IN THE UNITED STATES DISTRICT COURT FOR THE EASTERN DISTRICT OF PENNSYLVANIA

JANET LITTLE OWENS, Individually and as Administrator of the ESTATE OF ANDREW LITTLE, 249 Warwick Furnace Road Elverson, PA 19520 Plaintiff, v. DELAWARE COUNTY d/b/a GEORGE HILL CORRECTIONAL FACILITY 500 Cheyney Road Thornton, PA 19373 and CORRECTIONAL OFFICERS JOHN/JANE DOES (1-10) (fictitious) c/o DELAWARE COUNTY PRISON 500 Cheyney Road Thornton, PA 19373 and The GEO GROUP, Inc. 621 NW 53rd Street, Suite 700 Boca Raton, FL 33487 and WELLPATH LLC 3340 Perimeter Hill Drive Nashville, TN 37211 and KRISTEN GRADY c/o WELLPATH LLC 3340 Perimeter Hill Drive Nashville, TN 37211	Docket No.: JURY TRIAL DEMANDED

and :

MEDICAL PROVIDERS:: :
JOHN/JANE DOES (1-10) (fictitious) :
c/o WELLPATH LLC :
3340 Perimeter Hill Drive :
Nashville, TN 37211

COMPLAINT

THE PARTIES

1. Plaintiff, Janet Little Owens, is an adult individual residing at 249 Warwick Furnace Road, Elverson, PA 19520.

2. On October 17, 2022, Plaintiff was granted Letters of Administration by the Register of Wills Office of Delaware County, Pennsylvania to act as the Administratrix of the Estate of Andrew Little, her deceased son ("Little").

3. Little was born on September 19, 1987 committed suicide by hanging himself on June 4, 2022 while an inmate at Delaware County Prison ("Delco Prison"), a county prison located on 500 Cheyney Road in Thorton, Pennsylvania.

4. Defendant Delaware County ("the County") d/b/a Georgie Hill Correctional Facility is a municipality within the Commonwealth of Pennsylvania, located at 500 Cheyney Road in Glen Mills, Pennsylvania 19373. At all relevant times, the County owned and operated Delco Prison and employed the Officer Defendants identified below.

5. Defendant, The GEO Group ["GEO"], is a corporation or other jural entity organized and existing under and by virtue of the laws of the State of Florida and with a business address at 621 NW 53" Street, Suite 700, Boca Roton, FL 33487.

6. GEO is a private for-profit operator of correctional facilities. At all times relevant

thereto, Defendant GEO or its subsidiaries, successors in interest, or predecessors in interest had a contract with the County to operate the George Hill Correctional Facility, located in Delaware County Pennsylvania. At no time relevant hereto, was GEO a municipality, political subdivision, or of the Commonwealth of Pennsylvania.

7. Defendant Correctional Officers John/Jane Does (1-10) were correctional officers or supervisors employed by the County to work at Delco Prison. Plaintiff does not presently know the names of these defendants after conducting a reasonable search, including a review of pre-complaint discovery produced by the County. Plaintiff expects to learn the names of these additional correctional officers and/or supervisors through formal discovery and will promptly take steps to substitute actual names for these fictious names.

8. Defendant Wellpath LLC ("Wellpath") is an active Kansas LLC on with a principal place of business at the above-captioned address which, at all relevant times, was under contract with the County to provide medical care, including psychiatric and mental health services, to Delco Prison prisoners such as Little. Upon information and belief, at all relevant times, Wellpath employed the Medical Defendants identified below.

9. Defendant Kristen Grady ("Administrator Grady") was, at all relevant times, a licensed practical nurse who was working at Delco Prison, acting under the color of law and within the course and scope of her employment and/or agency with Wellpath.

10. Defendant Medical Providers John/Jane Does (1-10) were doctors, nurses, or other medical providers working at Delco Prison as employees and/or agents of Wellpath. Plaintiff does not presently know the names of these defendants after conducting a reasonable search, including a review of discovery produced by Wellpath. Plaintiff expects to learn the names of these

additional medical providers through formal discovery and will promptly take steps to substitute actual names for these fictious names.2

11. Defendant Wellpath LLC, Defendant Grady, and the Medical Provider Doe defendants are hereby collectively referred to as "Medical Defendants."

