**SUPERIOR COURT OF THE DISTRICT OF COLUMBIA**
**CIVIL DIVISION**

**ALFONZO FORTE**
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**LESTER WILKERSON**
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D.C. Correctional Treatment Facility
1901 E Street, S.E.
Washington, D.C. 20003

Plaintiffs,

v.

**DISTRICT OF COLUMBIA,**
400 Sixth Street, N.W.
Washington, D.C. 20001

Defendant.

Civil Action No. _____

JURY TRIAL DEMANDED

**COMPLAINT**

## PRELIMINARY STATEMENT

1. This is an action for damages based on negligent treatment endured by Plaintiffs Alfonzo Forte ("Mr. Forte"), Daniel Fleetwood ("Mr. Fleetwood"), Kevin Settles ("Mr. Settles"), Noah Summers ("Mr. Summers"), and Lester Wilkerson ("Mr. Wilkerson") carried out by correctional officers and other staff at the District of Columbia's Central Detention Facility ("CDF" or "the Jail").[1]

2. On September 15, 2023, Plaintiffs were trapped in their cells in the Jail's Mental Health Step-Down Unit ("MHSDU"), listening while fire burned unabated and filled the unit with thick black smoke they could not escape.

3. The fire was set by a resident who had spent the previous twelve hours crying for help from staff, yelling that he wanted to kill himself, and repeatedly requesting medical or psychological attention. After staff spent all night ignoring his calls for help, the resident eventually succeeded at pulling an electrical box fan from the hallway into his cell and using it to start a large electrical fire.

4. Jail staff ignored the resident's pleas and left him unattended during the three hours it took him to set up and light a series of small fires before the larger electrical fire. During their intermittent presence on the unit between approximately 7:00 a.m. and 10:45 a.m., staff witnessed the suicidal resident access and manipulate the electrical cord and outlet. However, despite this open and obvious hazard, the staff did nothing to intervene and ignored the explicit requests of Plaintiffs and other residents in violation of mandatory D.C. Department of Corrections ("DOC") policy.

[1] The District of Columbia Department of Corrections ("DOC") operates two facilities housing adults in its custody, the Central Detention Facility ("CDF") and the Correctional Treatment Facility ("CTF"). They are referred to collectively as the "Jail." For purposes of this Complaint, all relevant events alleged took place at CDF.

5. Visible flames burned off and on in the unit for almost an hour while on-duty staff remained unmoving in the glass control module overlooking the unit.

6. Plaintiffs could do nothing but watch in terror and bang on their cell doors as the fire grew. Only when the unit had filled completely with thick black smoke, choking and blinding Plaintiffs, did staff move to extinguish the fire and evacuate the residents.

7. The unit's fire alarms did not activate at any point before staff responded to the fire.

8. Plaintiffs each suffered severe discomfort and physical injuries from excessive smoke inhalation, including lasting breathing impairment and respiratory damage. They also experienced significant psychological distress from being trapped in close proximity to an active fire for an extended time, in fear for their lives. Absent staff intervention and powerless to act, their distress was compounded by Plaintiffs' known mental health vulnerabilities, the common factor around which the Mental Health Step-Down Unit is organized.

9. These harms are the predictable result of Defendant District of Columbia's failure to follow DOC's own basic policies—regarding mental health and suicide prevention, staffing, and fire safety and maintenance—after decades of well-documented neglect and dysfunction at the Jail.

10. The law requires the District to take steps before, during, and after a fire to prevent both the fires themselves and the harm they create. As described herein, the District failed Plaintiffs at every stage, and the physical and emotional harms Plaintiffs suffered, and continue to suffer, are a direct result of the conduct of Jail staff charged with protecting their rights and ensuring their safety.

## JURISDICTION

11. This Court has jurisdiction over this matter pursuant to D.C. Code § 11-921. All the acts and omissions complained of herein occurred in the District of Columbia.

12. Plaintiffs' claims against Defendant District of Columbia are subject to the notice requirement of D.C. Code § 12-309, which requires that written notice of a claim be given to the Mayor of the District of Columbia within six months of the injury.

13. Mr. Forte provided the D.C. Office of Risk Management ("ORM") with notice of this claim on November 1, 2023. The ORM issued an acknowledgement of the claim dated November 13, 2023, though Mr. Forte never received it. Exhibit A. Consequently, Mr. Forte has met his obligations under D.C. Code § 12-309 and this claim is legally ripe for presentation.

14. Mr. Fleetwood provided the ORM with notice of this claim on November 16, 2023. The ORM issued an acknowledgement of the claim dated November 21, 2023, though Mr. Fleetwood never received it. Exhibit B. Consequently, Mr. Fleetwood has met his obligations under D.C. Code § 12-309 and this claim is legally ripe for presentation.

15. Mr. Settles provided the ORM with notice of this claim on October 31, 2023. The ORM issued an acknowledgement of the claim dated November 6, 2023, though Mr. Settles never received it. Exhibit C. Consequently, Mr. Settles has met his obligations under D.C. Code § 12-309 and this claim is legally ripe for presentation.

16. Mr. Summers provided the ORM with notice of this claim on November 6, 2023. The ORM issued an acknowledgement of the claim dated November 13, 2023, though Mr. Summers never received it. Exhibit D. Consequently, Mr. Summers has met his obligations under D.C. Code § 12-309 and this claim is legally ripe for presentation.

17. Mr. Wilkerson provided the ORM with notice of this claim on November 6, 2023. The ORM issued an acknowledgement of the claim dated November 13, 2023, though Mr. Wilkerson never received it. Exhibit E. Consequently, Mr. Wilkerson has met his obligations under D.C. Code § 12-309 and this claim is legally ripe for presentation.

## PARTIES

18. Plaintiff Alfonzo Forte is a District of Columbia resident who, at all times relevant hereto, was housed at the Jail on its MHSDU. He is a 59-year-old Black man who currently resides at the Jail. Mr. Forte grew up in Southwest and Southeast D.C. and was diagnosed with bipolar disorder, depression, and post-traumatic stress disorder (PTSD) in approximately 2014.

19. Plaintiff Daniel Fleetwood is a District of Columbia resident who, at all times relevant hereto, was housed at the Jail on its MHSDU. He is a 32-year-old Black man who resides at a Bureau of Prisons facility in Atlanta, Georgia. Mr. Fleetwood lived in Prince George's County, Maryland as a teen and attended Parkdale High School, where he played multiple sports and competed for the school in track and field. Mr. Fleetwood was diagnosed with paranoid schizophrenia when he was first incarcerated in 2020 at age 26.

20. Plaintiff Kevin Settles is a District of Columbia resident who, at all times relevant hereto, was housed at the Jail on its MHSDU. He is a 39-year-old Black man who currently resides at U.S. Penitentiary Canaan in Waymart, Pennsylvania. Mr. Settles was diagnosed with attention-deficit/hyperactivity disorder (ADHD), schizophrenia, PTSD, and obsessive-compulsive disorder (OCD), and has a long history of suicide attempts beginning around age 25.

