STATE OF VERMONT

SUPERIOR COURT
CHITTENDEN UNIT

CIVIL DIVISION
Docket No.:

CHRISTINE SABENS,	*
as Administrator of the Estate of	*
DAVID L. BISSONNETTE,	*
and as next friend of L.S., a minor child,	*
PLAINTIFFS,	*
	*
v.	*
	*
STATE OF VERMONT,	*
CENTURION OF VERMONT, LLC,	*
CENTENE CORPORATION,	*
STEVEN FISHER, M.D.,	*
LURA BARROWS,	*
SHERRY BISSON,	*
BRIANA HOLLAND,	*
TERI FRANCES MARCH,	*
CYNDI MCGOVERN,	*
KELLY PLACE,	*
HEATHER RIPLEY,	*
JANICE WHITEHEAD,	*
JESSICA WILLIAMS,	*
GREG HALE, and	*
TRACY HONSINGER,	*
DEFENDANTS.	*

COMPLAINT

NOW COME Plaintiffs, Christine Sabens, as Administrator of the Estate of David L. Bissonnette, and as next friend of L.S., a minor child, by and through their attorneys, Costello, Valente & Gentry, P.C., and complain against Defendants in this following manner:

PARTIES

1. Plaintiff Christine Sabens is the Administrator of the Estate of David L. Bissonnette (hereinafter "Bissonnette"), who prior to his death resided in Chittenden County in the State of Vermont; and whose Estate is open in the Chittenden Superior Court – Probate

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Division. At the time of his death, Bissonnette was a prisoner incarcerated by and under the control of the State of Vermont.

2. Plaintiff Christine Sabens is also the mother and next best friend of L.S. Bissonnette was L.S.'s father. Both Ms. Sabens and L.S. reside in Chittenden County in the State of Vermont.

3. Defendant State of Vermont operated the prison system in which Bissonnette was incarcerated at the time of his death through its Department of Corrections, which is part of the Agency of Human Services.

4. Defendant Centurion of Vermont, LLC (hereinafter "Centurion") is a company registered to do business in the State of Vermont, which provided health care services to inmates in the prison system operated by the State of Vermont at the time of Bissonnette's death.

5. On information and belief, Defendant Centene Corporation, the parent company of Centurion, is a foreign corporation doing business in the State of Vermont, which has authority and control over Centurion, and has sufficient contacts with and activity in Vermont for personal judgment to be rendered against it.

6. Defendant Steven Fisher, M.D. is the medical director for Centurion and, on information and belief, was responsible for the care of Bissonnette throughout Bissonnette's incarceration, including on the day of his death.

7. Defendants Lura Barrows, Sherry Bisson, Briana Holland, Teri Frances March, Cyndi McGovern, Kelly Place, Heather Ripley, Janice Whitehead and Jessica Williams were all employees of Centurion, Centene, or the State of Vermont; and, on information and belief, all were responsible for the medical care and treatment of Bissonnette throughout his incarceration, including on the day of his death.

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8. Greg Hale was at all relevant times the Superintendent of Northwest State Correctional Facility, the facility where Bissonnette was held at the time of his death.

9. Defendant Tracy A. Honsinger was a corrections officer employed by the State of Vermont who, on information and belief, ordered that Bissonnette be placed in administrative segregation.

BACKGROUND

10. Bissonnette was born on May 22, 1978. As an adult, he struggled with opiate addiction and used drugs intravenously.

11. Bissonnette also had periods of sobriety and treatment. In 2015, after being charged with misdemeanor petit larceny (<$900), Bissonnette participated in Chittenden County's treatment court, appearing every other week for "check-in" conferences on February 5 and 19, and March 5, 2015.

12. On March 19, 2015, Bissonnette failed to appear for his regularly-scheduled conference. As a result, the Court issued an arrest warrant with bail set at $3,000.00.

13. Bissonnette was arrested on the warrant almost 20 months later, on November 5, 2016, and held for lack of the $3,000.00 bail. He was also charged with stealing a laptop and violating conditions of release.

14. At Bissonnette's November 7, 2016 arraignment, the court added $1,000.00 bail on his new charges, consecutive to the $3,000.00 on the underlying case. That meant Bissonnette had to post $4,000.00 bail or he would be incarcerated until the cases were resolved.

15. Bissonnette could not afford to post bail. Accordingly, after entering his pleas of "not guilty," Bissonnette was sent to Northwest State Correctional Facility (hereinafter "NWSCF"), located in Swanton, in the County of Franklin and State of Vermont.