12. At all relevant times, the County and Wellpath were acting, or alternatively failed to act, by and through their employees, agents, and/or ostensible agents, who were acting within the course and scope of their employment, agency, and/or ostensible agency.

JURISDICTION AND VENUE

13. This Court has jurisdiction of this action over all Defendants pursuant to 42 U.S.C. § 1983 as well as 28 U.S.C. § 1331. This Court has jurisdiction over the pendant state tort law claims pursuant to 28 U.S.C. § 1367(a).

14. Venue is proper in this Court pursuant to 28 U.S.C. § 1391 because a substantial part of the events and/or omissions giving rise to Plaintiff's claims took place here, as did Little's suicide.

FACTUAL BACKGROUND

15. Before he hung himself on June 4, 2022, Little's mental health issues and troubled history were well known to both the County and Wellpath.

16. According to County and Wellpath records, Little was committed to Delco Prison for a violation of his parole and for charges related to indecent exposure. Upon information and belief, Little had been there before.

17. Upon intake, he revealed a history of schizophrenia and that Little was not taking medication to control his illness. Wellpath's intake forms reflected, inter alia: (a) an inability to take a complete history; (b) an inability to adequately assess his mental health, as reflected in Wellpath records; (c) a previous commitment (date and location not reflected); and (d) that he was

a suicide risk.

18. Just a few months prior to his suicide, Little was transported to Riddle Hospital after he was found in distress and unconscious.

19. It was documented at this time that Little should have been taking numerous medications and the County was aware he was not taking them.

THE SUICIDE

20. Little was the lone occupant of cell 10A-210.

21. The County was aware that this cell was not "suicide proof" and that the sheet and bedframe posed a danger to Little.

22. Prison records show that the Delco Prison and its staff were aware that many of the cells on block 10 had malfunctioning doors.

23. Specifically the doors would not open properly when operated from the bubble and a manual key was required to open.

24. Despite this knowledge, the Delco Prison failed to take adequate measures to remedy this problem, even when their own employees raised concerns that it needs to be addressed before "these issues before it gets out of control." Also noting this requires "timely and urgent consideration and actions."

25. On June 4, 2022, even though, Little's cell was supposed to be monitored by Delco Prison staff, the staff did not discovery Little's suicide attempt.

26. At approximately 1: 11 pm, inmate Justin Janaitis alerted staff of a hanging motion and pointed to the top tier on10 A.

27. At this time, Officer Kpadeyea was exiting the unit octagon and Sgt. McDevitt

yelled for him to come up to the control room quickly. Sgt. McDevitt went to cell 1OA-210 and called a Code Blue-Man down attempted Suicide.

28. When Sgt. McDevitt arrived on location, he witnessed Andrew Little hanging by his neck from a white cloth attached to the side rail in the middle of the top bunk.

29. Sgt. McDevitt stated that the cell door was inoperable from the Control room, so he proceeded to the main hallway to retrieve the cell key from Officer Kpadeyea.

30. Sgt.McDevitt reported back to cell 1OA-210. At this time, Sgt. McDevitt opened the cell door and found Andrew Little unresponsive, Sgt. McDevitt hoisted Andrew Little up on his shoulder until he was able to get the white cloth off of the bed rail and laid him on the ground, Sgt. McDevitt proceeded to remove the cloth from Andrew Little neck.

31. Sgt. McDevitt finally began CPR due to him not having a pulse. Sgt. McDevitt completed a round of chest compressions before medical staff arrived on the unit and took over. At this time, medical staff arrived on location and hooked Little up to AED machine.

32. PA. Margaret Griffith, R.N Marlow Outlaw, Sgt H. Guerrier, Sgt. McDevitt, and R.N Edward Harris took turns doing chest compressions until Concordville EMS arrived on location and took over compressions.

33. At 1348hrs Paramedic Francis Smiley pronounced Incarcerated Person Andrew Little deceased per Medical Doctor Yo of Crozer Chester Medical Center. Paramedic Smiley notified Delaware County Medical Examiner Office of the death at 1350hrs.