21. Plaintiff Noah Summers is a District of Columbia resident who, at all times relevant hereto, was housed at the Jail on its MHSDU. He is a 44-year-old Black man who resides at Samaritan Inns, a residential treatment program in D.C. Mr. Summers grew up in D.C. and attended the now-closed City Lights Public Charter School in Eckington, designed as an alternative program for at-risk youth. Mr. Summers was diagnosed with schizoaffective disorder, intermittent explosive disorder, bipolar disorder, and PTSD in his youth.

22. Plaintiff Lester Wilkerson is a District of Columbia resident who, at all times relevant hereto, was housed at the Jail on its MHSDU. He is a 65-year-old Black man who resides

at the Jail. Mr. Wilkerson was separated from his mother as a child and spent multiple years in and out of Junior Village—a notorious D.C. orphanage and group home that operated from 1958 to 1973 before it was shut down for rampant abuse, including rape and systemic drugging of children with psychiatric pills.[2] Mr. Wilkerson has a cognitive disability, and his sister therefore acts as his legal guardian. Mr. Wilkerson was also diagnosed with severe depression, anxiety, and bipolar disorder when he was a child.

23. Defendant District of Columbia is a municipality that maintains and operates the Jail and is and was at all relevant times responsible for the actions, inactions, policies, procedures, and practices of the DOC and its employees and/or contracted agents. The District of Columbia is responsible for the safety and security of all individuals held in the Jail.

**FACTS**

24. Unit North Three ("N3") is the Mental Health Step-Down Unit ("MHSDU") at the D.C. Jail's Central Detention Facility—a "therapeutic unit" housing residents who have been discharged from the Jail's acute Mental Health Unit ("MHU") but are not yet considered ready to return to the Jail's general population.[3]

25. MHSDU residents have more programming opportunities and fewer restrictions than those in the MHU, but they are supposed to remain under the constant supervision of an

[2] *See, e.g.*, Diane Bernard, *It was created as a refuge for needy kids. Instead they were raped and drugged*, Wash. Post (May 18, 2019), https://archive.ph/FSVkT/image; Elliot C. Williams, *Pastor Who Helped Shut Down D.C. Orphanage Riddled With Abuse Has Passed Away*, D.C.ist (Nov. 27, 2019), https://D.C.ist.com/story/19/11/27/pastor-who-helped-shut-down-d-c-orphanage-riddled-with-abuse-has-passed-away/; *The Ghost of Junior Village*, Wash. Post (Jan. 19, 1990), https://www.washingtonpost.com/archive/opinions/1990/01/19/the-ghost-of-junior-village/3032a3b5-b702-4f7f-91e1-4ef4cD.C.1a0b1/.

[3] D.C. Dep't of Corr. Pol'y & Proc. No. 6000.3B, Mental Health Step-Down Unit at 3, 5 (Mar. 12, 2024), https://doc.D.C..gov/sites/default/files/D.C./sites/doc/publication/attachments/PP%206000.3B%20MHSDU%203-12-2024.pdf (hereinafter "MHSDU Policy").

interdisciplinary treatment team that involves correctional officers, case managers, and mental health staff.[4]

26. DOC policy recognizes the heightened vulnerabilities of residents in the MHSDU, and staff are required to act urgently when they assess a resident as having unstable mental health needs or potentially being a danger to themselves or others.

[redacted]

28. Generally, DOC's security protocols require an officer to conduct cell checks, or "rounds," every thirty minutes.[5] [redacted]

### *A. Relevant Incidents.*

*i. September 14 – 15, 2023*

29. Beginning late during the evening of September 14, 2023, N3 residents began hearing a resident ("John Doe"), who was housed in Cell 18 of N3, repeatedly yelling that he wanted to kill himself and requesting to speak with a staff supervisor or a doctor. Mr. Doe's cries were audible to residents throughout the unit.

[4] *Id.* at 5.

[5] Office of the D.C. Auditor, *Urgent Need for New D.C. Jail* 76 (May 28, 2025), https://D.C.auditor.org/wp-content/uploads/2025/05/JailUpdate_Print3.pdf (hereinafter "D.C. Auditor 2025 Report").

[redacted]

32. Mr. Doe's pleas for help continued throughout the night and into the early hours of September 15, 2023. Unable to sleep, residents on the unit heard Mr. Doe repeatedly ask to see a supervisor and a psychiatrist throughout the night, but no supervisor, psychiatrist, or other mental health professional responded to him at any point overnight or into the following morning.

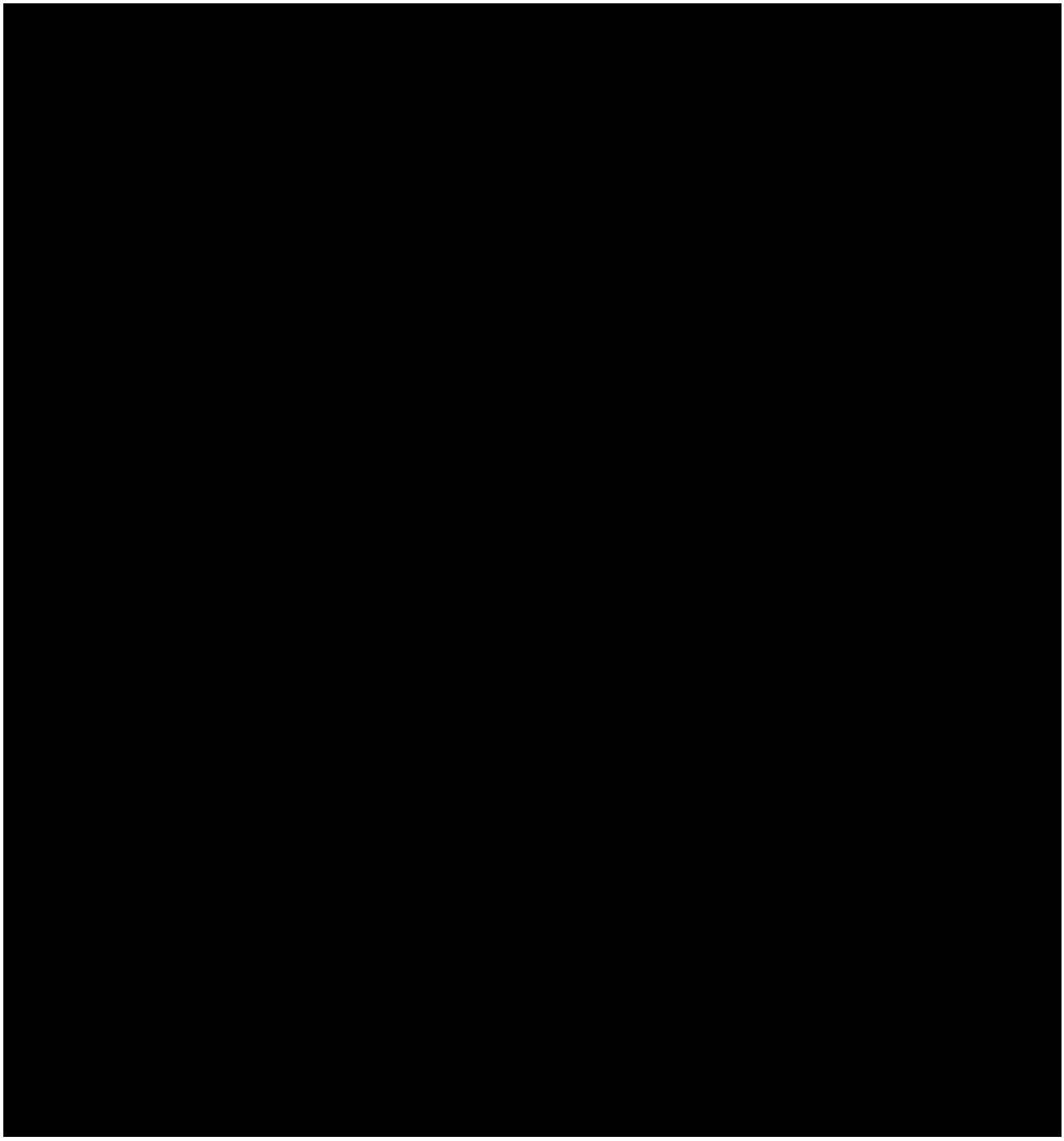
33. When staff did conduct rounds, the other residents on the unit, including some Plaintiffs, asked them to address Mr. Doe's repeated threats of suicide and his requests for staff attention, fearing that he posed a danger to himself and others.

