise the inmates serving food on the units are trained in food service operations, or, properly trained civilian staff should perform these tasks. Proper equipment for serving must be provided and used. All food service staff, including civilians, need food service training.

2. The County must assign more staff and supervisors to oversee food service and maintenance to ensure proper sanitation and safe food handling practices.

3. The County must repair or replace malfunctioning equipment, including refrigeration units, cooking units and dishwashing and tray washing units, and provide properly-sized units designed to serve a food service operation the size of SCJ.

4. The County must ensure that a dietician or nutritionist support the special medical diet operation. A dietician must also evaluate standard menus on at least an annual basis. Operations must be able to support the menu provided by the dietician.

5. The County must improve sanitation in the food service operations, housing units and medical intake and housing units. Adequate cleaning supplies and equipment should be provided on a more routine basis to help improve cell sanitation, in particular.

6. The County must improve pest control. Supervisors must receive training to ensure that this program is implemented effectively.

7. The County must provide adequate lighting in cells and showers.

8. The County must repair water leaks in cells and showers and clogged drains.

9. The County must conduct regular cell inspections to enforce Jail rules, including those prohibiting the blocking of air vents and storing large amounts of food, which contributes to the pest control problem. As noted previously, regular inspections will also help control the accumulation of life-threatening contraband (such as razors).

10. The County must implement appropriate housekeeping policies and procedures.

11. The County must ensure that fire and emergency drills are performed quarterly, in all areas including the administrative areas, on all shifts, so that all staff may participate in the drills. Inmate movement should be included in drills, except in those situations where security may be compromised. Adequate emergency operations plans must be developed for all potential natural and man-made disasters that may affect this facility. In-service training in fire safety, including fire drills, must be conducted and documented.

12. The County must develop and implement a written preventive maintenance program and priority-based work order system.

13. The County must provide adequate laundry service.

14. The County must ensure that quality control checks of medical equipment and supplies occur regularly, and, for some equipment, on a daily, per shift basis.

15. The County must improve the storage, labeling, and use of hazardous chemicals so that proper chemical name labels are put on all containers of chemicals and containers are stored with tight fitting caps or tops. An eye wash fountain must be provided where inmates handle hazardous chemicals, for example, in the laundry and storerooms.

16. The County must fix promptly the electrical system problems noted at Jail East, as delineated in an August 29, 2000 letter from EOC to Mr. Ward, Shelby County Maintenance Manager, especially those with a potential to affect life safety systems and those with a possibility of causing a fire.

17. The County must implement a facility-wide procedure, such as color coding and notching, to quickly identify appropriate emergency keys by touch and sight, and must train staff in use of emergency keys and manual override system for the jail's cell and sally-port doors.

18. The County must provide every inmate with a fire resistant mattress and replace paper wastebaskets with fire safe containers.

D. Access to the Courts

1. The County must ensure access to legal assistance by providing inmates with the tools they need to attack their sentences, directly or collaterally, and to challenge the conditions of their confinement.

E. Access to Recreation

1. The County must ensure that inmates have an opportunity to exercise a minimum of one hour per day, five days a week, including outdoor exercise as often as weather permits.

Pursuant to CRIPA, the Attorney General may institute a lawsuit to correct deficiencies of the kind identified in this letter forty-nine days after appropriate officials have been notified of them. 42 U.S.C. Section 1997b(a)(1). We would prefer, however, to resolve this matter by working cooperatively with you, and we have every confidence that we will be able to do so.

In light of the County's cooperation in this matter, under separate cover, we will send you our experts' reports. Although the experts' reports and work do not necessarily reflect the official conclusions of the Department of Justice, their observations, analyses and recommendations provide further elaboration of the issues discussed above, and offer practical assistance in addressing them.

We look forward to meeting with County officials to develop solutions to the noted deficiencies.

Sincerely,

/s/ William R. Yeomans

William R. Yeomans
Acting Assistant Attorney General
Civil Rights Division

/s/ Marron Hopkins

cc: The Honorable Marron Hopkins
Director
Shelby County Jail

/s/ A.C. Gilless

Mr. A.C. Gilless
Sheriff
Shelby County Jail

/s/ Donnie E. Wilson

Donnie E. Wilson, Esquire
Shelby County Attorney

/s/ Don D. Strother

Don D. Strother
Legal Advisor
Shelby County Sheriff's Office

/s/ Lawrence J. Laurenzi

Lawrence J. Laurenzi, Esquire
United States Attorney
Western District of Tennessee

1. The Sheriff's Office also is responsible for a secure ward at the University of Tennessee's Regional Medical Center, known as the MED.

2. SCJ inappropriately attempts to counter staffing shortages by assigning members of the Detention Response Team ("DRT"), the emergency response unit, to posts as pod officers in the housing units. We were advised that DRT members must often wait to be relieved from their post before they can respond to an emergency. Such a practice creates an unacceptably high security risk and compromises the safety of inmates and staff by delaying the DRT's response to emergency situations.

3. Each pod typically contains 46 inmates in 23 double-bunked cells.

4. The NIC report concurs in the conclusion that inmate supervision is poor, finding that any benefit of the court-ordered staffing was lost by placing the staff where they cannot and do not see the inmates, supervise the inmates on a moment-to-moment basis or talk with inmates frequently and informally. NIC Technical Assistance Report at 9.

5. Conversely, inmates are reportedly able to jam cell doors and open them manually without staff's knowledge.

6. Use of Chemical Agent reports frequently are not filled out by staff. For example, in August 2000, the SCJ's Monthly Summary Report notes 38 uses of chemicals, however, the SCJ produced only nine Use of Chemical Agent reports for this period.

7. It is a nationally accepted practice that if triage is utilized, it must be performed by a person with no less than a registered nurse's ("RN") training. At the SCJ, complaints are routinely triaged by licensed practical nurses ("LPN"), who have substantially less training than RNs. For example, an LPN evaluated an inmate's sick call slip complaining of an injured and swollen hand, and an LPN examined the injury six days later. The inmate was not seen by a doctor and sent to a hospital emergency room for his broken finger until seven days after his initial complaint.

8. The SCJ employs no licensed nurse practitioners (RNs with an advanced degree) or physician assistants, professionals who are licensed and qualified to examine, diagnose and treat patients and order prescription medication - tasks an RN or LPN may not perform. The only exception to this accepted practice is that RNs may evaluate and treat minor complaints pursuant to a doctor's standing orders. Thus, the only professionals licensed and qualified to examine more than 2,700 inmates at the SCJ are the Jail's medical doctors, whose hours of employment total less than two full-time-equivalent positions.

9. The SCJ provides only 23 hours per week of psychiatrist staffing, augmented by additional mental health workers equal to 5.2 full time positions. The SCJ employs "counselors" on each floor, however, they have no mental health training and their role appears to be limited to accessing hygiene items, phones, and mail.

10. It appears that no nutritionist or medical staff person provides guidance to food service in the preparation of medically-required diets for diabetics or inmates with high blood-pressure. In response to our request to review a week's menus at the SCJ, we received only regular diets. There was also no documentation of an annual menu evaluation by a qualified nutritionist or dietician. Thus it is unclear whether medically prescribed meals served at the SCJ meet basic nutritional or medical standards.

11. Similarly, deputy jailers on that same floor were unable to open cell doors with a manual override. This indicates a serious lapse in training and is a significant safety concern in the event of a fire or other emergency.

12. For example, in February 2000, when the average daily population was 2,972 inmates, the Jail reported only 3,991 trips to recreation, an average of 1.3 trips per inmate.

13. The court in Gilland cited many factors causing excessive violence in the SCJ that remain unchanged today: "insufficient security staff, the pod man/phone man system [superceded today by gang control, instead of pod man control of the phones], lack of exercise opportunity, frustration over scare resources and space, improper functioning of the disciplinary system, and an inadequate classification system." 718 F. Supp. at 688. The district court's supervision of the SCJ pursuant to its orders in Gilland terminated in 1993.

