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.,	)	**Case No.**
PLAINTIFF,	)	**COMPLAINT FOR VIOLATIONS OF THE CIVIL RIGHTS ACT OF 1871, 42 U.S.C. § 1983, and THE AMERICANS WITH DISABILITIES ACT OF 1990**
v.	)	
SHERIFF FLOYD BONNER, Jr., in his individual capacity; CHIEF JAILER KIRK FIELDS, in his individual capacity; and the GOVERNMENT OF SHELBY COUNTY, TENNESSEE,	)	**JURY TRIAL DEMANDED PURSUANT TO FED. R. CIV. PRO. 38(a) & (b)**
DEFENDANTS.	)	

COMPLAINT

TO THE HONORABLE DISTRICT COURT JUDGE:

Plaintiff Nicole Freeman, by and through her designated attorneys, for her 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 under 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 under 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 Right 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 include those that Plaintiff alleges below resulted in the brutalization and death of Mr.

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[2] *Id.* at 6.

[3] **Exhibit B**.

[4] *See id.* at 4.

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 things, 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 previously served

as a correctional officer in the Jail 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. 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 provided to them by the Davidson County District Attorney's Office (the "DCDAG"), which is investigating the incident for possible criminal charges. Concurrently with this pleading, Plaintiff moves for leave of this Court to file the camera-footage compilation as **Exhibit C** to this pleading and requests this Court to instruct

the Clerk's Office to accept custody of an electronic-storage device containing the compilation, to be delivered to the Clerk's Office by Plaintiff's counsel.

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 abnormal and uncharacteristic of him. His family suspected he was experiencing a mental-health crisis.

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. Upon information and belief, the Jail's perfunctory screening process failed to diagnose Mr. Freeman upon his arrival.

13. Sometime in the days following his arrival at the Jail, Jail staff transferred Mr. Freeman to the 4-Juliet cell pod, known also as the suicide pod, located on the fourth floor of the

Jail. Upon information and belief, this transfer required a determination by staff that Mr. Freeman was experiencing a mental-health crisis and posed an imminent risk of self-harm.

14. In the suicide pod, Jail staff put Mr. Freeman in a cell, naked and alone, with only a paper-like orange "tarp" to use for warmth.

15. 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."

16. Sometime prior to evening tray time on October 5, 2022, Mr. Freeman started to exhibit symptoms of active psychosis. Upon information and belief, the psychosis was a symptom of the psychiatric or psychological problems then afflicting him.

17. Come evening tray time, two correctional deputies entered the 4-Juliet pod. One carried a stack of trays. The other sauntered ahead of him, shaking a can of mace.[5]

18. Because many of the individuals in 4-Juliet pod suffer from severe mental health disorders and therefore pose a greater than average proneness to erratic behavior, Jail policy requires guards to feed the 4-Juliet inmates 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.

19. When the deputies reached Mr. Freeman's cell, in violation of policy and without good reason, but just as they had for the other cells in 4-Juliet, the deputies directed a third staff member, 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.[6]

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[5] **Ex. C** 00:00–40.

[6] 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

20. Holding up his orange tarp to shield himself from the deputy's mace, Mr. Freeman attempted to bat away the mace can in the deputy's hand.[7] 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.

21. As Mr. Freeman reached for the mace in the first deputy's hand, the second deputy stepped toward Mr. Freeman and struck him with an overhand "haymaker" punch, knocking Mr. Freeman to the floor.

22. 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.[8]

23. Watching the above unfold, the door operator, 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 could have called Jail medical staff immediately because the two correctional deputies had just maced Mr. Freeman and were actively beating him, 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. The door operator then beat Mr. Freeman with the metal cannister of mace.[9]

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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 subdue 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.

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

[8] *Id.* at 00:40–49.

[9] *Id.* at 00:50–58.

24. 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.

25. 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.[10]

26. A male Blackshirt fashioned handcuffs on his fist and struck Mr. Freeman no fewer than three (3) times with these makeshift brass knuckles.[11] Jail staff has a history of using handcuffs as striking implements.

27. 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.

28. 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, someone wearing a SCSO supervisor's shirt and tie grabbed Mr. Freeman and slammed him to the floor.[12]

[10] *Id.* at 00:50–51.

[11] *Id.* at 1:00–03.

[12] *Id.* at 2:46–56.

29. As Mr. Freeman lay on the floor, other Jail staff kicked him and doused him in more chemical irritant. Here again, Jail staff sprayed so much chemical irritant that it formed a pool on the floor.[13]

30. 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.

31. After Mr. Freeman reached the fifth floor, several deputies, who had followed him up the escalator, cornered him upstairs. They punched, kicked, and slammed Mr. Freeman to the floor once again.[14]

32. 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.

33. Deputies held Mr. Freeman in the facedown position for over five minutes, kneeling on his back, neck, and head.[15] At some point, Mr. Freeman stopped breathing.

34. Upon information and belief, Jail staff knew Mr. Freeman had stopped breathing by the time they lifted his limp body from the floor to reveal a pool of blood underneath his head.[16]

35. Although Jail staff must have known Mr. Freeman had stopped breathing when they lifted his limp and motionless body, they made no attempt to resuscitate him in the nearly three (3) minutes before medical staff arrived.