34. In the early morning hours of September 15, Plaintiff Wilkerson was on overnight work detail. Mr. Wilkerson had been let out of his cell at approximately 2:00 a.m. to clean the unit and prepare meal service for the following day. While on detail, Mr. Wilkerson heard Mr. Doe screaming and went to speak with him outside Cell 18. Mr. Doe asked Mr. Wilkerson and another resident on work detail to tell Corporal Bello that he needed help as soon as possible.

35. Mr. Wilkerson told Corporal Bello that the resident in Cell 18 needed to speak with him.

36. Mr. Wilkerson concluded his work detail duties and was locked back in his cell on N3 at approximately 7:00 a.m.

[redacted]



42. At approximately 8:00 a.m. on September 15, 2023, after hours of unanswered pleas for help, Mr. Doe began lighting fires, first in Cell 18 and then in the unit hallway.

[redacted]

[redacted]

[redacted]

*Figure 1:* [redacted]

[redacted]

*Figure 2:* [redacted]

*Figure 3:* [redacted]

48. Starting at 10:28 a.m., Mr. Doe repeatedly threw small burning pieces of paper and fabric out of his cell into the hall and onto the fan. Each burned itself out in a few minutes.

49. Residents in the neighboring cells, including some of the Plaintiffs, observed Mr. Doe repeatedly pushing burning pieces of paper and mattress through the cell door slot, attempting to feed the fire he had started in the hallway. Mr. Forte's cell was directly across from Cell 18 and started filling with smoke during Mr. Doe's first attempts at lighting a fire. Mr. Forte asked Mr. Doe to stop adding fuel to the flames, but Mr. Doe responded that he wanted to die and continued his efforts.

[redacted]

*Figure 4:* [redacted]

*Figure 5:* [redacted]

51. [redacted]

[redacted] The unit fire alarms still did not activate.

*Figure 6:* [redacted]

52. Residents on the unit, including Plaintiffs, increasingly feared for their safety and frantically tried to get the attention of staff. Up and down the unit, residents banged repeatedly on their cell doors and yelled that there was a fire. Some Plaintiffs and other residents closed their cell door slots, trying to keep out the smoke. Some used towels and linens to try to stuff the gaps in their doors and to create makeshift masks. Mr. Settles even wet his makeshift mask in the toilet water from his cell before wrapping it around his head to try to reduce smoke inhalation.

53. Because no one was responding to the residents' shouts for help, Mr. Forte tried to use his Jail-issued tablet to call someone from his cell, but he could not see the screen due to the smoke. Meanwhile, Mr. Summers had the same idea and used his tablet to call a local legal organization, Disability Rights D.C.,[7] for help, reporting there was a fire on his unit.

[7] Designated by the Mayor of D.C. as the District's protection and advocacy agency in 1996, Disability Rights D.C. "provides individual and systemic legal advocacy, community outreach and education, and investigation of abuse and neglect for adults, children, and youth with disabilities." *See, e.g.*, University Legal Services, *Our Mission and Story*, https://www.uls-D.C..org/ourstory (last accessed Aug. 23, 2026).

[redacted]

55. Next, Mr. Doe shoved a pillow onto the fan and then another small burning object on top of it. Finally, at 10:52 a.m., the pillow caught fire and then spread to the electrical fan underneath.

*Figure 7:* [redacted]

56. Multiple Plaintiffs saw or heard the doors to the tier (or "fire doors") close, making them feel even more trapped. It was this moment when both Mr. Forte and Mr. Summers felt like they were going to die. The residents continued to bang on their cell doors, screaming and pleading for their lives.

57. As the fire rapidly grew, eventually reaching a height comparable to that of the cell door itself, the unit filled with thick black smoke and a pungent chemical smell.

58. At this point, the unit was so smoky that multiple Plaintiffs could not see their hand in front of their faces.

*Figure 8:* [redacted]

*ii. Evacuation & Aftermath*

59. At approximately 10:53 a.m.—after three hours of continuous fire-starting attempts—Corporal Lewis entered the unit and deployed the fire extinguisher, extinguishing the fire and releasing a high volume of debris and particles onto the unit, especially the cells neighboring Cell 18. Afterwards, Corporal Lewis left the unit and closed the tier door behind him.

60. Plaintiffs and other residents on the unit remained locked inside their cells. Many of them began choking on the thick black smoke, unable to talk or breathe.

61. At approximately 10:56 a.m., the cell doors on the unit opened electronically. The residents immediately ran out towards the stairwell, causing mass confusion due to near-zero visibility and the residents' panic as they fled the flames after three hours of psychological distress.

62. By the time the cell doors were unlocked, Mr. Summers' cell had filled with smoke so thick that he was coughing, unable to breathe, unable to see, and was completely disoriented. He had to follow the resident directly in front of him to find his way off the unit.

63. Mr. Settles had to be guided out of the unit by staff because he could not see, his eyes burning from the smoke.

64. After escaping the unit itself, the residents of N3 were evacuated to a hallway outside the unit, [redacted]

65. Mr. Forte, coughing violently, collapsed into a crouching position on the floor, burying his head between his knees and trying to gain his breath. Afterwards, Mr. Forte asked to be taken to medical and was escorted to the infirmary.

66. All the other N3 residents were taken to the recreation yard, despite many also still coughing and struggling to catch their breath. There, they waited for medical attention for approximately an hour.

67. Mr. Summers, who suffers from asthma and uses an inhaler, requested more intensive care as he was still struggling to breathe. He was eventually taken to the infirmary while the other N3 residents continued to wait in the recreation yard.

