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UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

JESSE HERNANDEZ, CAIN AGUILAR, HA COBB, SUSAN DILLEY, CONNIE DOBBS, SEAN ESQUIVEL, RAMONA GIST, MARTHA GOMEZ, GEORGE GREIM, DENNIS GUYOT, JASON HOBBS, GLENDA HUNTER, ALBERT KEY, BRANDON MEFFORD, WESLEY MILLER, RICHARD MURPHY, JEFF NICHOLS, ANGEL PEREZ, SARAB SARABI, CLYDE WHITFIELD, and ROBERT YANCEY, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

COUNTY OF MONTEREY; MONTEREY COUNTY SHERIFF'S OFFICE; CALIFORNIA FORENSIC MEDICAL GROUP, INCORPORATED, a California corporation; and DOES 1 to 20, inclusive,

Defendants.

Case No. CV 13 2354 PSG

SECOND AMENDED CIVIL CLASS ACTION COMPLAINT FOR DECLARATORY AND INJUNCTIVE RELIEF

Judge: Paul S. Grewal

(1) **Failure to Protect Prisoners From Violence:** Violations of 8th and 14th Amendments of U.S. Constitution, and Article I, Sections 7 and 17 of California Constitution

(2) **Failure to Provide Adequate Medical Care to Prisoners:** Violations of 8th and 14th Amendments of U.S. Constitution, and Article I, Sections 7 and 17 of California Constitution

(3) **Failure to Provide Adequate Mental Health Care to Prisoners:** Violations of 8th and 14th Amendments of U.S. Constitution, and Article I, Sections 7 and 17 of California Constitution

(4) **Failure to Provide Reasonable Accommodations to Prisoners with Disabilities:** Violations of Americans with Disabilities Act, Rehabilitation Act, and California Government Code § 11135

NATURE OF ACTION

1. The Monterey County Jail in Salinas, California, is broken in nearly every way. Defendants County of Monterey ("Monterey County" or the "County"), Monterey County Sheriff's Office ("Sheriff's Office"), and California Forensic Medical Group ("CFMG" and collectively "Defendants") knowingly provide inadequate security, medical care, and mental health care to prisoners in the Monterey County Jail (the "Jail"), exposing prisoners to substantial, unreasonable, and life-threatening risks of harm. Defendants also routinely discriminate against and fail to accommodate prisoners with disabilities, excluding them from programs, services, and activities offered in the Jail.

2. This civil rights class action lawsuit seeks to remedy the dangerous, overcrowded, discriminatory, and unconstitutional conditions in the Jail. The twenty-one individual Plaintiffs in the Jail bring this action against the Defendants on behalf of themselves and those similarly situated.

3. Plaintiffs seek declaratory and injunctive relief under the United States and California constitutions against Defendants for their deliberate indifference to the exceedingly high levels of prisoner violence in the Jail. The causes of the violence—understaffing, overcrowded housing units, lack of training and adequate policies and procedures, antiquated and poorly designed Jail facilities, and an inadequate prisoner classification system—are well-known to and tolerated by Defendants. Violent incidents between prisoners occur with alarming frequency and in nearly every area of the Jail. According to the Sheriff's Office's own incident reports from January 2011 through early-September 2012, there were more than 150 separate incidents of violence between prisoners. In more than 100 of these incidents, at least one prisoner required medical treatment. Violent incidents were reported in 26 out of 29 housing units. Violence at the Jail is not an anomaly; it is a way of life. Forcing prisoners to live under ongoing threats of serious bodily injury is cruel and inhumane, especially when Defendants have the ability to prevent and reduce such violence.

4. Plaintiffs seek declaratory and injunctive relief under the United States and

California constitutions against Defendants for their deliberate indifference to their failure to provide prisoners with minimally adequate medical care. Monterey County outsources the provision of medical care to prisoners in the Jail to CFMG, a private corporation, which provides deficient medical care in nearly every respect. Prisoners at the Jail, most of whom are pretrial detainees or charged with violations of parole or probation, are not adequately screened for serious medical problems upon arrival at the Jail, and Defendants lack an effective system for prisoners to request medical or dental care. When prisoners do receive care, it is often after a delay of weeks or even months. The medical care staff employed by CFMG are insufficient in number to care for the more than 900 prisoners in the severely overcrowded Jail. Both prisoners who arrive at the Jail with existing medical care needs and those who develop conditions in the Jail fail to receive timely or appropriate treatment, resulting in unnecessary and prolonged pain, suffering, worsening of their conditions, and sometimes even death. As a result of Defendants' failure to provide minimally adequate medical care, Defendants are deliberately indifferent to the substantial risk of harm faced by all prisoners.

5. Plaintiffs also seek declaratory and injunctive relief under the United States and California constitutions against Defendants' deliberate indifference to their failure to provide prisoners with minimally adequate mental health care. Monterey County also outsources the provision of mental health care to prisoners in the Jail to CFMG, which provides deficient mental health care in nearly every respect. Prisoners are not adequately screened for serious mental health problems upon arrival at the Jail. Defendants lack an effective system for prisoners to request care. When prisoners do receive mental health care, it is often after a delay of weeks or even months, and may not include appropriate and necessary housing, medication, therapy, psychosocial intervention, and other mental health treatment. Both prisoners who arrive at the Jail with existing mental health concerns and those who develop conditions in the Jail fail to receive appropriate treatment. Defendants' approach to prisoners with serious mental health problems (including suicidality) relies too heavily on placing such prisoners in "rubber rooms"—filthy rooms with no features other

than a slot in the door for food and a grate in the floor for a toilet—which only exacerbates and prolongs their already dire mental health crises. In the last four years alone, there have been three completed and more than a dozen attempted suicides at the Jail. As a result of Defendants' failure to provide minimally adequate mental health care, Defendants are deliberately indifferent to the substantial risk of harm faced by all prisoners.

6. Defendants' failure to protect prisoners from violence and failure to provide minimally adequate medical and mental health care are particularly egregious given that Defendants have been aware of these problems and their causes for years, yet have failed to take the necessary actions to ameliorate the unconstitutional and illegal conditions. In 2007, the County commissioned a third-party evaluation of the Jail, which resulted in a report, dated June 19, 2007, entitled "County of Monterey, Office of the Sheriff, Needs Assessment" (hereinafter "2007 Needs Assessment" or "2007 Assessment"), which is attached hereto as **Exhibit A**. The 2007 report concluded that "[t]he current combination of insufficient beds, an inadequate detention facility and understaffing has resulted in an almost untenable situation." 2007 Assessment at Ex. 1-2. In 2011, the County asked the third-party consultant to update the 2007 report to reflect amendments to state law and changes within the Sheriff's Office and the Jail population. This updated report, dated December 30, 2011, reached the exact same, word-for-word conclusion: "The current combination of insufficient beds, an inadequate detention facility and understaffing has resulted in an almost untenable situation." County of Monterey, Office of the Sheriff, Jail Needs Assessment, December 30, 2011 (hereinafter "2011 Jail Needs Assessment" or "2011 Assessment"), attached hereto as **Exhibit B**, at Ex. 2. Defendants' deliberate indifference to prisoners' safety and medical and mental health is unconscionable, and must be stopped to prevent additional unnecessary loss of life, pain, and suffering.

7. Under the Americans with Disabilities Act ("ADA"), Section 504 of the Rehabilitation Act ("Rehabilitation Act"), and California Government Code § 11135, Plaintiffs seek declaratory and injunctive relief against Defendants as a remedy for their systemic and willful discrimination against, and failure to provide reasonable

accommodations in programs, services, and activities to, prisoners in the Jail who have disabilities. Defendants lack adequate policies and practices for identifying and tracking prisoners with disabilities and the accommodations those prisoners require. Defendants have no adequate administrative grievance process available to prisoners to request reasonable accommodations. Defendants do not provide effective communication or basic and reasonable accommodations, such as sign language interpreting services and hearing aids, to prisoners with hearing, speech, and other communication impairments, even for critical interactions with Jail staff, including for intake and classification, disciplinary hearings, and medical and mental health appointments. Many areas of the Jail are physically inaccessible to prisoners with disabilities, both because Defendants refuse to permit prisoners to possess needed assistive devices and fail to house prisoners with disabilities in accessible parts of the Jail. Defendants' systemic failure to accommodate prisoners with disabilities results in the widespread exclusion of prisoners with disabilities from many of the programs, services, and activities offered by Defendants, including health care services, exercise, religious services, sleeping, and educational and vocational programs. Moreover, Defendants' lack of adequate policies and procedures makes prisoners with disabilities vulnerable to exploitation and violence by other prisoners and increases their risk of serious injury or death.

8. As a remedy for the statutory and constitutional violations described herein, Plaintiffs seek a declaration that Defendants are violating federal and state law and an injunction compelling Defendants to provide prisoners with adequate protection from violence from other prisoners, to provide prisoners with adequate medical and mental health care, and to provide reasonable accommodations to and cease discriminating against prisoners with disabilities.

JURISDICTION

9. This Court has jurisdiction over the claims brought under federal law pursuant to 28 U.S.C. §§ 1331 and 1343. This Court has jurisdiction over the claims brought under California law pursuant to 28 U.S.C. § 1367. Plaintiffs seek declaratory and

injunctive relief under 28 U.S.C. §§ 1343, 2201, and 2202, 29 U.S.C. § 794a, 42 U.S.C. §§ 1983 and 12117(a), California Government Code § 11135, and Article I, Sections 7 and 17 of the California Constitution.

VENUE

10. Venue is properly in this Court, pursuant to 28 U.S.C. § 1391(b)(1), in that Plaintiffs' claims for relief arose in this District and one or all of the Defendants reside in this District.

PARTIES

11. PLAINTIFF CAIN AGUILAR was most recently detained at Monterey County Jail on July 6, 2013. During a prior term in the Jail, Plaintiff AGUILAR suffered a fractured cheekbone, other facial injuries, slurred speech, and loss of vision after being attacked by another inmate on February 10, 2013. The injury caused him severe pain, left him unable to open his mouth, and has resulted in ongoing pain, headaches, and blurred vision. Plaintiff AGUILAR did not receive adequate care from Defendants immediately following the incident. He also received inadequate pain management for his pain both before and after surgery to fix his fractured cheek bone. Defendants failed to provide Plaintiff AGUILAR timely access to a proper soft diet, which resulted in him not being able to eat for nearly two weeks after his surgery, and in significant weight loss, dizziness, and a more difficult recovery. Plaintiff AGUILAR continues to experience blurred vision in his right eye. An outside medical specialist recommended he see a specialist for his vision problems, but despite numerous requests to medical staff through sick slips and requests to custody staff through a grievance, he has yet to see such a specialist. Plaintiff AGUILAR has also had problems getting timely responses to his sick call slips concerning painful rashes and boils on his head and neck and has not received a response to his sick slip request to see the Jail therapist concerning his ongoing depression and anxiety. Plaintiff AGUILAR is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

12. PLAINTIFF HA (TRAN) COBB was most recently detained at Monterey

County Jail on April 4, 2013. Following her arrival at the Jail, Defendants provided untimely and inadequate care for Plaintiff COBB's severe kidney stones, including failing to timely diagnose her condition, failing to provide appropriate pain management, failing to provide appropriate and timely post-operative care after Plaintiff COBB had a surgical drain inserted into her kidney, failing to timely schedule necessary surgery for the removal of Plaintiff COBB's kidney stones, and failing to provide appropriate and timely post-operative care. As a result of Defendants' inadequate medical care, Plaintiff COBB has suffered severe and unnecessary pain and was placed at risk of permanent loss of kidney function. Plaintiff COBB still has a number of kidney stones for which she will continue to require treatment. Plaintiff COBB is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(m).

