COMMONWEALTH OF KENTUCKY
MADISON CIRCUIT COURT
CIVIL DIVISION
CASE NO. _____

REBECCA MANSFIELD, ADMINISTRATRIX OF THE ESTATE OF JONATHAN MANSFIELD

-and-

REBECCA MANSFIELD, GUARDIAN OF MINOR CHILD, J.M. **PLAINTIFFS**

VS.

MADISON COUNTY FISCAL COURT

-and-

STEVE TUSSEY, Former Jailer, Madison County Detention Center, In His Individual Capacity

-and-

JAMES HOLLINS, Former Captain, Deputy Madison County Detention Center, In His Individual Capacity

-and-

MIKEAL BURNS, Deputy, Madison County Detention Center, In His Individual Capacity

-and-

AUSTIN RAMSEY, Deputy, Madison County Detention Center, In His Individual Capacity

-and-

BRAD HEAD, Deputy, Madison County Detention Center, In His Individual Capacity

-and-

STEVEN HOWARD, Captain, Madison County

Detention Center, In His Individual Capacity

-and-

MADISON COUNTY EMS

-and-

TONYA DONSELMAN, Director
of Madison County EMS, In Her
Individual Capacity

-and-

MONICA WAGERS, Training Officer,
Madison County EMS, In Her
Individual Capacity

-and-

TYLER COLLINS, Madison County
EMS Paramedic, In His Individual Capacity

-and-

IAN PATTERSON, Madison County
EMS, Paramedic, In His Individual Capacity

-and-

DAKOTA FISH, Madison County
EMS, EMT, In His Individual Capacity

-and-

**WEST KENTUCKY CORRECTIONAL
HEALTHCARE, LLC**

-and-

JAMIE WELLS, West KY Correctional Healthcare,
Nurse, In Her Individual Capacity **DEFENDANTS**

COMPLAINT

Comes the Plaintiff, Rebecca Mansfield, Administratrix of The Estate Of Johnathon Mansfield, and as the Guardian of her minor child J.M., by Counsel, and for the Plaintiffs causes of action against the above-named Defendants, alleges and states as follows:

INTRODUCTION

1. Johnathon Mansfield tragically and unnecessarily died at the University of Kentucky Hospital on October 10, 2024, after being tased approximately forty (40) times at the Madison County Detention Center. Specifically, he was tased thirteen (13) times with both probe and drive stun tasers and then he was hit with what is called a "Generated Low Output Voltage Emitter" (G.L.O.V.E.) twenty-seven (27) times at the Madison County Detention Center by Defendants James Hollins and Mikeal Burns. The G.L.O.V.E. has been described as a hands on electric taser glove.[1] An internal investigation by the Madison County Detention Center found that "...Mr. Manfield [sic] suffered a cardiac arrest following the series of taser and G.L.O.V.E. exposures." Johnathon's Mansfield's cardiac arrest and subsequent death was caused by the actions, inactions, conscious disregard, willful and wanton, and depraved behavior of the Defendants in this case.
2. Johnathon's Mansfield's death was tragic, avoidable, and caused by the Defendants unlawful actions they took against him. Now, Johnathon Mansfield's wife, Rebecca Mansfield, as the Administratix of his Estate, brings this action to illuminate the truth, obtain some measure of justice for her husband's death and to recover damages sustained as a result of the

[1] https://hinaray.com/electric-taser-glove/

Defendants' conduct, and punitive damages to punish Defendants' conduct and to forever deter such conduct from happening again.

3. Rebecca Mansfield, as the Guardian of her minor child J.M., also brings a claim for loss of parental consortium on behalf of her minor child for the loss of his father, Johnathan Mansfield.

PARTIES

4. Plaintiff, Rebecca Mansfield, Administratrix of the Estate of Johnathan Mansfield, decedent, is a citizen and resident of Pulaski County, Kentucky. Rebecca Mansfield was appointed Administratrix of the Estate of Johnathon Mansfield on January 28, 2025 by the Pulaski District Court, Probate Division, Case No. 25-P-00024. (Exhibit #1: Order Appointing Administratrix).
5. Plaintiff J.M. is the minor child of the deceased, Johnathon Mansfield, and Rebecca Mansfield is his legal guardian and mother.
6. Defendant, Madison County Fiscal Court (hereinafter referred to as "MCFC") is and was at all relevant times a political subdivision of the Commonwealth of Kentucky, organized and existing under and by virtue of the laws and the Constitution of the Commonwealth of Kentucky. The Madison County Detention Center in Richmond, Kentucky (herein after referred to as "MCDC") is a department of Defendant MCFC.
7. At all times relevant to the matters alleged herein, Defendant MCFC was responsible for providing staffing, supervision, and control over the MCDC, including the areas where all inmates are detained and housed.
8. At all times relevant to the matters alleged herein, Defendant MCFC and MCDC were responsible for implementing all of the MCDC policies and procedures regarding the classification, detention and housing of all inmates, assisting in developing and implementing

those policies, and in training and supervising its employees regarding their duties on implementing said policies and procedures.