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Updated August 6, 2015

THE UNITED STATES DEPARTMENT of JUSTICE

U. V. SHELBY COUNTY JAIL SETTLEMENT AGREEMENT

I. INTRODUCTION

On August 24, 2000, the United States notified Shelby County officials of its intent to investigate conditions of confinement at the Shelby County Jail, pursuant to the Civil Rights of Institutionalized Persons Act, 42 U.S.C. ï½§ 1997. On October 4-6 and December 11-13, 2000, the United States toured the Shelby County Jail with consultants in the fields of penology, correctional health care, environmental health and safety, and mental health care.

Throughout the course of the investigation and inspection of the facilities, the United States received complete cooperation and access to all facilities and documents from Shelby County Sheriff A.C. Gilless and the staff of the Office of the Sheriff and the Sheriff's Legal Advisor, from Chief Jailer Marron Hopkins and his staff, and from County Attorney Donnie E. Wilson and Chief Administrative Officer Jimmy M. Kelly, and staff throughout the Shelby County government.

On June 27, 2001, the United States issued a findings letter ("Findings Letter"), pursuant to 42 U.S.C. ï½§ 1997(a)(1), which concluded that certain conditions in the Shelby County Jail violated the constitutional rights of detainees and recommended remedial measures. Attorneys for the United States met with Shelby County officials in July 2001, to begin negotiations on an agreement to address and remedy the concerns raised in the Findings Letter. County officials subsequently provided a substantive written response to the United States that proposed corrective measures and proposed means of monitoring and documenting those changes, many of which are incorporated in this proposed agreement.

The United States acknowledges that Shelby County has already begun drafting many of the new and revised policies and procedures required by the Settlement Agreement ("Agreement"), some of which may be completed prior to execution of this Agreement.

The parties agree that this Agreement does not constitute an admission by the defendants of the truth of findings contained in the Findings Letter and does not constitute an admission of liability by the defendants. The parties enter into this Agreement solely for the purpose of avoiding the risks and burdens of litigation.

II. DEFINITIONS

1. "County" shall refer to defendants Shelby County, Tennessee, the Sheriff of Shelby County in his official capacity, the Mayor of Shelby County in his official capacity, and their agents and successors in office.

2. "DOJ" shall refer to the United States Department of Justice.

3. "Inmates" or "detainees" shall refer to individualssentenced to, incarcerated in, detained at, or otherwise confined at Shelby County Jail.

4. "Shelby County Jail" ("SCJ") shall mean the jail facility located at 201 Poplar Avenue in Memphis, Tennessee (the "Jail"), and the facility currently housing female detainees in East Memphis ("Jail East"), as well as any facility that is built to replace or supplement the SCJ. The terms of this Agreement shall apply to all SCJ facilities, unless specifically noted otherwise.

5. "Jail Compliance Unit" shall refer to SCJ's internal unit responsible for conducting, inter alia, security audits, including audits of tool and key control practices, and other inspections and random checks required under this Agreement, except where another entity or staff person is specified by this Agreement to conduct such inspections (e.g., monitoring of gang activity, health care services, food services and maintenance).

6. "Gang Intelligence Unit" shall refer to the staff members with responsibilities related to monitoring and controlling gang activity at SCJ.

7. "Qualified Medical Professional" shall mean an individual with a minimum of masters-level education and training in medicine or nursing, who is currently licensed by the State of Tennessee to deliver those health care services they have undertaken to provide.

8. "Qualified Medical Workers" and "Qualified Medical Staff" shall refer to individuals who have completed an educational program at an accredited school of nursing, and who have complied with licensing requirements in the State of Tennessee; or, individuals with substantially equivalent education and training, and two years of experience providing health care services.

9. "Qualified Mental Health Professional" shall refer to: a) an individual with a minimum of masters-level education and training in psychiatry, psychology, counseling, social work or psychiatric nursing, who is currently licensed by the State of Tennessee to deliver those mental health services they have undertaken to provide; except that a social worker with masters-level education, training and experience may practice consistent with Tennessee state guidelines without obtaining a license in social work; or, b) a registered nurse with a bachelor's degree in nursing with a minimum of two (2) years psychiatric experience, or a registered nurse with a minimum of five (5) years psychiatric experience.

10. "Qualified Mental Health Workers" and "Qualified Mental Health Staff" shall refer to individuals with a minimum of a bachelor's degree and two years of experience providing mental health services.

11. The term "special needs inmates" shall refer to those inmates who are suicidal, mentally ill, mentally retarded, intoxicated, seriously or chronically ill, physically disabled, or otherwise a danger to themselves.

12. "Security staff" shall mean all employees, irrespective of job title, whose regular duties include supervision of inmates at the SCJ.

13. The term "Semi-annual Report" shall mean reports SCJ will submit to the United States to demonstrate its compliance with this Agreement as specified in paragraph 84 (below).

14. The term "100 Day Report" shall mean a report submitted by Shelby County to the United States within 130 days of execution of this Agreement to demonstrate its compliance with those provisions for which a 100 day report is specified.

III. SUBSTANTIVE REMEDIAL MEASURES

A. SECURITY, SUPERVISION AND PROTECTION FROM HARM

Security Staffing and Training

15. In order to improve sight and sound supervision of inmates in their housing units, the Jail shall convert the majority of inmate living spaces to a direct model of supervision in which the security staff's work station is located inside the inmate housing unit (either inside a pod or a dormitory). Within 100 days of this Agreement, the County shall provide DOJ with a written schedule for conversion of the living units that remain to be converted, and shall notify DOJ in writing of any subsequent delays in and/or modifications to that schedule. At a minimum, the plan shall provide for the completion of the conversion within one year from execution of this Agreement. Written notification to DOJ concerning any subsequent delays shall be provided within 30 days of any such delay or modification.

16. The County shall train all security staff in the principles of direct supervision:

a. The County shall ensure that all supervisors and managers complete a course in direct supervision for supervisors and managers no later than January 1, 2003.

b. The County shall report to DOJ on the changes made to its existing pre-service training that changes the focus of this training to direct supervision as the dominant form of supervision at the SCJ.

c. The County shall continue to provide comprehensive pre-service training to all security staff.

d. The County shall develop pre-service training for all non-security staff (including civilians)who have contact with inmates directly to provide services or supervision of inmates. This pre-service training, at a minimum, shall address:

i) emergency and evacuation procedures;

ii) preventing transmission of blood borne pathogens;

iii) recognition and reporting of signs of mental illness and/or suicide risks; and

iv) reporting requirements for use of force.

17. The County shall hire and train sufficient security staff to fill all shifts. In so doing the County shall adhere to the current overtime management policy (Chapter 106, Overtime Management). Additionally, the County shall not make any substantive changes to the Overtime Management Policy without first allowing DOJ to review the proposed substantive changes.

18. Within twelve (12) months of executing this Agreement, the County shall create and maintain individual training records for all staff, documenting the date and topic of all pre-service and in-service training completed, for all training completed on or after September, 2001.

Population Management

19. The County shall continue to engage in proactive population management to prevent a recurrence of excessive crowding, including collection and analysis of data, and implementation of the population management plan, as described in the Population Management Report by consultant A. Gaston, dated March 14, 2002.

Security Policies and Procedures

20. The County shall implement revised key control and tool control procedures. Within 100 days of signing this Agreement, the County shall provide to DOJ revised policies in these areas, and a schedule for implementation of the revised procedures. At a minimum, the County shall provide for implementation of revised policies within one year from execution of this Agreement. If implementation of the revised policies is not scheduled to begin within six (6) months of the date of the Agreement, then the County shall also provide, with its 100 day report, interim tool and key control plans.

a) At a minimum, the key control policy and interim measures shall:

i) assure maximum safety and security of staff, inmates and civilians in the SCJ;

ii) provide for emergency identification of keys by touch or other non-visual means;

iii) include revised post orders that reflect ongoing training in use of keys and both manual and electronic locking mechanisms;

iv) require routine testing and maintenance of keys and locks; and

v) ongoing inventory, audit and evaluation of key control.

b) At a minimum, the tool control plan and interim measures shall require ongoing inventory, audit and evaluation of tool use at the SCJ.