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16. NWSCF was at the time operated by the State of Vermont and medical care for its inmates (including Bissonnette) was directed by Centurion, supervised by Dr. Fisher, and administered by the other above-named individual defendants (except for Hale and Honsinger).

17. Until his November 5, 2016 arrest, Bissonnette had been actively using buprenorphine (also known as suboxone), and this fact was known to medical staff at NWSCF from the moment he entered the facility, because Bissonnette listed it on an "initial needs survey" and "intake medical screening form." Buprenorphine is a prescription-only medication designed to help those with opioid addiction avoid withdrawal and cease the use of more dangerous drugs like heroin or fentanyl.

18. The medical staff at NWSCF also knew that Bissonnette had a history of intravenous drug use.

19. Bissonnette disclosed in his "initial needs survey" that he was not (and had never been) suicidal, and that he had something to look forward to—seeing his daughter, L.S.

IMMEDIATE SEGREGATION

20. On November 7, 2016, Bissonnette was placed in "administrative segregation," which is colloquially referred to as "being put in the hole." Segregation can be imposed administratively or as a form of punishment (known as "disciplinary segregation").

21. Inmates in either type of segregation are assigned a cell, which they may not leave under any circumstances for 23 hours per day. Visitation is curtailed and those in segregation have virtually no access to work, education, or recreation. They cannot receive phone calls and can make only one (1) or three (3) collect calls per week (depending on the level of segregation).

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22. Segregation harms inmates. Studies have linked segregation to anxiety, panic, insomnia, paranoia, aggression, and depression. Bissonnette's friends and family observed that he suffered as a direct result of his placement in segregation.

23. According to the policies of the Department of Corrections, inmates are to be placed on administrative segregation only when the presence of the inmate in the general population would pose a "serious threat" to others (or the inmate himself); or to the security and order of the jail.

24. Pursuant to Department Policy #410.03(1), specific bases for placement on administrative segregation include: being charged with a disciplinary violation and awaiting a hearing thereon, which must be held within four (4) days; posing a serious escape risk; requiring protective custody; posing a danger to other inmates; threatening the orderly running of the facility; during the investigation of a crime; or upon the order of a medical provider.

25. None of these applied to Bissonnette. There is no record he was involved in any attempted or actual violence; or any attempted or actual escape; and his records show Bissonnette only received a single disciplinary report (known as a "DR"), on November 9, 2016 (after he had already been placed in segregation). That DR was for a "minor" violation—possession of a small amount of tobacco smoke or a small amount of tobacco; less than one (1) cigarette. **See** Exhibit 1, attached hereto.

26. Pursuant to the Department's Policy #410.01(d), segregation may not be imposed as punishment for a "minor" DR. (Even for many "major" DRs, segregation may not be imposed for more than 14 days. **Id.**)

27. Pursuant to the Department's Policy #410.03(2) *Placement on Ad Seg*, an administrative segregation placement report must be completed for every inmate placed on

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segregation status, and it must state the reason for placement. Then, staff must complete a notice of hearing (or waiver of hearing) for the inmate, which the inmate must sign.

28. After that, the superintendent must review the segregation placement report within 24 hours or during the following business day, and segregation may only continue if, after hearing or review, the Superintendent finds just cause for continuance. Records of any such findings must be preserved under the policy.

29. The foregoing policies recognize that foreseeable harm will result if inmates are arbitrarily placed in segregation; and that segregation should only be utilized when it is necessary to avoid serious threats to safety and administration of the prison.

30. An administrative segregation report was filled out for Bissonnette on November 7, 2016. It offered no reason for placement on administrative segregation other than a hand-written note: "ad seg." **See** Exhibit 2, attached hereto. There were no listed witnesses. **Id**. In the blank space for "evidence," someone wrote "per CFSS Honsinger." **Id**. (On information and belief, this refers to Defendant Tracy Honsinger, but it is unclear if Honsinger wrote the report—because it was never signed. **Id**.)

31. No record was made of the date Bissonnette went into segregation, nor to confirm he received a notice of hearing (or waived his right to hold one), nor whether he had special health needs, nor whether segregation was approved by medical staff. **Id**. Every field was simply left blank. **Id**.

32. In the section of the segregation report which should have been filled out by the "investigating officer," there was no indication that witnesses were interviewed, statements were taken, or Bissonnette was interviewed. **Id**. There was not even identification of the investigating officer. The entire section was blank. **Id**.