PREVALENCE OF INMATE SUICIDES AND ATTEMPTED SUICIDES

34. Unfortunately, Little's suicide was far from an isolated incident.

35. Although statistics are unknown, Little was certainly not the only suicide victim housed at Delco Prison (and most certainly not the only suicide victim housed in a prison serviced

by Wellpath), let alone attempted suicide victim.

36. In February of 2019, WHYY.org published an article titled "81 Pa. county jail suicides in 4 years: A look at how jails report deaths". In addition to the 81 reported suicides between 2015 and 2018 in Pennsylvania county jails, (including that referenced above at Delco Prison), there were a staggering 715 suicide attempts during the same 4 year period. The article cited to a 2015 report from The Marshall Project titled "Why Jails Have More Suicides than Prisons", proffering that those confined in jails have a higher rate of mental illness and that a jail's intake protocols are not under the same microscope as in state prisons.

37. The widespread prison suicide problem, far beyond just Delco Prison, has been well publicized for years now. In a February 20, 2020 Philadelphia Inquirer article titled Pennsylvania prison suicides are at an all-time high. Families blame 'reprehensible' medical- health care, Christine Tartaro, a professor of criminal justice at Stockton University, is quoted as saying: "Suicide is very preventable in prison and jail systems…Increases in institutional suicides are often tied to insufficient psychiatric screening and inadequate mental-health staffing levels".

38. At the Delco Prison, they had at least 6 suicides by inmates in the years leading up to Little's death.

PATTERN AND PRACTICE OF CONSTITUTIONALLY DEPRIVING PRISONERS WITH SERIOUS MENTAL ILLNESS

39. Long before the County and Wellpath allowed Little to end his life in their custody, they were well aware of their failures to appropriately treat numerous prisoners like Little suffering from mental illness and substance abuse.

40. In fact, several of the above-refenced non-Little incidents culminated in lawsuits against the County, Wellpath, and their representatives.

41. In addition to alleging deliberate indifference and medical negligence, prior lawsuits brought Monell based claims (e.g. failure to train, supervise, and maintain policies).

42. In addition to these publicly filed lawsuits, Defendant Wellpath's unconstitutional patterns and practices have been the subject of numerous news articles.

43. For example, in an April 8, 2015 article from MintPress News titled Did Prison Contractor Wellpath Cause Pennsylvania Inmate Deaths?, two particular lawsuits involving Lehigh County deaths were discussed. Notably, the article stated: "The stories outlined in these complaints line up perfectly with those coming out of other jails that have outsourced their medical care to companies like Wellpath and other private inmate medical contractors, across the country. In almost every case, an individual's most basic health needs are unarguably unmet as their condition visibly deteriorates. Many times the complaints involve shocking stories of

44. negligent or malicious behavior on behalf of medical staff who probably should have never been working there in the first place. It is at that point only — the point of no return for far too many inmates — that the private medical company finally springs into action, sending the inmate off to emergency rooms where many die or go on to suffer from lifelong injury."

45. A December 13, 2021 article published by Pennlive.com, focusing on Wellpath, stated that it was a named defendant in 18 federal lawsuits filed in Pennsylvania in 2021 alone. The article quoted Alexandra Morgan-Kurtz, managing attorney for the nonprofit Pennsylvania Institutional Law Project, as labeling healthcare in county jails "pretty abysmal". According to Morgan-Kurtz, for-profit companies like Wellpath under flat fee contracts with the counties have "significant financial incentives to not provide robust medical care" – the more services provided the less profits made. The article also cited a 2020 analysis by Reuters, finding that county jails relying on private medical providers like Wellpath had a higher death rate than those that used

public providers.

46. Despite numerous and repeated inmate suicides and suicide attempts over the years, the County and Wellpath failed to create, implement and/or enforce the necessary policies and customs and adequate staffing to protect civil rights of Delco Prison prisoners, thereby establishing a custom of violating civil rights of those within their custody and control.

47. The County failed to adhere to the Mission Statement stated on its website: The mission of the Delaware County Prison is to ensure the public, as well as the correctional staff, a safe environment that provides detention, rehabilitative, recidivism risk reduction, and re-entry services to those who are incarcerated so that they may live in a clean, humane, and secure environment and re-enter the community as a productive citizen and Wellpath failed to adhere to its Vision Statement: "Wellpath LLC is committed to managing and reducing risk in correctional healthcare by providing cost-effective quality healthcare management, continuously improving the standards of care, and striving for national accreditation for all facilities. Dedicated to correctional healthcare, Wellpath Medical prides itself on our strong client relationships, effective and efficient management of healthcare services. These attributes continue to be the hallmark of our success."

