

# DELAWARE DEPARTMENT OF JUSTICE REPORT ON THE DEATH OF RONALD W. SHOUP

*December 15, 2015*

On February 27, 2014, Ronald W. Shoup died while he was incarcerated at the Sussex Correctional Institute. Because of the circumstances of his death, the details of which are described below, the Delaware State Police and the Delaware Department of Justice initiated an investigation of his death on the day that he died. The purpose of the investigation was to determine whether any person had committed a crime under Delaware law during the actions that led to Mr. Shoup's death. The investigation has been lengthy, in part because DOJ sought the advice of an outside medical expert to assist in the investigation. DOJ wishes to thank Mr. Shoup's family for its patience and cooperation during the course of this investigation.

As is discussed in greater detail below, DOJ has concluded that Mr. Shoup's death was caused by one or more correctional officers, and it is also possible that the absence of prompt and appropriate medical attention contributed to his death. However, DOJ was not able to conclude that any of the officers or medical professionals involved in Mr. Shoup's death committed criminal homicide with the state of mind that is required by the Delaware Criminal Code for criminal prosecution. Additionally, a number of factors would likely make it difficult to prove beyond a reasonable doubt that any single correctional officer, or group of officers, was criminally responsible for his death. Mr. Shoup's family may choose to pursue a civil complaint against DOC to determine whether individual correctional officers, medical professionals, or DOC itself violated Mr. Shoup's constitutional rights, a question that is subject to a different standard than proving criminal wrongdoing and is outside the scope of this investigation.

DOJ does not typically issue written reports explaining its decision not to bring criminal charges in matters other than those involving police officers' use of deadly force. However, we have elected to do so in this instance because of the complexity of the factual issues involved and the importance of the public understanding the facts and legal standards that led to DOJ's decision. Additionally, we believe it is important to highlight areas where heightened attention must continue to be given to DOC training and procedures to ensure the safety of other inmates.

## **Scope of Investigation**

The Delaware State Police and DOJ interviewed the medical staff employed in the SCI infirmary, SCI correctional officers, and other inmates housed in the infirmary for the time period in question. DOJ also reviewed the autopsy prepared by the state's Medical Examiner<sup>1</sup>, the formal Department of Correction policies that correctional officers interacting with Mr. Shoup were required to follow and relevant training documents (as determined by DOC)<sup>2</sup>, Mr. Shoup's medical records, and an independent medical assessment (based upon records) requested by DOJ and conducted by Dr. Victor Weedn, chair of Forensic Sciences at George Washington

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<sup>1</sup> Mr. Shoup's family has given DOJ permission to disclose the results of Mr. Shoup's autopsy in this report, and DOJ is grateful to the family for doing so in order to allow a full review of the record for the public.

<sup>2</sup> The Department of Justice asked DOC to provide copies of the training materials used by the correctional officers involved in the incident and the relevant policies in place at the time of the incident.

University.<sup>3</sup> While this Report allows that certain forms of civil liability might result from the operative facts set forth herein, such determinations are outside the scope of this investigation and must be assessed by an independent trier of fact according to the statutory and common law associated with any applicable civil action. This report is not intended to have any preclusive effect on any resulting civil litigation relating to or in response to any aspect of the factual or legal conclusions set forth herein.

### **Results of Investigation**

Mr. Shoup was arrested on February 4, 2014 for his fifth Driving Under the Influence charge. He was not initially detained. However, when Mr. Shoup appeared in court for his preliminary hearing on February 20, 2014, he was intoxicated and was therefore committed to SCI.

#### ***Mr. Shoup Is Transferred to the Infirmary on February 25, 2014***

On February 25, 2014, Mr. Shoup was transferred to the infirmary after exhibiting what was described by prison officials as strange and aggressive behavior, including threats against officers and other inmates. Upon admittance to the infirmary, Mr. Shoup was placed on a “Level Two” watch in solitary confinement with observations by mental health observers to occur every fifteen minutes.<sup>4</sup> Mr. Shoup was examined by a nurse who noted that he was disoriented to time and place and was experiencing delusions which included believing he was at his parents’ home. The comprehensive psychiatric evaluation found Mr. Shoup to be evasive and uncooperative.