9. Defendant Steve Tussey, by information and belief, is a citizen and resident of Madison County, Kentucky and at all times relevant to the matters alleged herein was employed by Defendant MCFC as the elected Jailer of MCDC and was responsible for administering all policies and procedures of Defendant MCFC regarding MCDC including, but not limited to, being responsible for ensuring the safety and well-being of inmates detained and housed at the MCDC and providing appropriate supervision of inmates housed in the MCDC. Defendant Steve Tussey is sued in his individual capacity.
10. Defendant James Hollins, at all times relevant hereto, was a Captain at MCDC. Defendant James Hollins is sued in his individual capacity and is believed to be a Madison County, Kentucky resident.
11. Defendant Mikael Burns, at all times relevant hereto, served as a Deputy at the MCDC. Defendant Mikael Burns is sued in his individual capacity and is believed to be a resident of Madison County, Kentucky.
12. Defendant Austin Ramsey, at all times relevant hereto, served as a Deputy at the MCDC. Defendant Austin Ramsey is sued in his individual capacity and is believed to be a resident of Madison County, Kentucky.
13. Defendant Brad Head, at all times relevant hereto, served as a Deputy at the MCDC. Defendant Brad Head is sued in his individual capacity and is believed to be a resident of Madison County, Kentucky.

14. Defendant Steven Howard, at all times relevant hereto, served as a Captain at the MCDC. Defendant Steven Howard is sued in his individual capacity and is believed to be a resident of Madison County, Kentucky.
15. Defendant Madison County EMS is ambulance service district in Madison County, Kentucky, created pursuant to KRS 108.150 with an address of 556 S. Keeneland Drive, Richmond, KY 40475.
16. Defendant Tonya Donselman, at all times relevant hereto, served as the Director of the Madison County EMS and is believed to be a resident of Madison County, Kentucky.
17. Defendant Monica Wagers, at all times relevant hereto, served as the Training Officer of the Madison County EMS and is believed to be a resident of Madison County, Kentucky.
18. Defendant Tyler Collins, at all times relevant hereto, served as a Paramedic with the Madison County EMS and is believed to be a resident of Madison County Kentucky.
19. Defendant Ian Patterson, at all times relevant hereto, served as a Paramedic with the Madison County EMS and is believed to be a resident of Madison County Kentucky.
20. Defendant Dakota Fish, at all times relevant hereto, served as an EMT with the Madison County EMS and is believed to be a resident of Madison County Kentucky.
21. Defendant, West Kentucky Correctional Healthcare, LLC. ("WKCH"), is a limited liability company which at all times mentioned herein, was responsible for administering healthcare to inmates at MCDC and was responsible for the employment, training, supervision and conduct of its' health care professionals operating in MCDC.
22. Defendant, Jamie Wells, at all times relevant hereto, was an employee of WKCH and served as a Nurse in MCDC.

JURISDICTION AND VENUE

23. The transactions which give rise to the dispute occurred in Madison County, Kentucky and therefore venue is proper in Madison County, Kentucky.

24. The amount in controversy exceeds the jurisdictional minimum.

25. A certificate of merit is attached as Exhibit "#2".

FACTUAL BACKGROUND

26. On September 27, 2024, Johnathon Mansfield ("Mr. Mansfield") was booked into the custody of MCDC in Richmond, Madison County, Kentucky for public intoxication.

27. Upon arrival at the MCDC, while handcuffed behind his back, Mr. Mansfield calmly stepped out of the back of the police vehicle and was immediately placed in an arm locked position by Defendants James Hollins ("Defendant Hollins") and Mikael Burns ("Defendant Burns").

28. Mr. Mansfield was then slowly escorted into MCDC with his arms handcuffed behind his back and Defendants Hollins and Burns locked into each arm separately.