68. Mr. Settles suffers from a heart condition and a history of childhood asthma, and he also requested additional treatment.[8] Staff refused his request and instead recommended that he take a shower. Mr. Settles' request for an inhaler—because the smoke inhalation exacerbated his pre-existing respiratory problems—was denied by staff, who responded that no inhaler was available and he would have to wait to receive one.

[8] Mr. Settles had asthma and a heart monitor as a child. In addition, his DOC medical records show a diagnosis of reactive airway disease.

69. In 2020, Mr. Wilkerson was hospitalized for COVID-19 and pneumonia, and he was prescribed two types of inhalers to treat ongoing respiratory issues. Despite this documented medical history, Mr. Wilkerson's request to go to the infirmary was also denied by staff.

70. The N3 residents remaining in the yard, all suffering the ill effects of prolonged smoke inhalation, had their vitals checked and were given COVID tests before being cleared to return to the unit, which had not yet been cleared of smoke.

71. Mr. Forte was still choking and short of breath when he arrived at the infirmary. DOC medical staff told him to drink water, then took his vitals, and then finally advised Mr. Forte that he was choking because of his still smoky clothing. Although they instructed him to take a shower and gave him new clothes, they did not prescribe him any medication for his presenting symptoms.

72. While in the infirmary, Mr. Summers was wheezing, short of breath, and in pain. When asked by medical staff how he would rate his pain on a scale of 1-10, Mr. Summers said his pain was a 20 on account of how badly his chest hurt. Medical staff told him that his heart did not sound good. He was given oxygen, an injection for his chest pain, and an inhaler before being sent back to the N3 unit.

73. When the residents, including Plaintiffs, returned to the N3 unit at approximately 2:30 p.m.—nearly six hours after Mr. Doe first started setting the fire—they found it still smoky and their cells covered in debris from the fire extinguisher.

74. Plaintiffs were then forced to assist in the clean-up of the N3 unit without any proper safety equipment, which exacerbated their respiratory distress. Each resident was responsible for cleaning their own cell, and residents assigned to work details cleaned throughout the unit, exposing them further to the debris. Mr. Fleetwood was tasked with sweeping and mopping up debris and fire extinguisher foam, while Mr. Wilkerson helped paint over the cell door

where the fire had originated. Residents were not provided with any face masks for protection as they cleared out chemicals and ash on the smoky unit.

75. After hours of anxiety, fear, and uncertainty stemming from a preventable fire on the MHSDU, Plaintiffs were returned to N3 with physical injuries, psychological distress, and more questions than answers.

76. For at least several days following the fire, no DOC official interviewed any of the Plaintiffs or, upon information and belief, any other resident of the N3 unit regarding the circumstances of the fire.

77. In fact, with the exception of Mr. Forte, who was provided new clothing at the infirmary, Plaintiffs had to use their smoky clothing and bedding for days after the fire. Although Plaintiffs asked DOC staff for clean linens right away, they did not receive any until they were finally able to make their request to Deputy Warden Williams, who came to their unit in the weeks after the fire. Deputy Warden Williams also told Plaintiffs during that visit that he had seen the footage of the fire and was disturbed by how long it took DOC officers to respond.

78. Within a month after the fire, Plaintiffs also observed individuals who appeared to work for the fire department check the fire alarms on their unit on multiple occasions. After these inspections, the alarms would randomly go off on their unit. During one of these visits, Mr. Forte asked one of the individuals why the fire alarm did not go off during the fire, and she replied that the alarm was broken that day.

79. Mr. Forte, Mr. Fleetwood, Mr. Summers, and Mr. Wilkerson submitted additional grievances explaining that they feared for their lives during the fire and how that trauma negatively affected their mental health, and they also expressed concern for their safety because the correctional officer who had ignored Mr. Doe's repeated pleas for help continued to work on the N3 unit.

80. In response to many of these grievances, multiple Plaintiffs received formal denials from DOC stating that "[t]here [was] no indication that [they] were personally affected by a Department or facility action or policy/procedure." The denials also included an attachment stating that the fire alarm had worked and all designated responders promptly showed up.

81. A few weeks after the fire, Mr. Forte met with Deputy Warden Williams and other executive officers to discuss the Plaintiffs' grievances. DOC staff asked Mr. Forte what they could do to resolve these grievances. Mr. Forte requested that Officer Bello be removed from N3, because he was still working there despite having put Plaintiffs in harm's way by ignoring Mr. Doe's mental health emergency. Mr. Forte also explained that the Plaintiffs wanted assurances that DOC staff would follow both safety and mental health protocols moving forward to ensure something like the fire would not happen again. Although the officers listened to Mr. Forte, they did not say whether they would implement any changes.

*iii. Plaintiffs' Injuries*

82. As a result of their prolonged exposure to the fire and being trapped in their smoke-filled cells, Plaintiffs suffered physical injuries including smoke inhalation and respiratory issues. The life-threatening ordeal also caused Plaintiffs severe emotional distress that has continued to manifest in ongoing psychological symptoms, including anxiety, sleep disturbances, hypervigilance, racing thoughts, and recurring panic attacks when recalling the incident.

a. Alfonzo Forte

83. Mr. Forte had no pre-existing respiratory problems before the fire.

84. While at the Jail in September and October of 2023, Mr. Forte continued to report suffering from a raw and sore throat, coughing, and trouble breathing.

85. According to Mr. Forte's medical records, he was seen by DOC medical staff three additional times in September after the day of the fire. During the first visit, on September 17, they

noted that his cough, caused by the smoke exposure, was stable, but that it was associated with chest pain; he was instructed to follow up by sick call if symptoms continued.

86. On September 22, Mr. Forte reported to medical staff that his cough had worsened, along with shortness of breath and blood in his phlegm, all of which also caused insomnia. Despite noting these symptoms, DOC medical staff also reported that Mr. Forte was "trying to imitate asthma [symptoms]," but ended up prescribing Benzonatate and Mucinex anyway.

87. On September 28, at Mr. Forte's chronic care appointment, his doctor recorded Mr. Forte's ongoing cough, phlegm, congestion, and throat irritation due to the fire. His doctor noted that the Benzonatate and Mucinex had "failed," told Mr. Forte to drink more water, and ordered him throat lozenges.

88. Mr. Forte continued to experience coughing, throat irritation, and respiratory problems in the weeks and months after the fire, and he repeatedly requested further medical care or a specialist visit. He was never scheduled to see a specialist at the Jail and, by October 13, 2023, when he reiterated his need for further medical care, he was told that DOC medical staff had already cleared him.

89. Mr. Forte thought he was going to die the day of the fire and was deeply traumatized by the incident, exacerbating his pre-existing PTSD and bipolar diagnoses. During group and individual therapy sessions with other MHSDU residents in the months following the fire, Mr. Forte repeatedly brought up the fire and how his mental health was suffering as a result.

90. Mr. Forte has never fully recovered from the respiratory issues he suffered because of the fire. He still gets frequent coughs, approximately every few weeks, and his snoring has significantly worsened—his cellmates have told him that they can hear him grinding his teeth and choking in his sleep, causing them concern. Mr. Forte's trauma from the fire also persists to the

present day, and he regularly has nightmares about the fire and panic responses when he is reminded of the fire.

b. Daniel Fleetwood

91. Mr. Fleetwood had no pre-existing respiratory problems before the fire.

92. From September to November 2023, Mr. Fleetwood suffered from an irritated throat, cough, and chest congestion, and he frequently submitted sick calls and grievances to the Jail asking for treatment.

