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2312 CHICHESTER AVENUE
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ATTY I.D. No. 64645

✓ JESSICA BRYANT, Administratrix of the :
✓ Estate of her father, Thomas Bryant, deceased :
1009 ANDERSON AVENUE :
MARCUS HOOK, PA 19061 :
Plaintiff

vs.

✓ THE GEO GROUP, INC. ✓
1 PARK PLACE
621 N.W. 53RD STREET, SUITE 700
BOCA RATON, FL 33487

and

✓ RONALD NARDOLILLO ✓
4165 HODGSON CIRCLE
WEST GROVE, PA 19390-1380

and

✓ MICHAEL MOORE ✓
C/O GEORGE W. HILL CORRECTIONAL
FACILITY
500 CHEYNEY ROAD
THORNTON, PA 19373

And

✓ CORRECTIONAL OFFICER T. HAMMETT ✓
C/O GEORGE W. HILL CORRECTIONAL
FACILITY
500 CHEYNEY ROAD
THORNTON, PA 19373

ATTORNEYS FOR PLAINTIFF

COURT OF COMMON PLEAS

DELAWARE COUNTY

NO.:

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Set

And

✓
CONNIE DANLEY
C/O GEORGE W. HILL CORRECTIONAL
FACILITY
500 CHEYNEY ROAD
THORNTON, PA 19373

09-07-10

And

✓
WILLIAM PURNER, M.D.
1088 WEST BALTIMORE PIKE
APT. 3311
MEDIA, PA 19063-5146
And
283 STANTON COURT
GLEN MILLS, PA 19342-2032

FILED
2009 JUN -5 AM 11:21
OFFICE OF THE
JUDICIAL SUPPORT
DELAWARE COUNTY, PA

And

JANE DOE ✓

✓
JOHN DOE PRIVATE EMPLOYEES OF
THE GEO GROUP'S MEDICAL STAFF AT
THE GEORGE W. HILL CORRECTIONAL
FACILITY, INCLUDING NURSES,
PHYSICIAN'S ASSISTANTS, PHYSICIANS,
PSYCHOLOGISTS AND OTHER MEDICAL
PROVIDERS RESPONSIBLE FOR MEDICAL
CARE GIVEN AT THE GEORGE W. HILL
CORRECTIONAL FACILITY TO
DECEASED, THOMAS BRYANT, DURING
HIS CONFINEMENT OF NOVEMBER 13,
2007 THROUGH NOVEMBER 16, 2007-
500 CHEYNEY ROAD
THORNTON, PA 19373

Defendants

COMPLAINT

1. Jessica the adult daughter of decedent Thomas Bryant, having been duly appointed as the Administratrix of his Estate on May 11, 2009.
2. Defendant The GEO Group, Inc. (hereinafter "GEO") is a private business entity and Florida Corporation who at all times material hereto did business in the Commonwealth of Pennsylvania with its principal Pennsylvania place of business at the George W. Hill

Correctional Facility (hereinafter "GWHCF") on Cheney Road in Thornton, Delaware County, Pennsylvania. The defendant GEO maintains its corporate offices at 1 Park Place, 621 N.W. 53rd Street, Suite 700, Boca Raton, FL 33487.

3. At all times pertinent and material hereto, defendant GEO operated and managed the GWHCF pursuant to a contract with Delaware County, and as a part of the management contract for that Delaware County prison, GEO agreed to provide health care, suicide screening and precautions, and mental health services to inmates at that correctional facility, and GEO agreed to provide appropriate medical and mental health screening, assessment and training, including any and all appropriate precautions and treatment for drug detoxification of opiate-dependent individuals, and appropriate suicide screening assessment and precautions and psychological and psychiatric treatment and substance abuse counseling associated therewith.

4. Upon information and belief defendants Ronald Nardolillo, Michael Moore, Correctional Officer T. Hammett, Connie Danley, and Michael Purner, M.D. were all employees of GEO working at the GWHCF in November of 2007, and all of their actions were in the course and scope of their employment with defendant GEO. Upon information and belief those individual defendants are Pennsylvania residents with last known addresses as set forth above in the Complaint.

5. On or around November 13, 2007 Thomas Bryant was committed to the GWHCF and into the custody, care and control of GEO, at which time Ronald Nardolillo was the warden of that prison hired by GEO; Michael Moore was GEO's classification counselor; T. Hammett was a correctional officer responsible for timely checks on Mr. Bryant's cell; Connie Danley was the acting Health Services Administrator; and Michael Purner, M.D. was the acting Medical Director.

6. In addition to the above, the John Doe individuals are alleged to have been Pennsylvania residents and part of the GEO medical staff responsible for treatment and care to Thomas Bryant, including nurses, physicians assistants, doctors, psychiatrists, physicians, or other medical providers whose identities can not be determined from the medical chart or prison records produced to date, but all of whom are believed to have been employees of GEO at the GWHCF responsible for providing medical treatment and care including suicide prevention assessment and precautions, and drug detoxification and substance abuse treatment.