13. PLAINTIFF SUSAN DILLEY was detained at Monterey County Jail on June 28, 2013. She has been housed in the Women's Section of the Jail since that date with the exception of one week in August, when she was temporarily released for the Jail. Plaintiff DILLEY has preliminarily been diagnosed with Multiple Sclerosis ("MS"). For the entire time she has been in the Jail she has suffered from physical and neurological problems, including numbness in her legs, problems maintaining her balance, substantial nerve-related pain, cognitive issues, and memory loss. It is extremely difficult and causes her severe pain any time she has to walk long distances or up more than one or two stairs. During her time in the Jail, she has requested or been prescribed by outside medical doctors numerous accommodations for her impairments, including a cane, an extra mattress, a shower chair, and special shoes. She experienced substantial delays and other problems obtaining each of these accommodations. For example, the shower chair Defendants provided her is too large for both her and the chair to safely fit in the shower at the same time. Even with the accommodations, Plaintiff DILLEY encounters numerous obstacles in the Jail that prevent her from accessing Jail activities, programs, and services. She has not been able to access a number of programs, including the exercise yard, religious services, and educational programs, because they are only offered to her up a

long flight of stairs that she can only climb with great difficulty and pain. Plaintiff DILLEY is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

14. PLAINTIFF CONNIE DOBBS has been detained at the Jail since September 15, 2012. While in custody in November 2012, Plaintiff DOBBS sustained a fractured nose, a permanent post-traumatic tremor in her right hand from mild traumatic brain injury, and nerve damage, pain, and numbness in her left leg, knee, and ankle when she fell at the courthouse while shackled at the ankles, waist, and wrists. Defendants failed to provide Plaintiff DOBBS with timely and appropriate medical care, including, but not limited to, failing to receive timely diagnostic tests, proper pain medication, or follow-up tests after her serious injury. For example, Defendants did not diagnose the nasal fracture for nearly two weeks. As result of her fall and other chronic, pre-existing injuries, Plaintiff DOBBS has chronic pain, particularly in her left leg, hip, knee, and lower back. Defendants did not provide her proper pain management for over four months after her fall. Though she currently is prescribed Gabapentin and ibuprofen for her pain, she has experienced interruptions in these medication when her prescriptions are set to expire; she has been required to put in sick call slips and grievances to restart her medications. Even with the medication, Plaintiff DOBBS has impaired mobility and cannot access all of the programs and services of the Jail, such as religious services, because it is difficult for her to climb the stairs to get there. Plaintiff DOBBS also suffers from Right Carpal Tunnel syndrome which may have been exacerbated by her fall. Despite the recommendation by her outside neurologist for a hard wrist splint over a year ago, and despite Jail medical staff ordering her such wrist splint seven months ago, she has still yet to receive the splint. Without the splint Plaintiff DOBBS continues to experience pain, numbness, and tingling in her right wrist and hand which keeps her up at night. Plaintiff DOBBS is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(m).

15. PLAINTIFF SEAN ESQUIVEL was detained at Monterey County Jail on

March 3, 2014. Plaintiff ESQUIVEL is a full-time wheelchair user. He has been a prisoner in the Jail many times over the past 20 years, including three times in the past year. During previous terms in the Jail, Defendants have failed to accommodate Plaintiff ESQUIVEL's disability by, among other things, denying Plaintiff ESQUIVEL access to functioning wheelchairs and placing him in housing units where he could not access the shower, toilet, or the exercise yard. Plaintiff ESQUIVEL also has a large tumor on his leg that causes him considerable pain and requires consistent medical attention, including repeated surgeries and follow up care. Defendants have repeatedly failed to provide Plaintiff ESQUIVEL with appropriate medical care for his tumor, including failing to follow post-operative orders in ways that placed him at risk for infection and other complications and caused him pain. Plaintiff ESQUIVEL also has sleep apnea and requires the use of a CPAP machine to sleep safely. Defendants have failed to provide him with a CPAP machine in a timely manner during his last two stays at the Jail. Moreover, Defendants only permit Plaintiff ESQUIVEL to use the CPAP machine in the infirmary, meaning he cannot not sleep until custody staff are available to bring him from his housing unit to the infirmary—sometimes as late as 1 am—and has to wake up to return to his dorm when custody staff are available—sometimes as early as 4 am. Plaintiff ESQUIVEL also suffers from a number of chronic medical conditions, including diabetes, asthma, and hypertension. Defendants have failed to provide Plaintiff ESQUIVEL with the insulin, inhalers, medication, and treatment he needs to manage these conditions in a safe and consistent manner. Finally, Plaintiff ESQUIVEL has serious mental health conditions including depression, attention deficit hyperactivity disorder ("ADHD"), and anxiety, for which he is currently receiving no treatment at the Jail. Plaintiff ESQUIVEL is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

16. PLAINTIFF RAMONA GIST has been a prisoner in the Jail approximately ten times over the past fifteen years, including three times over the past two years. Plaintiff GIST was most recently detained at Monterey County Jail on December 20, 2013.

Plaintiff GIST has a history of mental health conditions and suffers from schizophrenia, bipolar disorder, anxiety, and insomnia. These conditions make it difficult for Plaintiff GIST to effectively communicate with Jail staff, to understand the rules and processes of the Jail, and to access Jail programs and services without accommodations. Defendants have repeatedly failed to provide Plaintiff GIST with appropriate and timely mental health care, including, but not limited to, denying her access to psychiatric medications prescribed by her outside physician. For example, Defendants previously denied prescribed psychiatric medications to Plaintiff GIST for up to 90 days upon her booking into the Jail. When Defendants deny Plaintiff GIST her medications, her mental health deteriorates and she suffers unnecessarily. Plaintiff GIST additionally has developmental disabilities, including fetal alcohol syndrome and mild Down syndrome. Plaintiff GIST encounters obstacles to participating in the Jail's educational programs due to these disabilities. Upon information and belief, she is unable participate in the Jail's GED program because she has difficulty understanding the classes. If there were special education opportunities she would participate. Plaintiff GIST also has a number of physical medical conditions, including scoliosis and congenital hip problems, from which she experiences chronic pain. Despite numerous requests, Defendants have failed to provide Plaintiff GIST with appropriate medical care for these conditions, including, but not limited to, failing to provide the muscle relaxant she is prescribed by her outside physician. Plaintiff GIST's conditions affect her balance, causing her to fall often and making it painful to walk for long periods or upstairs. Plaintiff GIST encounters numerous obstacles in the Jail that prevent her from accessing Jail activities, programs, and services, including the exercise yard, religious services, and Alcohol and Narcotics Anonymous classes, because of her cognitive impairments, mental illness, and physical disabilities. Plaintiff GIST is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

17. PLAINTIFF MARTHA GOMEZ has been detained at the Jail since January 13, 2014. She has previously been detained in the Jail on a number of other

occasions. Plaintiff GOMEZ experiences chronic pain due to injuries and degenerative conditions including back pain, numbness and stiffness in her legs, pain in her right side from pinched nerves, pain from arthritis in her knee and hands, and pain from when a disease destroyed much of her muscle in her left shoulder. Plaintiff GOMEZ also suffers from chronic hypertension, migraines and dementia. Plaintiff GOMEZ frequently falls and injures herself, which happens often due to her pain and degenerative conditions. Plaintiff GOMEZ uses a walker to ambulate. Defendants deprived Plaintiff GOMEZ of a walker for two weeks, despite her repeated requests, which caused her serious problems ambulating in the Jail and accessing Jail programs, services, and activities, including the bathroom. Plaintiff GOMEZ has had and still is having problems receiving appropriate and timely pain medication for her chronic conditions. Plaintiff GOMEZ also has mental health problems which cause her anxiety, cause her to hear voices, and make it difficult for her to sleep and cope with her various problems. Defendants have failed to provide Plaintiff GOMEZ with timely and appropriate mental health care, including psychiatric medications and other treatment. Plaintiff GOMEZ is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

18. PLAINTIFF GEORGE GREIM was detained most recently at Monterey County Jail in September 2012. Plaintiff GREIM has a long history of severe mental illness, and experiences severe anxiety, insomnia, and depression. Defendants are aware of Plaintiff GREIM's psychiatric conditions, but have repeatedly failed to provide him with adequate care, treatment, or medication. In late-July 2013, Plaintiff GREIM was transferred to the Alameda County Jail pursuant to a contract between Monterey County and Alameda County, described in Paragraph 178, *infra*. Plaintiff GREIM was transferred back to the Monterey County Jail on or about September 6, 2013. When Plaintiff GREIM returned to the Jail from Alameda County Jail, Defendants discontinued the psychiatric medication he had been provided in Alameda County. Due to Defendants' failure to timely and adequately determine and treat Plaintiff GREIM's serious mental illness, he

experienced significant mental health decompensation, with increasing anxiety, racing thoughts, depression, and insomnia. As a result, Plaintiff GREIM had difficulty communicating effectively with Jail staff, understanding the rules and processes of the Jail, and accessing Jail programs and services without accommodations. Plaintiff GREIM was also a victim of violence at the Jail in which custody staff did not intervene, due to Defendants' serious understaffing and lack of appropriate supervision of prisoners at the Jail. Additionally, Plaintiff GREIM has an injured right knee, which has caused him serious pain throughout his time in the Jail. Defendants have failed to provide adequate care for his knee. Plaintiff GREIM is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

19. PLAINTIFF DENNIS GUYOT was detained at Monterey County Jail on March 3, 2013. On March 15, 2013, Plaintiff GUYOT was assaulted by a group of other prisoners at the Jail, outside of the visual and audio supervision of any staff. Defendants unreasonably failed to protect Plaintiff GUYOT and failed to timely intervene in the attack. As a result of the assault, Plaintiff GUYOT experienced serious dental trauma for which he had to undergo invasive oral surgery. Plaintiff GUYOT also suffered a concussion, and continues to suffer from blurred vision, sensitivity to light, and serious migraines. Defendants failed to provide adequate medical care for his post-concussion medical needs, including, but not limited to, egregiously delaying in referring him for necessary specialist evaluations. Plaintiff GUYOT is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(m).