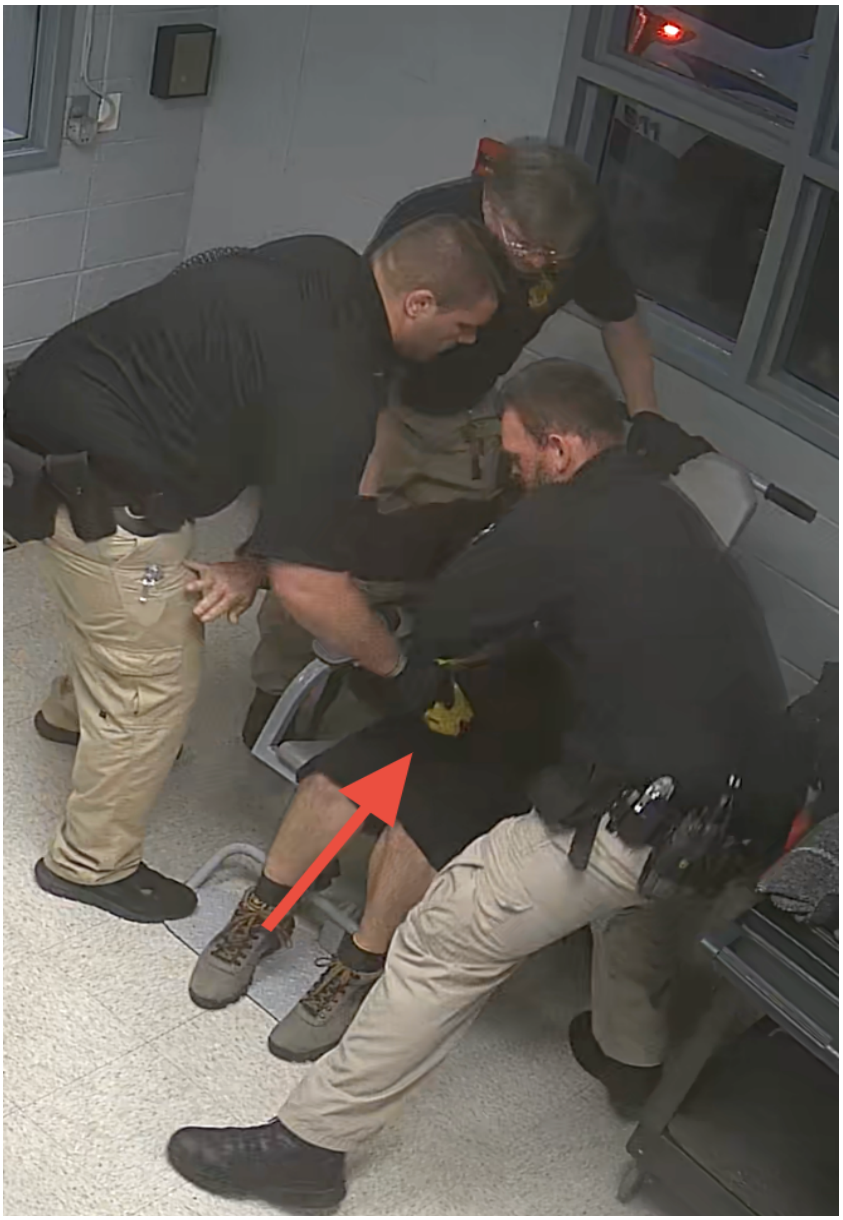
29. As Mr. Mansfield was entering MCDC, he slowly fell to the floor with both Defendants Hollins and Burns on his sides holding each handcuffed arm separately.

30. Mr. Mansfield was then placed into a restraint chair with his arms still handcuffed behind his back.

31. After being placed in the restraint chair, Mr. Mansfield was moved into the booking area lobby.

32. Once in the booking area lobby, with Defendant Burns and another Defendant jail deputy by his side, Defendant Hollins pulled his taser out, displayed it and threatened Mr. Mansfield that the taser will be used on him "unless" he "complied." Keep in mind that Mr. Mansfield was strapped into a restraint chair with his hands cuffed behind his back:

33. Shortly thereafter, Defendant Hollins unlawfully administered a drive stun tase to Mr. Mansfield in the lower stomach / groin area while he was strapped into the restraint chair:



34. This drive stun tase by Defendant Hollins on Mr. Mansfield was the first of what would be approximately forty (40) taser and / or G.L.O.V.E. electronic shocks unlawfully administered to Mr. Mansfield during his short stay at MCDC.

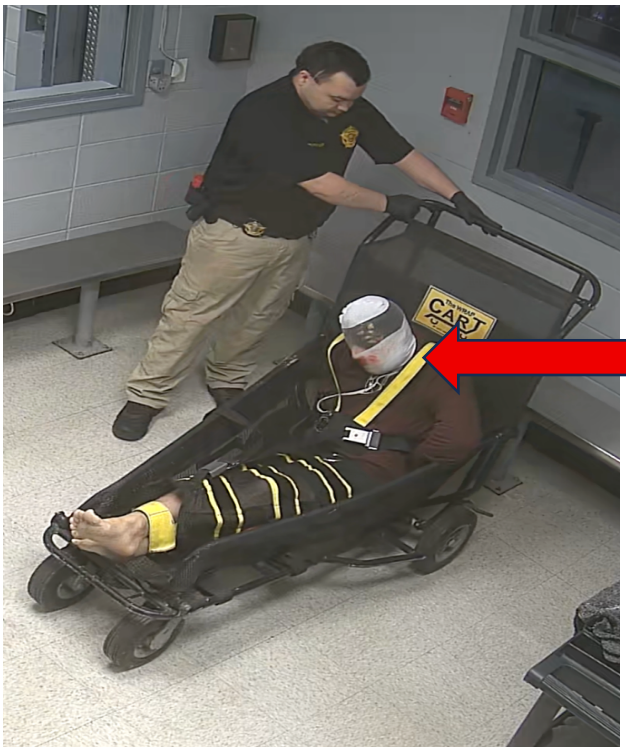
35. After being in the restraint chair for eighteen (18) minutes and twenty-four (24) seconds, Defendant Hollins then placed Mr. Mansfield in a spit mask for no justifiable reason:

36. Prior to having the spit mask placed over his head, Mr. Mansfield had not spit on any jail employee nor did he threaten to spit on any jail employee.

37. After spending approximately fifty-five (55) minutes in the restraint chair, Defendants Hollins, Burns and other MCDC Deputies took Mr. Mansfield in the restraint chair to a single isolation jail cell.

38. After being removed from the restraint chair and placed in the isolation cell, Defendants Hollins and Burns excessively tased and applied the G.L.O.V.E. numerous times to Mansfield in the cell.