7. All defendants (hereinafter GEO defendants) were responsible for the medical healthcare, including psychiatric care of Thomas Bryant while in their custody and control, yet they failed to exercise reasonable diligence and care, while breaching the standards of medical care to an opiate-dependent inmate, as more fully set forth below.

8. Around 9:50 P.M. on the evening of November 13, 2007, Thomas Bryant was committed to the custody and care of GEO defendants at the GWHCF in Thornton, Pennsylvania and initially placed by them in the orientation dormitory.

9. Documents provided by defendants indicate that on or about 3:15 A.M. of November 14, 2007, Thomas Bryant underwent a mental health screening and health services physical examination at which point his opiate dependency and narcotic dependence was made known to defendants, but no psychiatric consultation or drug abuse treatment was prescribed by defendants.

10. During his confinement Thomas Bryant began to manifest signs and symptoms of drug withdrawal and he requested medical treatment from defendants, complaining, inter alia, of inability to sleep or eat for three days, nausea, cold sweats, and unbearable pain, but his complaints went ignored, and defendants failed to treat him for drug withdrawal or substance

abuse-related issues and failed to have him examined by an appropriate psychiatric expert for purposes of determining the level of his suicide ideation related to these withdrawal symptoms.

11. Not only was decedent's opiate dependency and narcotic dependence known to defendants, from his physical symptoms it was known or should have been known to them that he was in the midst of serious withdrawal symptoms and required appropriate medical treatment, care and suicide precautions during the withdrawal, with appropriate detoxification therapy, mental health assessment, suicide precautions and watch, and other related medical and mental health care treatment.

12. On or about November 15, 2007 decedent again asked defendants for treatment for substance abuse which was ignored and/or denied, and upon information and belief he was taken off of initial commitment fifteen minute checks, despite the continuing withdrawal symptoms that he was manifesting and the suicide risks related thereto.

13. After refusing and/or unreasonably failing to provide Thomas Bryant with requested necessary medical treatment for drug withdrawal and mental health treatment and suicide prevention related thereto, on November 16th defendants including Correctional Officer T. Hammett, removed his cellmate Michael Gunning from his cell, and allowed Thomas Bryant to remain alone and unobserved in his cell with linens and clothing issued by defendants that could be tied to anchor points in the cell for suicide by hanging, and while ignoring his obvious mental distress and medical distress and need for immediate medical treatment.

14. Decedent's cellmate, Michael Gunning, advised the prison authorities of these apparent signs and manifestations of drug withdrawal and the fact that his cellmate was unable to eat, was exhausted, and sweating, while another inmate, Tom Blackman, has stated that it was known that decedent was "depressed."

15. Notwithstanding the above which should have been known to defendants, defendants allowed Thomas Bryant to remain alone and unobserved for a long and inappropriate period of time in a cell with anchor points and with linens that could be tied into a ligature device, despite the fact that "suicide-proof" linens and cells were available and despite the availability of correctional officers to observe him during the short period of time that his cellmate was absent from the cell.

16. Had defendants provided Thomas Bryant with the appropriate medical care for his opiate withdrawal, drug detoxification, and/or appropriate suicide screening and precautions for known risks related thereto, Thomas Bryant would have been unable to commit suicide.

17. After his cellmate left the cell on November 16th, Thomas Bryant hung himself with linens provided by defendants in a cell containing anchoring points sufficient to permit him to commit suicide by hanging, and he was discovered in his cell by Mr. Gunning around 11:47 A.M. on November 16th.

18. Defendant GEO had a long history of failure to provide appropriate medical care and mental health care to inmates at GWHCF, which led directly to a number of fatalities in that prison as follows:

- A. Suicide by hanging of John Focht on February 5, 2002;
- B. The death due to improper blood pressure medications given to Rosalind Atkinson on October 18, 2002;
- C. The death after a fist fight of Clyde Taylor on March 27, 2005;
- D. The death due to a heroin overdose of Brian Sullivan on April 15, 2005;
- E. The attempted suicide by hanging of an unidentified inmate who was resuscitated after a suicide attempt in July of 2005;

- F. The suicide by overdose of Kevin Parks of August 2, 2005;
- G. The suicide death in his cell of Michael Rafferty on August 18, 2005;
- H. The death of Vincent Burton in his cell on August 21, 2005;
- I. The death due to hyperthyroidism of Cassandra Sandy Morgan on March 29, 2006;
- J. The death of David Dewees of a seizure in October 2007.

19. In addition to those 9 prior deaths (3 by suicide), subsequent to the Bryant suicide on November 16, 2007, GEO continued to experience deaths due to its inadequate medical care including the April 25, 2008 death of Kenneth Keith Kallenbach who died of cystic fibrosis due to improper medical care and the October 28, 2008 death by suicide hanging of an unidentified 44 year old man from East Lansdowne, Pennsylvania.