93. During this period, Mr. Fleetwood saw medical staff four times for his respiratory issues. He was prescribed three medications to treat these symptoms, including an albuterol inhaler. Mr. Fleetwood had previously never used an inhaler; in contrast, after the fire and through at least early December 2023, Mr. Fleetwood used an inhaler around twice a day to treat his symptoms.

94. In addition, during individual and group therapy sessions with other MHSDU residents in the months following the fire, Mr. Fleetwood discussed how his mental health suffered due to the fire. For example, for at least a few weeks following the incident, he experienced vivid terror-filled dreams about being trapped in a fire, even though normally he rarely had nightmares. He also reported that he was experiencing increased auditory hallucinations of voices in his head after the fire.

95. Today, Mr. Fleetwood still suffers intermittent coughing fits and difficult-to-clear chest congestion when waking up or going to sleep, which he did not experience before the fire. When his chest congestion is particularly bad, he attempts to alleviate it by using Vicks topical rub purchased from commissary, but it does not do much to help.

96. Moreover, Mr. Fleetwood also gets winded faster as a result of his ongoing respiratory issues since the fire, which has negatively impacted his ability to exercise and maintain the high athletic stamina he had throughout his life before this incident.

c. Kevin Settles

97. Throughout September and October 2023, Mr. Settles continued to report respiratory issues to DOC staff, submitting both sick calls and grievance forms.

98. Despite requesting an inhaler on the day of the fire, it was not until weeks later, on September 28, that Mr. Settles received an albuterol inhaler. During this visit, DOC medical staff recorded that he sounded congested and was short of breath.

99. On October 3, Mr. Settles experienced strong chest pains and asked to be taken to the hospital. Instead, he was seen by medical staff at the Jail. During his visit, he reported that he had inhaled too much smoke and was struggling to breathe. Mr. Settles was required to use his prescription inhaler to address his ongoing symptoms.

100. On October 26, Mr. Settles was again seen because he was short of breath. He explained that his trouble breathing was now causing him to have back spasms too, and he was prescribed a muscle relaxant to treat the spasms.

101. The next day, Mr. Settles once again went to medical to discuss these issues. He was prescribed a Medrol dose to manage his symptoms.

102. Mr. Settles continued to experience chest pains and shortness of breath. At the beginning of 2024, he struggled to exercise as much as he had before the fire because of these symptoms, which negatively affected his overall health.

103. Mr. Settles has had to use his inhaler continuously since the fire, whereas before he used it only rarely, on an as-needed basis. His mental health also continues to be affected by the trauma from the fire, specifically amplifying his feelings of hopelessness and hypervigilance. For

example, he experiences heightened anxiety at night and often cannot sleep for fear that his cell is going to catch on fire.

d. Noah Summers

104. Mr. Summers was seen by DOC medical staff multiple times in September and October 2023 for ongoing respiratory issues. Throughout this period, he was prescribed five different medications for these issues, as well as a Symbicort steroid inhaler for his exacerbated asthma. Despite this, medical staff told him during a visit in October that his lungs still did not sound good, and he would ultimately need a specialist. During his chronic care appointment on October 20, 2023, Mr. Summers' doctor noted that his asthma had deteriorated. By this time, Mr. Summers was using an inhaler approximately six times per week.

105. Mr. Summers' mental health also suffered as a result of the fire. His cell was only two cells away from Cell 18, and he could see Mr. Doe's persistent efforts to light a fire in the hallway.[9] Watching the fire grow with no staff intervention, Mr. Summers felt terrified, helpless, and genuinely thought he was about to burn alive in his cell. He considers the day of the fire as one of the worst of his life.

106. Today, Mr. Summers still suffers from shortness of breath, wheezing, and chest pain. He experiences these symptoms multiple times per week. He also feels more claustrophobic and anxious as a result of the fire, and he was prescribed anxiety medication for his increased symptoms in 2025. Mr. Summers has regular anxiety attacks, nightmares, and panic responses related to the fire. For example, when he sees a fire on TV or if someone uses a lighter near him, Mr. Summers feels himself start to panic, with an elevated heart rate and racing thoughts. He continues to go to therapy to treat this increase in his PTSD and anxiety.

[9] Mr. Summers was in Cell 16, which was two cells down from Mr. Doe's (Cell 18), on the same side.

e. Lester Wilkerson

107. Mr. Wilkerson's pre-existing respiratory issues were exacerbated by smoke inhalation during the fire, which is reflected in his requests for medical care through grievances and sick calls.

108. In addition, Mr. Wilkerson's mental health was significantly negatively impacted by the trauma he endured while being trapped in his cell as the fire raged. After the fire, Mr. Wilkerson reported multiple times that his anxiety was increasing, both to psychology staff at the Jail and to his legal advocates. He asked DOC medical and psychology staff specifically for a change in his anxiety medication because he felt that his medication at the time was not helping to reduce his symptoms. Even though he eventually got his requested medication, he continued to suffer increased anxiety.

109. These severe psychological symptoms culminated on November 15, 2023, with an attempt to take his own life. Mr. Wilkerson was placed on suicide watch for approximately three days before being moved to a suicide precaution unit (N1). On November 19, he attempted suicide a second time and was placed on suicide watch before being downgraded and returned to unit N1 on November 20. Mr. Wilkerson was eventually transferred back to unit N3 on or around December 27, 2023.

110. Today, when Mr. Wilkerson goes on a longer walk and when it is hot outside (or he is in a heated room), Mr. Wilkerson experiences shortness of breath. He continues to use both the inhalers that he has been prescribed approximately every 4–6 hours.

### *B. DOC Policy Violations.*

111. The fire occurred following multiple serious violations of DOC policy.

*i. Suicide Prevention and the MHSDU*

112. The Jail's MHSDU policies acknowledge the risk of suicidality and outline special procedures and protections for suicidal residents. [redacted]

113. DOC maintains a written policy governing the prevention of, and response to, suicide and self-harm among residents in its custody.[10] That policy requires correctional staff to take seriously all threats of suicide or self-harm and requires staff who observe, or are informed, that a resident is displaying signs of suicidal behavior, including verbal threats of suicide, to immediately notify a medical or mental health professional and the shift commander, and maintain a constant watch over the resident until medical or mental health staff arrive.

114. DOC policy further requires that, once notified, a medical or mental health professional respond to evaluate the resident within four minutes if the situation is deemed an emergency, or within one hour if deemed a non-emergency.[11]

115. If the medical or mental health professional deem the resident to be at risk for self-injury, staff are required to transfer them to the MHU and implement suicide precaution protocols. When released from suicide precaution, they must be admitted to the MHU until the treatment team deems them ready to return to the MHSDU.