48. Egregious and rampant failures on the part of the Officer Defendants and the Medical Defendants led to Little's tragic and preventable suicide.

49. Plaintiff now seeks recovery from all Defendants for the catastrophic and fatal injuries, damages, and economic losses suffered by Little and his parents, as more fully described below.

FIRST CAUSE OF ACTION –
WRONGFUL DEATH PLAINTIFF V. DEFENDANTS

50. Plaintiff incorporates all preceding paragraphs as if set forth more fully herein.

51. Plaintiff is the legal representative of the Estate of Andrew Little.

52. Plaintiff brings this action by virtue of 42 Pa. C.S.A. §8301 and Pennsylvania Rule of Civil Procedure 2202 and claims all benefits of the Wrongful Death Act on behalf of herself and all other persons entitled to recover under the law, including Andrew Little's Mother and Father.

53. By reason of Little's tragic death, his Administratrix and/or his beneficiaries have suffered pecuniary losses and seek recovery of all medical, funeral, and administration expenses incurred as well as lost support, comfort, society, companionship, guidance, solace, protection and other services Little would have provided during his lifetime.

WHEREFORE, Plaintiff demands judgment in her favor and against Defendants, jointly and severally, for wrongful death and survival damages, compensatory and punitive damages in an amount in excess of One-Hundred and Fifty Thousand Dollars ($150,000.00), plus interest, costs, attorney's fees and such other relief as the Court deems just and proper.

SECOND CAUSE OF ACTION –
SURVIVAL ACTION PLAINTIFF V. DEFENDANTS

54. Plaintiff incorporates all preceding paragraphs as if set forth more fully herein.

55. Plaintiff brings this action on behalf of the Estate of Andrew Little by virtue of 42 Pa. C.S.A. §8302 and claims all benefits of the Survival Act on behalf of herself and all other persons entitled to recover under the law, including Andrew Little's mother and father.

56. Plaintiff claims on behalf of Little all damages suffered, including, but not limited to, significant conscious pain and suffering, catastrophic and fatal physical injuries and mental anguish, great fright, scarring, disfigurement, embarrassment, humiliation, loss of ability to enjoy life's pleasures, as well as the loss of future earning capacity from June 4, 2022 onwards.

WHEREFORE, Plaintiff demands judgment in her favor and against Defendants, jointly and severally, for wrongful death and survival damages, compensatory and punitive damages in

an amount in excess of One-Hundred and Fifty Thousand Dollars ($150,000.00), plus interest, costs, attorney's fees and such other relief as the Court deems just and proper.

COUNT I - VIOLATION OF CIVIL RIGHTS
(8th and 14TH AMENDMENT) PLAINTIFF v. DEFENDANTS

57. Plaintiff incorporates all preceding paragraphs as if set forth more fully herein.

58. At all relevant times, Defendants, acting under color of law, were deliberately indifferent to Little's serious medical needs in violation of the Eighth and Fourteenth Amendment's ban on cruel and unusual punishment.

59. In particular, Defendants were deliberately and recklessly indifferent to Little's vulnerability to suicide, which they each knew or should have known about on or before June 4, 2022.

60. For months, Defendants possessed actual knowledge of Little's failed suicide attempt -- at Delco Prison, serious mental illness, repeated and depression -- all of which amounted to telltale suicide risks.

61. Despite such knowledge, Defendants ignored, if not exacerbated, Little's obvious suicidal propensities and failed to take necessary and available precautions which would have saved his life, such as housing him in the appropriate observation unit and/or with a cellmate; providing the appropriate diagnoses and treatments, including medications, counseling, and trained medical and mental health professionals including a Psychiatrist; obtaining and reviewing their own prison and medical records from Little's April 2021 detainment; ensuring that he was observed at all times or at least at regular intervals; accurately documenting such observations; properly assessing his suicide risk; denying him a means to commit suicide (i.e. placing him alone in a cell with a bedsheet and an elevated bedframe); and rendering aid immediately and emergently once Little started hanging.