20. During the five years that GEO was managing the GWHCF they averaged more than two deaths per year, including one suicide per year, yet they continued to fail and/or refused to provide inmates with necessary medical attention and care including mental health screening and suicide prevention precautions. Likewise, GEO has similar histories in other prisons they have managed in other states.

21. GEO's past history of failing to provide appropriate and necessary medical care was known to all defendants herein who turned a willfully blind eye to this careless and reckless conduct, allowing GEO to continue to breach its duties to provide appropriate health care to inmates such as Thomas Bryant.

22. Defendants knew or by the exercise of reasonable care should have known of decedent's particular vulnerability to suicide, particularly given his drug abuse history and opiate dependency and withdrawal, yet they failed to provide any suicide precautions such as suicide

linens, suicide observation cells, suicide guards or checks, and failed to provide appropriate psychiatric care and drug withdraw care to decedent Thomas Bryant. On the contrary, defendants provided Thomas Bryant with a bed sheet, clothing and linens that could be torn into a ligature device, and defendants left him alone and unobserved in a cell with anchoring points that would facilitate a suicide.

23. Defendants acted negligently and with reckless indifference to the rights of decedent by:

- A. Failing to provide him with appropriate suicide precautions;
- B. Failing to provide appropriate suicide checks and placement in a psychiatric observation cell;
- C. Failing to provide appropriate guard observation, particularly when being left alone without a cellmate;
- D. Failing to provide appropriate medical treatment and care for drug dependency, opiate withdrawal, and substance abuse;
- E. Failing to appropriately assess and diagnose decedent's medical needs and mental health needs;
- F. Failing to provide appropriate psychological counseling or psychiatric consultations and care;
- G. Failing to provide appropriate treatment for drug detoxification and withdrawal;
- H. Leaving decedent unattended and unwatched for periods of time with linens that could be used for a suicidal hanging in an unguarded cell with anchoring points during times of drug withdrawal;

- I. Failing to use available audio and video monitoring systems;
- J. Failing to provide appropriate medical care and mental health care and appropriate psychiatric screening of suicide risk, in violation of the medical standards of care for treating an opiate-dependent individual undergoing drug withdrawal symptoms;
- K. Failing to move decedent to an appropriate hospital or otherwise getting him prompt medical evaluation, treatment and care.

24. Decedent's suicide was the direct and proximate result of the negligence and recklessness of the defendants and their failure to provide him with appropriate medical care and suicide preventions and precautions as set forth more fully above.

COUNT I-WRONGFUL DEATH

25. Plaintiff incorporates the preceding paragraphs of this pleading.

26. Jessica Bryant brings this action on behalf of the Estate of her deceased father, Thomas Bryant, as the Administratrix of his Estate.

27. As the result of the negligence and recklessness of defendants, Thomas Bryant committed suicide and his family has been deprived of his earnings, love, companionship and support and his wife has been deprived of his consortium and companionship.

28. Thomas Bryant did not bring any action during his lifetime for such damages nor has any other civil complaint for his death been filed against defendants.

29. Thomas Bryant brings this action under and by virtue of the Wrongful Death Act, 42 Pa. C.S.A. §8371 et. seq., for any and all losses suffered by the Estate and any and all survivors, including punitive damages, costs, fees and other relief as the court may deem proper.

WHEREFORE, Plaintiff demands judgment against Defendants in an amount in excess of \$50,000.

COUNT II- SURVIVAL ACTION

30. Plaintiff incorporates the preceding paragraphs of this pleading.

31. Plaintiff also brings this action on behalf of the Estate by virtue and under the act known as the "Pennsylvania Survival Act," 42 Pa. C.S.A. §8202 et. seq., 20 Pa. C.S.A. §3371 et. seq.

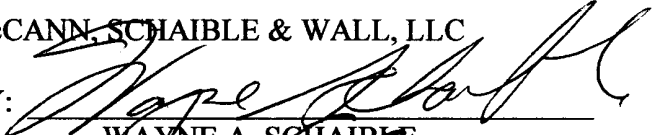
32. Plaintiff claims on behalf of the Estate of Thomas Bryant all losses set forth above and all losses personal to him during his lifetime and due to his death, including all damages for his pain and suffering, mental anguish, and damages for loss of past personal wages and benefits, loss of earning capacity, loss of future wages and benefits, and for the loss of life's pleasures.

33. As a result of the death of Thomas Bryant, his Estate has further been deprived of the economic value of decedent's life, and plaintiff claims damages for the pecuniary losses suffered by Thomas Bryant by reason of his death, including punitive damages.

WHEREFORE, Plaintiff demands judgment against the Defendants in an amount in excess of \$50,000, including punitive damages, costs, fees and any other relief that the Court may deem proper.

McCANN, SCHAIBLE & WALL, LLC

BY:


WAYNE A. SCHAIBLE
Counsel for Plaintiff

HEAVENS LAW OFFICES

BY:


CHRISTOPHER J. HEAVENS
Co-counsel for Plaintiff