#### ***Mr. Shoup’s Symptoms Accelerate Later in the Day on February 26, 2014***

There is no indication that Mr. Shoup received any type of medical treatment other than restriction to solitary confinement and the insertion of an IV tube for fluids from the time that he was assessed with mild to moderate alcohol withdrawal symptoms at 8:30 a.m. until at least nine hours later, when his outward behavior began to further escalate.

In the late afternoon on February 26, 2014, a mental health observer who was assigned to watch Mr. Shoup noted that he had become agitated, “trying to bust out of the cell,” “asking for tools to take the door apart” and was yelling and talking to himself. Additionally, at 17:31 hours on February 26, 2014, Mr. Shoup began tampering with his IV<sup>5</sup> and threatened to rip it out.

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<sup>3</sup> DOC indicated that there was no video available showing the inside of Mr. Shoup’s cell, where the incident occurred. There was video available of the first QRT team (which is not the QRT team believed to have caused Mr. Shoup’s injuries) preparing to enter Mr. Shoup’s cell and exiting his cell. However, the video equipment was not functioning outside Mr. Shoup’s cell when the second QRT team prepared to enter Mr. Shoup’s cell and exited his cell – the Delaware State Police reviewed the video, video system, and hard drive from this period of time and determined that no tampering occurred.

<sup>4</sup> There are three levels of risk as outlined by the Department of Corrections (“DOC”). Level Two watch is considered a moderate risk, as opposed to Level One high risk and Level Three low risk. Level Two watch mandates that the inmate be placed in a suicide gown, with no bed linens, no sharp items, no personal items, no pens/pencils, no plastic bags, and no eating utensils. In Mr. Shoup’s case, a provision for no shoe strings was also added.

<sup>5</sup> Mr. Shoup was on an IV in order to receive fluids for hydration because he was not permitted to have a cup or pitcher.

During this time period, an infirmary nurse attempted to hang another bag from Mr. Shoup's IV. The bag itself was located outside of Mr. Shoup's room, with the tube running through the wall to Mr. Shoup. Mr. Shoup began to pull the IV tubing out of the nurse's hands, while she was positioned outside of the cell and he was positioned inside the cell. Due to the pulling, the tubing snapped, causing Mr. Shoup to begin bleeding from his arm. At this time, three correctional officers were able to handcuff Mr. Shoup and shackle his legs, but because he continued to resist while shackled, the prison medical staff informed correctional officers that they still would not be able to reinsert the IV and Mr. Shoup was therefore unshackled and the correctional officers left the cell at approximately 17:38 hours.

After correctional officers left his cell, Mr. Shoup was reported to be yelling, struggling, banging, and mumbling, and eventually began to threaten officers through the door of his cell and trying to unscrew his toilet and remove a portion of his room's baseboard.

### ***The QRT is Summoned for the First Time on the evening of February 26, 2014***

Because of the deterioration in Mr. Shoup's condition, at 18:45 hours, an infirmary nurse phoned an on-call doctor, and received approval to administer a shot of Ativan<sup>6</sup> to calm Mr. Shoup. The Ativan was prescribed by a doctor who had not personally examined Mr. Shoup, but who instead relied upon the observations of the nurse. Prior to requesting permission to administer Ativan, a nurse had already summoned the Quick Response Team ("QRT") to restrain Mr. Shoup for purposes of administering the Ativan.<sup>7</sup>

The members of the QRT were assembled and briefed prior to arriving in the infirmary. The QRT arrived in the infirmary at 18:53 hours on February 26, 2014. Prior to entering Mr. Shoup's cell, the supervisor attempted to make contact with Mr. Shoup through the cell door but Mr. Shoup was unresponsive to his commands. The QRT entered Mr. Shoup's cell where he was handcuffed and shackled. The nurse then entered the cell to administer the shot of Ativan in Mr. Shoup's right buttock. The QRT then moved Mr. Shoup from the cell he was in to the cell next door due to the destruction he had caused in the first cell. This entire episode took less than ten minutes, and there is no indication that Mr. Shoup suffered any serious physical injuries from his interaction with the first QRT team.