21. The Jail Compliance Unit shall verify that SCJ conducts and documents random checks of the security staff's familiarity with emergency tool and key procedures on a monthly basis.

22. The County shall provide security audit training for the Jail Compliance Unit and designated supervisory staff. Sufficient staff will be trained in time for the County to initiate an internal security audit within nine months of this Agreement. An internal security audit will be conducted every six months thereafter for the duration of this Agreement.

23. The County shall continue to utilize members of the specially trained Detention Response Team ("DRT") to conduct frequent and random shake-down searches of inmate housing areas, on both day and evening shifts. The County shall add to the shakedown log a section to record a summary of contraband confiscated.

24. The County shall provide timely escort of inmates, as required, to attend necessary programming.

Classification and Inmate Discipline

25. The County shall revise its inmate classification system. The revised system shall, at a minimum, incorporate the following changes:

a) Any revised classification system shall meet professional standards prior to its final implementation;

b) Inmates shall be reviewed periodically for possible re-classification (upward or downward) based on institutional behavior; and

c) The County shall implement a system of warning flags that alert intake workers of specific indicators in the records of an inmate's past incarceration at the SCJ, which, if present, require immediate referral to medical staff before classification is completed or the inmate assigned to housing. The indicators shall include, at a minimum:

i) Diagnosis or treatment for mental illness at any time during a past incarceration;

ii) Diagnosis or treatment for serious chronic illness, including but not limited to diabetes, hypertension, heart disease, seizure disorders, tuberculosis or HIV infection;

iii) Placement on heightened observation for suicide, risk at any time during a past incarceration at the SCJ; and

iv) Any medical contraindications for the use of chemical sprays.

26. The County shall include in its 100 day report a schedule for implementing a revised classification system, and any anticipated changes to the revised system. The County shall also provide an interim plan for implementing periodic re-classification reviews and a system of warning flags based on past history, pending implementation of the new classification system. At a minimum, the County shall provide for the implementation of the new classification system within one year from execution of this Agreement.

27. The County shall implement procedures for assigning vulnerable, assaultive or special management inmates to administrative segregation and shall provide a sufficient number of single-occupancy cells to enable prompt segregation of these inmates.

28. The County shall implement an effective and timely system of inmate discipline and provide a sufficient number of single-occupancy cells for the prompt segregation of all inmates sentenced to the disciplinary segregation unit.

Use of Force Policies

29. The County shall revise its policies on the use of force, including the use of chemical agents and the use of restraints, to provide operational guidance to staff. The revised policy will be provided to DOJ for approval prior to implementation. At a minimum, the revised policies shall ensure that:

a) use of physical force is limited to those situations clearly identified by the policy;

b) SCJ shall conduct periodic inventory of chemical agents, and shall appropriately respond to indications of mis-use or excessive use of chemical agents;

c) mental health professionals are consulted before any planned use of force or non-routine use of restraints on any inmate with a diagnosis of mental illness;

d) all uses of force, including chemical agents and restraints, are reported pursuant to policy and all reports are reviewed by supervisory staff;

e) staff are subject to discipline for failure to report a use of force when policy requires such a report;

f) all uses of force and all failures to report a use of force are investigated thoroughly and appropriately by trained investigators; and

g) inmates may report allegations of the use of excessive force orally to any staff member, who shall reduce the report to writing.

30. The County shall implement an effective system for the prompt discipline of staff who violate policies on reporting and use of force.

31. The County shall revise its policy on use of the restraint chair to require pre-authorization and supervision by mental health staff for any non-emergency use of the restraint chair involving inmates with mental illnesses.

32. No hoods may be used under any circumstances. The County shall submit to DOJ for approval a revised policy to permit the use of a disposable spit cap in limited circumstances; the policy shall, at a minimum, prohibit the use of spit caps which restrict an inmate's airway.

33. Security staff shall receive special training on all revised use of force policies.

34. The County shall require all security staff to attend annual in-service training on the use of force and de-escalation techniques.

Grievance Procedures

35. Grievance forms shall be available in all housing units at all times without the need to request one from a counselor or other staff member. The County shall provide a secure and confidential method for delivery of grievances, such as a secure lockbox in an area accessible to inmates. The County shall continue to record and maintain records of inmate grievances, including dispositions, for a minimum of one year. The County shall ensure that inmate grievances are investigated and responded to within a reasonable time frame. Inmates shall be provided at least one level of appeal. The County shall not retaliate against inmates who file grievances or appeals, and shall not limit an inmate's ability to file repetitive grievances, except as consistent with state law. In appropriate cases, the SCJ's response to a repetitive filing may be a reference to an earlier response.

36. The SCJ shall periodically review inmate grievances and the disposition of these grievances to identify trends or emergent problems that may require a management response.

Gang Management

37. The County shall identify and control inmates who are members of organized gangs. Illicit gang-related behavior shall be a factor considered in increasing an inmate's classification status.

B. MEDICAL AND MENTAL HEALTH CARE

Screening, Medication, and Specialty Care

38. The County shall comply with its stated policies to provide medical and mental health intake screening to all inmates; shall provide a 14-day health assessment and examination; shall ensure continuation of prescription medications within 24 hours of intake; shall comply with stated policies to screen inmates for infectious disease; shall continue to provide mental health evaluations for all inmates whose histories or whose responses to initial screening questions indicate a need for such an evaluation; shall provide accurate diagnoses for inmates in need of mental health services; and shall continue to provide timely and appropriate referrals for specialty care.

39. The County shall comply with its stated policy for medication administration, particularly in documenting any missed doses of medication.

Sick Call and Staffing

40. The County shall provide access to sick call to all inmates a minimum of five days per week; shall ensure that sick call request forms are reviewed by qualified medical staff within 24 hours; and shall ensure that, for non-emergency requests, inmates are seen by a qualified medical professional no more than 24 hours after submission of the request, or, if requests are first reviewed by qualified staff, within another 24 hours of that review, except that inmates may be seen within 72 hours of submission of a request on weekends.

41. The County shall hire additional staff to ensure that all sick call examinations are conducted by appropriately qualified and licensed medical professionals or medical staff, pursuant to licensing standards for medical professionals

and nurses in the State of Tennessee. At a minimum, in its contract with its medical care provider beginning July 1, 2002, the County shall increase the number of medical doctors to a minimum of three (3) full time equivalent ("FTE") positions (one of the FTE medical doctor positions may be satisfied by substituting one and one half (1 ï½½) FTE mid-level practitioner such as a licensed nurse practitioner or physician's assistant); the County shall also use its best efforts to hire at least ten (10) additional registered nurses to fill the currently authorized nursing positions.

42. The County shall hire additional mental health professionals to ensure delivery of necessary mental health services. At a minimum, the County shall increase psychiatrist staffing to one and one-fifth FTE positions, and shall add a minimum of two FTE positions for mental health professionals to the staffing level authorized through addendum no. 11 to its health care contract.

43. The County shall assess the impact of the chargeable-care policy on delivery of medical and mental health care, consistent with the recommendations contained in the March 31, 1996 position statement on Charging Inmates a Fee For Health Care Services by the National Commission on Correctional Health Care.

44. The County shall provide to DOJ in its 100 Day Report a copy of all materials through which the SCJ explains the chargeable-care system for health care to inmates, including all materials prepared for non-literate and non-English speaking inmates.

45. Mental health workers shall make regular rounds to all housing units, including administrative segregation, in accord with SCJ stated policy; mental health workers shall speak regularly with pod officers on these rounds to assess whether inmates in general population, who have not self-identified as requiring mental heath care, should be evaluated by a mental health professional.

Mental Health Information and Intervention

46. The County shall provide sufficient qualified medical and mental health staff to respond promptly to requests from security staff for medical information/intervention, including, without limitation, assessment and monitoring of inmates identified at intake by the medical alert (or flag) system described in paragraph 25, above; intervention prior to a planned use of force on an inmate known to suffer from mental illness, as required in paragraph 29, above; and identification of inmates for whom the use of chemical agent sprays is medically contraindicated.