20. PLAINTIFF JESSE HERNANDEZ was detained at Monterey County Jail on April 28, 2012. He remained in the Jail until September 27, 2013, when he was released from the Jail to participate in a supervised home confinement program in lieu of serving the remainder of his Jail term. From September 27, 2013 until February 19, 2014, he lived in Salinas, California, and was supervised by the Monterey County Probation Department. On February 19, 2014, he was arrested related to his home confinement and incarcerated in

the Jail. He has been in the Jail since February 19, 2014. Prior to his initial incarceration, Plaintiff HERNANDEZ underwent an ileostomy as treatment for serious gunshot wounds. Defendants provided untimely and inadequate medical care, including, but not limited to, repeated failures to reverse, and delays in reversing, the ileostomy. Even after Plaintiff HERNANDEZ finally received the ileostomy reversal surgery in December 2012, Defendants failed to provide adequate medical care, including, but not limited to, proper post-operative follow-up care. As a result of Defendants' delayed and inadequate medical care, Plaintiff HERNANDEZ has suffered from unnecessary and avoidable pain and symptoms, including, but not limited to, intestinal swelling, bleeding, severe stomach pain, fevers, cold sweats, and an obstructed bowel. On two occasions in December 2012 and January 2013, delays by Defendants to respond to emergencies related to Plaintiff HERNANDEZ's post-operative care caused Plaintiff HERNANDEZ serious pain, resulted in hospitalizations of one week and seven weeks respectively, and placed Plaintiff HERNANDEZ's life at grave risk. When Plaintiff HERNANDEZ was arrested on February 19, 2014, he was scheduled for abdominal surgery the following day. Defendants refused to permit him to move forward with the scheduled surgery and have not rescheduled him for the surgery. In the past and currently, Plaintiff HERNANDEZ has been denied appropriate pain medications for his serious and painful abdomen and shoulder injuries. Plaintiff Hernandez still suffers serious pain and requires medical attention for his abdomen and shoulder injuries. Plaintiff HERNANDEZ is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(m).

21. PLAINTIFF JASON HOBBS was detained at Monterey County Jail on November 12, 2013. Plaintiff HOBBS suffers from a number of serious medical and psychiatric conditions. He has been diagnosed with asthma, Hepatitis C, and degenerative disc disease. Plaintiff HOBBS also suffers from depression and anxiety, which make it difficult for him to communicate effectively with Jail staff. Around 2006, Plaintiff HOBBS had major back surgery to fuse part of his spine at L4-S1. Plaintiff HOBBS's

back problems, which cause him constant pain, were severely aggravated when another prisoner in the Jail attacked him, without provocation, on November 17, 2013. The damage he sustained in the attack has caused him serious problems with walking and balance, and significant pain. After the attack, Defendants failed to provide Plaintiff HOBBS with adequate medical treatment, including, but not limited to, adequate pain medication, rehabilitative services, and access to outside medical specialists. In addition, Defendants did not timely provide him with a cane which he needed and requested to ensure his balance when walking. Moreover, because of the lack of a safe and adequate shower chair in his housing unit, on December 22, 2013, Plaintiff HOBBS fell while showering and further aggravated his back condition. Finally, in July 2013 during a prior term in the Jail, despite Plaintiff HOBBS's requests, Defendants refused to provide him with a lower bunk housing assignment; that same month, forced to sleep in the middle bunk of a triple bunk, Plaintiff HOBBS fell and injured his back attempting to climb down from his bed. Plaintiff HOBBS is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

22. PLAINTIFF GLENDA HUNTER was detained at Monterey County Jail on March 16, 2013. Plaintiff HUNTER has been released from custody at the present time; however, she is on probation under the supervision of Monterey County Probation Department until September 2014. As such, she may be incarcerated in the Jail at any time without establishing a violation of any law and with little to no judicial process, subjecting her to the violations of her constitutional and statutory rights described herein. Plaintiff HUNTER has been diagnosed with numerous medical conditions, including diabetes, fibromyalgia, high blood pressure, chronic back pain, bone cancer, and seizures, and she has been prescribed and requires various medications to treat her illnesses and alleviate her symptoms. Despite repeated requests, Defendants failed to provide timely and appropriate medical care, including, but not limited to, failing to provide Plaintiff HUNTER with necessary prescription medications and treatment. Plaintiff HUNTER has also been diagnosed with mental illness, including manic depression, dementia, anxiety, and panic

attacks, all of which make it difficult for Plaintiff HUNTER to communicate effectively with Jail staff. Plaintiff HUNTER requires mental health treatment and other accommodations to alleviate her symptoms and to function in the Jail. Defendants failed to provide timely and appropriate mental health care to Plaintiff HUNTER, including, but not limited to, appropriate medications (which Plaintiff HUNTER brought with her to the Jail but which were taken from her by Defendants), and timely and adequate mental health assessments, treatment, and interventions. As a result of Defendants' inadequate medical and mental health care, Plaintiff HUNTER experienced unnecessary and avoidable pain and symptoms during her incarceration, including, but not limited to pain, nightmares, anxiety, panic attacks, and auditory hallucinations. Plaintiff HUNTER is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

23. PLAINTIFF ALBERT KEY was detained at Monterey County Jail on March 17, 2013. Plaintiff KEY is a Vietnam War veteran with a long history of post-traumatic stress syndrome and bipolar disorder, and has received psychiatric care and medications from various providers including doctors employed by Defendants and by the California Department of Corrections and Rehabilitation ("CDCR") for over a decade. Nevertheless, on multiple occasions when he has arrived at Monterey County Jail, Defendants have subjected him to their inhumane and medically unjustified "detoxification" process, during which he is denied prescribed psychiatric medication for 90 days. During each incarceration, Plaintiff KEY has experienced extreme delays in obtaining correct and appropriate psychiatric medications, and other necessary mental health interventions and care, and as a result suffers auditory hallucinations, racing thoughts, severe depression, nightmares, and periods of suicidal ideation. Plaintiff KEY also has a recurrent tumor on his neck for which Defendants have failed to provide appropriate medical care. As a result of Defendants' inadequate medical and mental health care, Plaintiff KEY has experienced unnecessary and avoidable pain and symptoms during his incarceration. Plaintiff KEY is a person with a disability as defined in 42 U.S.C.

§ 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

24. PLAINTIFF BRANDON MEFFORD was detained at Monterey County Jail on December 3, 2013. Plaintiff MEFFORD has severe and chronic mental illness, including borderline personality disorder, severe depression and anxiety, and ADHD, all of which make it difficult for Plaintiff MEFFORD to communicate effectively with Jail staff, understand Jail rules and processes, and access Jail programs and services. In prison, CDCR officials considered Plaintiff MEFFORD eligible for inpatient and enhanced outpatient levels of care. Plaintiff MEFFORD has previously attempted suicide on multiple occasions and has a strong tendency to self-mutilate when anxious. While at the Jail, Defendants have failed to provide Plaintiff MEFFORD with timely and appropriate mental health care. Plaintiff MEFFORD has been placed in the Jail's punitive and unsanitary rubber rooms for periods as long as three days without receiving appropriate care from mental health care staff and without being adequately observed by Jail custody staff. Defendants have also housed Plaintiff MEFFORD by himself in an administrative segregation unit; Plaintiff MEFFORD is only permitted outside of his cell for a maximum of one hour per day. These isolating conditions negatively affect his mental health, cause him significant anxiety, and occasionally lead him to engage in acts of self-harm. In addition, he has been provided with inadequate and inconsistent psychotropic medications to manage his conditions and has not been provided with adequate therapy. Plaintiff MEFFORD also suffers from chronic medical conditions, including asthma and hypertension. Defendants have failed to provide adequate treatment of his hypertension and have, at various times, refused to provide him with an inhaler. Plaintiff MEFFORD was also attacked by another prisoner while in the presence of custody staff, who failed to intervene in a timely manner. Plaintiff MEFFORD is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) (m).

25. PLAINTIFF WESLEY MILLER was detained at Monterey County Jail on January 8, 2013. Plaintiff MILLER has severe Type 1 diabetes. As of October 31, 2013,

Defendants had not provided Plaintiff MILLER with consistent and appropriate treatment for his diabetes, resulting in multiple serious diabetic episodes, seizures, and periods of unconsciousness. On February 11, 2013, an employee of Defendant CFMG improperly administered insulin to Plaintiff MILLER, resulting in his emergency transport to Natividad Medical Center in an unconscious state and his near death. Plaintiff MILLER is losing his vision as a result of his diabetes, and Defendants, as of October 31, 2013, failed to ensure appropriate and necessary care for his vision loss, including failing to ensure timely visits to necessary specialists. As of October 31, 2013, Defendants also failed to provide effective communication and otherwise to accommodate Plaintiff MILLER's vision impairment to ensure he could participate in programs, services, and activities at the Jail. As a result of Defendants' inadequate medical care and failures to accommodate Plaintiff MILLER's disability, he has suffered unnecessary and avoidable pain, diabetic complications, and permanent loss of vision. Plaintiff MILLER is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(m).

26. PLAINTIFF RICHARD MURPHY was detained at Monterey County Jail on January 18, 2013. Plaintiff MURPHY has a mobility impairment and requires a cane or walker to ambulate without significant pain. Despite repeated requests made by Plaintiff MURPHY, Defendants failed to provide him with reasonable accommodations to allow him to walk without pain, and to access the programs and services offered by Defendants. Plaintiff MURPHY also has nerve damage in his back, and requires pain medication as well as cortisone shots. Despite his repeated requests, Defendants failed to provide Plaintiff MURPHY with timely or adequate medical care, including, but not limited to, necessary medications at the Jail. Plaintiff MURPHY has been diagnosed with mental illness and has been prescribed and requires various prescription psychiatric medications to treat his illness and alleviate his symptoms. Despite repeated requests, Defendants failed to provide timely and appropriate mental health care, including, but not limited to, the failure to provide correct dosages of the medications Plaintiff MURPHY requires, the

failure to adequately monitor the administration of medications, and the failure to provide adequate psychotherapy and other treatments and interventions. As a result, Plaintiff MURPHY experienced unnecessary and avoidable pain and symptoms, including, but not limited to, hearing voices, seeing shadows, depression and suicidality, and inability to sleep more than a few hours per night. Defendants placed Plaintiff MURPHY in a rubber room on at least five occasions. Plaintiff MURPHY is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

27. PLAINTIFF JAMES JEFFREY NICHOLS was detained at Monterey County Jail on June 20, 2013. Plaintiff NICHOLS has a permanent mobility impairment arising from a motor vehicle accident many years ago. Although he normally uses a cane to ambulate, when he arrived at the Jail he neither had nor was provided with any assistive devices. On June 21, 2013, the staff at the Jail provided him with a wheelchair after he presented to medical staff with complaints of falling on his head three times. After entering the Jail, Plaintiff NICHOLS was assigned to a middle bunk which was difficult and painful for him to access. Defendants then moved him to the Jail's "Rotunda" area where, although the bed assigned to him was accessible, he was not able to access the recreational yard because of structural barriers. Because Defendants provided Plaintiff NICHOLS with a wheelchair rather than his accustomed cane, he was less physically active at the Jail than he is able and would like to be, suffered deterioration of his overall physical condition, and was denied equal access to programs, services, and activities offered by Defendants. Plaintiff NICHOLS also has brain injuries from the same car accident that resulted in his mobility impairment. The brain injuries impair both his cognitive function and his left arm, of which he only has partial use. Plaintiff NICHOLS is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

28. PLAINTIFF ANGEL PEREZ was detained at Monterey County Jail on December 30, 2012. Plaintiff PEREZ has a potentially cancerous tumor on his right foot.