62. At a minimum, Defendants were duty bound to follow well-established suicide prevention standards and guidelines, the collective purpose of which was to protect and enhance the mental health of inmates such as Little.

63. The 2014 Standards for Health Services in Jails and 2015 Standards for Mental Health Services for Correctional Facilities, promulgated by the National Commission on Correctional Health Care, contain a **SUICIDE PREVENTION PROGRAM** (Section J-G-05 and Section MH-G-04, respectively). The Program established, *inter alia*:

- Nonacutely suicidal inmates should be placed on suicide precautions and observed at staggered intervals not to exceed every 15 minutes (e.g. 5, 10, 7 minutes), with unpredictable, documented supervision maintained;
- Patients are reassessed regularly to identify any change in condition indicating a need for a change in supervision level or required transfer or commitment. The evaluation includes procedures for periodic follow-up assessment after the
- individual's discharge from suicide precautions;

- Treatment strategies and services to address the underlying reasons (e.g. depression) for the inmate's suicidal ideation are to be considered, including treatment when the inmate is at heightened risk as well as follow-up interventions and monitoring to reduce the likelihood of relapse;

- Procedures for communication between mental health care, health care, and correctional personnel regarding inmate status are in place to provide clear and current information; and

- Housing. Unless constant supervision is maintained, a suicidal inmate is not isolated but is housed in the general population, mental health unit, or medical infirmary, and located in close proximity to staff. All cells or rooms housing suicidal inmates are as suicide-resistant as possible (e.g., without protrusions of any kind that would enable hanging).

64. In addition, the 2015 Standard contained Section MH-E-09 **CONTINUITY AND COORDINATION OF MENTAL HEALTH CARE DURING INCARCERATION**, mandating that all aspects of an inmate's mental health care are coordinated and monitored throughout the inmate's incarceration, in accordance with written policy and defined procedures.

In relevant part, the Standard stated:

When an inmate returns from a psychiatric hospitalization, urgent care, or emergency department visit that pertains to mental health, a mental health professional sees the patient, reviews the discharge orders, and issues follow-up orders as clinically indicated.
…
When delays or long wait times for specialty appointments occur, mental health staff should take intermediate care measures (e.g. placement in an observation cell) to monitor the inmate's mental status while waiting for these appointments.

65. Defendants' failure to treat, monitor, and address Little's legitimate and serious medical needs transcended contemporary standards of decency, are shocking to the conscience of mankind, and violated his Fourteenth Amendment right to be free from cruel and unusual punishment.

66. Defendants' unreasonable, egregious, malicious, willful, and intentional acts and omissions constitute a deliberate indifference and callous disregard for Little's life, safety, and well-being.

67. As a direct and proximate result of Defendants' unlawful and unconstitutional behavior, Little suffered serious bodily harm and death, and Little and his parents suffered other catastrophic damages as set forth below.

WHEREFORE, Plaintiff demands judgment in her favor and against Defendants, jointly and severally, for wrongful death and survival damages, compensatory and punitive damages in an amount in excess of One-Hundred and Fifty Thousand Dollars ($150,000.00), plus interest, costs, attorney's fees and such other relief as the Court deems just and proper.

COUNT II - VIOLATION OF CIVIL RIGHTS (*MONELL* CLAIMS) PLAINTIFF v. THE COUNTY AND WELLPATH

68. Plaintiff incorporates all preceding paragraphs as if set forth more fully herein.

69. The violations of Little's constitutional rights as set forth above were directly and proximately caused by the deliberate indifference of the County and Wellpath to the need for

hiring, training, supervision, investigation, monitoring, and/or discipline with respect to the provision of specialized medical care to inmates such as Little, under their custody and control.

70. The violations of Little's constitutional rights as set forth above were directly and proximately caused by the encouragement, tolerance, ratification of, and deliberate indifference of the County and its private mental health provider to the policies and practices of their agents and employees of refusing, delaying, interfering with, or negligently providing timely and appropriate medical care and treatment to those in special need like Little.

71. The violations of Little's constitutional rights as set forth above were directly and proximately caused by the abject failure of the County and its private mental health provider, with deliberate indifference, to develop, implement, update, and/or enforce policies and practices to ensure that inmates like Little received timely, necessary, and appropriate medical care for serious mental illness and critical life-saving measures.