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33. According to Department Policy #410.03(1), Bissonnette should not have been held in administrative segregation for more than four (4) days prior to a hearing. If a hearing had been held, based on the evidence above, there would have existed no grounds to continue his segregation.

34. Defendant Hale was responsible for ensuring a hearing occurred (or was waived). There is no record of any hearing having been held or waived; or that Hale ever reviewed whether there was a good reason for Bissonnette's placement on segregation.

35. Even if a hearing had been held and administrative segregation was continued, pursuant to the Department's policy, it should have been reviewed by a committee or Hale's designee every seven (7) days.

36. Although Bissonnette's time in segregation lasted two (2) weeks, it does not appear his placement in segregation was ever reviewed. Bissonnette remained in segregation for at least 15 days, with neither basis nor oversight, from November 7, 2016 until November 22, 2016, the day he died.

37. Although there are no records Bissonnette was segregated for one of the bases identified in Department policies, contemporaneous documents from the day of assignment indicate the actual reason. They show that the officials from NWSCF who assigned Bissonnette to segregation expected Bissonnette would be going through withdrawal (as they would not allow him to continue to use buprenorphine).

38. It thus appears that officials from NWSCF addressed the problem they created by stopping buprenorphine by imposing administrative segregation in contravention of their own policies, so that they would not be forced to actively supervise someone going through the torment of sudden opioid withdrawal.

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39. As a result of the foregoing, Bissonnette was subjected to cruel and unusual punishment in violation of the Eighth Amendment of the United States Constitution; and a violation of his right to due process under the Fourth Amendment of the United States Constitution and Article 11 of the Constitution of the State of Vermont. Bissonnette was injured and damaged as a proximate result of these violations.

INADEQUATE MEDICAL CARE

40. Department of Corrections Policy #351 provides that healthcare services in all prisons "shall be administered in a humane and professional manner, with respect to inmates' constitutional rights to healthcare and protection from cruel and unusual punishment."

41. This requires that health services staff "shall" ensure that inmates have the right to "professional medical, mental health, and dental care in accordance with the prevailing medical standards." In other words, the State of Vermont has undertaken to provide the same standard of care as Vermont hospitals (and other healthcare facilities) for its medical care in prisons. **Id**.

42. At the time of Bissonnette's incarceration, the State of Vermont had retained Centurion to provide healthcare for its prisoners; but the State nevertheless maintained a responsibility to ensure that Centurion provided healthcare in accordance with the generally accepted standard of care. The State furthermore exercised physical control of prisoners, and with that control, it was obligated to ensure that Centurion's ability to provide adequate care was neither prevented nor hindered.

43. Centurion and its employees (including Defendants Fisher, Barrows, Bisson, Holland, March, McGovern, Place, Ripley, Whitehead and Williams) were also independently responsible for providing healthcare in accordance with the generally accepted standard of care.

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44. On November 6, 2016, on Bissonnette's second day in NWSCF, he reported to Defendant Whitehead problems with his chest and noted that "at times when I lay back it gets hard to breathe." Bissonnette's blood oxygen level was at 89%. Whitehead did not follow up or investigate.

45. On November 12, 2016, Bissonnette indicated to Defendant Lura Barrows that he was suffering from chest pain and a headache. He also asked for Tylenol and told her he was fatigued, felt "something isn't right," and "started making noises like crying with eyes closed." After Bissonnette sat down, he began to moan in pain, and told Barrows that he had been fine "this morning" and "it started when I got back [to the unit]."

46. In response, Barrows told Bissonnette that he was detoxing, and that he had received an electrocardiogram ("EKG") the night before which was within normal limits. (Barrows apparently disregarded Bissonnette's statement that the symptoms began "that morning.") Bissonnette responded: "but my lungs hurt, and my chest hurts now and I'm getting a headache," and Barrows's reaction was to "do a nursing pathway for indigestion."

47. Barrows then told Bissonnette to leave the infirmary. Bissonnette told Barrows "I feel less anxious here," and in response, Barrows had an officer escort Bissonnette back to his cell to continue segregation.

48. The EKG from the prior night had been ordered by Defendant Williams in response to what Williams believed was a panic attack, which included chest pain. Bissonnette's records indicate that the EKG showed his heartbeat was normal (in "normal sinus rhythm," or "NSR"). However, the actual graphic results of the EKG were destroyed or lost. The failure to preserve those results prevents determination of whether the EKG showed evidence of further heart problems, such as acute endocarditis.