During his time in the Jail, Defendants have failed to provide Plaintiff PEREZ with timely and appropriate medical care, including, but not limited, failing to provide diagnostic services and treatment for his tumor. Despite the fact that multiple doctors at Natividad Medical Center have ordered that Plaintiff PEREZ see an expert in orthopedic oncology at a tertiary facility to examine his tumor, Defendants have failed over the course of six months to send Plaintiff to such an expert. Plaintiff PEREZ has been told that if he does not receive treatment or evaluation from such an expert, he is at risk of having his foot amputated. Despite Plaintiff PEREZ's use of the sick slip and grievance process, he has not been able to receive timely and adequate treatment for the severe pain he experiences from the tumor, nor has he been able to receive adequate information about when he will be treated for the tumor and what kind of treatment he should expect to receive. The tumor on his foot also cause Plaintiff PEREZ tremendous pain and impairs his ability to walk. Defendants have failed, at various times, to provide Plaintiff PEREZ with appropriate and timely pain medications. Plaintiff PEREZ is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(m).

29. PLAINTIFF SARAB SARABI was detained at Monterey County Jail on February 2, 2013. Plaintiff SARABI had a mobility impairment for many months as a result of a serious injury he sustained to his right leg when he was attacked by another prisoner at the Jail. Plaintiff SARABI did not receive timely or adequate medical care from Defendants for his injury. Plaintiff SARABI was released from Monterey County Jail to a three-year term of supervision by Monterey County Probation Department. As such, he may be incarcerated in the Jail at any time without establishing a violation of any law and with little to no judicial process, subjecting him to the violations of his constitutional and statutory rights described herein. Plaintiff SARABI is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(m).

30. PLAINTIFF CLYDE WHITFIELD was detained at Monterey County Jail on November 30, 2013. Plaintiff WHITFIELD has severe narcolepsy with cataplexic attacks.

Narcoleptics may fall asleep at any time, and, without treatment, may sleep for upwards of 20 hours a day. Cataplexy is a sudden loss of muscle control that may occur anywhere without warning, causing Plaintiff WHITFIELD to collapse and risk serious injury. When not in the Jail, Plaintiff WHITFIELD controls these conditions with a combination of medications, Provigil and Xyrem, prescribed for him by a doctor. Defendants have failed to provide Plaintiff WHITFIELD with appropriate and timely treatment for his narcolepsy. Defendants have not provided Plaintiff WHITFIELD with Xyrem, which controls cataplexy. As a result, Plaintiff WHITFIELD has experienced four cataplexic attacks since being detained on November 30, 2013. Normally, Plaintiff WHITFIELD experiences one such attack approximately every six months. Defendants also did not provide Plaintiff WHITFIELD with Provigil for approximately two months after his arrest, despite knowing he was prescribed the medication prior to incarceration. During that time, Plaintiff WHITFIELD was unable to leave his bed most hours of the day and spent 20 hours a day asleep. As a result, Plaintiff WHITFIELD experienced serious depression and anxiety and was put at increased risk for violence and theft from other prisoners. Plaintiff WHITFIELD also has sleep apnea. Plaintiff WHITFIELD is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

31. PLAINTIFF ROBERT YANCEY was detained at Monterey County Jail on December 2, 2012. He has a hearing impairment and has been completely deaf since birth. Plaintiff YANCEY also has a speech impairment that makes it impossible for him to be understood when speaking. His primary method of communication is American Sign Language. Plaintiff YANCEY ordinarily is able to communicate in a limited manner using written notes; however, for much of his time in the Jail, his right hand was in a cast, making it difficult and painful for him to write legibly. Despite multiple requests, Plaintiff YANCEY did not receive reasonable accommodations from Defendants to allow him to access the programs and services offered by Defendants. Defendants never provided Plaintiff YANCEY with a sign language interpreter at any time during his time in the Jail.

Plaintiff YANCEY is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

32. DEFENDANT COUNTY OF MONTEREY (the "COUNTY" or "MONTEREY COUNTY") is a public entity, duly organized and existing under the laws of the State of California. Under its authority, Defendant COUNTY operates and manages the Jail and is, and was at all relevant times mentioned herein, responsible for the actions and/or inactions and the policies, procedures, practices, and customs of the MONTEREY COUNTY SHERIFF'S OFFICE and its respective employees and/or agents. The Board of Supervisors for the COUNTY authorized and approved the contract between Defendant MONTEREY COUNTY SHERIFF'S OFFICE and Defendant CALIFORNIA FORENSIC MEDICAL GROUP INCORPORATED for CFMG to provide medical and mental health care to prisoners in the Jail. The COUNTY by law retains the ultimate authority over and responsibility for the health care, treatment, and safekeeping of Plaintiffs and the class they seek to represent. The COUNTY employs 50 or more persons.

33. DEFENDANT MONTEREY COUNTY SHERIFF'S OFFICE (the "SHERIFF'S OFFICE") is a public entity, duly organized and existing under the laws of the State of California. Sheriff Scott Miller is the elected Sheriff of the County of Monterey. The SHERIFF'S OFFICE is responsible for the day-to-day operations of the Jail facilities, including promulgating policies and procedures for the operation of the facilities. The SHERIFF'S OFFICE has contracted with CFMG to provide all health care services in the Jail, but by law retains the ultimate authority over and any responsibility for the health care, treatment, and safekeeping of prisoners in the Jail. The SHERIFF'S OFFICE employs 50 or more persons.

34. DEFENDANT CALIFORNIA FORENSIC MEDICAL GROUP INCORPORATED ("CFMG") is a for-profit corporation organized under the laws of the State of California. Pursuant to a contract with the SHERIFF'S OFFICE that was approved by the Board of Supervisors for the COUNTY, CFMG provides all health care services to prisoners in the Jail, including medical and mental health care. The current

contract extends from April 1, 2012 through June 30, 2015. At all times when CFMG and its employees provide medical and mental health care to prisoners in the Jail, CFMG and its employees have acted and continue to act under color of state law. CFMG employs 50 or more persons.

35. Plaintiffs are ignorant of the true names and capacities of defendants sued in this complaint as DOES 1 through 20, inclusive, and therefore sue these defendants by such fictitious names. Plaintiffs will amend this complaint to allege their true names and capacities when ascertained. Plaintiffs are informed and believe and thereon allege that each of the fictitiously named Defendants is responsible in some manner for the occurrences alleged in this complaint.

36. At all times mentioned in this complaint, each Defendant was the agent of the others, was acting within the course and scope of this agency, and all acts alleged to have been committed by any one of them was committed on behalf of every other Defendant.

FACTUAL ALLEGATIONS

I. DEFENDANTS FAIL TO PROTECT PRISONERS FROM INJURY OR VIOLENCE FROM OTHER PRISONERS

37. Defendants MONTEREY COUNTY, the MONTEREY COUNTY SHERIFF'S OFFICE, and CFMG ("Defendants") have created and maintain a jail environment in which prisoners in all areas of the Jail face a substantial risk of being harmed by violence from other prisoners. Defendants have been aware of these risks since at least 2007, when the SHERIFF'S OFFICE and the Monterey County Board of Supervisors contracted with TRG Consulting to produce a needs assessment for the Jail. TRG Consulting completed its report, attached hereto as **Exhibit A,** and entitled "County of Monterey, Office of the Sheriff, Needs Assessment" (hereinafter, "2007 Needs Assessment" or "2007 Assessment"), on June 19, 2007. The Monterey County Board of Supervisors explicitly accepted the report that same day by unanimous vote. In the report, TRG acknowledged that "this needs assessment would not have been possible without the

assistance of a number of professionals from Monterey County," and specifically recognized a number of people "who helped make this planning effort a success." 2007 Assessment at 1. Among the people listed are two current members of the Monterey County Board of Supervisors, as well as former Sheriff-Coroner-Marshall Mike Kanalakis, former Undersheriff Nancy Cuffney, and former Custody Bureau Chief, Bert Liebersbach. *Id.*

38. Upon information and belief, in 2011, Sheriff Scott Miller requested that TRG Consulting update the 2007 Needs Assessment. As a result, TRG Consulting produced a new report, attached hereto as **Exhibit B,** entitled "County of Monterey, Office of the Sheriff, Jail Needs Assessment" (hereinafter "2011 Needs Assessment" or "2007 Assessment"), dated December 30, 2011. Upon information and belief, the 2011 Jail Needs Assessment was transmitted to Sheriff Miller and other officials in Monterey County on or around December 30, 2011. In the 2011 Jail Needs Assessment, TRG Consulting recognized by name "the primary contributors who helped make this planning effort a success." 2011 Assessment at 1. The list includes all five members of the Monterey County Board of Supervisors, all of whom remain in their elected positions as of the filing of this first amended complaint. *Id.* The list also includes Sheriff Miller and former Custody Bureau Chief Jeffrey J. Budd. *Id.*

39. Both the 2007 Needs Assessment and the 2011 Jail Needs Assessment concluded that, "[t]he current combination of insufficient beds, an inadequate detention facility and understaffing has resulted in an almost untenable situation." 2007 Assessment at Ex. 1-2; 2011 Assessment at Ex. 2. Both reports find that the conditions in the Jail and policies and practices of the SHERIFF'S OFFICE create an unreasonable risk of violence between prisoners. Because Defendants are aware of the unreasonable risk of violence and have not acted to reduce the risk, they are deliberately indifferent to the danger of assault faced by all prisoners.

A. Defendants' Understaffing of the Jail Creates an Environment in Which Violence Flourishes

40. Defendants staff the Jail in a manner that creates an unreasonable risk of prisoners being assaulted by other prisoners. For the past few years the Jail has routinely housed more than 1,100 prisoners. Defendants generally staff the Jail with as few as 24 and no more than 26 officers. A significant number of officers are required to staff areas of the Jail other than the housing units, like the booking area, visitor processing areas, and kitchen. Thus, usually no more than a handful of officers are responsible for directly supervising the prisoners in the jail. In 2011, outside consultants (TRG) notified Defendants that the current authorized staffing for the Jail was "woefully inadequate." 2011 Assessment at Ex. 7.

41. The minimum staffing plan utilized by the SHERIFF'S OFFICE does not provide for a sufficient number of officers to safely operate the Jail. As the 2011 Jail Needs Assessment explained, "[i]t appears that the staffing provided by the County salary ordinance is based on the rated capacity of [the Jail], not on how many inmates are actually in custody." 2011 Assessment at Ex. 6. Currently, the population in the Jail is more than 15% above the facility's rated capacity.

42. Though the staffing plan being used by Defendants is not sufficient on its face, Defendants have not even hired staff to fill all of the authorized positions. As the 2011 Jail Needs Assessment stated, "[v]acancies, extended periods of leave, and normal staff attrition have resulted in a significant amount of vacant … positions. The jail has an increased reliance on overtime to meet minimum staffing." 2011 Assessment at Ex. 7. Upon information and belief, these staffing shortfalls identified at the end of 2011 continue to exist today.

43. The 2011 Jail Needs Assessment noted that "[b]aseline staffing should be above minimum staffing," but "[d]ue to vacancies and other factors, the Monterey County Jail constantly is using overtime to staff *up* to their self-imposed minimum staffing. **This level is *not* adequate to provide basic safety and security for staff and inmates**." 2011

Assessment at Ex. 7 (bolded emphasis added, italics emphasis in original).