### ***A Second QRT Team is Summoned Just After Midnight on February 27, 2014***

Although the shot of Ativan was administered at 18:58 hours, the shot seemed to have little effect on Mr. Shoup's agitation and aggression. At 19:15 hours, Mr. Shoup began to pick the paint off the wall. At 19:30 hours, Mr. Shoup was at the cell door trying to get out. By 21:00 hours, Mr. Shoup was observed talking to himself, and banging and yelling at his cell door. Between 22:00 hours and 22:45 hours, Mr. Shoup continued to push and bang on the cell door. At 22:45 hours, the nurse received doctor's approval for a second shot of Ativan – once again

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<sup>6</sup> Also known as Lorazepam, an immediate acting benzodiazepine.

<sup>7</sup> The QRT program was accepted by the Bureau of Prisons in September of 1991. Its intention is to be a group of responders on each shift to handle minor disturbances as they occur. All correctional officers receive QRT training as part of the Correctional Officer Basic Course and then again annually by Correctional Emergency Response Team ("CERT") Headquarters and its institutional QRT instructors. Officers are assigned to the QRT at the beginning of each shift and consist of one supervisor defined as a Lieutenant or above and five correctional officers.

without the doctor seeing Mr. Shoup – and called for the QRT’s assistance in restraining Mr. Shoup. The supervisor from the first QRT declared that this second shot of Ativan would occur after his shift which ended at midnight.

In the early morning hours of February 27, 2014, a second QRT was assembled and briefed prior to arriving in the infirmary.<sup>8</sup> The QRT arrived in the infirmary at 00:50 hours. Prior to entry, the supervisor attempted to make contact with Mr. Shoup through the cell door but Mr. Shoup was unresponsive to the supervisor’s commands. Mr. Shoup was described as crouched in a ball, facing away from the door when the QRT team entered the cell.

The first QRT member who entered the cell hit Mr. Shoup with a shield, knocking him onto his right side. The four other QRT members restrained Mr. Shoup’s arms and legs, and Mr. Shoup was rolled over to a prone position and handcuffed and shackled. Doctor Weedn has concluded, based on the factual evidence available to him and his examination of Mr. Shoup’s medical records, that the weight of more than one correctional officer was placed on Mr. Shoup during at least part of this QRT intervention. Mr. Shoup was not combative or aggressive during this time. The nurse administered the second shot of Ativan at 00:50 hours. The QRT members then exited the cell; this entire episode took less than five minutes and the QRT left the infirmary at 00:55 hours.

#### ***Mr. Shoup’s Condition Deteriorates Following Incident With Second QRT Team***

When the QRT members left the cell, Mr. Shoup was lying on the floor. Prison staff described Mr. Shoup as getting up after the QRT team exited and the door was shut, and being generally quiet and sitting immediately thereafter.

Two mental health observers continued to watch Mr. Shoup every fifteen minutes. At 01:05 hours on February 27, 2014, Mr. Shoup was observed sitting in the cell. At 01:20 hours, Mr. Shoup was observed at the cell door and then moved to the toilet within the cell. At 01:30 hours, Mr. Shoup was observed again lying down; a half hour later he transitioned to a seated position. At 03:30 hours, Mr. Shoup was observed sitting on the toilet, fifteen minutes later he was sitting on the floor and at 04:00 hours Mr. Shoup was observed again lying down. By 04:55 hours it was noted that he appeared to be sleeping.

During the four hour time period from 00:55 hours to 04:55 hours, Mr. Shoup was observed either quiet or mumbling; the mental health observers did not observe any struggling, yelling, or crying.