[redacted]

117. Upon information and belief, correctional officers did not notify mental health staff, medical staff, or the shift commander in response to Mr. Doe's repeated outbursts that he wanted

[10] DOC Policy & Procedure No. 6080.2G, *Suicide Prevention and Intervention* (Aug. 9, 2017), https://doc.D.C..gov/sites/default/files/D.C./sites/doc/publication/attachments/PP%206080.2G%20Suicide%20Prevention%20and%20Intervention%208-9-2017.pdf ("Suicide Prevention Policy").

[11] *Id*. § 17(j).

to kill himself. They did not maintain a watch over Mr. Doe or take any actions that the Plaintiffs recognized as typical following resident expressions of suicidal ideation.

118. Had correctional staff complied with DOC's suicide-prevention policy and notified medical or mental health staff of Mr. Doe's repeated threats of self-harm, a clinician would have responded within minutes and the fire described above would have been prevented.

*ii. Staffing and Attention to Duty*

119. On the morning of September 15, 2023, there were insufficient correctional officers present and attentive on the unit to promptly detect the fire, sound an alarm, or evacuate residents in accordance with DOC's mandatory protocols.

122. Upon information and belief, Corporal Bello's staffing assignment was changed to a different unit due to his performance failures described above.

*iii. Fire Safety*

126. A fire is considered an "*Extraordinary Occurrence*" under DOC policy, defined as "Any event, planned or unplanned, which results in loss of life, serious bodily injury or poses an immediate threat to the health, safety and/or welfare of staff, inmates or the general public."[12] As such, any employee who witnessed or became aware of a fire was mandated to immediately notify a Correctional Supervisor/Office Chief/Manager.[13]

[12] DOC Policy & Procedure No. 1280.2J, *Reporting and Notification Procedures for Significant Incidents and Extraordinary Occurrences* (March 28, 2022), https://doc.D.C..gov/sites/default/files/D.C./sites/doc/publication/attachments/PP%201280.2J%20Reporting%20and%20Notification%20Procedures%20for%20Significant%20Incidents%20and%20Extraordinary%20Occurrences%2003-28-2022.pdf ("Significant Incident Reporting Policy").

[13] *Id.* at 8.

127. The District of Columbia's Property Maintenance Code requires that buildings within the District, including DOC facilities, be equipped with operable smoke alarms appropriately placed to provide early warning of fire.[14]

128. Upon information and belief, and consistent with the District's Office of Inspector General's (OIG) 2021 finding that DOC had for years neglected to fund repairs to other life-safety and monitoring equipment in its facilities,[15] DOC likewise failed to ensure that smoke detectors and fire alarms in Plaintiffs' housing unit were installed, maintained, and in working order.

129. The D.C. Auditor's 2025 report, *Urgent Need for New D.C. Jail*, noted consistent smoke detector deficiencies and twenty-two fires at the Jail between July 1, 2023, and June 30, 2024.[16]

130. As a result of this failure, smoke detectors and fire alarms on the unit failed to activate when the fire described herein produced enough smoke to fill the housing unit and obscure Plaintiffs' vision as they attempted to evacuate.

131. Defendant's actions and inactions created a substantial and unreasonable risk to Plaintiffs' safety that directly resulted in the fire, Plaintiffs' entrapment, and the physical and emotional injuries they suffered.

### *C. D.C. Jail Background.*

132. The D.C. Jail has a well-documented history of chronic and severe understaffing, inadequate staff supervision and training, and systemic neglect of its residents.[17] As of 2025, its

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[14] D.C. Mun. Regs. tit. 12-G (Property Maintenance Code), ch. 7, § 704 (smoke alarm requirements).

[15] July 2021 OIG Report.

[16] D.C. Auditor 2025 Report at 14-15.

[17] *See, e.g.*, *Chronology of D.C. Jail Crisis*, Wash. Post (Mar. 23, 1986), https://web.archive.org/web/20250126002435/https://www.washingtonpost.com/archive/local/1986/03/23/chronology-of-D.C.-jail-crisis/3bd80546-0323-476d-9ee6-ba6ce8396a3f/; Findings and Order Appointing Receiver, *Campbell v. McGruder*, No. 1462-71 (WBB), consolidated with *Inmates of D.C. Jail v. Jackson*,

death rate (including suicides, murders, and overdoses) was more than 3.5 times the national average.[18]

133. The District has known for well over a decade that its correctional staff do not reliably identify, respond to, or escalate residents' threats of suicide and self-harm in accordance with DOC's own policies.

134. Following a cluster of resident suicides at the Jail in 2012 and 2013, then-DOC Director Thomas Faust sought the assistance of an outside suicide-prevention consultant through the National Institute of Corrections.[19] The consultant's resulting assessment found, among other things, that the amount of suicide-prevention training provided to correctional, medical, and mental health staff at the Jail was inadequate.

135. A subsequent review of conditions at the Jail similarly found that correctional staff assigned to work with residents who had mental illness received no specialized training in suicide

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No. 75-1668 (WBB) (D.D.C. Jan. 11, 1995); *Inmates of D.C. Jail v. Jackson*, 158 F.3d 1357 (D.C. Cir. 1998); Serge F. Kovaleski, *D.C. Finds Dangers in Ailing Jail*, Wash. Post (Sept. 16, 2000), https://www.washingtonpost.com/archive/politics/2000/09/17/D.C.-finds-dangers-in-ailing-jail/c1795a71-92d9-4693-892c-5f0b054628ea/; U.S. Gen. Accounting Office, GAO/T-GGD-00-173, *District of Columbia Receivership: Selected Issues Related to Medical Services at the D.C. Jail*, Statement of Laurie E. Ekstrand, Director, Administration of Justice Issues, Testimony Before the Subcomm. on the District of Columbia, H. Comm. on Government Reform (June 30, 2000), https://www.gao.gov/assets/t-ggd-00-173.pdf; Washington Lawyers' Committee for Civil Rights & Urban Affairs, *D.C. Prisoners: Conditions of Confinement in the District of Columbia* (June 11, 2015), https://www.washlaw.org/pdf/conditions_of_confinement_report.pdf (hereinafter "2015 WLC Conditions Report"); Office of the D.C. Auditor, *Poor Conditions Persist at Aging D.C. Jail; New Facility Needed to Mitigate Risks* (Feb. 28, 2019), https://D.C.auditor.org/report/poor-conditions-persist-at-aging-d-c-jail-new-facility-needed-to-mitigate-risks/ (hereinafter "D.C. 2019 Auditor Report"); Statement by the U.S. Marshals Service Re: Recent Inspection of D.C. Jail Facilities, U.S. Marshals Service (Nov. 2021), https://www.usmarshals.gov/news/press-release/statement-us-marshals-service (hereinafter "2021 USMS Statement"); D.C. Auditor 2025 Report.

[18] D.C. Auditor 2025 Report.