44. Typically, custody officers work 12-hour shifts. Because of the insufficient staff employed by Defendants, Defendants often utilize a system of mandatory overtime, whereby staff are required to work an additional four hours before or after their 12-hour shifts to cover a vacancy preceding or following their shift. This dangerous practice may result in staff being exhausted, unfocused, and unable to properly handle the duties required of them. Moreover, even when mandatory overtime is used, the extra four hours of coverage on either end of the preceding or following 12-hour shift leaves a four-hour gap uncovered in the middle of the shift. As the 2011 Jail Needs Assessment explained, "[u]nderstaffing has resulted in insufficient staff coverage.… At times the middle of a shift may be as many as three or four officers short. This has been exacerbated by recent staff reductions. As a result there are not enough officers present in the jail to respond to a major crisis or natural disaster.… There are insufficient staff on some shifts to make the required safety checks." 2011 Assessment at Ex. 3-4. The staffing at the Jail is not adequate to keep prisoners safe.

45. The staffing shortages are particularly acute in the housing units and for escort officers. As described in the 2011 Jail Needs Assessment, "[a] review of the current staffing pattern as practiced by the Monterey County Jail and the best practices staffing plan included in the 2006 *Staffing Analysis* indicates that the critical needs are for the extra staffing in the housing units and for facility-wide escort deputies. These positions will ensure required safety checks are made, there is some level of supervision in the kitchen, laundry and medical areas and adequate staffing is available to respond to emergencies and unusual situations. Recent cuts in staffing have made this situation much worse …." 2011 Assessment at Ex. 7. Upon information and belief, these staffing problems identified at the end of 2011 continue to exist today.

46. Assaults experienced by prisoners where staff failed to intervene demonstrate the risks posed by Defendants' understaffing of the Jail. Plaintiff GUYOT was assaulted by a group of other prisoners 12 days after his arrival at the Jail, while

housed in C-Dorm. No deputies intervened in the assault and no deputies either saw or heard the incident while it was occurring. Plaintiff GUYOT's severe injuries only came to the attention of custody staff when he "came up to the front of C-wing with all of his belon[g]ings" at some time after the assault concluded. Similarly, Plaintiff GREIM was attacked by other prisoners in A-Dorm, and received a black eye and other facial injuries as a result of the attack. Custody staff were apparently unaware of the attack until Plaintiff GREIM appeared at the door of A-Dorm and asked to be moved to another housing unit.

47. Plaintiff AGUILAR was brutally attacked by another inmate when deputies cleared the approximately 65 inmates from D-Dorm to conduct a search. All of the inmates were placed into the small isolation day room during the search where they were crowded together shoulder-to-shoulder. There were no guards present in the day room at the time and the only observation was from the guard tower. The inmates had been crowded into the day room for approximately half an hour at which point a large fight broke out during which Plaintiff AGUILAR was attacked. Plaintiff AGUILAR suffered a fractured cheekbone, other facial injuries, slurred speech and loss of vision due the attack. He had to undergo surgery to fix the fractured cheekbone and to this day experiences pain, headaches, and blurred vision as a result of the injury.

48. When Plaintiff SARABI was attacked by another prisoner, the other prisoner hit Plaintiff SARABI 10-15 times on his head and legs, knocking him unconscious. The two guards who were supposed to be monitoring the dorm did not intervene or otherwise attempt to stop the attack. Plaintiff SARABI's only recollection of guard involvement was when he awoke from his unconscious state as he was being dragged by a guard to a holding room, well after the attack had finished.

49. The severe understaffing creates a high risk of violence any time prisoners are escorted out of their housing units and in the presence of prisoners from incompatible classifications. For example, according to an incident report dated April 1, 2012, and prepared by employees of the SHERIFF'S OFFICE, visiting is a particular "time of disorder" with a single deputy expected to maintain order "with as many as 9-18 inmates

filing into three rooms," even though "differing and often conflicting classifications [are] present at the same time." According to the same incident report, in the visiting area, lock-down inmates are moved as a group and are unsecured. The April 1, 2012 incident report also describes a serious incident in which three or four prisoners classified as Administrative Segregation-Sophisticated Sureño forced their way into an unlocked room in which Administrative Segregation-Sensitive Needs prisoners were located. The Sophisticated Sureño prisoners were leaving the visiting area as the Sensitive Needs prisoners were arriving. One deputy failed to lock the visiting room door to secure the Sensitive Needs prisoners, because it would have forced him to lose visual contact with another deputy who was responsible for escorting the seven Administrative Segregation-Sophisticated Sureño prisoners out of the visiting area. Three or four of the Sureño prisoners rushed past the deputies and into the unlocked room. Then, one prisoner blocked the visiting room door while the others assaulted a prisoner inside the room and outside of the deputies' sight. The deputies let the assault continue until back-up arrived. In addition, according to another incident report prepared by employees of the SHERIFF'S OFFICE, in February 2012, two Norteño gang members assaulted a prisoner while being escorted through the Rehabilitation Infirmary.

50. Defendants have frequently acknowledged the understaffing of the Jail. For example, in a June 2, 2013 article in *The Salinas California*, Sheriff Miller was quoted as saying that with a population of about 1,100 prisoners, "[w]e are getting to the level we're becoming uncomfortable with the ratio of inmates."

B. The Jail Is Severely Overcrowded, Which Increases the Risk of Prisoner-on-Prisoner Violence, but Defendants Have Not Utilized Available Solutions to Ameliorate the Problem

51. The Jail is severely overcrowded. The Jail has a rated capacity for 825 prisoners, but has in the recent past housed as many as 1,200 prisoners, nearly 150 percent of capacity. From January 1 to March 11, 2014, the Jail's population was above 900 all but one day and was as high as 975 prisoners. Some areas of the Jail are considerably more overcrowded than the Jail as a whole, especially the women's section.

52. The Jail has been so overcrowded that, for many years now, Defendant SHERIFF'S OFFICE applies on a monthly basis to the Superior Court for the County of Monterey for an order to release prisoners on an accelerated basis pursuant to California Penal Code § 4024.1. To support the application, the former Chief Deputy Sheriff for the County and, upon information and belief, the current Chief Deputy Sheriff, swore on multiple occasions that unless the SHERIFF'S OFFICE is able to release some prisoners, the overcrowding in the Jail would "compromise[] the inmate classification plan as well as the safety and security of the detention facilities." Defendants' failure to implement an effective classification system, which is exacerbated by overcrowding, places prisoners at a serious risk of harm, as described more fully in Section I.D, below. In addition, in support of the application, Dr. Taylor Fithian (Director of Defendant CFMG) "advised that the excessive number of inmates housed in the Jail compromises the health of the inmates and the staff working at the facility."

53. The severe overcrowding was also identified as a problem in the 2011 Jail Needs Assessment. Specifically, the Assessment found that

> [t]here are not enough beds to meet the current adult detention needs, let alone the needs in the near future.… The jail is so overcrowded that no allowance can be made for peaking and classification or the routine or emergency maintenance required in inmate housing areas. Severe overcrowding has resulted in inmates being held in the intake area for up to forty-eight hours. This is not permitted by the California Code of Regulations. Severe overcrowding has forced the Sheriff to use areas for housing that were not designed or intended for that use (e.g., the rotunda area). This makes these areas much more difficult for officers to manage and control. Overcrowding has forced the Sheriff to operate the jail as an indirect supervision facility, while the jail was designed for direct supervision. This creates significant command, control and management problems.

2011 Assessment at Ex. 2.

54. The 2011 Jail Needs Assessment further noted that "[o]vercrowding creates a number of issues that affect staff and inmates, and put the County at risk. Overcrowding causes stress on both inmates and staff. **Inmate vs. inmate assaults typically occur more frequently, as do other disciplinary infractions**." 2011 Assessment at Ex. 9 (emphasis added).

55. Defendants have also admitted to the dangerously overcrowded conditions in public statements regarding potential new jail construction. In an October 5, 2012 press release, Sheriff Miller stated that "[o]vercrowding has been a serious problem at the jail for many years, creating a dangerous situation for inmates, jail staff and the community." Sheriff Miller recently commented on the "overcrowded nature of the current facility." *See* Sunita Vijayan, *Jail Funds Welcome, More Money Sought*, The Salinas Californian, Dec. 10, 2012. More recently, on May 28, 2013, he was quoted in the *Monterey Herald* as saying that "we realized the jail was overcrowded, that overcrowding can create problems." In addition, a document on the SHERIFF'S OFFICE's website entitled "Jail Housing Addition Fact Sheet" states that "[t]he Monterey County Jail has been significantly overcrowded for many years. The jail has a design bed capacity of 825 but currently houses a total of 1150 detainees. Such overcrowding puts officers, staff, inmates and the public at risk." The Fact Sheet also states that the Jail has "[i]nsufficient beds for existing inmate population."

56. Despite the profound and persistent overcrowding, Defendants have not availed themselves of numerous available opportunities to safely relieve the population pressures in the Jail. For example, Defendants have failed to undertake adequate measures to address their high pretrial population, including by failing to ensure that the maximum number of people possible are evaluated with the County's risk assessment tool. Such evaluation could result in lower risk persons being released from potentially unnecessary detention prior to their case disposition. Defendants have also failed to ensure that county departments are adequately staffed and that there is appropriate inter-agency coordination to ensure the pretrial services program is assessing and serving the greatest number of people possible. Increased capacity and coordination could also result in an increase of appropriate pretrial persons being safely managed in the community rather than housed in Jail prior to case disposition. Defendants have also failed to undertake adequate measures to expand capacity for their existing work release program for sentenced individuals, and have failed to investigate opportunities for collaboration between agencies and to expand

their capacity to supervise individuals on mandatory supervision as part of a split sentence. Defendants have also failed to adequately implement alternatives to incarceration found safe and effective in other jurisdictions, including, but not limited to, diversion and use of home and GPS monitoring.

57. According to the Monterey County Community Corrections Partnership AB109 Statistical Report for Fiscal Year 2013/2014, Second Quarter: October 2013-December 2013, since the inception of the County's pretrial release program in October 2012, there have been more than 17,000 prisoners booked into the Jail. The County has only interviewed and assessed 491 prisoners for eligibility for pretrial release and has actually released only 209 individuals. At the same time, the population of pretrial defendants in the Jail rose to approximately 77 percent during the last quarter of 2013, up from 71 percent during the last quarter of 2012.

58. The County has also failed to utilize split sentences to reduce the Jail population. During the last quarter of 2013, an average of only nine individuals per month were given split sentences. As of December 2013, there had been a total of 85 individuals who had received a split sentence out of the total of 665 individuals sentenced under California Penal Code § 1170(h) in the County since October 2011. As of the end of September 2013 the rate of split sentencing in Monterey County—at that time 11 percent—was the tenth lowest rate of split sentencing in the state and far below the statewide average of 28 percent, according to data collected by the Chief Probation Officers of California.

C. The Jail's Physical Structure Is Inadequate, Which Makes It More Difficult for Staff to Safely Monitor Prisoners and Increases the Risk of Prisoner Violence

59. The Jail, which consists of two primary buildings—the Rehabilitation Center and the Main Jail Building—constructed over the past 42 years, is a patchwork of makeshift spaces, thrown together to keep up with Monterey's fast-growing Jail population. Throughout the housing units and other spaces, there are numerous blind spots where staff cannot safely monitor prisoners. As found in the 2011 Jail Needs Assessment,

"[t]he design of the jail and the manner in which additions have been constructed results in a physical plant that is difficult to manage and control and unnecessarily expensive to operate.… There is poor observation from most deputy stations. Officers cannot observe inmates areas in Pods A through J. The wing walls in the dormitories are approximately four feet high and provide a number of areas where inmates cannot be observed. The manner in which additions have been constructed has resulted in a facility that lacks any real central control or command post that would be used in the event of a major disturbance or disaster." 2011 Assessment at Ex. 2.