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[13] *Id.* at 4:05–15.

[14] *Id.* at 4:50 – 5:10.

[15] *Id.* at 05:00 – 10:20.

[16] *Id.* at 10:23–10:28.

36. 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 lifeless form, glancing down as he passed.[17] Not a single corrections officer attempted to initiate CPR.

B. *No Accountability*

37. 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.

38. 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.

39. 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.

40. In response to the release of the jail-camera footage by the Davidson County District Attorney General's office (the "DCDAG"),[18] Sheriff Bonner criticized the DCDAG for its transparency, falsely accused the DCDAG of releasing the video "out of context," and announced

[17] *Id.* at 11:13–23.

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

he would refrain "from taking further administrative action" against any SCSO employees involved, pending the outside criminal investigation.[19]

41. Upon information and belief, Sheriff Bonner had not taken any administrative action prior to the statement above; by saying he would refrain from taking *further* action, Sheriff Bonner meant he would refrain from taking *any* action. His inaction means that Jail staff currently under criminal investigation by the DCDAG are still working in the Jail, where they have authority and control of potential witnesses. Thus, Sheriff Bonner has not merely ratified his subordinates' actions. His inaction threatens the integrity of the criminal investigation.

42. 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 Jail, as discussed below.

C. *Pattern and History of Jail Problems*

43. 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.

44. The fact that at least fourteen (14) correctional officers committed the violent acts described above in front of one another, with no fear of punishment or lowering of esteem, *by itself* reveals a custom of tolerance to the use of excessive force against prisoners.

[19] Lucas Finton, *Surveillance footage from jail shows officers kneeling on inmate's back for almost six minutes*, THE COMMERCIAL APPEAL (March 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 March 3, 2023, 6:28 AM).

45. 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.[20] Only one (1) of these resulted in a Jail staff member's termination.[21] The County chose not to terminate its employees involved in the other incidents, despite their criminal conduct.[22]

46. Sheriff Bonner has actively resisted the implementation of policies intended to curb the use of excessive force within the SCSO. He testified before the County's legislative body in opposition to a proposed ordinance that would have implemented a tracking system for excessive-force incidents, disqualified SCSO applicants for excessive-force violations in prior employment, and mandated revocation of certain law-enforcement certifications of officers disciplined for excessive force.

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

48. 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

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

[21] 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.

[22] **Ex. D**.

to incidents of excessive force in the Jail. Almost by definition, willful blindness *to* excessive force permits the continued use *of* excessive force.[23]

49. 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.

50. 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.

51. The Jail saw eight (8) prisoner deaths between January 1, 2022 and October 5, 2022, not including Mr. Freeman.[24] 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.

52. 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.

[23] Plaintiff's counsel ultimately obtained evidence of the instances of substantiated excessive force through discovery in a case remarkably similar to this instance.

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

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.

53. The allegations above show that the SCSO has entirely failed to adequately train Jail staff at all levels that, *inter alia*:

> (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).

54. 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.

55. 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

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

57. The Defendants, acting under color of state law, violated the rights of Mr. Freeman secured by the Fourth, Eighth, and Fourteenth Amendments.

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

58. 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.

59. 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.

60. 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 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;

(g) 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;

(h) 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;

(i) 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

(j) 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.

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

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

63. 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.

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

B. *Count 2 - Supervisory Liability under 42 U.S.C. § 1983 (Against Sheriff Bonner)*

65. 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.

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

67. 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 prisoners;

(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 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;

(g) 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

(h) 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.

68. 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.

69. 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 and mental-health and other medical protocols.

70. 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.

71. 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.

72. 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 3 - Supervisory Liability under 42 U.S.C. § 1983 (Against Chief Fields)*

73. 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.

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

75. 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 prisoners;

(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 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;

(g) 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

(h) 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.

76. 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.

77. 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' rights. This level and degree of ignorance demonstrates that Chief Fields failed to properly train or supervise subordinate Jail staff regarding use of force and mental-health and other medical protocols.

78. 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.

79. 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.

80. 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.

D. *Count 4 – Violation of the Americans with Disabilities Act (Against the County)*

81. "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)).

82. 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.

83. 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.

84. 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).

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

86. 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).

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

88. 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.

89. 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.

90. Further, 4-Juliet pod was supervised by senior deputies with authority to provide reasonable modifications that would accommodate Mr. Freeman's disability or otherwise remedy practices that violated the ADA.

91. 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.

92. 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.

93. 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.

94. 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).

VI.

PENDANT CAUSES OF ACTION

95. Plaintiff incorporates, re-alleges, and reiterates the allegations in Paragraphs 1-94 as if set forth verbatim under this count.

96. 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):

97. 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

98. Plaintiff incorporates, re-alleges, and reiterates the allegations above as if set forth verbatim under this count.

99. 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.

100. 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.

101. Plaintiff and her minor child have suffered and will continue to suffer economic loss and have otherwise been emotionally and economically injured.

102. Plaintiff's injuries and damages are permanent and will continue into the future. 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. Permit Plaintiff leave to amend this Complaint after reasonable discovery;

B. Empanel a jury to try this matter;

C. Award Plaintiff compensatory damages in an amount to be determined according to the proof;

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

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

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

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

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

Dated April 4, 2023.

Respectfully submitted,

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