72. On and well before June 4, 2022, the County and its private mental health provider knew or certainly should have known of the need to improve and correct failed hiring, training, supervision, investigation, monitoring, discipline, policies, and practices by virtue of, inter alia, a laundry list of other suicides and suicide attempts, published statistics and news articles, and other similar lawsuits, alleged above.

73. The above-referenced failures proximately caused Little's serious bodily injuries and death in that they directly and in natural and continuous sequence produced, contributed substantially or enhanced such injuries and death.

74. The aforementioned acts and/or omissions constitute willful and wanton misconduct in disregard of the rights, health, well-being, and safety of Little, to his detriment and that of his daughters.

WHEREFORE, Plaintiff demands judgment in her favor and against Defendants, jointly and severally, for wrongful death and survival damages, compensatory and punitive damages in an amount in excess of One-Hundred and Fifty Thousand Dollars ($150,000.00), plus interest, costs, attorney's fees and such other relief as the Court deems just and proper.

COUNT III – MEDICAL NEGLIGENCE (STATE LAW)
PLAINTIFF v. MEDICAL DEFENDANTS

75. Plaintiff incorporates all preceding paragraphs as if set forth more fully herein.

76. At all relevant times, the Medical Defendants were, upon information and belief, licensed to practice medicine in the Commonwealth of Pennsylvania, and had a duty to comply with generally accepted medical and mental health standards of care in their medical treatment of Little.

77. The Medical Defendants violated their duty of care to Little and were careless, negligent, and reckless in the following respects:

a. Failure to timely and accurately recognize, diagnose, and treat Little's medical condition, including serious mental illness;

b. Failure to timely and accurately diagnose Little's behavior as suicidal and not just self-serving;

c. Failure to perform a structured suicide risk assessment and reassessment on a timely and accurate basis;

d. Failure to implement and maintain an intense and appropriate treatment plan to minimize the risk of suicide;

e. Failure to render proper and timely treatment and care to Little, including on an emergency/stat basis as required under the circumstances;

f. Failure to obtain timely and appropriate consultation from specialists, including psychiatrists and psychologists;

g. Failure to timely and appropriately prescribe and administer necessary medications;

h. Failure to provide appropriate and effective detox treatment to address Little's drug addictions and withdrawal;

i. Failure to provide necessary medical information to Little about the care he required and providing incomplete and incorrect information to him regarding his care;

j. Failure to provide necessary, complete, and correct medical information to other medical professionals caring for Little about the care he required and/or was provided;

k. Failure to timely appreciate the grave danger he was in and take seriously his prior and recent incidents of mental health treatment at the Delco Prison;

l. Failure to timely appreciate Little's changes in mental status, mood swings, and sleeplessness;

m. Failure to house Little in the appropriate housing unit and/or with a cellmate, which was critical to saving his life;

n. Failure to ensure that Little was placed on Suicide Watch and/or Psychiatric Observation and properly observed at documented, regular intervals, per standards, guidelines, and orders;

o. Failure to ensure that Little was not provided with the means to hang himself – a bedsheet and elevated bedframe readily accessible while in his cell alone;

p. Failure to prevent Little from firmly attaching his bedsheet to the top of the bedframe, and creating a noose;

q. Failure to timely and appropriately respond by immediately initiating a Code Blue when Little was hanging in his cell;

r. Failure to ensure that Little possessed an anti-suicide smock and blanket at all relevant times;

s. Failure to ensure that others, including supervisors, were timely and appropriately notified when Little had access to the means of suicide;

t. Failure to timely obtain and review Little's prior prison and mental health records from his prior detainments;

u. Failure to follow appropriate suicide related training and policies; and

v. Entrusting Little's care to individual(s) who it should have known would perform his/her/their duties in a negligent and/or reckless manner.

78. The Medical Defendants' violation of their duty of care, in reckless and wanton disregard for Little's safety and well-being, increased the risk of harm to Little and was a direct and proximate cause and substantial factor in bringing about Little's serious bodily injuries and death.

79. To the extent that the individual Medical Defendants were acting as employees, agents and/or ostensible agents of Wellpath, acting within the scope and course of their employment, agency, and/or ostensible agency, Wellpath is vicariously liable to Plaintiff.