47. The County shall ensure that mental health professionals monitor all use of therapeutic restraints pursuant to its revised use of force policy, and shall ensure that mental health professionals are consulted prior to any planned uses of force involving inmates identified as having a mental illness.

Chronic and Critical Care

48. The County shall implement a system to track inmates with serious and/or chronic illnesses, including mental illnesses, to ensure that these inmates receive necessary diagnosis, monitoring and treatment.

49. The County shall implement a protocol for enhanced communication between medical professionals who transfer any inmate between the SCJ and an outside medical facility, including, but not limited to, transfers between the SCJ and the Regional Medical Center ("the MED"), and between the SCJ and the Memphis Mental Health Institute ("MMHI"). The protocol shall, at a minimum:

a) be implemented within 6 months of signing this Agreement;

b) shall be monitored as part of the County's quality assurance program;

c) shall expressly authorize a SCJ physician to refuse, on medical grounds, to admit (or refuse to accept a transfer of) an inmate from any outside medical facility (specified above), consistent with state law; and

d) in addition, SCJ internal Policies and Procedures shall be revised to provide direction to staff in accomplishing the transfer inmates to outside medical facilities once a SCJ physician determines, on medical grounds, that the inmate should no longer be housed at the SCJ.

50. The County shall revise its Policies and Procedures on segregation of special needs inmates (currently BK 5201.01-1.04 to BK 52. 02.00-05). At a minimum, the revised policy shall:

a) prescribe a protocol to identify inmates requiring heightened medical and/or mental health monitoring;

b) prescribe a method of triaging these special needs inmates for classification and assigning housing based on assessed need; and

c) specify means of providing enhanced monitoring for inmates who require such close monitoring, pursuant to the County's policies, but for whom no space is available in the housing unit referred to as special needs housing.

Suicide Prevention

51. The County shall continue to provide appropriate clothing, such as paper gowns or suicide smocks, to all inmates placed under suicide precautions.

52. The County shall implement revised policy and procedures for suicide observation cells (currently Pod 2K) to address the lack of direct visual observation for certain of these cells.

53. All SCJ staff shall receive annual training on suicide prevention.

Universal Precautions

54. The County shall, within six months, draft and implement a written infection control program to ensure compliance with universal precaution procedures in all SCJ operations. At a minimum, the program shall ensure provision of appropriate cleaning and personal protective equipment, and shall include training on preventing transmission of blood borne pathogens, as well as general sanitation issues.

Critical Incident Reviews

55. The County shall request an autopsy and shall conduct a critical incident/mortality review for every inmate who dies while in the SCJ (or at the Jail ward of the MED), as part of the County's ongoing quality improvement program. Critical incident review teams shall involve physicians, nurses and other relevant County personnel, including SCJ security staff, and shall seek to determine whether there was a pattern of symptoms or in the SCJ's response which might have resulted in earlier diagnosis and intervention. The review team shall also examine events immediately surrounding the inmate death to determine if appropriate interventions were undertaken.

C. ENVIRONMENTAL HEALTH AND SAFETY

Food Services

56. Within 150 days of the execution of this Agreement, the County shall have in place a permanent food service provider for SCJ.

57. All food service staff must be trained in food service operations, safe food handling procedures and proper sanitation. The County shall ensure that the temporary food service provider, hired to provide food services during the transition to a private provider, is staffed with a sufficient number of properly supervised and trained personnel.

58. The County shall ensure that its contract with a permanent food service provider contains provisions requiring that all civilian food service staff receive 40 hours of pre-service training in the principles of safe food handling, proper service, and sanitation. Civilians who will have contact with inmates during food preparation or service shall, in addition, receive pre-service training relating to security, emergency evacuation and blood borne pathogen concerns. Inmate food service workers shall receive training in principles of safe food handling and sanitation, although the SCJ shall retain discretion to provide fewer than 40 hours of such training to inmate workers.

59. The County shall ensure that the SCJ's food sanitation practices and procedures comply with state and local health codes.

60. The County shall ensure that the newly-established environmental health and safety manager ("EHM") or his/her designee checks and records on a daily basis the temperatures in the refrigerator, coolers, walk-in-refrigerator, the dishwasher water, and all other equipment with temperature monitors. The EHM shall also verify that the manifold pressure gauge on the dishwasher is checked and recorded on a daily basis. Likewise, to ensure proper sanitation, the EHM shall verify that maintenance personnel check and record on a weekly basis the speed of the dish conveyor to ensure that it conforms to manufacturer specifications. SCJ shall purchase temperature recording strips to measure the

accuracy and adequacy of dishwashing machine temperatures (for both wash and final rinse cycles), and shall purchase chemical sanitizing strips and routinely check to ensure proper sanitizing when food service equipment is washed in sinks.

61. The County shall have inmate meals reviewed annually by a registered dietician to ensure the nutritional adequacy of inmate meals. Menus must be evaluated annually to ensure compliance with nationally recommended basic daily nutritional requirements. A dietician shall also review all special medical diets annually, or more often as necessary. The County shall provide support to its food service manager from a dietician in order to make nutritionally adequate menu substitutions on those occasions when specified menu items are unavailable.

62. The County will construct a new kitchen adjacent to the Jail Annex currently under construction, and will contract for completion of the new kitchen within eighteen to twenty-four months. In the new kitchen, the County shall install new, properly-sized kitchen equipment, i.e., designed to provide food service to the rated capacity of SCJ, including refrigeration units, cooking units and dishwashing and tray washing units.

63. In its 100 day Report the County shall produce an interim plan to DOJ that corrects the problem of broken, malfunctioning, and/or improperly-sized food service equipment. At a minimum, the plan shall designate personnel to perform preventive maintenance and conduct quality assurance checks on all existing food service equipment, including daily checks and documenting of freezer, cooler, refrigerator and holding oven temperatures and daily checks of all sanitizing equipment.

Housekeeping, Preventative Maintenance and Pest Control

64. The County shall immediately revise its written housekeeping and sanitation plan to ensure the proper routine cleaning of housing and shower areas, which shall include routine housing inspections to assess compliance with its revised plan. The housekeeping plan shall, at a minimum, be revised to specify routine cleaning schedules for the kitchen, medical and other common areas outside inmate housing.

65. The County shall develop a written preventative maintenance plan to improve upon the recently-adopted priority-based work order system, and shall provide a copy of the written plan to DOJ for its comments and approval within 100 days. At a minimum, the plan shall specify a protocol for accurate and timely entry of information into the system, and shall provide for routine audits of the system by the Jail Compliance Unit to assess its efficiency and utility.

66. The County currently utilizes portable eye wash stations. These should be added to SCJ's preventative maintenance plan and inspected annually. To the extent SCJ utilizes any stationary eyewash stations, the County shall ensure that these stations are inspected and flushed on a weekly basis to prevent blockages and to ensure proper pressure. This task shall be added to the preventative maintenance list.

67. The County shall ensure adequate pest control throughout the housing units, medical intake and food storage areas. The County shall maintain a contract for professional exterminator services for the main Jail and Jail East, and the new Jail Annex when it opens. Services should provide for routine spraying and additional spraying as needed.

Personal hygiene and laundry

68. The County shall ensure that personal hygiene items, including an adequate supply of soap, hair shampoo, toothbrushes, toothpaste, toilet paper, a comb, deodorant, shaving equipment, and feminine hygiene products are made available, as necessary, to every inmate. The Jail Compliance Unit shall review and assess its compliance with this requirement at least twice annually, including a review of inmate grievances concerning hygiene items.

69. The County is currently soliciting bids for an outside contractor to replace the Jail's laundry services which were recently destroyed by a fire. Jail East will continue to do its own laundry. The County shall ensure that its stated policies and procedures regarding the laundering of inmate clothing are implemented by both the temporary and permanent laundry providers, and that inmates are provided clean clothing, underclothing and bedding in compliance with policy. The County shall revise its laundry exchange schedule to ensure equitable distribution and pickup service to all housing areas. The County shall specify in its laundry policy and/or inmate handbook that it will provide inmates two sets of clothing, at a minimum. The Jail Compliance Unit shall review and assess its compliance with laundry policy at least twice annually, including a review of inmate grievances concerning laundry.