At 04:55 hours, one of the mental health observers contacted the nurse because it appeared that Mr. Shoup was breathing slowly. At 05:06 hours, prior to the next fifteen minute observation period, the mental health observer contacted the nurse because he was unable to determine if Mr. Shoup was breathing. The nurse entered Mr. Shoup’s cell and noted there was no pulse; the nurses then began CPR. Paramedics arrived at 05:20 hours. At 05:35 hours a pulse was detected. Mr. Shoup was transported to Beebe Hospital at 05:40 hours and arrived at Beebe Hospital at 06:27 hours. Mr. Shoup was pronounced dead at 09:25 hours.

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<sup>8</sup> Because of a shift change, the second QRT was made up of a different supervisor and different correctional officers than the first QRT.

### ***The State Conducts an Autopsy the Day After Mr. Shoup's Death***

A medical autopsy was performed on February 28, 2014 in the Office of the Chief Medical Examiner by Dr. Vershovsky. Upon conclusion of the autopsy, Dr. Vershovsky found, as her major pathologic diagnoses, blunt force injury of the torso and blunt force injuries to the upper and lower extremities. The cause of death was certified as "multiple blunt force injuries," the manner of death as "homicide," and the description of circumstances as "inmate found unresponsive in his cell after being restrained multiple times by prison response team."

### ***The State Requests a Second Medical Review of Mr. Shoup's Death***

The DOJ requested an independent review of Mr. Shoup's death by Victor M. Weedn, MD, JD, a forensic pathologist. Dr. Weedn's conclusions about the cause of Mr. Shoup's death evolved over the course of his interaction with DOJ prosecutors. His initial conclusion was that Mr. Shoup's death was the result of complications associated with alcohol withdrawal. By the time that he prepared a written report, however, Dr. Weedn generally agreed with Dr. Vershovsky's medical opinion regarding cause and manner of death. Dr. Weedn opined that Mr. Shoup died of blunt force trauma as a result of the second QRT episode. This was based upon forensic evidence of a patterned abrasion attributed to the pinning shield employed by the second QRT. This abrasion was in the area of rib fractures and crush injuries found within the chest. Dr. Weedn attributed these results to the weight of the members of the second QRT upon Mr. Shoup as they attempted to restrain him.<sup>9</sup>

### **Criminal Liability of QRT members for Mr. Shoup's death**

DOJ has concluded, based on the formal autopsy conducted by the state and the analysis conducted by Dr. Weedn, that Mr. Shoup's death was caused by injuries that he received from the intervention by the second QRT team. That conclusion, however, is not the end of DOJ's inquiry – DOJ must determine not just whether the correctional officers caused Mr. Shoup's death, but also whether DOJ believes there is probable cause that one or more of them violated Delaware's criminal statutes in doing so. This report does not seek to determine whether the correctional officers who caused Mr. Shoup's death were properly trained, or to determine whether they complied with the Department of Corrections' procedures during their efforts to subdue Mr. Shoup. Instead, this report seeks to determine whether there is probable cause to believe that any of the correctional officers in question committed a crime.

Under Delaware law, in order for an individual to have committed a criminal offense in these circumstances, the state must prove that the individual acted with a particular state of mind. 11 Del.C. 251. There are three states of mind that are potentially relevant in these circumstances,

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<sup>9</sup> Dr. Weedn also noted injuries found on Mr. Shoup that he did not attribute to actions by the QRT. Specifically, Dr. Weedn noted injuries to Mr. Shoup's knuckles and forefeet that were believed to have been caused by Mr. Shoup striking the cell walls and door during periods of agitation. Other injuries may have been caused by transport of the body and resuscitative efforts. Dr. Weedn noted contusions to the knees and elbows "involve areas of prominence that tend to be injured in alcoholics" such as Mr. Shoup. Dr. Weedn also specifically mentioned that Mr. Shoup was more susceptible to trauma due to his poor physical condition.

as defined at 11 Del. C. §231, any one of which would have to be proven beyond a reasonable doubt by the state:

**Intentionally** — A person acts intentionally with respect to an element of an offense when, in the context of this case, it is the person's conscious object to engage in conduct of that nature or to cause that result.