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49. Failure to preserve the results of the EKG was a breach of the standard of care on the part of Defendant Centurion for improper training and lack of procedures; and whichever individuals were in possession thereof; which appears to have included Defendant Williams and one unidentified "hcp," which presumably stands for "health care provider."

50. On November 14, 2016, an "initial comprehensive health assessment" was performed on Bissonnette. During the assessment, Defendant March listened to Bissonnette's heart. She observed and recorded that Bissonnette had a "loud systolic" heart murmur. She further observed that Bissonnette was "pale," and "moaning frequently," suffered from headaches "out of nowhere," and was urinating blood. Despite those observations, March did not order any testing related to the murmur (nor other follow-up regarding potential heart problems).

51. On November 16, 2016, Bissonnette reported that he had chest pain, and yelled from his cell: "I can't breathe." Defendant was evaluated by Defendant Bisson and told her "my chest hurts so bad!" Bisson did not initiate any examination or order testing to determine whether Bissonnette was suffering from heart problems. Instead, Bisson reassured Bissonnette that his vital signs were stable, so he was likely having an anxiety attack, not a cardiac event. Bisson gave him a book of word search puzzles to help distract him from his perceived "anxiety."

52. On November 19, at 2:41 a.m., Defendant Williams saw Bissonnette for a complaint of a rapid heart rate. Williams encouraged him to do deep breathing techniques but did not pursue any further investigation into whether Bissonnette might be suffering from heart (or other serious) problems.

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53. At all relevant times, Defendants Whitehead, Barrows, Williams, March and Bisson knew or should have known that Bissonnette had a history of intravenous drug use.

54. Patients with a history of intravenous drug use are at a high risk for developing acute endocarditis, which occurs when bacteria enter the bloodstream and attach to heart valves, causing an infection. When left untreated, acute endocarditis is fatal.

55. One of the symptoms of acute endocarditis is a heart murmur, including a "loud systolic" heart murmur.

56. Other symptoms include fatigue, shortness of breath, chest pain during breathing, and blood in the urine.

57. The appropriate standard of care required further investigation or analysis after observing potential symptoms of acute endocarditis—particularly Bissonnette's "loud systolic" heart murmur and reports of chest pain. The failure of the individuals examining Bissonnette to follow up was a breach of the standard of care and indicates that Centurion failed to adequately train and supervise them. Furthermore, it indicates that the State failed to adequately monitor the adequacy of Centurion's care.

58. The foregoing breaches of the standard of care lessened and likely eliminated the possibility of diagnosis and treatment for Bissonnette's acute endocarditis (which may have included surgery or the administration of antibiotics). With appropriate treatment, mortality at discharge for those suffering from bacterial endocarditis is significantly below 50% (and in fact closer to 20%).

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DEATH OF BISSONNETTE

59. Inmates on administrative segregation are supposed to be checked every thirty (30) minutes by a correctional officer, pursuant to Department Policy #410.06 *Conditions of Confinement*. They must be directly monitored, and "living, breathing flesh must be observed."

60. It appears that Bissonnette was not monitored; although it is possible that records of monitoring were either destroyed or lost.

61. On November 21, 2016, at 11:01 a.m. Bissonnette met with Defendant Holland (a mental health worker) in response to a report that one of Bissonnette's caseworkers had observed him "engaging in slow and odd behaviors." When Bissonnette met Holland, he began to breathe heavily and hold his chest, and said: "my heart is pounding loudly." Bissonnette explained that it had been going on "for a few days." Bissonnette told Holland that the deep breathing exercises were not helping and said: "I just feel like you guys and medical are not paying enough attention to me." He continued: "the nurses won't pay attention to me," and "you people are not giving me what I need." Holland concluded that Bissonnette was "not receptive of support and recommendations," and scheduled a follow-up meeting for November 28, 2016. She neither followed up nor sought further evaluation.

62. Approximately twelve (12) hours later, at 12:00 a.m., Defendant Ripley examined Defendant. He told her, as recorded in her note to Bissonnette's electronic health records: "My heart hurts. Been getting worse. Trouble breathing as well. Shallow. I'm scared. I've tried everything please help." **See** Exhibit 3, attached hereto.

63. Ripley did nothing. She didn't even check Bissonnette's vital signs.

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64. Two hours later, at 2:23 a.m., Defendant Place examined Bissonnette. He told her, as recorded in those same records: "My heart hurts. Been getting worse. Trouble breathing as well. Shallow I'm scared. I've tried everything please help." **See** Exhibit 4, attached hereto. (It appears Place copied Ripley's prior electronic entry.)