70. The County shall ensure adequate lighting in all inmate housing and work areas to enable inmates to read without eyestrain, to maintain adequate personal hygiene, and to facilitate proper sanitation. The County is currently engaged in a bidding process to procure a contractor to repair the lighting in the SCJ's cells, catwalks and showers. The County shall publish/disseminate the RFP and engage a contractor so as to provide sufficient lighting within six months of this Agreement. The County shall notify DOJ in writing of any delays in and/or modification to these time frames.

Plumbing

71. The County shall revise its preventative maintenance plan to define plumbing emergencies, and shall specify back-up procedures to address plumbing emergencies on weekends and outside of business hours.

72. The County shall complete outstanding repair requests and maintain in good working order all toilets, lavatories and showers. These items shall be incorporated on the list of items to be addressed in the SCJ's preventative maintenance plan described in paragraph 65, supra.

Ventilation

73. The County shall ensure adequate ventilation throughout the SCJ to ensure that inmates receive an adequate supply of fresh air and reasonable levels of heating and cooling. Maintenance staff shall review and assess compliance with this requirement at least twice annually; the Jail Compliance Unit shall review inmate grievances concerning heating, cooling and ventilation on a semi-annual basis.

Fire Safety and Emergency Preparedness

74. The County shall develop and implement a comprehensive fire safety program and ensure compliance is appropriately documented. The initial fire safety plan shall be approved by the City or County Fire Marshall. The fire safety plan shall be reviewed thereafter by the Fire Marshall at least every two years, or within six (6) months of any revisions to the plan, whichever is sooner.

75. The County shall forthwith provide DOJ with a plan that ensures that comprehensive fire drills are conducted every three (3) months on each shift. The 100 Day Report shall provide documentation of these drills, including start and stop times and the number and location of inmates who were moved as part of the drills. The County shall ensure that fire safety equipment, including fire extinguishers and self-contained breathing apparatus, is regularly inspected and properly secured, and that inspections are documented.

76. The County shall ensure that staff are able to manually unlock all doors (without use of the manual override in the event of an emergency in which the manual override is broken), including in the event of a power outage or smoke buildup where visual examination of keys is generally impossible. The Jail Compliance Unit shall conduct and document random audits to test staff proficiency in performing this task on all shifts, a minimum of three times per year.

77. The County shall eliminate all electrical hazards, and ensure the proper use of extension cords and proper repair of wiring.

78. The County shall control combustibles and eliminate highly flammable materials throughout the institution and inmate living areas (e.g., inmates' use of paper bags as trash receptacles, ripped fire-retardant mattress covers and, improperly stored and labeled flammable liquids and other chemicals). The County shall remove all impediments compromising the effectiveness of sprinkler heads including, specifically, those in the food storage units in the kitchen area.

79. The Jail Compliance Unit shall conduct regular security inspections and the County shall provide ongoing maintenance to security devices such as door locks and manual unlocking mechanisms to ensure these devices function properly in the event of an emergency.

80. The County shall revise and implement a specific facility tailored Emergency Response Plan within one year of execution of this Agreement. At a minimum, the Emergency Response Plan shall address fire-related emergencies, other emergencies or crisis situations such as escapes, bomb threats, hostage taking and negotiations; and provide for announced and unannounced bi-annual drills to ensure the staff and inmate population understand their respective roles in specific emergency scenarios. All training drills shall be conducted consistent with the injunctive relief ordered in

American Federation of State v. A.C. Gilless, et al., CV.00-2540 (W.D. Tenn.). The County shall produce a copy of the draft plan to DOJ within 100 days.

D. ACCESS TO THE COURTS AND EXERCISE OPPORTUNITIES

81. The County shall provide to DOJ within six months a revised policy regarding access to the law library, which at a minimum, shall ensure:

a) provision of individual storage bins or lockers in which inmates may store legal materials;

b) that inmates on locked units (psychiatric, administrative and disciplinary segregation, protective custody, and other special needs housing) receive access to legal materials and legal assistance equivalent to that of inmates in the general population;

c) that inmates who are illiterate and/or have limited or no English proficiency receive meaningful assistance in order to access legal materials and legal assistance;

d) that a trained aide be available to assist inmates with the law library resources; and

e) in the event SCJ provides computer access to inmates, inmates will be provided reasonable assistance with this resource.

82. All inmates shall be informed of the policies and procedures for accessing legal assistance at the SCJ.

83. The County shall provide inmates with routine access to outside recreational activities, consistent with the recommendations contained in the NIC Recreation/Programs technical assistance report (#02J1078), dated February 18, 2002. At a minimum, the County shall use its best efforts to provide a minimum of two and one-half (2 ï½½) days of outdoor recreation each week, weather permitting. These efforts are to be documented and provided to DOJ upon request. The County shall utilize the redesigned outdoor rooftop program area in addition to the gym, seven (7) days a week unless the temperature falls below freezing (32 degrees), rises above 95 degrees, or there is potentially life-threatening inclement weather (e.g., thundershowers or tornados).

IV. REPORTING REQUIREMENTS

84. The County, through its Criminal Justice Coordinator, shall report semi-annually to the United States Department of Justice ("DOJ") concerning its compliance with the terms of the Agreement (the "Semi-annual Report"). The first Semi-annual Report shall be due six months from the date of this Agreement, and every six months thereafter, until the Agreement is terminated as provided in paragraph 98. At a minimum, the Semi-annual Report shall include the following sections:

a. A narrative summary of the County's compliance with the terms of this Agreement; where applicable, the summary shall specifically note when the County has failed to meet any deadline specified in this Agreement.

b. A training summary, in which the County reports the number of hours and type of training provided to staff during the reporting period, separately by supervisory and non-supervisory staff, and, if applicable, separately for security, medical, mental health and civilian staff.

c. A copy of all substantive court filings made during the reporting period by either the County or the Special Master in the case of Little v. Shelby County, No.96-2520(W.D. Tenn.)

d. Copies of supporting data and/or reports as specified within this Agreement and itemized in paragraph 85 below.

85. The Semi-annual Report shall include the following documentation and reports:

a. an update on the status of SCJ's conversion from the indirect to direct supervision model as described in paragraph 15, supra.

b. a schedule that ensures completion of the 40 hour direct supervision training by all security staff no later than June, 2003, and a report on the SCJ's compliance with this schedule;

c. an update on steps taken to hire and retain qualified security staff, including: a summary of turnover rates and new hiring; copies of any consultant reports prepared on the issue of staff recruitment and retention; and changes in recruitment or selection procedures, job standards or job descriptions.

d. copies of the Jail Monthly Summary Report.

e. documentation demonstrating the Jail Compliance Unit's monthly random checks of the security staff's familiarity with emergency tool and key procedures as described in paragraph 21, supra.

f. copies of SCJ's audits and a report documenting SCJ's progress in training staff to conduct internal audits as described in paragraph 22, supra.

g. the number and types of inmate disciplinary infractions referred to the disciplinary committee during the report period, a summary of the dispositions, and the total number of cases abandoned for lack of a timely hearing.

h. copies of one week's shakedown-logs summarizing contraband confiscated, as described in paragraph 23, supra, from any week of any month in the reporting period.

i. a summary of the number and types of force used during the reporting period and the results of the reviews conducted on the uses of force during the reporting period, including any staff discipline imposed.

j. copies of the monthly medical quality assurance committee minutes, and all audits of medical or mental health services.

k. reports on both medical and mental health staffing described in paragraph 41-42, supra, including the number of vacancies in authorized medical and mental health positions on the first day of each month.

l. copies of all audits concerning the chargeable care policy, and any findings of those audits, as described in paragraph 43, supra, and a review of any inmate grievances concerning access to or provision of medical or mental health care.

m. copies of any revised or supplemental materials provided to inmates, including a script used by staff to explain the chargeable care policy as described in paragraph 44, supra. The script shall be provided for DOJ's review within 100 days.