[19] Report on Suicide Prevention Practices Within the District of Columbia, Department of Corrections' Central Detention Facility (Sept. 13, 2013), https://doc.D.C..gov/sites/default/files/D.C./sites/doc/release_content/attachments/D.C.%20JAIL-LH.pdf.

prevention.[20] In 2015, the widow of a man who died by suicide at the Jail in 2013 filed a federal lawsuit against the District, alleging that Jail staff had failed to adequately treat her husband's mental illness and had given him access to an item he used to harm himself.[21] The District ultimately agreed to pay $1.5 million to settle the widow's claims.

136. As recently as July 2021, the D.C. Office of the Inspector General ("OIG") audited DOC's procedures for responding to incidents involving resident safety and use of force and found that DOC staff repeatedly failed to consistently and correctly apply the Department's own operating procedures.[22] The same July 2021 D.C. OIG audit found that DOC had operated the Jail in a chronically understaffed condition for years without developing a plan to remedy it.[23]

137. In late 2021, following an unannounced inspection of CDF, the United States Marshals Service ("USMS") publicly reported that conditions at the facility failed to meet minimum detention standards, which prompted the USMS to remove hundreds of people in federal custody from the facility.[24]

138. The USMS announced that the inspection was prompted by "recent and historical concerns" and found "evidence of systemic failures" in both the conduct of the staff and condition of the facility.[25] Their public memo included the following about CDF in particular:

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[20] *Suicides, Poor Conditions at D.C. Jail Remain Critical Issues Despite Progress,* PRISON LEGAL NEWS (Feb. 29, 2016), https://www.prisonlegalnews.org/news/2016/feb/29/suicides-poor-conditions-D.C.-jail-remain-critical-issues-despite-progress/.

[21] *Id.* (referencing *Mannina v. District of Columbia*, 1:15-cv-00931-ACR (D.D.C. filed June 17, 2015)).

[22] DOC's Current Procedures for Receiving, Investigating, and Resolving Use of Force Incidents Are Not Operating Effectively, District of Columbia Office of the Inspector General, OIG Project No. 20-1-26FL (July 2021), https://oig.D.C..gov/sites/default/files/Reports/OIG%20Final%20Report%20No.%2020-1-26FL%20--%20Department%20of%20Corrections%20Use%20of%20Force.pdf ("July 2021 OIG Report").

[23] *Id*.

[24] 2021 USMS Statement.

[25] *Id.*

> [W]ater and food appear[ed] to be punitively withheld from detainees; 'large amounts of standing human sewage' in the toilets of multiple occupied cells causing 'the smell of urine and feces' to overpower; detainees in certain areas not being able to drink water, wash hands or flush toilets because water had been shut off for days; that DOC staff 'confirmed to inspectors' that the cells' water is 'routinely shut off' punitively; that food delivery and storage was 'inconsistent with industry standards; evidence of 'pervasive' drug use; that DOC staff were observed 'antagonizing detainees;' that detainees had 'observable injuries with no corresponding medical or incident reports available to inspectors,' and that 'supervisors appeared unaware or uninterested in any of these issues.'[26]

139. The November 2021 USMS inspection found that resident supervision and monitoring at the Jail fell below minimum detention standards.[27]

140. A 2019 report from the Committee on Facilities & Services to the District Task Force on Jails & Justice similarly concluded that the Jail was "chronically understaffed."[28]

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[26] Madeleine Carlisle, *The Crisis at the D.C. Jail Began Decades Before Jan. 6 Defendants Started Raising Concerns*, TIME, 4 (Jan. 8, 2022), https://www.congress.gov/118/meeting/house/116626/documents/HHRG-118-JU10-20231205-SD003.pdf (quoting USMS Statement).

[27] 2021 USMS Statement.

[28] *See* District Task Force on Jails & Justice, *Report of the Committee on Facilities & Services to the District Task Force on Jails & Justice*, 6 (Aug. 19, 2019), https://web.archive.org/web/20240423180237/http:/www.courtexcellence.org/uploads/publications/FacilitiesServices.pdf ("The CDF and CTF are also chronically understaffed. Overtime costs at DOC have been increasing every year since FY13. The increase was particularly sharp in FY16, when actual costs began to significantly outstrip the approved budget."); DOC Responses to D.C. Council Question FY2023 and FY2024 to Date, at *4 ("In FY23, DOC had 1,028 filled positions. There were 205 vacancies. Approximately 200 positions (73%) were vacant for over a year; about half of the vacancies, 133 positions (48.5%), were for uniformed staff. Ninety-two (92) DOC positions were frozen in FY23."); D.C. Auditor 2025 Report at 26–27 ("During the audit period, DOC had one of the lowest ratios in the nation of residents to correctional officers in jails based on the most recently available data . . . [a]t the end of the audit period (6/30/24), DOC reported that about 15% (125 funded positions) were vacant."); *id.* at 49 (noting that DOC "does not appear to provide adequate staff training related to required protocols surrounding security checks"); *id.* at 41-46 (describing high no-show rates among staff for DOC trainings, as well as inconsistencies and gaps in training participation, and noting that the lack of attendance at trainings is particularly concerning for topics such as mental health).

141. The District has repeatedly been sued by individuals alleging harms resulting from understaffing at the Jail.[29]

142. Upon information and belief, these staffing and supervisory deficiencies persisted, unremedied, through September 2023 and directly contributed to the insufficient number of officers present and attentive on Plaintiffs' unit at the time of the fire.

143. The District has also known for well over a decade that the deteriorating physical condition of the D.C. Jail was dangerous for both residents and staff.[30] A 2015 report noted persistent presence of vermin and mold, frequent electricity issues and frayed wiring, broken fire and smoke alarms, leaking, flooding, extreme heat/cold, unusable cells, and plumbing and maintenance failures.[31]

144. The DOC has formally taken the position that the current D.C. Jail is unfit and should be replaced by a new facility.[32]

145. The District openly acknowledges that the people in its custody are put in life-threatening danger by the physical conditions of the D.C. Jail and have been for decades. In 2021, in response to the USMS inspection and report, then D.C. Attorney General Karl Racine testified before the D.C. Council:

> Concerns about conditions in the jail have been raised since almost the moment it was built. Class action lawsuits about conditions in the jail resulted in a decades-

[29] *See, e.g.*, *Bah v. District of Columbia*, Amended Complaint ¶¶ 17-32, No. 1:23-cv-01248-JDB (D.D.C. June 22, 2023); *Brown v. District of Columbia* Compl., No. 2022-CA-004282-B (D.C. Super. Ct. Apr. 4, 2023).

[30] *See, e.g.*, 2015 WLC Conditions Report, 2019 D.C. Auditor Report, 2021 USMS Statement; 2025 D.C. Auditor Report.

[31] Washington Lawyers' Committee for Civil Rights & Urban Affairs, *D.C. Prisoners: Conditions of Confinement in the District of Columbia* (June 11, 2015), https://www.washlaw.org/pdf/conditions_of_confinement_report.pdf.

[32] Tom Fitzgerald, *D.C. Jail's Death Rate More than Three Times the National Average, Audit Says*, FOX 5 D.C. (May 28, 2025), https://www.fox5D.C..com/news/D.C.-jails-death-rate-mo1re-than-three-times-national-average-audit-says.