39. The Defendant Deputy Jailers eventually exited the isolation cell and left Mr. Mansfield alone in the cell. During this time period, Mr. Mansfield followed the orders of the jail deputies, laid down in his cell and appeared to go to sleep.
40. Despite being compliant, calm, and laying down in his cell, Defendants Hollins, Burns, Ramsey, Head, Captain Howard and two Madison County Sheriff's Department Deputies rushed back into Mansfield's cell and pounced on top of him with a shield.
41. While these individuals were on top of Mr. Mansfield, the WRAP restraint device was brought to the door of the cell that Mr. Mansfield was in. Defendant Captain Howard, with the assistance of Defendants Hollins, Burns, Ramsey and Head then unjustifiably placed Mr. Mansfield into the WRAP full body restraint device. These Defendants, again for the second time, placed the spit mask back over Mr. Mansfield's face after placing him in the WRAP.
42. During this course of events, it is believed that Mansfield was again unlawfully tased numerous times.
43. The WRAP is a full body restraint system not unlike a full-body straitjacket. Due to the extreme nature of the WRAP, one United States Federal Judge likened its' use to torture when used improperly. *C.P.X. through S.P.X. v. Garcia*, 450 F.Supp.3d 854, 914-15 (S.D. Iowa 2020).
44. After being unjustifiably placed in the WRAP with a spit mask on, Mr. Mansfield was removed from the isolation cell and moved back into the lobby of the booking area.
45. Video surveillance from the booking area reveals that Mr. Mansfield was in the midst of a medical emergency after being placed in the WRAP because blood stains could be clearly seen forming around the mouth area of the spit mask which was placed over his head and face:



46. Defendants Hollins, Burns, Ramsey, Head, Captain Howard, the Madison County EMS Defendants and Defendant Nurse Jaime Wells failed to do any medical evaluation of Mr. Mansfield to determine why a large blood stain continued to form around the mouth area of Mr. Mansfield's spit mask.

47. Further, after being placed in the WRAP, Mr. Mansfield went quiet and completely motionless with his head slumped down and forward onto his chest. The WRAP's manufacturer has an application manual regarding their product. Specifically, it states and advises:

> "**Medical Attention:**
>
> Upon immediate application of The WRAP, the subject should be assessed for any safety, comfort and/or medical considerations. **If a restrained subject complains of or exhibits any medical concerns, seek immediate medical attention**. Note: If needed, various medical treatments can be provided while the subject is restrained in The WRAP.
>
> Some examples of health concerns that should be immediately addressed are:

• A respiratory or pain complaint by the subject
• Respiratory Distress (i.e., coughing, gasping, gagging, shortness of breath)
• Sudden quiet or inactivity (especially after a violent struggle)
• Chest pains, shooting pains down the arm
• Change in facial color
• Elevated body temperature (I'm burning up!)
• Vomiting
• Suspected drug behavior
• Sweating profusely
• Emotional Distress"

(Emphasis Added).[2]

48. The manufacturer of the WRAP explicitly advises that "...immediate medical attention" shall be sought anytime the inmate exhibits signs of any medical concerns.

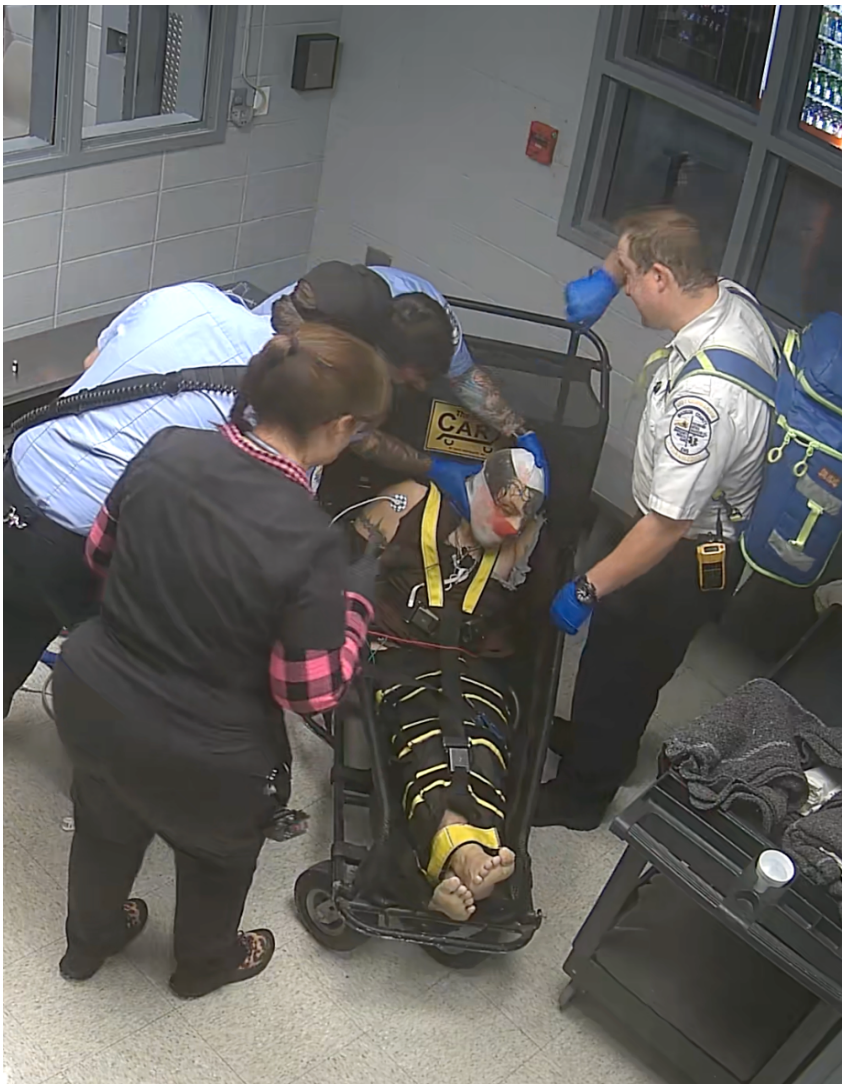
49. The Defendants failed to provide Mr. Mansfield any type of medical evaluation nor did they seek immediate medical attention despite the numerous signs that he was in the midst of a medical emergency after being placed in the WRAP.