65. Place, like Ripley, did nothing. She also didn't measure Bissonnette's vital signs. Bissonnette spent almost four (4) more hours in segregation before his next contact.

66. Around 7:00 a.m., an unidentified medical worker requested that Bissonnette be brought to the medical facility. That request was denied by an unidentified correctional officer working for the State of Vermont, "as [Bissonnette] was just brought to [the housing unit known as] Delta by use of force for not complying with officer's commands." This will be referred to as the "Delta incident."

67. There are no disciplinary records indicating Bissonnette was charged with any infraction related to the "Delta incident"—they were either never created, destroyed, or lost. The only record which explains the "Delta incident" was a "refusal of treatment" form filled out at 6:20 a.m. indicating "Officer Bailey stated patient unable to come down for lab draw. Patient moved to segregation per SI [Superintendent Hale] for not following orders. Per SI patient security risk for current behavior." **See** Exhibit 5, attached hereto.

68. The "refusal" form was not signed by Bissonnette, although there was a space for him to certify that he understood its contents. **Id**. It is unclear if Bissonnette was aware the form existed. In any event, it seems unlikely Bissonnette refused treatment, considering the record showing that he had been begging for medical care at 12:00 and 2:23 a.m. that morning.

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69. Unmentioned on the form was any description of the "security risk" which triggered the "refusal of treatment," and which would later be revealed—Bissonnette was so severely incapacitated that he was unable to put his pants on. **Id**.

70. Four (4) hours later, at 11:07:32 a.m., Defendant Ripley authored a late entry into the medical records describing the earlier incident at Delta. Ripley indicated that Bissonnette "was seen in Delta this morning after being brought there for not following officer's commands. He presents this morning as jaundiced, rapid breathing, bilateral pedal non-pitting edema. Pupils sluggish. He is not responding to any verbal commands." (Bilateral pedal non-pitting edema means that both feet were swelling and responded irregularly to pressure, suggesting a problem with the thyroid or lymphatic system.)

71. Ripley also measured vital signs and found Bissonnette's oxygen saturation was extraordinarily low, at 78%. (Oxygen levels below 88-90% cause hypoxia).

72. Ripley responded by summoning the on-call physician, Dr. Mitchell Miller. In addition, oxygen was administered, an ambulance was called, and Bissonnette was rushed to the emergency room at Northwest Medical Center in St. Albans.

73. Ripley failed to document exactly when her observations occurred (or when emergency measures were initiated), but she titled her entry about the post-Delta examination at "10:41 a.m." There is an electronic entry indicating that Bissonnette left the prison by ambulance at 10:47:39 a.m. Dr. Mitchell filled out the emergency room referral form at 10:22:32 a.m. A second electronic entry asserts that Bissonnette left the location at 10:38:00 a.m.

74. At 10:50 a.m., Jane Sutton, a mental health professional, entered another (more detailed) description of the Delta incident. She revealed that the "conduct" which led to

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Bissonnette's re-segregation and denial of transfer to the medical unit had been his inability to put sweatpants on.

75. Moreover, Sutton disclosed that when she conducted her mental health examination, she observed that Bissonnette could not concentrate, was confused, could not speak intelligibly, was "not making sense and…just mumbling," with flat affect and "unclear" thought process.

76. It is not clear exactly when Sutton's 25-minute-long observation occurred, because her entry to the electronic medical record was at 12:23 p.m. (long after Bissonnette left the facility).

77. No matter when Bissonnette was examined, it should have been apparent he was suffering from a medical emergency hours before he was sent to the emergency room around 10:20 a.m.

78. At or around 11:13 a.m., Bissonnette arrived at Northwest Medical Center, the general hospital in St. Albans. EMS and prison guards informed the on-call doctor that "symptoms began this morning," of "acute altered mental status," and that "he had been sluggish since he was incarcerated 3 weeks ago."

79. The on-call doctor was further informed that "he was due to be brought down to the infirmary when it was noted that he was confused, moaning, not responding appropriately and tachypneic." (The records show, as set forth above, that Bissonnette was in fact *denied* from accessing the infirmary by physical force because he was too confused to put his pants on.)

80. At Northwest Medical Center, Bissonnette was promptly intubated and observed to be "critically ill," so the decision was made to transfer him to intensive care at the University of Vermont Medical Center, which occurred at approximately 1:58 p.m.