n. a copy of SCJ's protocol for enhanced communication between medical professionals who transfer any inmate between the SCJ and an outside medical facility as described in paragraph 49, supra, and a report on compliance with the protocol.

o. documentation of the SCJ's basic blood borne pathogen training and in-service training for all staff as described in paragraph 54, supra.

p. list the personal protective equipment currently available to SCJ staff;

q. copies of quarterly spore count test results for autoclaves;

r. report all mortality statistics for inmates who die in custody or upon transfer to an outside hospital, including the number of deaths; date of death; age; and suspected cause of injury or death. The County shall also describe any quality improvement measures implemented during the reporting period pursuant to the recommendation of the critical incident review committee as described in paragraph 55, supra.

s. a status report summarizing safe food handling, proper service and sanitation training received by food service employees as described in paragraph 57-58, supra.

t. a status report on SCJ's preventive maintenance efforts and documentation regarding the degree of compliance with the plan as described in paragraph 65, supra.

u. documentation describing SCJ's provision of personal hygiene items described in paragraph 68, supra, and a semi-annual review and assessment of inmate grievances concerning hygiene items.

v. documentation describing SCJ's compliance with its laundry policy described in paragraph 69, supra, including a semi-annual review of any inmate grievances concerning laundry.

w. documentation describing SCJ's compliance with the requirement to provide adequate ventilation, including its semi-annual review of any inmate grievances concerning heating, cooling and ventilation.

x. copies of the Fire Marshall's reports regarding SCJ as described in paragraph 74, supra.

y. documentation that the Jail Compliance Unit has verified that the SCJ has conducted random audits to test staff proficiency in unlocking all doors manually as described in paragraph 76, supra.

86. In addition to the Semi-annual Report, the County shall provide to DOJ, within 130 days of this Agreement, a report describing its compliance with those tasks for which a 100 day report is specified.

87. During the term of this Agreement, upon reasonable notice, the United States and its consultants shall have access to all facilities referenced in this Agreement and to the records of inmates and compliance records to the extent necessary to assure compliance with the specific terms of this Agreement. Upon request, the County shall provide to the United States, within a reasonable time, copies of, or access to, SCJ documents or records and/or documents or records created by any agent or contractor authorized by Shelby County to work or to provide services at the SCJ.

88. The United States shall have the right to conduct confidential interviews with inmates. The County shall continue to permit inmates to send and to receive confidential legal mail to attorneys of record, courts and to representatives of the Department of Justice.

89. Nothing in this Agreement shall be construed to limit DOJ's right to request additional documentation and/or conduct inspections in addition to those specified herein.

V. IMPLEMENTATION, ENFORCEMENT and TERMINATION

90. The County shall implement immediately all provisions of this Agreement which involve the continuation of current County policies, procedures, and practices.

91. The County shall provide to DOJ each plan, policy, form and/or training materials revised pursuant to this Agreement within the time specified herein. Any subsequent revisions to these materials shall also be submitted to DOJ during the term of this Agreement. The United States shall expeditiously review all plans, policies, procedures, forms and/or training materials for which this Agreement requires approval from the United States prior to implementation.

92. In the event that DOJ does not approve policies and procedures required to be approved pursuant to the terms of this Agreement, the parties will agree to a schedule for Shelby County to submit additional revisions for appropriate approval. In any matter requiring its approval under this Agreement, DOJ shall not unreasonably withhold any such approval.

93. The parties agree to file this Agreement with the Court in conjunction with a joint motion, pursuant to Fed. R. Civ. P. 41(a)(2), for the dismissal of this case. The dismissal shall be conditioned upon the County's achieving substantial compliance with the entire agreement and maintaining compliance for at least one year thereafter. The motion shall request that the case be placed on the Court's inactive docket.

94. Substantial Compliance with each term of this Agreement shall fully satisfy the Agreement. The burden shall be on the County to demonstrate that it is in substantial compliance with each of the provisions of the Agreement. Noncompliance with mere technicalities, or temporary failure to comply during a period of otherwise sustained compliance, shall not constitute failure to maintain substantial compliance. At the same time, temporary compliance during a period of otherwise sustained noncompliance shall not constitute substantial compliance.

95. Substantial compliance may be achieved separately in any of the four substantive areas addressed in this settlement agreement (medical and mental health care, security and protection from harm, environmental health and safety, and/or access to exercise and to the courts). If the County achieves substantial compliance in any of the four substantive areas of the Agreement, prior to achieving full compliance with the entire Agreement, and then maintains that compliance for a period of one year, then the County may discontinue those portions of the Semi-annual report

which concern compliance with that substantive area of the Agreement. The County shall remain obliged, however, to provide this information, or other specific information requested by the Department, upon request.

96. The United States reserves the right to file a motion to restore this case to the Court's active docket for purposes of litigating the allegations in the Complaint if it believes Shelby County is not in substantial compliance with the Agreement. The United States shall give Shelby County thirty (30) calendar days' written notice before the filing of such motion and will attempt to resolve such disputes cooperatively.

97. In the event the United States believes that the County has failed to substantially comply with the terms of this Agreement, in whole or in part, and such non-compliance threatens the immediate health and safety of inmates, the United States may, without further notice, file a motion to restore the case to the Court's active docket.

98. Once the County has determined that it is in substantial compliance with this Agreement or any of its four substantive areas, the County shall notify the United States in writing, by certified mail, return receipt requested. If the United States does not provide a written objection to such determination within forty-five (45) days of receipt of said notice, the County will be deemed to be in substantial compliance beginning on the date of the notice. If the United States provides a written objection to such determination, in whole or in part, the parties shall make good faith efforts to resolve the dispute. One (1) year from the date the County has reached and maintained substantial compliance with the terms of the entire agreement, the parties shall file a joint motion for final dismissal of this action.

99. In the event that the allegations in the underlying complaint are litigated (i.e., through a trial or dispositive motions), this Agreement shall not be introduced or used as evidence.

100. Notice under this Agreement shall be provided by Federal Express overnight delivery and shall be provided to the Shelby County Sheriff's Legal Advisor, the Shelby County Attorney, and the United States Department of Justice, at the addresses used in the signature pages of this Agreement, or as otherwise designated in written notice to all signers of the Agreement.

101. The parties do not intend to create in any other individual or entity the status of third party beneficiary, and this Agreement shall not be construed so as to create such status. The rights, duties, and obligations contained in this Agreement shall operate only between the parties to the Agreement, and shall inure solely to the benefit of the parties to this Agreement. This Agreement is not intended to impair or expand the right of any person or organization to seek relief against the County for its conduct or the conduct of County employees or agents; accordingly, it does not alter legal standards governing any such claims.

102. Except as otherwise provided by law, nothing in this Agreement shall preclude the United States from filing an action against any of the defendants under any other applicable provision of law.

103. This Agreement shall be applicable to and binding upon all parties, their officers, agents, employees, assigns, and their successors in office, all in their official capacities.

104. The County shall make the substantive terms of this Agreement available to all inmates by maintaining a complete copy of the Agreement in the law library, and providing a complete copy to any inmate upon request.

FOR THE UNITED STATES:

/s/ Terrell L. Harris

TERRELL L. HARRIS
United States Attorney
Western District of
Tennessee

/s/ Ralph F. Boyd, Jr.