50. After lying motionless and unresponsive in the WRAP for approximately eight (8) minutes and fifty-eight (58) seconds with blood forming around his mouth, the Madison County EMS Defendants finally checked Mr. Mansfield for a pulse.

51. The delay by the Madison County EMS Defendants and Defendant Nurse Wells who were present and saw blood in Mr. Mansfield's spit mask, in checking for a pulse on Mr. Mansfield after he was placed in the WRAP violated the medical standard of care that they were to uphold when seeing a person in obvious need of medical attention.

52. Approximately ten (10) minutes after being placed into the WRAP, Madison County EMS Defendants determined that Mr. Mansfield was experiencing cardiac arrest and began life saving measures:

[2] http://www.aflunky.com/uploads/2/3/4/3/23436122/the-wrap-training-manual_8_14.pdf



53. Subsequently, Mr. Mansfield was transferred from MCDC to Baptist Health Hospital in Richmond, Kentucky. However, due to the severity of his medical condition, Baptist Health Hospital had him transferred to the University of Kentucky Hospital in Lexington, Kentucky.

54. While Mr. Mansfield was in the hospital at the University of Kentucky, the Madison County Sheriff's Department began an investigation into the actions of the Sheriff's Deputies that were present in the jail when Mr. Mansfield was tased approximately forty (40) times.

55. As part of their investigation, Sgt. Donovan Nolan of the Sheriff's Department spoke with one of Mr. Mansfield's treating physicians at UK – Dr. Collins. Sgt. Nolan reported that Dr. Collins

stated to him that she and the other doctors believed that Mr. Mansfield's condition and cardiac arrest was caused by being tazed multiple times at the jail:

> [redacted] Dr. Collins then told me that they thought Mr. Mansfield's condition was caused by cardiac arrest due to multiple taser deployments. [redacted]

(Excerpt from Madison County Sheriff's Department's investigation file.)

56. Mr. Mansfield was at the University of Kentucky Hospital from September 28, 2024, until his death on October 10, 2024.

Madison County Detention Center Major Dwight Hall's Internal Investigation & Findings That Excessive Force Was Unlawfully Used:

57. Major Dwight Hall of the MCDC was tasked with conducting an internal "Review" of the use of force used upon Mr. Mansfield by Defendants Hollins and Burns.

58. In Major Hall's report he found that Mansfield had been tased in some form forty (40) different times:

Per your request, I conducted a thorough review of the use of force incidents involving Mr. Jonathan Manfield that occurred from September 27, 2024, to September 28, 2024.

During this period, four distinct use of force incidents were recorded between 23:51 and 01:04 hours, resulting in a total of 13 taser exposures—comprising both probes and drive stun applications—lasting between 23 to 28 seconds. Additionally, there were 27 exposures using the G.L.O.V.E., with 4 from the right G.L.O.V.E. and 23 from the left G.L.O.V.E.

Summary of Findings:

1. **Taser Deployments:**
    - 2 probe deployments: 1 ineffective, 1 effective.
    - 13 drive stuns with exposure durations ranging from 1 to 3 seconds.
2. **G.L.O.V.E. Exposures:**
    - 23 total exposures, with 2 exceeding the recommended 15 seconds—one lasting 45 seconds and another lasting 99 seconds.

(Major Hall, Review of Use of Force Pg. 1).

59. Major Hall then notated the risks associated with "extended exposures" to tasers:

Risks Associated with Extended Exposures:

The training provided to our staff emphasizes not exceeding 15 seconds of exposure, as extended exposure poses significant health risks, including but not limited to:

- Impaired breathing and respiration.
- Potential heart rhythm disturbances, including sudden cardiac arrest, even in individuals without pre-existing conditions.
- Increased blood pressure and heart rate.
- Altered blood chemistry and heightened adrenaline levels.

- An increased risk of severe complications, particularly for individuals with pre-existing medical conditions or substance use issues.

(Major Hall, Review of Use of Force, Pg. 1-2).