60. The 2011 Jail Needs Assessment further noted that "visual supervision is problematic in the existing jail," and "[a]t best there is intermittent observation of the inmates. In the Rehabilitation Facility, a Deputy Sheriff must walk into the inmate housing area to see the entire living and shower area. It appears there is an attempt to remedy the problem with the use of cameras. Unfortunately, this is not working." 2011 Assessment at Ex. 8. Upon information and belief, despite being made aware of these problems in 2011, Defendants have not remedied the problems. These physical limitations, especially when combined with the severe understaffing and overcrowding in the Jail, create an unreasonable threat of harm to the safety and security of staff, visitors, volunteers, and prisoners.

61. Upon information and belief, on or around April 29, 2013, the Jail was under lockdown due to several attacks in the K-Pod. These beatings took place behind a pillar in the K-Pod that blocks the view of Jail staff (both from camera and window perspectives). Upon information and belief, one prisoner was injured so badly in these beatings that he was airlifted out of the Jail and taken to a hospital in San Jose where he received treatment for a fractured skull.

62. According to incident reports prepared by employees of the SHERIFF'S OFFICE, cell doors in many pods throughout the Jail can be easily popped open by prisoners, allowing prisoners to leave their cells without authorization at any time. This includes cell doors in lockdown units that house active gang members. Numerous incident

reports recount assaults on prisoners who are on their authorized out-of-cell time or are in a unit for kitchen work, times when all other prisoners should be locked in their cells. In one example, a prisoner on his out-of-cell hour in a lockdown unit told a nearby deputy who was passing out medication with a nurse that particular prisoners in his unit were planning to "pop" their doors to fight him. Before the deputy could get back-up or enter the unit himself, two cell doors were "popped," and two prisoners chased the first prisoner into a cell on the top tier to assault him, just as he had predicted.

63. As another example from an incident report dated April 1, 2013, and prepared by an employee of the SHERIFF'S OFFICE, a prisoner housed in G-Pod was assaulted by another prisoner in the pod. G-Pod is a celled housing unit, meaning all prisoners are housed in cells with doors. Prior to the assault, the prisoner had informed the classification unit that the assailant had been threatening him, had demonstrated to the prisoner that the assailant could open his cell door at will, and had shown the prisoner a large jail-made shank that he possessed. The prisoner requested that the assailant be moved to a different pod, but Jail staff took no action to move the assailant to another housing unit. The following day the prisoner was alone in the common area of G-Pod for his hour of daily recreation; all of the other prisoners in G-Pod were in their cells with their doors closed and purportedly locked. The prisoner then saw the assailant use the shank to attempt to open his cell door. To protect himself, the prisoner ran to the assailant's door and used his body to keep the door from opening; he was forced to remain in that position for the remainder of his hour outside of his cell. The assailant was, however, able to cut the prisoner multiple times in his upper stomach area by wielding the shank through the food tray slot, which was also not secured and which the assailant was able to open.

64. On December 15, 2013, Plaintiff MEFFORD and other prisoners housed in G-Pod, an administrative segregation lockdown unit, were able to "pop" their tray slots—that is, open them from the inside. The tray slots are metal are cut-outs in the cell door that can be shut with a metal flap and locked closed from the outside. That prisoners are able to open their own tray slots runs contrary to the entire design of the lockdown unit, which

is supposed to prevent prisoners from any access to the outside from inside their cells.

65. Poor jail design also exacerbates the dangers of understaffing. According to another incident report prepared by an employee of the SHERIFF'S OFFICE, in September 2011, one deputy opened a secure door to a Norteño unit to escort a single prisoner to different part of the jail while six prisoner workers and three other employees were in the area. Three prisoners classified as Norteños pushed past the deputy when he opened the door and all four prisoners proceeded to assault a single prisoner worker. Another deputy from the control tower heard the fighting but could not see what was happening. He opened a secure door to allow back-up to arrive, but in doing so, he revealed another deputy who was escorting three prisoners classified as Norteños to the infirmary. All three attempted to join the fight when the door opened, because of their gang allegiances. Two were able to enter the area where the fight was continuing and the deputies had to repeatedly deploy their Tasers to get control of the situation until back-up could arrive.

66. Defendants have repeatedly acknowledged the dangers posed by the Jail's structure. In an October 24, 2013 article in the Monterey County Weekly entitled "Monterey County Closer to Jail Expansion, Amid Criticism," Sheriff Miller stated that "**right now we lack adequate housing by any standards**." (Emphasis added.) In an April 4, 2013 article in the Monterey Herald, Sheriff Miller called the Jail "antiquated" and referred to the Jail as the "Winchester Mystery House of jails." The "Jail Housing Addition Fact Sheet" posted on the SHERIFF'S OFFICE's website states that the "[t]he labyrinth-like manner of jail additions has created security and evacuation issues." A 2006 article on the Monterey County Jail in the Monterey County Weekly was titled "Hell Hole: The Monterey County Jail is an overcrowded pit of violence and despair. There is no plan to fix it." The article discussed how "[t]he jail was designed with little practical knowledge and almost no foresight. It's made up of 27 separate housing units, each tacked to the next in partially-funded bursts of administrative desperation...." The then-Chief Deputy of the Jail, Burt Liebersbach, was quoted extensively throughout the article and

provided the author access to the Jail. After describing the deficiencies in the Jail's design and an increase in prisoner-on-prisoner violence, Chief Deputy Liebersbach was quoted as saying that "[i]f things continue this way, the possibility for a riot exists."

D. Defendants Routinely Fail to Adequately Classify and Assign Prisoners to Housing Locations Where Prisoners Will Be Safe from Violence and Injury

67. Defendants fail to adequately classify and assign prisoners to housing locations in the Jail where they will be safe from injury and violence. Before prisoners are assigned to certain housing locations in the Jail, they are "classified" based on a number of factors including their criminal charges, gang affiliation, race, and history of violence. These classification procedures are inappropriate and ineffective, however, and prisoners who are incompatible for various reasons, including rival gang memberships and/or histories of assaultive behaviors, are housed together in the Jail. Moreover, the severe overcrowding at the Jail makes proper and accurate classifications next to impossible. As the 2011 Jail Needs Assessment found, "[a]dequate separation and segregation resulting from classification of inmates cannot occur because of the severe overcrowding and lack of a sufficient number of single and double cells. Thus, while the staff has the ability to classify, they do not have the ability to physically segregate those inmates who should be separated because of their classification. This creates an environment that is unsafe for officers, inmates and visitors." 2011 Assessment at Ex. 2.

68. The 2011 Jail Needs Assessment further noted that, "[i]t is obvious that the system is dangerously out of balance in terms of the types of beds available and the classification of inmates held.… In Monterey County there is the possibility of misclassifying inmates based on space rather than security level. Overcrowding reduces the ability to classify. This is further compounded by the dormitory design. Normally, 10%-15% of the beds should be empty and available for classification spikes and maintenance.… Proper separation and segregation of inmates as envisioned in the Sheriff's classification plan is very difficult because of insufficient staff, an inadequate physical plant layout and … severe overcrowding …." 2011 Assessment at Ex. 4-5.

69. For example, Plaintiff SARABI was attacked by a fellow prisoner on or around March 6, 2013, in the B-Dorm of the Jail. After the attack, Plaintiff SARABI was moved to C-Dorm, so he would not be in the same housing areas as the prisoner who attacked him. However, on or around April 11, 2013, the Jail moved his attacker into Plaintiff SARABI's C-Dorm, so the person who attacked him just five weeks prior would be sleeping just five beds away from him. The Jail did not remove Plaintiff SARABI's attacker until the attacker himself was assaulted by other prisoners in the dorm a few hours later.

70. Upon information and belief, on August 22, 2013, a gang-related stabbing occurred in one of the housing units at the Jail. Upon information and belief, a prisoner was airlifted to San Jose for treatment as a result of the stabbing.

71. In an October 10, 2013 article in the Salinas Californian, Sheriff Miller was quoted as saying that an entire portion of the Jail, the Rehabilitation Facility, was not useful for housing prisoners because it was designed for prisoners with lower risk than the prisoners actually detained in the Jail: "[T]he Rehabilitation Facility" he said, "has about outlived its usefulness.... Everyone low risk who comes in is generally released early so the people we have locked up are more hardcore. It makes them more difficult to deal with." The "Jail Housing Addition Fact Sheet" posted on the SHERIFF'S OFFICE's website states that in the Jail, Defendants have "[i]neffective separation of potentially dangerous inmates, such as rival gang members."

E. Defendants Fail to Adequately Train Staff How to Prevent and Respond to Violence Between Prisoners in the Jail

72. Upon information and belief, Defendants do not adequately train custody staff in how to prevent and appropriately respond to prisoner violence. The lack of training is evident from the incidents and security lapses described above, which endanger prisoner safety. As a result of a lack of adequate training, staff do not timely respond to violent incidents at the jail, do not recognize apparent dangers that can result in prisoner-on-prisoner assaults, do not timely carry out their responsibilities to adequately monitor

prisoner activity in the housing units and elsewhere where prisoner assaults occur, do not adequately classify and assign prisoners to housing locations in the Jail where prisoners will be safe from injury and violence, allow security lapses that endanger prisoners, and fail to appropriately intervene when prisoner assaults and security breaches occur. Such training is of even greater import given the chronic understaffing and overcrowding at, and structural inadequacy of, the Jail.

F. Defendants Are Deliberately Indifferent to the Constitutionally Unacceptable Risk of Violence Faced by Prisoners

73. Violent incidents between prisoners occur regularly. According the SHERIFF'S OFFICE's own incident reports from 2011 and from January to early-September 2012, there were more than 150 separate incidents of violence between prisoners. Some of the incident reports were incomplete and lack important pieces of information. Upon information and belief, there are many more incidents of violence that were not captured in incident reports.

74. Most instances of prisoner-on-prisoner violence involve injury to at least one participant that requires medical attention at the Jail or even at the local hospital. In more than 100 of the reported incidents from 2011 and from January through early-September 2012, at least one prisoner involved in the altercation required some medical treatment. In 13 of the incidents, the injuries suffered by at least one of the participants were so severe that they had to be taken to an outside medical facility for treatment. Plaintiff HOBBS, who had existing serious back problems prior to his incarceration, required medical attention for his back after he was attacked by another prisoner. To this day, Plaintiff HOBBS experiences serious back pain and problems with mobility as a result of the attack.

75. Violent incidents between prisoners occur in nearly every area of the Jail. Violent incidents were reported in 26 of the 29 housing units in the Jail from 2011 and from January through early-September 2012. There were multiple reports of violent incidents in 21 of the 29 housing units. In the A-Dorm of the Main Jail alone, there were

19 incidents, while in the C-Wing of the Rehabilitation Center, there were 15 incidents. Violent incidents also occurred in the booking area, the kitchen where prisoners work, the infirmary, and the visiting area.