**Recklessly** — A person acts recklessly with respect to an element of an offense when the person is aware of and consciously disregards a substantial and unjustifiable risk that the element exists or will result from the conduct. The risk must be of such a nature and degree that disregard thereof constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation. In this case, in order to find a reckless state of mind with respect to any correctional officer, a jury would need to find beyond a reasonable doubt that the officer was aware of and consciously disregarded a substantial and unjustifiable risk of death to Mr. Shoup. The same state of mind would need to be found if reckless conduct by a provider of medical care were to be established.

**Criminal negligence** — A person acts with criminal negligence with respect to an element of an offense when the person fails to perceive a risk that the element exists or will result from the conduct. The risk must be of such a nature and degree that failure to perceive it constitutes a gross deviation from the standard of conduct that a reasonable person would observe in the situation. With respect to this case, to find criminal negligence a jury would need to find beyond a reasonable doubt that an individual correctional officer failed to perceive the risk, in a manner that represents a gross deviation from the standard of conduct that a reasonable person would observe in the situation, that his actions would result in Mr. Shoup's death. And again, the same standard would apply to finding a criminally negligent state of mind on the part of any provider of medical care: the care provider would need to fail to perceive the risk, in a manner that represents a gross deviation from the standard of conduct of a reasonable provider, that his or her actions would cause Mr. Shoup's death.

**The Defense of Justification.** In addition to proving state of mind in a criminal proceeding, the state must also overcome the legal defense of “justification” that is available to correctional officers. Under 11 Del.C. 468(5), correctional officers can use force if the use of force was reasonable and moderate, and (1) the person using force believes that the force used is necessary for the purpose of enforcing the lawful rules or procedures of the institution; and (2) the nature or degree of force used is not forbidden by any statute governing the administration of the institution. Thus, regardless of the state of mind that the state might be able to establish with respect to any correctional officer, the state would also need to show either that the use of force was not reasonable and moderate, or that the correctional officer did not believe the force used was necessary.<sup>10</sup> If any reasonable doubt were raised by a correctional officer's invocation of the justification defense, a jury would be required to find him not guilty.<sup>11</sup>

**Causation.** Finally, in addition to proving a criminal state of mind, the state would need to prove that the actions of an individual correctional officer charged with a crime were actually a cause of Mr. Shoup's death. This requirement presents two independent challenges. First,

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<sup>10</sup> There are no provisions of the Delaware criminal code that address the specific uses of force employed by the correctional officers in this case.

<sup>11</sup> Hamilton v. State, 343 A.2d 594, 595 (Del. 1975)

although DOJ has concluded that Mr. Shoup's death was caused by correctional officers, the medical expert retained by DOJ originally came to a different initial conclusion and communicated that initial conclusion to DOJ attorneys. His original conclusion was that Mr. Shoup had died from complications caused by alcohol withdrawal syndrome. Although DOJ's medical expert later reached a different conclusion, the fact that he initially believed that the correctional officers likely did not cause Mr. Shoup's death would have presented significant challenges to the state at trial in establishing beyond a reasonable doubt that the correctional officers caused Mr. Shoup's death. The second challenge presented by the need to establish causation is that, with the exception of the first correctional officer to enter the cell who used a shield and therefore left abrasions on Mr. Shoup that could be traced back to an individual correctional officer, it would be difficult or impossible to tell which of Mr. Shoup's other blunt force injuries were caused by which correctional officer. And, under the DOC policies in place at the time of Mr. Shoup's death, the correctional officer carrying the shield was the one correctional officer who, by policy, was actually supposed to deliver a blunt force blow to Mr. Shoup as part of the QRT team process.

1. ***The Decision to Use the QRT Team Was Not a Crime.*** It does not appear that the decision by prison officials to use the QRT team to subdue Mr. Shoup was a violation of DOC policy, much less an act that created criminal liability. Under the use of force policies that were in place at the time of Mr. Shoup's death, all of his conduct – both his outward and active aggression, and his intervals of non-responsiveness between those outbursts of aggression – justified the use of non-lethal force to assist in administering prescribed medication. Once that decision to use force is justified, the use of the QRT team was not only permitted but was actually encouraged by DOC policy.