60. Next, Major Hall gave his assessment on Defendants Hollins' and Burns' use of force on Mr. Mansfield and concluded that it was excessive and caused Mansfield to suffer cardiac arrest:

Assessment of Use of Force:

During our use of force training, staff are instructed to have alternative strategies when initial force options fail. It is critical that officers do not continue to employ the same force option if it is ineffective. The principle of using the least amount of force necessary is paramount.

In my assessment, the initial drive stun exposure at 23:51 on September 27, 2024, was excessive. Lesser force options, such as basic strength control techniques and G.L.O.V.E. were available but not utilized.

The use of taser drive stun and G.L.O.V.E. on Mr. Manfield did not achieve the desired effect of pain compliance, making the subsequent exposures unreasonable. These actions not only inflicted unnecessary pain but also heightened the risk of serious health complications.

Notation of Incident:

At 01:20 on September 28, 2024, Mr. Manfield suffered a cardiac arrest following the series of taser and G.L.O.V.E. exposures.

Recommendations:

(Major Hall, Review of Use of Force, Pg. 2).

61. Ultimately, after his review and investigation, Major Hall recommended that Defendant Hollins be fired, and that Defendant Burns be suspended:

Recommendations:

Given the findings of this review, I conclude that:

- Captain James Hollins and Deputy Mikeal Burns acted with inefficiency and negligence, violating both Axon and Complaint Technology standards and our internal training protocols regarding the use of force.
- I recommend Captain Hollins be terminated. As the incident commander, he holds a higher level of accountability.
- Deputy Burns also failed to adhere to the standards and should be issued a 5-day suspension.

(Major Hall, Review of Use of Force, Pg. 2).

62. Further, on November 1, 2024, after Mr. Mansfield died, Defendant Burns was notified that he was prohibited from ever using the G.L.O.V.E. again while he served as a MCDC deputy due to his inappropriate use of it on Mr. Mansfield:

To: Deputy Mikeal Burns
From: Major Dwight Hall
Re: Revocation of Certification
Date: 11/01/2024

Deputy Burns,

This letter serves as formal notification that, effective immediately, you are prohibited from using or possessing the G.L.O.V.E. while serving in your role as Deputy Jailer at the Madison County Detention Center. This decision is a result of your inappropriate application of the G.L.O.V.E. during the incident involving Mr. Jonathan Mansfield on September 27-28, 2024.

As a reminder, the G.L.O.V.E. is an elective certification and is not mandatory for your position; thus, this restriction will not impact your essential job responsibilities.

I urge you to apply the training you have received regarding use of force and to focus on enhancing your judgment in similar situations. Your progress will be closely monitored as part of an ongoing evaluation process.

63. It is clear that Defendant Hollins and Burns use of force on Mr. Mansfield was unlawful and ultimately contributed to his death.

64. MCDC Policy 6-14 specifically states that "Deputies of this jail have an affirmative duty to intervene if they witness a use of force that is clearly unreasonable." Defendants Ramsey, Head and Howard breached this duty when they failed to intervene to stop the unreasonable use of force that was being used on Mr. Mansfield by Defendants Hollins and Burns.

Defendant Hollins Disciplined Numerous Times in the Course of his Employment at MCDC:

65. Prior to unlawfully tasing and contributing to the death of Mr. Mansfield, Defendant Hollins was no stranger to being disciplined by MCDC.

66. On August 28, 2024, just one month before excessively tasing Mr. Mansfield, Defendant Hollins was disciplined for the following use of excessive force with a taser and OC spray:

6-25-2024 Hollins was involved in a Use of Force which included tasing and OC spraying an inmate. Upon reviewing this Use of Force it was determined that due to an emotional reaction by Hollins this Use of Force should not have occurred. Due to this Hollins is receiving a Written Warning. He also is charged with a two (2) day suspension; however, waved for 3 months from date of occurrence. Although waved should there be another issue with Use of Force such as this the 3 day suspension will be enacted.

(Defendant Hollins Personnel File).

67. On June 21, 2024, Defendant Hollins was disciplined for not timely completing a use of force packet which also involved the use of a taser and for other violations as seen below:

Issues discussed with Captain Hollins, 6-13-2024

- Intakes not being restrained in Passive Booking
- Better at serving trays as they come out, keep eye on this
- Shift reports and tray pictures to me
- Not completing fingerprints
- Perceived disrespect in text and calls
- Use of Force packets not completed in a timely manor

Hollins advises he will work on these issues.

(Defendant Hollins Personnel File).

68. On August 3, 2023, Defendant Hollins was disciplined for not properly completing use of force packets for numerous incidents where he used force:

Summary of Violation:
(Please include any additional documentation) Hollins has received 4 verbal warnings in reference to Use of Force Packets, documents that are to be included, reports required, the overall Packet needs in it's entirety. Since these Verbal Warnings he received a Use of Force Packet Checklist.
Hollins recently turned in more Use of Force Packets that lacked documents, reports and assessments. For this Hollins will be receiving a Written Warning.

(Defendant Hollins Personnel File).