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81. Bissonnette arrived at UVMMC at or around 2:57 p.m. He was in septic shock. He had no pulse. Bissonnette's EKG was examined, and it was immediately determined that he suffered from bacterial endocarditis which caused growths of vegetation in the mitral valve of his heart. It was the first EKG performed on Bissonnette since November 11, even though he had complained of chest pain and shortness of breath on multiple occasions, to multiple employees of Centurion, between November 11 and 22.

82. At that point, UVMMC doctors determined it was too late for surgery. Despite the administration of the maximum doses of epinephrine, norepinephrine, and vasopressin, Bissonnette suffered from multiple cardiac arrests. Bissonnette's mother, who had arrived, agreed to discontinue resuscitation efforts, and Bissonnette passed away.

83. An autopsy was performed on Bissonnette which indicated that the cause of his death was bacterial endocarditis of the mitral valve.

84. Bissonnette was 38 years old at the time of his death. His daughter, L.S., was nine (9).

85. The failures of the individuals who were aware of Bissonnette's complaints up to and on the day of his death (and particularly those at 12:00 a.m. and 2:23 a.m. on November 22, 2016), including but not limited to the failure to check vital signs, or order an EKG, or follow up in any way, were below the standard of care. These failures allowed Bissonnette's bacterial endocarditis to progress to a degree that his death was the proximate and foreseeable result thereof.

86. Those failures suggest that the individuals were inadequately trained and supervised by Defendants Centurion and the State of Vermont.

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87. The intervention of correctional staff who refused to allow Bissonnette's transfer to the medical unit at 7:00 a.m. on the day of his death increased the risk of foreseeable harm to Bissonnette and prolonged his suffering.

88. Taken together, the acts and failures in the days leading up to and on the date of Bissonnette's death resulted in multiple missed opportunities for diagnostic investigation, treatment of the bacterial endocarditis, and timely emergency medical care. Those acts and failures proximately caused Bissonnette's death.

89. As a result thereof, Bissonnette suffered physical pain and mental anguish, followed by death. As a result of Bissonnette's death, L.S. lost the love, support, guidance and companionship of her father.

COUNT I

90. Plaintiff incorporates the foregoing paragraphs as though fully contained herein.

91. The acts and neglects of Defendants Hale, Honsinger, and the State of Vermont violated Bissonnette's right to due process and to be free from cruel and unusual punishment under the United States Constitution.

92. The acts of those defendants thus violated 42 U.S.C. § 1983.

93. As a result, Bissonnette was damaged as set forth in Paragraph 89.

COUNT II

94. Plaintiff incorporates the foregoing paragraphs as though fully contained herein.

95. The acts and neglects of Defendants Centurion, Centene, Fisher, Barrows, Bisson, Holland, March, McGovern, Place, Ripley, Whitehead, Williams and the State of Vermont were below the standard of care for a prudent health care professional engaged in a similar kind of practice, under the same or similar circumstances.

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96. As a result, Bissonnette was damaged as set forth in Paragraph 89.

COUNT III

97. Plaintiff incorporates the foregoing paragraphs as though fully contained herein.

98. The acts and neglects of Defendants reflected a failure to exercise the same care a reasonable person would have exercised under similar circumstances, taking into account the foreseeable risk of injury caused by their actions.

99. Defendants Centurion, Centene, Fisher, and the State of Vermont all undertook to provide medical care to Bissonnette which they knew or should have known was necessary for his protection; then failed to exercise reasonable care in performing that care, which increased Bissonnette's risk of harm.

100. Defendants Centurion, Centene, Fisher, and the State of Vermont were negligent in employing and retaining improper persons or instrumentalities in work involving risk of harm to others, and in condoning or failing to prevent negligence by servants and agents upon premises and with instrumentalities under their control.

101. As a result, Bissonnette was damaged as set forth in paragraph 89.

COUNT IV

102. Plaintiff incorporates the foregoing paragraphs as though fully contained herein.

103. The acts and neglects of Defendants were the foreseeable and proximate cause of David Bissonnette's death.

104. As a result thereof, both Bissonnette and L.S. were damaged as set forth in paragraph 89.

WHEREFORE, Plaintiffs request that the Court grant compensatory and punitive damages, attorneys fees, costs, and whatever further relief it deems appropriate.

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ENTRY ON APPEARANCE

NOW COMES Costello, Valente and Gentry, P.C., and enters its appearance for Plaintiffs.