> long consent decree and a federal takeover of the jail's medical care. In 2019, the D.C. Auditor issued a report documenting poor conditions and highlighting an aging physical plant and a failure to make capital improvements recommended by jail officials. The Auditor recommended the District commit adequate funds and build a new facility.
>
> Then, just last week, the U.S. Marshals reported indications of systemic failures in the jail . . . A lack of money is not the reason these problems persist. There is a lack of will and leadership – and it comes from the top . . .
>
> The most recent allegations will lead to changes at the jail. They will have to.[33]

146. Despite the multiple public inspections and audits that have confirmed the dangerous condition of the D.C. Jail's fire safety and maintenance, the District has not conducted sufficient maintenance to repair or sufficiently mitigate the buildings' deterioration.

**COUNT ONE**

**Negligence**

147. Plaintiffs incorporate by reference as though fully stated herein, the allegations set forth in Paragraphs 1–146 above.

148. Under District of Columbia common law, a negligence claim is established by: (1) the existence of a duty of care; (2) breach of that duty; (3) legal causation; and (4) damages. *See District of Columbia v. Cooper*, 483 A.2d 317, 321 (D.C. 1984); *District of Columbia v. Wilson*, 721 A.2d 591, 597 (D.C. 1998).

149. Defendant District of Columbia owed Plaintiffs a duty of reasonable care for their safety while housed at the Jail. DOC has statutory responsibility for "the safekeeping, care, protection, instruction, and discipline of all persons committed to [its] institutions," D.C. Code § 24-442; *Matthews v. District of Columbia*, 387 A.2d 731, 734 (D.C. 1978), as well as a

[33] District of Columbia Office of the Attorney General, *AG Racine Testimony on Conditions at DC Jail (As Prepared for Delivery)* (November 10, 2021), https://oag.dc.gov/release/ag-racine-testimony-conditions-dc-jail-prepared.

responsibility to abide by the duty of care outlined in its policies pertaining to MHSDU, which recognize the unique vulnerabilities of the residents who live there.

150. Defendant District of Columbia breached that duty by, among other things, failing to maintain operable smoke detectors and fire alarms in Plaintiffs' housing unit, failing to adequately staff the unit, and failing to respond to the fire in a timely and adequate manner.

151. The District of Columbia is also vicariously liable for the negligence of its employees who acted within the scope of their employment, including but not limited to Corporals Bello, Ibeawuchi, Okpara, Kalu, Animusaun, and Lewis; Shift Captain Cobb; case manager Vactor; and Sergeant Shawn Franklin.

152. As a direct and proximate result of the negligence and carelessness of the District of Columbia and its employees, Plaintiffs were trapped in a smoke-filled housing unit and suffered physical and emotional injuries, for which they seek compensatory damages from the District of Columbia in an amount to be determined at trial.

**COUNT TWO**

**Negligent Supervision and Training of Staff**

153. Plaintiffs incorporate by reference as though fully stated herein, the allegations set forth in Paragraphs 1–152 above.

154. To prevail on a negligent supervision/training claim under D.C. law, a plaintiff must show that (1) the employer knew or should have known the employee behaved in a dangerous or incompetent manner, and, (2) with that actual or constructive knowledge, failed to adequately supervise or train, and (3) that this failure was a substantial factor causing the harm. *See, e.g.*, *Giles v. Shell Oil Corp*., 487 A.2d 610, 613 (D.C. 1985); *District of Columbia v. Tulin*, 994 A.2d 788, 794 (D.C. 2010); *Blair v. District of Columbia*, 190 A.3d 212, 229 (D.C. 2018)**.**

155. Defendant District of Columbia is responsible for ensuring that all DOC staff are properly trained and supervised. Prison authorities owe a duty to exercise reasonable care in protecting prisoners and in supervising and controlling employees. *Daskalea v. District of Columbia*, 227 F.3d 433, 444–45 (D.C. Cir. 2000); *see also Morgan v. District of Columbia*, 449 A.2d 1102, 1108 & n.3 (D.C. 1982), *rev'd on other grounds*, 468 A.2d 1306 (1983) (en banc).

156. Defendant District of Columbia had actual or constructive knowledge that its correctional officers and jail staff were behaving in a deficient, dangerous, or otherwise incompetent manner with respect to maintaining adequate staffing on units and conducting timely, policy-compliant rounds, as evidenced by, among other things, (a) the November 2021 USMS inspection which found that resident supervision and monitoring at the Jail fell below minimum detention standards, (b) the 2019 report from the Committee on Facilities & Services to the District Task Force on Jails & Justice that identified chronic understaffing at the Jail, and (c) multiple lawsuits against the District alleging harms resulting from understaffing at the jail.

157. Defendant District of Columbia also had actual or constructive knowledge that its correctional officers were behaving in a deficient, dangerous, or otherwise incompetent manner with respect to their compliance with DOC's suicide-prevention and crisis-response policies, as evidenced by, among other things: (a) the 2013 outside consultant's assessment finding inadequate suicide-prevention training among staff who worked with residents with mental illness; (b) the 2021 OIG audit's finding that correctional staff did not consistently or correctly follow DOC's own operating procedures; (c) the 2021 USMS inspection's similar finding that resident supervision at the Jail fell below minimum standards; and (d) the D.C. Auditor 2025 Report's findings that DOC staff frequently skipped trainings, including trainings on mental health in corrections.

158. Despite this repeated, documented notice of the chronic understaffing at the Jail and the fact that the Jail's correctional staff did not reliably understand or follow DOC's own policies, including its policy for responding to residents in psychiatric crisis, Defendant District of Columbia failed to hire sufficient staff for the Jail and failed to retrain, re-supervise, or otherwise ensure that staff complied with the suicide-prevention policy described above.

159. As a direct and proximate result of Defendant's failure to train and supervise, as detailed above, staff assigned to the N3 Unit on September 15, 2023, went hours without completing mandatory PIPE rounds; were diverted from their assigned posts; abandoned their posts early without supervisory approval; were left alone on their posts; were not responsive to commands; actively ignored Mr. Doe's repeated cries for help and threats of suicide; failed to maintain a constant watch over Mr. Doe; and failed to take reasonable steps to prevent or respond to the fire that resulted in Plaintiffs' entrapment and resulting injuries. This type of behavior from staff was tacitly tolerated and predictable given the record of chronic understaffing at the D.C. Jail and correctional staff's consistent failure to comply with DOC's own policies.

160. As a direct and proximate result of this lack of training and supervision, Plaintiffs have suffered injuries for which they seek compensatory damages in an amount to be determined at trial.

**PRAYER FOR RELIEF**

WHEREFORE, Plaintiffs respectfully request that this Court:

a. Enter judgment in favor of Plaintiffs;

b. Award Plaintiffs compensatory damages in an amount to be determined at trial for the injuries, pain, and suffering caused by Defendant District of Columbia; and,

c. Grant such additional relief and further relief, including equitable or injunctive relief as warranted, as this Court deems just and proper.

**JURY DEMAND**

Plaintiffs, by and through undersigned counsel, hereby demand a trial by jury on all issues so triable.

September 14, 2026

Respectfully submitted,

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