76. Violent incidents occur at approximately equivalent per prisoner rates in the portions of the Jail that house men and women. 21 of the more than 150 incidents involved female prisoners, while another 137 incidents involved male prisoners.

77. Prisoners with disabilities are at increased risk of being the victims of violence because of their perceived or actual inability to defend themselves. For example, in many of the incidents described in incident reports, prisoners with mental health problems were attacked by or attacked other prisoners because of behavior attributable to their mental illness.

78. In more than 35 of the incidents with full reports, custody staff at the Jail were not able to identify the assailant. Though the SHERIFF'S OFFICE has installed cameras in the Jail, upon information and belief, only two cameras monitoring two units that house few prisoners have recording capabilities. The understaffing of the Jail means that officers are rarely in a position to identify the attackers visually. Moreover, because the conditions in the Jail are so unsafe, the victims of attacks frequently refuse to volunteer the name of their assailants for fear of retaliatory attacks. As a result of Defendants' deliberate indifference to prisoner safety, they have failed to sufficiently staff the Jail and to put in place other policies and practices that would (1) result in the staff identification of assailants in a far greater number of attacks, and (2) create an environment in which victims feel sufficiently safe such that they identify their attackers.

79. Weapons are readily available inside the Jail, greatly increasing the danger to prisoners and staff. In addition to the incident discussed above involving a shank, prisoner assaults have also involved the use of a "Tomahawk" made from a razor and a 13 to 19-inch long copper pipe.

80. Upon information and belief, Defendants fail to adequately train custody staff in how to timely and appropriately intervene to stop violent incidents, and how to

identify and confiscate weapons before they are used in an altercation.

81. Upon information and belief, Defendants lack any policy or practice for regularly reviewing incident reports in order to identify systemic problems regarding the manner in which Defendants keep prisoners safe from violence from other prisoners.

82. Defendants have known of these conditions and the violence they create for years, including through their own incident reports and the 2007 and 2011 Jail Needs Assessments.

II. DEFENDANTS FAIL TO PROVIDE ADEQUATE MEDICAL CARE TO PRISONERS

83. Defendants MONTEREY COUNTY, MONTEREY COUNTY SHERIFF'S OFFICE, and CFMG have a policy and practice of failing to provide adequate medical care to prisoners in the Jail, and are deliberately indifferent to the fact that their failure to do so subjects prisoners to a substantial risk of unnecessary suffering, serious injury, clinical deterioration, or death.

84. CFMG is a for-profit corporation. CFMG provides medical, mental health, and dental services to prisoners in the Jail pursuant to its contract with Defendants MONTEREY COUNTY and the SHERIFF'S OFFICE. The term of the agreement is from April 1, 2012, through June 30, 2015. The COUNTY and the SHERIFF'S OFFICE compensate CFMG for providing health care to prisoners with a flat fee payment made annually for the term of the contract. In the first year of the contract, CFMG was paid $4,826,195. In the second and third years of the contract, the amount paid to CFMG is supposed to be increased according to the Medical Consumer Price Index for San Francisco/Oakland. In addition, CFMG receives an additional $4.02 each day for each prisoner housed in the Jail in excess of a population of 1,065. The COUNTY has the right to terminate the agreement if CFMG violates any of the material terms of the agreement. The material terms of the agreement include that CFMG "shall perform all work in a safe and skillful manner and in compliance with all applicable laws and regulations."

85. Defendants fully control all medical, mental health, and dental care available

to prisoners in the Jail. Defendants prohibit prisoners from obtaining any medications, including over-the-counter medications like ibuprofen and Tylenol and prescription medication for which prisoners possess valid prescriptions, without approval from Defendants. Prisoners at the Jail cannot be seen by any medical professionals, inside or outside of the Jail, without approval from Defendants. Prisoners cannot receive laboratory or other diagnostic testing without approval from Defendants. Put simply, Defendants control every aspect of provision of medical care to prisoners in the Jail.

A. Defendants Routinely and Systematically Fail to Maintain Sufficient Numbers of Health Care Professionals

86. Defendants maintain insufficient numbers of health care professionals to provide minimally adequate care to the more than 900 prisoners in the Jail. There are not sufficient health care staff to timely respond to prisoners' requests for medical evaluations and treatment, to adequately screen, monitor, and provide follow-up care to prisoners who are suffering from serious and chronic illnesses, or to treat prisoners on an emergency basis.

87. For example, when Plaintiff SARABI was attacked by another prisoner the night of March 6, 2013, he was seen by a nurse who placed an ACE bandage on his right foot and ankle and gave him a wheelchair. Plaintiff SARABI complained for the next several hours about the serious pain in his foot and a possible concussion, but his repeated requests for help and medical care were ignored. When a nurse finally brought him back to the infirmary at approximately 3:00 a.m., she informed Plaintiff SARABI that there was no qualified medical staff present at that hour to evaluate and help him, so he would have to wait until 6:00 a.m. to receive his needed pain medications. Plaintiff SARABI was not transported to a local hospital for treatment.

88. The insufficient number of custody staff, discussed in Section I.A, *supra*, makes it even more difficult for Defendants to provide minimally adequate health care. Within the Jail, any time that a prisoner must be transferred to or from a housing unit to another area of the Jail for health care services, at least one custody officer must

accompany and transport the prisoner. Similarly, anytime that a prisoner requires transport to an outside medical facility for treatment, at least one custody officer must accompany the prisoner and remain present for the duration of time that the prisoner is at the outside medical facility. To timely transport all prisoners to and from all health care services would require Defendants to hire and staff the jail with additional custody officers. Defendants have been aware of the insufficiency of the number of custody staff for some time, including as a result of the 2007 and 2011 Jail Needs Assessments. Defendants, however, refuse to adequately staff the Jail.

89. Prisoners are routinely unable to see medical or dental staff because of a lack of available custody staff for escorting prisoners to and from medical appointments. For example, a doctor requested to see Plaintiff HOBBS on or around December 19, 2013, but the appointment could not take place because custody staff were unavailable to escort Plaintiff HOBBS from his housing unit to the appointment. Many other plaintiffs experienced similar problems where appointments with medical staff or ordered treatment (such as the taking of vital sign or the changing of dressings) did not take place as ordered because of a lack of custody staff to escort the plaintiffs to the infirmary.

B. Defendants Routinely and Systematically Fail to Supervise the Conduct of Health Care and Custody Staff

90. Upon information and belief, the small number of health care staff that Defendants do employ are not sufficiently trained or supervised to provide the care they provide. At the Jail, much of the health care is provided by the one Physician's Assistant ("PA") employed by CFMG. The PA, who has prescribing authority but must be supervised by a physician, is not adequately supervised by the physicians at the Jail. As a result, the PA has, at least in part because of lack of supervision, provided inappropriate and untimely care to prisoners and caused many lapses in care.

91. In addition, Licensed Vocational Nurses ("LVNs") and Licensed Psychiatric Technicians ("LPTs") are entry-level health care providers who must only practice under the direct supervision of physicians, psychologists, registered nurses, social workers, or

other qualified professionals, and are not qualified to do their own patient evaluations or assessments. Yet, upon information and belief, Defendants improperly allow untrained entry-level providers such as LVNs and LPTs to practice outside of the scope of their licensure and perform medical gatekeeping functions, including independently assessing and responding to prisoners' medical and dental care requests and correctional officers' referrals for health care.

92. For example, Plaintiff SARABI suffered a serious leg injury when he was attacked by another prisoner on March 6, 2013. Plaintiff SARABI was initially seen and treated by nurses only for the first two weeks following the injury. The nurses wrapped his injured foot and ankle in an ACE bandage immediately after the attack, then approximately a week later placed a splint on his right foot and ankle. The splint was placed too low, resulting in discomfort and continued pain for Plaintiff SARABI. When Plaintiff SARABI finally saw a doctor for the first time (nearly two weeks after his date of injury), the doctor informed him that he likely had a peroneal nerve injury that required specific nerve medication and would take at least a month if not longer to heal. When Plaintiff SARABI asked why it took medical staff so long to diagnose the nerve injury, the doctor replied that it was a "staff problem" because the staff erroneously diagnosed Plaintiff SARABI's nerve damage as a sprain.

93. Plaintiff MILLER received an improper insulin injection from a CFMG nurse-employee on February 11, 2013. As a result, he suffered a severe diabetic episode and was transported to Natividad Medical Center by ambulance in an unconscious state. The pain, distress, and permanent physical impairment that Plaintiff MILLER has suffered, and continues to suffer, as a result of this episode are directly attributable to Defendants' failure to adequately train and properly supervise health care staff.

94. Physicians at the Jail ordered that lower-level medical staff change dressings on wounds for Plaintiffs HERNANDEZ and COBB at regular intervals. Lower-level staff, on numerous occasions, failed to change the dressings as ordered. During periods of time when lower-level medical staff failed to change Plaintiff HERNANDEZ's dressing as

ordered, he experienced unnecessary pain and developed numerous abscesses in his abdomen that required multiple hospitalizations, including a seven-week hospitalization in January and February 2013.

95. Defendants also fail to maintain medical accreditations. Specifically, the Institute for Medical Quality ("IMQ") offers voluntary accreditation to correctional and detention facilities throughout California based upon meeting standards developed by the IMQ. According to a certificate prominently placed on the wall of the lobby for the visiting area of the Jail, Monterey County Jail's IMQ accreditation expired on November 17, 2011. On information and belief, Defendant CFMG contacted IMQ in or around May 2013 to request a reaccreditation survey. To date, Defendants have not received an updated accreditation from IMQ.

C. Defendants Lack Sufficient Facilities to Provide Adequate Medical Care

96. The physical spaces in the Jail used to deliver medical care are not sufficient for the population of prisoners. As the 2011 Jail Needs Assessment found, "Medical/mental health treatment spaces are not adequate for the rated beds, let alone the actual number of inmates held." 2011 Assessment at Ex. 3. The Assessment further noted the direct impact of overcrowding on prisoners' overall health: "Overcrowding affects inmates' mental and physical health by increasing the level of uncertainty with which they regularly cope." 2011 Assessment at Ex. 9. The lack of sufficient treatment space places prisoners at an unreasonable risk of harm from inadequate medical care, compromises the delivery of medical care, and fails to ensure confidentiality and safety during the delivery of such care.

97. Upon information and belief, medical screening procedures and appointments are routinely conducted in non-confidential treatment space and hallways. For example, Plaintiff COBB was seen by a member of CFMG's medical staff in a non-confidential hallway setting for a treatment discussion that included, among other things, a discussion of the staff member's view that Plaintiff COBB's poor personal hygiene was a contributing factor to her recurrent alleged urinary tract infections. Plaintiff COBB in fact

had severe kidney stones that the Jail medical staff had failed to diagnose.