CERTIFICATE OF MERIT

NOW COMES James A. Valente, Esq., counsel for Plaintiffs, and, pursuant to 12 V.S.A. § 1042, certifies as follows:

This is a civil action to recover damages resulting from personal injury and wrongful death occurring after February 1, 2013, in which it is alleged that such injury and death resulted from the negligence of a health care provider.

I hereby certify that I have consulted with a health care provider qualified pursuant to the requirements of Rule 702 of the Vermont Rules of Evidence (and any other applicable standard) and that, based on the information reasonably available at the time the opinion is rendered, the health care provider has:

1. Described the applicable standard of care;

2. Indicated that based on reasonably available evidence there is a reasonable likelihood that Plaintiffs will be able to show that the defendants failed to meet the standard of care; and

3. Indicated that there is a reasonable likelihood that Plaintiffs will be able to show that the defendants' failure to meet the standard of care caused Bissonnette to be injured.

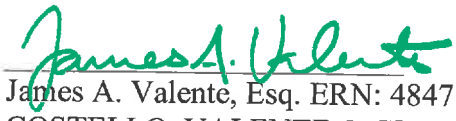
This certification relates to each defendant identified in the complaint.

COSTELLO, VALENTE & GENTRY P.C.

51 PUTNEY ROAD
P.O. BOX 483
BRATTLEBORO, VERMONT
05302

802-257-5533

DATED at Brattleboro, County of Windham, and State of Vermont, this 20th day of February, 2019.

By: 

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State of Vermont Department of Corrections
Inmate Disciplinary Report

PLAINTIFF'S EXHIBIT 1

Part I - Completed by Reporting Officer

Facility: Northwest State Correctional Facility

Docket number:

Inmate name: Ali, Hassin

DOB: 08/29/90 Living assignment: H106A

Date/Time of incident: 11-4-16 1600hrs

Location of incident: H104

☐ Check if the witness(es) is/are confidential. If so, do not list.

Witnesses:

Minor Violation:

19. Possession or use, to include being in the presence of tobacco smoke or a small amount of tobacco; <1 cigarette. M44

Major Violation:

None

Evidence:

see report

Signature of Reporting Officer: [signature]

Delivered by: COL Oyler

Initials & Date/Time of delivery: RD 11-9-16 1937

Part II - Completed by Shift Supervisor

Was the inmate segregated as a result of the charged violation? ○ Yes ◉ No Date segregated:

If Yes, the Notice of Hearing must be delivered within three (3) business days, the hearing held within four (4) business days.

Is the inmate SFI? ○ Yes ◉ No If Yes, refer inmate to a QMHP for assessment before hearing is held.

Name of QMHP performing assessment:

If SFI and moved to segregation, were contraindications checked before being moved? ○ Yes ○ No

Did a Physician approve this housing? ○ Yes ○ No Name of approving Physician:

Supervisor signature:

Employee assigned as Investigator:

Part III - Completed by Investigating Officer

Did you interview confidential informants? ○ Yes ○ No If Yes, see *Confidential Informant Form* for guidance.

Did you interview relevant witnesses? ○ Yes ○ No

Briefly explain:

Did you interview the inmate? ○ Yes ○ No

Briefly explain:

Did you compile available documentary evidence and statements of witnesses? ○ Yes ○ No

Briefly explain:

Investigating Officer's recommendation:

☐ Refer for resolution ☐ Do not refer for resolution

☐ Modify violation to:

Investigating Officer's signature:

Note: If the inmate is SFI by evidence of Part II, an assessment report by the QMHP must accompany this form to the Hearing Officer prior to the hearing.

Distribution: *Hearing packet, Offender*

State of Vermont Department of Corrections
Administrative Segregation Placement Report

PLAINTIFF'S EXHIBIT 2

Part I - Completed by Reporting Officer

Facility: NWSCF

Docket number:

Inmate name: Bissannett David

DOB: 5.22.78 PID #

Living assignment: D39

Date/Time of incident: 11/7/16

Location of incident: Delta

☐ Check if the witness(es) is/are confidential. If so, do not list.

Witnesses:

Reason for Placement on Administrative Segregation:

Ad Seg

Evidence:

Per CFSS Honsinger

Signature of Reporting Officer:

Delivered by:

Initials & Date/Time of delivery

Part II - Completed by Shift Supervisor

Date segregated:

Notice of Hearing must be delivered within three (3) business days, the hearing held within four (4) business days.