RALPH F. BOYD, JR.
Assistant Attorney General

Civil Rights Division

/s/ Steven H. Rosenbaum

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FOR SHELBY COUNTY:

/s/ Jim Rout

JIM ROUT
Mayor of Shelby County
in his official capacity

/s/ Donnie Wilson

DONNIE WILSON
Shelby County Attorney
in his official capacity
FOR THE SHERIFF OF SHELBY COUNTY:

/s/ A.C. Gilless

A.C. GILLESS
Sheriff of Shelby County
in his official capacity

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Updated August 6, 2015

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN SECTION OF TENNESSEE
WESTERN DIVISION

NICOLE FREEMAN, as wrongful death representative of Gershun Freeman and next friend of minor child T.F., PLAINTIFF, v. SHERIFF FLOYD BONNER, in his individual capacity; CHIEF JAILER KIRK FIELDS, in his individual capacity; SHELBY COUNTY, TENNESSEE, a Tennessee municipality; and JOHN/JANE DOES 1-14, Shelby County correctional officers, in their individual capacities, DEFENDANTS.	**Case No. 2:23-cv-02193-MSN-tmp** **COMPLAINT FOR VIOLATIONS OF THE CIVIL RIGHTS ACT OF 1871, 42 U.S.C. § 1983** **JURY TRIAL DEMANDED PURSUANT TO FED. R. CIV. PRO. 38(a) & (b)**

EXHIBIT C PLACEHOLDER

In accordance with ECF No. 11, Plaintiff has previously transmitted a copy of the video compilation of in-jail surveillance footage which captured many of the details alleged in the Complaint with the Clerk and Court. This form serves only as a placeholder and notice of such filing.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN SECTION OF TENNESSEE
WESTERN DIVISION

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PLAINTIFF'S RULE 1006 SUMMARY OF SUBSTANTIATED EXCESSIVE FORCE VIOLATIONS BY SHELBY COUNTY CORRECTIONAL OFFICERS AT 201 BETWEEN JUNE 2018 AND SEPTEMBER 2021

Case #	Date of Incident	Incident Summary	Punishment Received	DISCOVERY PAGES
SI2018-261	06/05/18	Inmate Christopher Henderson filed a grievance stating Officer Kenneth Faulner pushed him down the steps. Surveillance was viewed and substantiated Inmate Christopher Henderson's account.	Oral Reprimand	SC 853 - 54
SI2018-433	07/27/18	Officer Nicholas Hyman was observed on surveillance footage using Freeze Plus P chemical agent to spray an inmate that was secured bhind his cell door. Officer Hyman was not in harms' way because the inmate was secured.	Oral Reprimand	SC 859 - 60

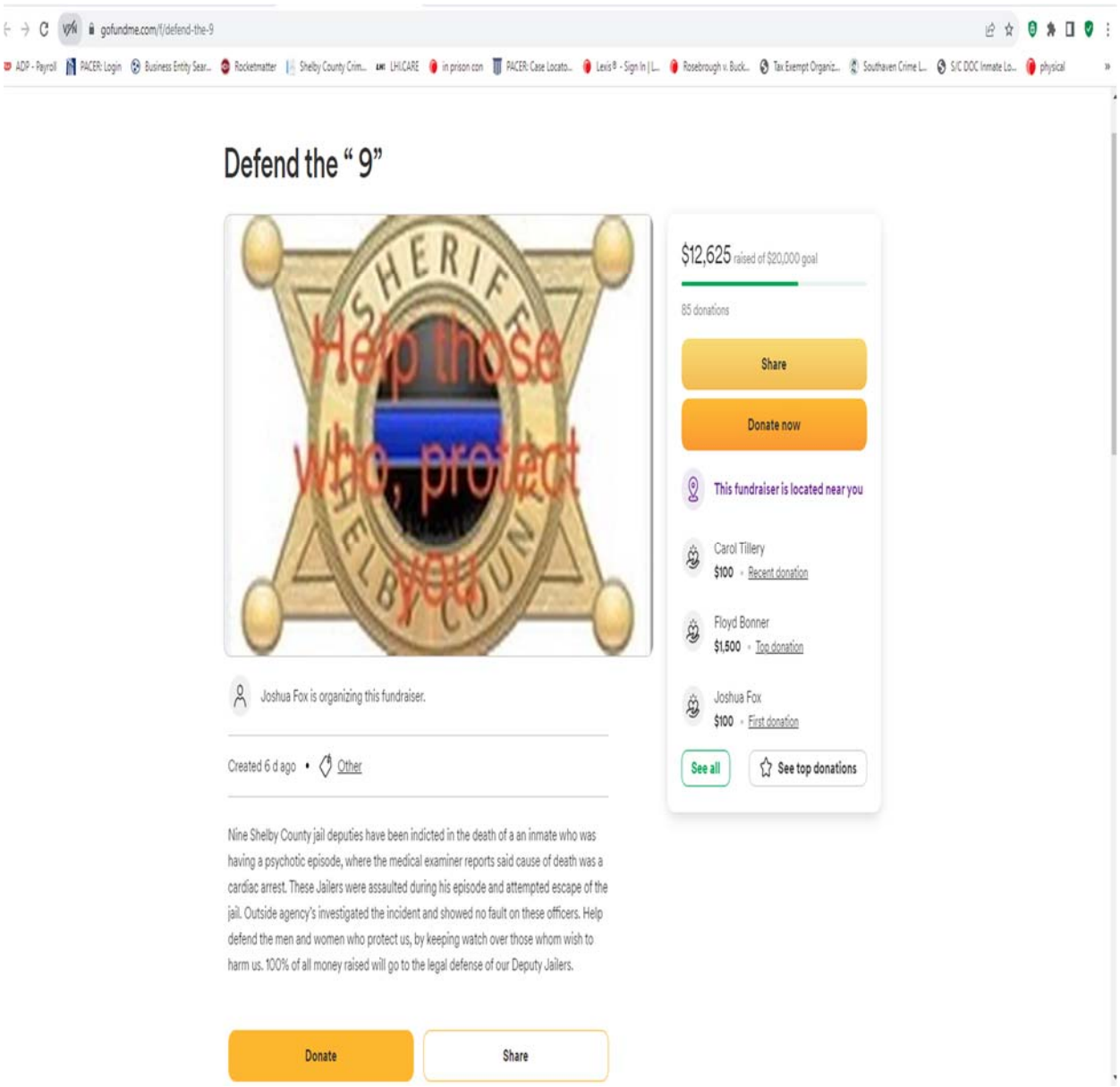
SI2018-404	08/03/18	Inmate Patrick Shaw complained that Officer Danielle May sprayed him with the Biovex used to clean the mattresses, while he was sitting on his bunk. Surveillance footage was reviewed and proved Officer May inmate Shaw multiple times. During the investigation Officer May lied to investigators and it was determined that Officer May sprayed the inmate with the bleach solution.	Three (3) day suspension without pay	SC 855 - 58
SI2018-508	10/03/18	Officer Kenneth Faulker pushed Inmate Meco Hampton a total of seven times during an incident. Surviellance footage did not show Inmate Hampton displaying any aggressive behavior during the time of the incident.	Three (3) day suspension without pay; EAP referral to anger management	SC 861 - 64
SI2018-565	10/18/18	Officer Katisha Walker was seen on surveillance footage pushing Inmate Kelvin Collins in his chest on two separate times and it was determined that the force was not required.	Written Reprimand	SC 869 - 70
SI2018-545	10/19/18	Officer Pierre Finnie deployed Freeze Plus P into the face of an inmate who was secured in full restraints. Officer Finnie was found to have used nedless force, failed to have used reasonable alternatives prior to using freeze plus, and failed to maintain self-control.	Three (3) day suspension without pay	SC 865 - 68
SI2018-576	11/06/18	Officer Andre Bardwell was seen on surveillance footage, spraying into an open cell security flap with his chemical agent, assaulting an inmate with the chemical agent. Officer Bardwell was not in harm's way nor was there a threat to anyone else.	Oral Reprimand	SC 871 - 72
SI2018-594	11/10/18	Officer Haliburton was escorting inmate Griggs out of the pod (inmate Griggs was not comative and per Officer Haliburton complying) when Officer Terita Payne came up and sprayed both the inmate and Officer Haliburton.	Written Reprimand	SC 873 - 74