2. ***The Use of A Shield By the QRT Team Was Not a Crime.*** The equipment worn and used by the second QRT team was within the guidelines established by DOC policy. QRT team members are instructed to wear helmets, vests, and body armor, and the QRT supervisor had the discretion under the policy in place at the time to use a convex pinning shield.

3. ***DOJ Cannot Establish That the Actions of Any Individual Correctional Officer or Care Provider During the QRT Intervention Constituted a Criminal Offense.*** The QRT policy manual specifically addresses the roles of each member of the QRT. The first step in the QRT procedure is for the supervisor to attempt to bring the situation to an end with verbal action and/or with progressive use of force. In Mr. Shoup's case, the QRT supervisor responded first to the infirmary cell, attempted to communicate verbally with Mr. Shoup, but was unable to obtain a response from Mr. Shoup.

Under the QRT training documents provided by DOC, once a decision is made to intervene with an inmate physically, each team member, other than the supervisor, is assigned an area or limb of responsibility. The QRT training manual dictates that the first officer in the cell, or "initial contact person," should be the largest and/or most experienced person. The first officer is instructed, and trained, to drive into the inmate, place the shield of the helmet into the middle of the inmate's chest, and pin the inmate against the wall of the cell. The second person, or "left-side arm person," is assigned to the left arm of the inmate and maintains the handcuffs while the third person, or "right-side arm person," is assigned to the right arm of the inmate. The fourth person is assigned to the inmate's left leg while the fifth and final person is assigned to inmate's right leg and maintains possession of the leg shackles. The QRT training manual contained no

exceptions or modifications permitted to the QRT protocol for inmates who were passively as opposed to aggressively resisting, nor were there any exceptions or modifications permitted therein for inmates whose medical condition might make them more susceptible to injury from the use of standard QRT techniques. (DOC has indicated to DOJ that training and/or procedures have changed since the time of Mr. Shoup's death in this area.)

Based on a review of the backgrounds of the QRT members themselves, it appears that the officers chosen to be the first members into the cell in both QRT episodes were appropriately chosen.

The intervention itself obviously did not unfold exactly as envisioned by the QRT training materials. Those training materials indicate that the mandated method of intervention is designed to avoid having correctional officers pile on inmates in the process of subduing them, yet the results of Dr. Weedn's medical examination suggest that in the process of attempting to restrain Mr. Shoup's arms and legs, other members of the second QRT team placed their weight on top of Mr. Shoup and that their combined weight caused the multiple fractures that ultimately led to his death.

It is impossible for DOJ to fully reconstruct the second incident with the QRT team, which was chaotic and lasted only seconds. However, there is no evidence that any member of the QRT team – regardless of their ultimate adherence to the letter of their training – acted with the state of mind necessary to charge an individual member with a crime. Specifically, there is no evidence that it was the conscious object of any member of either the first or second QRT to cause the death of Mr. Shoup. Because the QRT members appear to have been attempting to follow their training in carrying out their actions, there is no evidence that any member of either QRT consciously disregarded a substantial and unjustifiable risk of causing Mr. Shoup's death, in a manner that constituted a gross deviation from the standard of conduct of a reasonable person. And there is no evidence that any member of either QRT failed to perceive a risk (constituting a gross deviation from the standard of conduct of a reasonable person), that his conduct might result in Mr. Shoup's death. In short, there is no evidence that any member of either QRT team initiated his actions with respect to Mr. Shoup with any intention other than compliance with his training and DOC policy (flawed though both the training and execution may have been), and to the extent that there was any divergence from their training during the incident itself, no evidence that the divergence met the high standard for criminal negligence or the even higher standard required for other levels of criminal liability. Finally, in addition to the barrier to proving criminal state of mind, there is also insufficient evidence to establish causation. Specifically, there is no evidence that the blunt force trauma applied to Mr. Shoup can be attributed to any individual correctional officer other than the correctional officer with the shield who first entered the cell – and who, under DOC training in place at the time, was the one officer who was supposed to apply blunt force trauma to Mr. Shoup prior to the other officers restraining Mr. Shoup's limbs. Therefore, there is not sufficient evidence to establish either criminal state of mind or causation necessary to pursue criminal charges against any of the DOC correctional officers involved in the incident that caused Mr. Shoup's death.