69. On July 25, 2023, Defendant Hollins was disciplined for the use of excessive force on an inmate that was handcuffed in the back of a police cruiser. Specifically, Defendant Hollins drive stun tased the inmate and then OC sprayed the inmate while he sat defenseless in the back of the police cruiser. Major Dwight Hall made the following conclusions regarding Defendant Hollins use of force in this incident:

> I find the use of force excessive and unwarranted. I find there is an absence of institutional need for staff to utilize force against Inmate Martin under the circumstances documented in the incident reports.
>
> I have reviewed the video which yielded no new evidence. The perceived threat level Inmate Martin presented was extremely low, being he was handcuffed behind the back and restrained with a seatbelt and refused to place his leg back into the cruiser.
>
> There is no evidence Inmate Martin was attempting to harm anyone or damage county owned property.
>
> As documented in the staff incident reports, Inmate Martin was subjected to force because he refused to place his leg back into the cruiser. Lt. Hollins used force which I find is excessive.

(Defendant Hollins Personnel File).

70. On June 13, 2023, Defendant Hollins was disciplined for not turning in a use of force packet where an inmate was placed into a restraint chair:

> **Summary of Violation:**
> **(Please include any additional documentation) 6-13-2023 it was brought to my attention that Lieutenant Hollins had a use of force , Inmate Hartman and failed to hand in a Use of Force Packet. Hollins has been instructed the importance of the packets and the liability held within. Document attached**

(Defendant Hollins Personnel File).

71. Defendant Hollins personnel file also revealed that he admitted to making decisions based on "feelings and emotions" which often resulted in a "negative" outcome.

72. Defendant Hollins should never have been employed by MCDC at the time Mr. Mansfield was housed in MCDC when considering his checkered employment history at the jail.

73. Due to Defendant Hollins' past disciplinary record of using unlawful and excessive force on inmates, Defendant Tussey knew or should have known that Defendant Hollins would continue this type of unlawful behavior and severely injure or kill an inmate while on duty at MCDC.
74. By allowing Defendant Hollins to continue his employment at MCDC despite his disciplinary record, Defendant Tussey ratified and accepted the unlawful behavior of Defendant Hollins and Defendant Burns.
75. It took the death of Mr. Mansfield for MCDC and Defendant Tussey to finally fire Defendant Hollins.
76. In this case, the MCDC Defendants tortured, abused, battered and used unlawful / excessive force which caused the tragic and unnecessary death of Mr. Mansfield.
77. The Madison County EMS Defendants and Defendant Nurse Wells violated the medical standard of care that should have been applied to Mr. Mansfield. Their combined delay in checking Mr. Mansfield's vitals and seeking immediate medical attention contributed to the death of Mr. Mansfield.
78. Because of all of the Defendants' conduct described above, and other facts to be more fully developed in discovery, the Defendants caused Mansfield's death for which the Plaintiffs are entitled to recover damages in an amount to be determined at trial.

CAUSES OF ACTION

COUNT I: NEGLIGENCE / WRONGFUL DEATH
(AGAINST ALL INDIVIDUAL DEFEENDANTS)

79. Plaintiff incorporates by reference the allegations previously set forth in this Complaint.
80. At all times relevant hereto, the Defendants named herein, along with their employees, agents, representatives, and servants, were charged with a duty to exercise ordinary care to avoid foreseeable injuries to its inmates, including Mr. Mansfield.

81. At all times relevant hereto, the Defendants named herein, along with their employees, agents, representatives, and servants, knew or should have known that their actions as discussed *supra* were likely to cause harm to Mr. Mansfield.

82. The Defendants named herein, along with their employees, agents, representatives, and servants, breached their duty to Mr. Mansfield, and thereby directly and proximately caused the injuries, damages and death to Mr. Mansfield as set out herein.

83. As the direct and proximate result of the Defendants wanton, reckless, willful, negligent and grossly negligent conduct, which resulted in the death of Mr. Mansfield, Mr. Mansfield's estate suffered damages, including pain and suffering, loss of power to earn money, funeral expenses, medical expenses, all in an amount to be determined at trial.

COUNT II: GROSS NEGLIGENCE
(AGAINST ALL DEFENDANTS)

84. Plaintiff incorporates by reference the allegations previously set forth in this Complaint.

85. The actions of the Defendants demonstrated an intentional, wanton and reckless disregard for Mr. Mansfield's safety and life.

86. Mr. Mansfield died as a result of the Defendants' gross negligence and wanton and reckless actions.

87. As the direct and proximate result of the Defendants wanton, reckless, willful, and grossly negligent conduct, which resulted in the death of Mr. Mansfield, Mr. Mansfield's estate suffered damages, including pain and suffering, loss of power to earn money, funeral expenses, medical expenses, and punitive damages all in an amount to be determined at trial.

COUNT III: NEGLIGENT TRAINING, SUPERVISION & RETENTION
(DEFENDANT TUSSEY)

88. Plaintiff incorporates by reference the allegations previously set forth in this Complaint.

89. Defendant Tussey had a ministerial duty to train MCDC employees and/or agents regarding the use of force and the safety and well-being of the inmates placed in MCDC, but breached his duty to Mr. Mansfield, and created an unjustifiable risk of harm to Mr. Mansfield resulting in damages and Mr. Mansfield's death.
90. Defendant Tussey had a ministerial duty to properly supervise his employees and / or agents. Defendant Tussey breached his duty and his inadequate supervision of his employees and / or agents created an unjustifiable risk of harm to Mr. Mansfield resulting in damages and Mr. Mansfield's death.
91. Defendant Tussey had a ministerial duty to terminate employees who violated MCDC policy and not retain MCDC employees who consistently violated policies and procedures and his inadequate retention of unqualified employees and / or agents created an unjustifiable risk of harm to Mr. Mansfield resulting in damages and Mr. Mansfield's death.
92. As a result of Defendant Tussey's negligent training, supervision, and retention which resulted in the death of Mr. Mansfield, Mr. Mansfield's estate suffered damages, including medical expenses, pain and suffering, loss of power to earn money, and funeral expenses, all in an amount to be determined at trial.