SI2019-151	02/25/19	Inmate Derron Pegues observed on surveillance footage walking towards Officer Damian Cooper's desk. Officer Cooper stood to his feet and another inmate stood between them with his hands held out, as if to keep them apart. Inmate Pegues remained about six to eight feet away from Officer Cooper, and still behind the taped security line on the floor in front of the officer's desk. When the inmate standing between them walked away, inmate Pegues began backing up with his hands down at his side as Officer Cooper began walking toward him. Officer Cooper then reached for his chemical agent and inmate Pegues began to turn away. Officer Cooper then reached around inmate Pegues' head and sprayed him in the face. Officer Cooper then grabbed the back of Inmate Pegues' hair from behind and pulled him to the floor. Once they reached the floor, Officer Cooper began punching inmate Pegues with his left first. Officer Cooper then put Inmate Pegues in a headlock.	Oral Reprimand	SC 893 - 94
SI2019-226	04/09/19	Officer Kimberly White observed striking inmate Lildarryl Clark in the face and then with a closed fist unprovoked.	One day suspension without pay; reduced to written reprimand	SC 895 - 98
SI2019-303	04/10/19	Lt. Conolly observed stomping and kicking inmate Antwon Robinson while he was being held down on the floor.	One day suspension without pay	SC 907 - 08
SI2019-265	05/07/19	Lieutenant Todd Connolly walked up to a gated bar door and sprayed a chemical agent at Inmate Brandon McClendon. Officer E. Chaney opened the bar door and Inmate McClendon came out. Several officers followed the inmate as well as Lt. Connolly. Lt. Conolly sprayed inmate McClendon again while he was handcuffed and had his head down.	One day suspension without pay	SC 901 - 904
SI2019-348	06/27/19	Officer Katisha Walker observed standing in front of Inmate Damien Boone's cell shaking her Freeze P plus and spraying two bursts into the cell and then walking away. Officer Walker failed to notify command of deploying her chemical agent and did not create an incident report.	Ten (10) day suspension without pay	SC 909 -12

AI2019-035	08/14/19	Officer Fredrick McCloud accosted inmate Jeremy Fields, while he was handcuffed and assaulted him in a vicious and retaliatory manner. Officer McCloud followed inmate Fields to 2nd floord medical without any prior authorization to do so, where he conducted the assault. This assault resulted in inmate Fileds receiving significant head injuries and required treatment at the emergency room. A grand jury indicted Officer McCloud on 11/13/2019, of felony misconduct and aggravated assault.	Termination	SC 881 - 87
SI2019-569	10/26/19	Inmate Monterio Towles was complying with an order to walk towards the holding tank as instructed. Officer Ronald Nesbit was observed running behind Inmate Towles and placing his arms around inmate Monterio Towles' neck and choking him out to the point that Inmate Towles either passed out or appeared to pass out.	Oral Reprimand	SC 916 - 19
AI2019-050	11/04/19	Corrections Deputy Cleosha Lee jeopardized her safety as well as Officer Alamin's safety by confronting an irate inmate and engaging in an unnecessary physical altercation. Inmate Lurry did not pose an immediate threat to herself or others at the time of the incident.	30 Day suspension without pay	SC 888 -892
SI2020-85	01/13/20	Surveillance footage shows Sergeant Camry Porter pulling inmate Carlisle from the back of his head and putting her arm around his neck.	Three (3) day suspension without pay	SC 928 - 31
SI2020-328	03/28/20	Officer Latricia Edwards deployed chemical agents against inmate Ralph Johnson when inmate Johnson did not pose a threat and was retreating back into his cell.	Oral Reprimand	SC 933 - 34
AI2020-016	05/06/20	Officer Lee Simmons assaulted inmate Deandre Mitchell. Inmate Mitchell did not have a hostile posture and both his arms were at his side while surrounded by four officers. Officer Simmons struck Inmate Mitchell from behind with a closed fist in the facial area. Inmate Mitchell did not swing at any staff member and only take actions to block blows by staff.	Ten (10) day suspension without pay	SC 920 - 25; Askew upheld punishment SC 926 - 27
SI2020-376	07/05/20	While staff attempted to cuff Inmate Katrina Boone on the ground, Sergeant Halliburton kicked her.	Three (3) day suspension without pay	SC 936 - 39

SI2020-431	07/20/20	Inmate D. Edwards was struck in the face by Officer LaTricia Edwards in the face with a closed fist then placed in a headlock while posing no threat to Officer Edwards. Officer Edwards straddled the inmate and struck him multiple times with a closed fist while the inmate did not fight back or protect himself.	One (1) day suspension without pay	SC 940 - 44
SI2020-456	07/20/20	Officer Stevon Jones retaliated against Elvis Hester for exercising his First Amendment right to file a grievance against the correctional officer. The incident also involved Damian Cooper, James Perry, and Steveland Freeman. However, only Officer Jones was found to have utilized excessive force. Officer Jones, without justification, sprayed freeze plus P into Mr. Hester's cell and then entered Mr. Hester's cell to confront him when Mr. Hester posed no threat of harm. Furthermore, Mr. Hester alleged some, if not all, of the correctional officers beat him in the head with handcuffs in his cell.	Ten (10) day suspension without pay	SC 945 - 48
SI2020-457	07/20/20	Officer Marico Johnson was delivery food in third floor P-pod. The pod was on lockdown due to staff shortages on this day. Once Officer Johnson mate it to 3-P-18 the door was rolled open for Inmate Brandon Clay. Inmate Clay walked out of the cell with his belongings in his hand and nonthreatening. Officer M. Johnson sprayed inmate B. Clay with freeze plus p, inmate B. Clay then turned and ran back into his cell. Officer M. Johnson is seen on surveillance footage going into the cell behind the inmate. Seconds later, Officer M. Johnson can be seen at the door pulling inmate B. Clay out of the cell by his shirt, slanging him clear across the pod to the other side.	Ten (10) day suspension without pay	SC 949 - 52
SI2021-089	01/08/21	At 1910 on Friday January 8, 2021, Inmate Henderson can be seen exiting the strip search tank without a face mask on. The mask was in his hand as he approached Officer Cooper. Officer Cooper and inmate Henderson were facing each other exchanging words when Officer Cooper pushed Henderson in the chest with an open hand palm into the wall. At no time did inmate Henderson make an aggressive move toward officer Cooper. Then Officer Cooper struck inmate Henderson with a closed fist on the left side of his face.	Ten (10) day suspension without pay	SC 965 - 67
SI2021-131	01/08/21	Officer Quintin Draper assisted Officer Cooper in the above incident. Officer Draper placed inmate Henderson in a choke hold.	Written Reprimand	SC 971 - 72

SI2021-228	03/19/21	Despite being instructed on several occasions by Captain Rudd and LT. Lee not to go into the strip search tank without a male officer being present Officer Quintin Draper entered the strip search tank on March 19, 2021. Inmate Ventrell Collins tossed his shirt on the ground and told Officer Draper to pick it up. Officer Draper was then observed striking inmate Collins with a closed fist.	Ten (10) day suspension without pay	SC 973 - 76
SI2021-544	05/26/21	Officer Steveland Freeman was observed on surveillance striking inmate Cortez Davis, while handcuffed, in the facial area and spraying him chemical agents for being in his personal space.	One (1) day suspension without pay	SC 977 - 80
SI2021-617	06/13/21	Officers Kenneth Boykin deployed his chemical agent at two (2) inmates multiple times in reference to Incident #21-0613-120. After the inmate's actions didn't warrant any further escalated use of force with chemical agents, Officer Boykin continued to deploy his chemical agent.	Ten (10) day suspension without pay	SC 981 - 84
SI2021-629	06/29/21	Officer Desmon Haywood observed grabbing inmate Barnes from behind as inmate Barnes was proceeding to his bunk and placed an arm around his neck. A physical altercation ensued.	Ten (10) day suspension without pay; referral to EAP	SC 985 - 88
SI2021-797	09/13/21	Surveillance footage shows Officer Cortez Sims engaging in an altercation with inmate Darshun Holliday three times without inmate Holliday fighting back. Officer Sims pushed Inmate Holliday several times and swung towards his facial area.	Five (5) day suspension without pay	SC 989 - 92
SI2021-823	09/13/21	Officer Markus Buchanon deployed chemical agent against inmate Roderick Moore after inmate Moore raised his hands and laid on the floor on his stomach.	Five (5) day suspension without pay	SC 993 - 96



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