Again, the fact that criminal liability does not exist in this case does not diminish the tragedy of Mr. Shoup's death, does not rule out the possibility that the actions of correctional officers, supervisors, and DOC might be scrutinized in civil litigation under a less demanding legal standard, and does not mean that the policies, training, and procedure in place at the time of

Mr. Shoup's death were adequate. DOC has engaged in subsequent remedial measures, including policy and procedure revisions, in response to this incident.

DOJ's decision not to pursue criminal charges against the correctional officers responsible for Mr. Shoup's death should not be misunderstood as an indication that the fact that an individual was following orders or following written procedures will always be an adequate defense to criminal liability. Individuals do have responsibility to decline to carry out orders or follow policies that would require them to engage in patently criminal behavior. But the actions of these correctional officers do not rise to that level.

The evidence is also insufficient to pursue criminal charges against any of the providers of medical care to Mr. Shoup, both because the medical examiner and DOJ's medical expert found that Mr. Shoup's medical care was not the cause of his death, and because Delaware's Board of Medical Licensure and Discipline staff did not find the conduct of the medical providers to be either incompetent or grossly negligent after a review of the records.<sup>12</sup>

### **Additional Observations and Recommendations**

DOJ does not have any independent expertise in either medicine or tactics for restraint of inmates. Nevertheless, there are three areas involving Mr. Shoup's death where DOJ believes it is not only qualified but compelled to comment on DOC policies and/or procedures in place at the time of the incident, even though that commentary is from the perspective of laypersons.

**Propriety of Using QRT Team.** The QRT team, based on the materials made available to DOJ, appears to be specifically chosen, trained, and equipped to deal with dangerous situations involving violent or affirmatively resistant inmates. Not all situations in correctional facilities that require the use of force require correctional officers with this type of background and training – indeed, it appears that the first correctional officer intervention with Mr. Shoup was not conducted by the QRT team, and resolved without apparent injury to Mr. Shoup. It does not appear to DOJ that every planned use of force by correctional officers in DOC facilities should be performed by a QRT team.

**Tactics Used by QRT Team.** Even if a QRT team must be used, the training provided for such QRT teams did not at the time of Mr. Shoup's death allow for any divergence from the tactics described above. Specifically, they did not allow for the fact that (a) the inmate against whom force should be used might not be affirmatively resisting correctional officers, and/or (b) be in a medically or physically fragile state. If a QRT team must be used against an inmate who is passive and/or in a fragile physical condition, DOJ believes that QRT team should not use the same tactics that it would use against a physically robust inmate who is affirmatively resisting the QRT team's efforts.

**Direct Medical Attention.** Alcohol withdrawal is a potentially dangerous condition, and even at the levels demonstrated by Mr. Shoup can result in significant medical emergencies if not properly monitored. Yet, no doctor ever examined Mr. Shoup in spite of his significant and spiraling symptoms. Both of his Ativan injections were prescribed by a doctor over the

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<sup>12</sup> The findings of the Board of Medical Licensure and Discipline or its staff are not binding on DOJ and will not necessarily guide determinations regarding criminal liability or probable cause in all cases, but were deemed in the context of the facts in this case to preclude a finding of criminal wrongdoing.

telephone, without any actual observation of Mr. Shoup. While this type of long-distance care may not have caused Mr. Shoup's death in this instance, it should not be the norm for patients in Mr. Shoup's condition.

### **Conclusion**

Again, we are grateful to Mr. Shoup's family for their patience and assistance during this investigation, and we extend our condolences for the loss of Mr. Shoup. Although we find no basis for criminal charges against any of the individuals involved in the incident, the family does have other legal avenues through which to seek redress, and we are hopeful that the changes DOC has indicated that it has made will prevent future tragedies of this type from occurring.