WHEREFORE, Plaintiff demands judgment in her favor and against Defendants, jointly and severally, for wrongful death and survival damages, compensatory and punitive damages in an amount in excess of One-Hundred and Fifty Thousand Dollars ($150,000.00), plus interest, costs, attorney's fees and such other relief as the Court deems just and proper.

COUNT IIV—-NEGLIGENCE - VICARIOUS LIABILITY
Plaintiff v. Defendant GEO

80. The previous paragraphs are incorporated herein by reference as if set forth in full.

81. The negligence of GEO by and through its agents, servants, and/or employees, with the course and scope of their agency and employment at George W. Hill Correctional Facility,

after reasonable investigation consists of the following:

a. negligently and recklessly failing to respond to Little' window being covered;

b. negligently and recklessly failing to perform rounds;

c. Failure to perform a structured suicide risk assessment and reassessment on a timely and accurate basis;

d. Failure to implement and maintain an intense and appropriate treatment plan to minimize the risk of suicide;

e. Failure to adequately staff the Delco Prison;

f. Failure to obtain timely and appropriate consultation from specialists, including psychiatrists and psychologists;

g. Failure to timely appreciate the grave danger he was in and take seriously his prior and recent incidents of mental health treatment at the Delco Prison;

h. Failure to timely appreciate Little's changes in mental status, mood swings, and sleeplessness;

i. Failure to house Little in the appropriate housing unit and/or with a cellmate, which was critical to saving his life;

j. Failure to ensure that Little was placed on Suicide Watch and/or Psychiatric Observation and properly observed at documented, regular intervals, per standards, guidelines, and orders;

k. Failure to ensure that Little was not provided with the means to hang himself – a bedsheet and elevated bedframe readily accessible while in his cell alone;

l. Failure to prevent Little from firmly attaching his bedsheet to the top of the bedframe, and creating a noose;

m. Failure to timely and appropriately respond by immediately initiating a Code Blue when Little was hanging in his cell;

n. Failure to ensure that Little possessed an anti-suicide smock and blanket at all relevant times;

o. Failure to ensure that others, including supervisors, were timely and appropriately notified when Little had access to the means of suicide;

p. Failure to timely obtain and review Little's prior prison and mental health records from his prior detainments;

q. Failure to follow appropriate suicide-related training and policies; and

r. Entrusting Little's care to individual(s) who it should have known would perform his/her/their duties in a negligent and/or reckless manner.

s. negligently and recklessly failing to supervise inmates, including Little;

t. negligently and recklessly failing to check on Little' well-being on June 4, 2022;

u. negligently and recklessly leaving the unit without checking on Little;

v. negligently and recklessly failing to lay eyes on Little before.

WHEREFORE, Plaintiff demands judgment in her favor and against Defendants, jointly and severally, for wrongful death and survival damages, compensatory and punitive damages in an amount in excess of One-Hundred and Fifty Thousand Dollars ($150,000.00), plus interest, costs, attorney's fees and such other relief as the Court deems just and proper.

DEMAND FOR JURY TRIAL

In accordance with the Federal Rules of Civil Procedure, Plaintiff demands a trial by jury as to all counts and issues raised herein.

LAMB McERLANE PC

Date: May 31, 2024 By: Jake D. Becker

Dawson R. Muth
Jake D. Becker
24 E. Market Street, P.O. Box 565
West Chester, PA 19381-0565
(610) 430-8000
Attorneys for Plaintiff

VERIFICATION

I make this verification subject to the penalties of 18 Pa.C.S.A. §4904, relating to unsworn falsification to authorities. The attached Plaintiff's Complaint is based upon information which I have furnished to my counsel and information which has been gathered by my counsel in preparation for instituting and prosecuting this lawsuit. The language contained in the attached Complaint is that of counsel and not of me. I have read the Complaint, and, to the extent that it is based upon information which I have given to my counsel, it is true and correct to the best of my knowledge, information and belief. To the extent that the contents of the Complaint constitute language of counsel, I have relied upon counsel in making this verification.

Janet Little Owens

Signature

JANET LITTLE OWENS

Print Name

Date: 5/30/24