COUNT IV: NEGLIGENT TRAINING & SUPERVISION
(AGAINST DEFENDANTS WKCH, MADISON COUNTY EMS, DONSELMAN & WAGERS)

93. Plaintiff incorporates by reference the allegations previously set forth in this Complaint.
94. Defendants WKCH, Madison County EMS, Donselman & Wagers had a duty to train their employees and/or agents regarding the health and well-being of patients and inmates placed in the Madison County Detention Center but breached their duty to Mr. Mansfield and created an unjustifiable risk of injury and death Mr. Mansfield resulting in his death.

95. Defendants WKCH, Madison County EMS, Donselman & Wagers had a duty to properly supervise their employees and / or agents.

96. Defendants WKCH, Madison County EMS, Donselman & Wagers breached their duty and the inadequate supervision of their employees and / or agents created an unjustifiable risk of harm to Mr. Mansfield resulting in his death.

97. As a result of Defendants WKCH, Madison County EMS, Donselman & Wagers negligent training, and supervision which resulted in the death of Mr. Mansfield, Mr. Mansfield's estate suffered damages, including medical expenses, pain and suffering, loss of power to earn money, and funeral expenses, all in an amount to be determined at trial.

COUNT V: BATTERY
(DEFENDANTS HOLLINS & BURNS)

98. Plaintiff incorporates the preceding allegations as if stated fully herein.

99. At the time of the transactions which give rise to this dispute, Defendants Hollins and Burns unlawfully and maliciously contacted Mansfield causing injuries.

100. As a result of the injuries sustained, Plaintiff is entitled to compensation in excess of the jurisdictional limit of this Court for damages including, but not limited to, bodily injury, physical impairment, pain and suffering, mental anguish, inconvenience, disfigurement, disability, punitive, and all other damages to be proven at trial.

COUNT VI: RESPONDEAT SUPERIOR
(AGAINST DEFENDANTS MCFC, MADISON COUNTY EMS, DONSELMAN, TUSSEY, & WKCH)

101. Plaintiff incorporates the preceding allegations as if stated fully herein.

102. Defendants Hollins, Burns, Head and Howard, were employees of the Madison County Detention Center which was led by Defendant Steve Tussey and is a department of the Madison County Fiscal Court at all relevant times hereto. These employees were within the

course and scope of their employment at the time of all of their unlawful actions described above.

103. Defendant Nurse Wells was an employee of WKCH at all relevant times hereto. Defendant Nurse Wells was within the course and scope of her employment at the time of her unlawful actions described above.

104. Defendants Collins, Patterson, and Fish were employees of the Defendant Madison County EMS which is led by Defendant Donselman and is a department of Defendant MCFC at all times relevant hereto. These employees were within the course and scope of their employment at the time of all of their unlawful actions described above.

105. Mr. Mansfield's death was the direct and proximate result of these Defendants' negligence, gross negligence and battery.

106. As the employers of these individual Defendants named above, Defendants MCFC, Defendant Tussey, Defendant Madison County EMS, Defendant Donselman and Defendant WKCH are liable for the actions of their employees under the doctrine of Respondeat Superior.

107. As the direct and proximate result of the Defendants' wanton, reckless, willful, and grossly negligent conduct, which resulted in the death of Mr. Mansfield, Mr. Mansfield's estate suffered damages, including pain and suffering, loss of power to earn money, funeral expenses, medical expenses, and punitive damages all in an amount to be determined at trial.

COUNT VII:
LOSS OF CONSORTIUM
J.M. A MINOR
(AGAINST ALL DEFENDANTS)

108. Plaintiff incorporates the preceding allegations as if stated fully herein.

109. At all times relevant to this Complaint, Mr. Mansfield was the father to J.M., a minor.

110. As a result of the wanton, reckless and/or negligence, gross negligence, malicious, or oppressive conduct of the Defendants, J.M. has suffered and will continue to suffer the loss of affection, support, companionship, and paternal relationship with his father which constitutes a valid claim for loss of consortium of his father.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs request that the Court grant the following relief:

1. Judgment, jointly and severally, in Plaintiffs' favor against all Defendants and an award of actual damages for Mr. Mansfield's wanton and unnecessary pain and suffering preceding his death, medical expenses, his loss of enjoyment of life, and for his Estate's loss of his ability to labor and earn money, funeral expenses, punitive damages, loss of consortium as set out above and other special damages for Defendants' unlawful actions.
2. An award of attorney fees, costs, and expenses incurred in prosecuting this action;
3. Trial by jury;
4. All other relief to which the Plaintiff may be entitled.

Respectfully submitted,

/s/ Noel Caldwell

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