Is the inmate SFI? ◯ Yes ◯ No If Yes, refer inmate to a QMHP for assessment before hearing is held.

Name of QMHP performing assessment:

If SFI and moved to segregation, were contraindications checked before being moved? ◯ Yes ◯ No

Did a Physician approve this housing? ◯ Yes ◯ No Name of approving Physician:

Supervisor signature:

Employee assigned as Investigator:

Part III - Completed by Investigating Officer

Did you interview confidential informants? ◯ Yes ◯ No If Yes, see *Confidential Informant Form* for guidance.

Did you interview relevant witnesses? ◯ Yes ◯ No

Briefly explain:

Did you interview the inmate? ◯ Yes ◯ No

Briefly explain:

Did you compile available documentary evidence and statements of witnesses? ◯ Yes ◯ No

Briefly explain:

Investigating Officer's recommendation:

☐ Refer for resolution ☐ Do not refer for resolution

☐ Modify violation to:

Investigating Officer's signature:

Note: If the inmate is SFI by evidence of Part II, an assessment report by the QMHP must accompany this form to the Hearing Officer prior to the hearing.

Distribution: Hearing packet, Offender

May 2012

Treatment				11-22-2016 Tue 12:00 AM
BISSONNETTE, DAVID L	**Patient ID# 10001381**	**Gender: Male**		**DOB 05-22-1978**
Order:	Nurse - Sick Call Visit			
Instructions:	"My Heart hurts. been getting worse, Trouble Breathing as well. shallow Im scared. Ive tried eveverything pleas help."			
Carried Out?:	"My Heart hurts. been getting worse, Trouble Breathing as well. shallow Im scared. Ive tried eveverything pleas help." Yes			
By:	HRIPLEY			
On:	Tue 11-22-2016			
Shift:	Noon			
Reason:				
Verbal Order?:	No			
Comments:				

Order	11-22-2016 Tue 02:23 AM
BISSONNETTE, DAVID L	**Patient ID# 10001381 Gender: Male DOB 05-22-1978**
Order:	Nurse - Sick Call Visit
Instructions:	"My Heart hurts. been getting worse, Trouble Breathing as well. shallow Im scared. Ive tried eveverything pleas help."
Status:	Completed
Entered by:	KPLACE
Approval Status:	Pending
Approved/Rejected by:	
Approved/Rejected on:	
Requested Start Date:	Tue 11-22-2016
Requested Start Shift:	Noon
Requested End Date:	Tue 11-22-2016
Requested End Shift:	Noon
Actual Start Date:	Tue 11-22-2016
Actual Start Shift:	Noon
Actual End Date:	Tue 11-22-2016
Actual End Shift:	Noon
Renewal Date:	
Assigned to:	
Requesting Provider:	Place, Kailey
Supervising Department:	Clinical
Implementation Department:	Clinical
Verbal Order?:	No
Comments:	

Refusal of Treatment

Patient Name	Patient Number	Booking Number	Date of Birth	Today's Date
Bissonnette, David	10001381		5/22/78	11/22/2016

I, Bissonnette David (Name of Patient) have this day, knowing that I have a condition requiring medical care as indicated below:

- ☐ A. Refused medication
- ☐ B. Refused dental care
- ☐ C. Refused an outside medical appointment
- ☐ D. Refused laboratory services
- ☐ E. Refused X-Ray service
- ☐ F. Refused other diagnosis services
- ☐ G. Refused physical exam
- ☒ H. Other (Please Specify) B/C unit called for patient. Patient on list for lab draw for DPH, Hepc ab, Hiv oral Swab.

Reason for Refusal B/C Officer Bailey stated patient unable to come down for lab draw. Patient move to segregation per SI for not following orders. Per SI patient security risk for current behavior.

Potential Consequences Explained:

- ☒ A. Worsening of Medical Conditions
- ☒ B. Death
- ☒ C. Permanent Disability
- ☐ D. Other _____

I acknowledge that I have been fully informed of and understand the above refused treatment and the risks involved in refusing. I hereby release and agree to hold harmless Centurion and correctional personnel from all responsibility and any ill effects which may result from this refusal.

I have read this form and certify that I understand its contents.

Witness Signature: Tracy L Utter / LPN

Witness Signature: Susan Blum RN

Patient Signature: _____

Date: 11/22/2016

Time: 0930 am

Contract Vendor: Centurion of VT

PLAINTIFF'S EXHIBIT 5