D. Defendants' Inadequate Screening and Intake Process Fails to Identify and Treat Medical Care Problems of Newly Arriving Prisoners

98. Defendants fail to adequately identify and treat the medical problems of newly arriving prisoners during the screening and intake process. Defendants' policies and practices for medical screening are inadequate. Defendants fail to adequately train custody and medical staff in how to timely and appropriately identify medical problems during the screening and intake process. When a prisoner is newly booked into the Jail, medical staff may not even play a role in screening the prisoner. Custody staff (who are not sufficiently trained to identify medical needs) complete a brief one-page health screening form during a cursory interview with the prisoner in a non-confidential space. Medical staff only evaluate prisoners at intake if the custody staff note a problem on the screening form. The screening form used by custody fails to capture critical and basic information necessary to identify prisoners in need of medical attention. Upon information and belief, Defendants fail to take every prisoner's vital signs (including blood pressure and temperature), and only take them for prisoners whom custody staff refer to medical staff for assessment. Upon information and belief, comprehensive intake evaluations by medical staff, when they occur at all, frequently do not take place until days or weeks after a prisoner is booked into the jail.

99. Because the screening process is inadequate to identify prisoners with serious or chronic health care problems, prisoners are at a significant risk of serious harm. For example, prior to being booked into the Jail, Plaintiff MURPHY had permanent nerve damage that was caused by a bulge in his L4 and L5 vertebrae. When he went through the screening process, Plaintiff MURPHY was experiencing significant pain from the nerve damage because he had not taken his pain medication and did not have a cane to assist him in walking. The screening form for Plaintiff MURPHY does not indicate that he had any potential or existing nerve damage or back problems. Similarly, although Plaintiff COBB reported during her intake screening that she had recently been seen by an outside medical

provider and referred to a urologist for cloudy and discolored urine, her intake screening form does not indicate any urology concerns.

100. During the intake process Defendants also under-identify prisoners with chronic illness, including hypertension, asthma, and diabetes.

E. Defendants Fail to Provide Prisoners with a Reliable and Timely Way to Alert Health Care Staff of Their Medical Needs

101. Defendants fail to provide a reliable way for prisoners to alert health care staff of their need for evaluation of medical or dental problems, and are deliberately indifferent to the harm and risk of harm to prisoners that their failure creates. Defendants' policies and practices for providing prisoners with a means for alerting health care staff of medical or dental needs are inadequate. Upon information and belief, Defendants fail to adequately train custody and medical staff in how to properly process and timely respond to prisoners' requests for medical or dental evaluation.

102. To request medical care, prisoners are supposed to submit a "sick call slip" to medical staff when medical staff comes through a housing unit to distribute medications. Prisoners may also submit sick call slips in boxes in some housing units that are designed for submission of grievances. These boxes are not sufficiently confidential, as custody staff are the only staff who have keys to the boxes, and thus have access to prisoners' confidential sick call slips. Once a sick call slip is received by medical staff, the prisoner is supposed to be seen by medical staff on the next available sick call day.

103. Though prisoners report little difficulty submitting sick call slips to medical staff, they frequently receive no response to their requests for medical care. Other times, when prisoners do receive a response to a sick call slip, it is not until many days after the sick call slip was submitted.

104. The failure to timely respond to sick call slips is caused, at least in part, by Defendants' failure to create an effective tracking and scheduling system for health care appointments.

105. Upon information and belief, Defendants do not adequately train health care

staff in how to review, process, and respond to sick call slips submitted by prisoners.

106. Though Defendants have a policy that all prisoners are supposed to be seen by medical staff on the next available sick call day after submitting a sick call slip, in practice, Defendants use Licensed Vocational Nurses (LVNs) to screen the sick call slips and determine whether the prisoner should actually be seen by medical or mental health care staff. No standardized protocols exist to guide LVNs' exercise of discretion in determining when prisoners should receive a face-to-face appointment with a nurse or other medical or mental health care clinician. Consequently, LVNs arbitrarily determine whether the content of a sick call slip, often written by a prisoner who can barely read or write, warrants an appointment with a nurse or physician.

107. These failures to respond and delays in response from medical staff place prisoners in danger. For example, during Plaintiff HERNANDEZ's term of incarceration from April 28, 2012 to September 27, 2013, he required significant medical attention for his ileostomy and, after the ileostomy was removed, for his post-surgical care. On many occasions, Plaintiff HERNANDEZ submitted sick call slips complaining of abdominal pain or other related symptoms. He frequently experienced significant delays before he was seen by medical staff. As one example, he submitted a sick call slip on October 2, 2012, complaining of not receiving certain medications for his stomach and was experiencing strong cramping pains; he was not fully evaluated by appropriate medical staff until October 26, 2012—24 days later. As another example, Plaintiff HERNANDEZ submitted sick call slips related to pain in his abdomen on November 18, 25, and December 2, 2012. He was not evaluated by an appropriate provider prior to being transferred to the hospital on or around December 11, 2013 for his ileostomy reversal surgery, a period of 23 days.

108. Prisoners can file grievances through the Jail's grievance procedure if they do not receive the care they need after filing a sick call slip. However, Defendants routinely fail to respond or to provide an adequate response to submitted grievances. For example, Plaintiff DOBBS attempted to use the grievance process to request Gabapentin

and ibuprofen that Defendants had prescribed for her after Defendants failed to provide them to her. Defendants did not provide appropriate or timely responses to the grievances, and failed to provide the prescribed medications for more than 20 days.

109. As another example, Plaintiff WHITFIELD had to submit five sick call slips and two grievances before he was able to obtain the emergency dental care he needed to extract an infected wisdom tooth. Plaintiff WHITFIELD was not given an appointment with a dentist until after he had first seen two different nurses to complain of his serious pain. At the same time, it took weeks for Plaintiff WHITFIELD to get the ibuprofen he requested. Even after he did obtain an order for the pain medication, it was given to him intermittently and inconsistently. Plaintiff WHITFIELD's dental pain ceased as soon as the dentist extracted his tooth—over a month after Plaintiff WHITFIELD first alerted the Jail to his emergency dental need.

110. Upon information and belief, Defendants have failed to implement appropriate triage procedures to ensure that non-emergency medical needs are attended to before they develop into emergencies. For example, Methicillin-resistant Staphylococcus aureus ("MRSA", commonly known as "staph") infections are frequently reported at the Jail. Many prisoners report filing multiple sick call slips for emerging and beginning staph-related wounds, but are not seen until their wounds develop into serious and emergency conditions requiring intense treatment. For example, one prisoner was not seen for a staph-infection-caused wound until it developed into cellulitis and a necrotizing soft tissue infection, requiring intensive and invasive treatment. Another prisoner had a staph-infection-caused abscess that required the insertion of a surgical drain into the wound, which Defendants then failed to properly monitor and cleanse following the procedure.

111. Even when the sick call process operates as set forth in Defendants' written policies, the sick call process places prisoners at an unreasonable risk of harm. For example, on July 28, 2012, a prisoner was booked into the Jail whose colon had begun to rupture shortly before or after his arrest. Once the prisoner was placed in a housing unit in the Jail, his symptoms from his condition began to worsen. During the night he was

booked into the Jail, he filed a sick call slip stating that he had been experiencing severe abdominal pains for the previous eight hours. The sick call slip was not reviewed by any staff at the Jail until 5 p.m. on July 29, 2012. Moreover, the prisoner was not seen by medical staff until 12 p.m. on July 30, 2012, at which time his temperature was 102 degrees. The prisoner was rushed to the Emergency Department at Natividad Medical Center, where he was diagnosed with a perforated bowel and had an emergency colostomy procedure that same day. According to the medical records maintained by CFMG, at least 36 hours passed between when the prisoner requested and received medical attention from staff at the Jail. The delay in response caused the prisoner considerable and unnecessary pain, and placed him at a significant risk of death.

112. Upon information and belief, custody staff do not adequately respond to requests from prisoners for medical care. When Plaintiff SARABI complained about intense pain in his right foot/ankle, and voiced concern about a broken ankle and a possible concussion one hour after he was attacked by another prisoner, one of the guards outside his room said, "You're a tough guy, suck it up, if you had broken your ankle you would be in more pain." Delays in treating Plaintiff SARABI and other prisoners have created unnecessary suffering and worsened health outcomes. Upon information and belief, Defendants do not adequately train custody staff in how to respond to prisoners' requests for emergency medical attention.

F. Defendants Routinely and Systematically Fail to Provide Adequate Medical Care

113. Defendants fail to provide timely access to medical and dental care. Defendants' policies and practices for providing timely access to medical and dental care are inadequate. Upon information and belief, Defendants fail to adequately train custody and medical staff in how to provide timely access to medical and dental care. If prisoners are seen by health care providers at all, they often experience substantial delays in receiving those appointments. Prisoners also experience long delays before they are seen and treated by outside specialists, before they receive surgery at outside facilities, or before

they receive dental care. The Jail has also failed to institute adequate policies and practices to treat prisoners with chronic conditions. Prisoners commonly wait several weeks, sometimes several months, before they are evaluated by clinicians for medical symptoms. As a result of these deficiencies, prisoners with serious and life-threatening conditions unnecessarily suffer and are put at risk of harm.

114. For example, in October, November, and December 2013, Plaintiff PEREZ was seen by three specialists at outside medical facilities regarding the tumor on his foot. Each of these specialists instructed that Plaintiff PEREZ needed to be seen by an expert in orthopedic oncology at a tertiary facility such as Stanford or UCSF for evaluation and treatment of the possibly cancerous tumor. Upon information and belief, to date, more than six months after the original referral, Plaintiff PEREZ still has not been seen by an orthopedic oncologist. Plaintiff PEREZ was informed by at least one of the three doctors whom he saw that if he did not receive proper attention for his tumor, he was at risk of having his foot amputated.

115. Plaintiff HERNANDEZ was supposed to have his colostomy reversed in June 2012. However, CFMG medical staff repeatedly refused to perform the colostomy reversal surgery, at first claiming that it was improper for Jail doctors to do so when an outside doctor had performed the original colostomy, and then claiming that the procedure was "non-emergency" so could not be done at the Jail. The Jail also refused to transfer Plaintiff HERNANDEZ to a facility where he could receive the reversal surgery, and in August 2012 denied Plaintiff HERNANDEZ the day pass necessary to go to Santa Clara County for the surgery. In total, Plaintiff HERNANDEZ had to wait eight months to have his colostomy surgery after he arrived at the Jail, during which time he suffered from intestinal swelling, bleeding, and pain.

116. Plaintiff COBB disclosed during her intake screening on April 4, 2013, that she had seen an outside provider and been referred to a urologist for complaints of cloudy and discolored urine. Over the next eight weeks, Defendants repeatedly failed to diagnose Plaintiff COBB's severe kidney stones, at times treating her for a urinary tract infection

and at times offering no treatment at all. On June 1, 2013 she was taken to Natividad Medical Center in an ambulance due to a high fever and severe pain. At Natividad, she was finally diagnosed as having large kidney stones. Doctors at Natividad instructed that she be seen by a urologist immediately. She was not seen by a urologist until June 19, 2013, at which time the urologist was concerned about whether Plaintiff COBB had lost so much kidney function that her kidney would have to be removed. On June 25, 2013, Plaintiff COBB had a surgical drain inserted into her kidney, and shortly thereafter it was determined that her affected kidney only had approximately 31% remaining function. She did not receive any surgery to remove any kidney stones until September 13, 2013. She has suffered severe and unnecessary pain and risk of permanent loss of kidney function due to Defendants' failure to timely diagnose and appropriately treat her medical condition.

117. Other prisoners have repeatedly been denied necessary medical treatments or experienced significant delays in receiving what they needed or had been prescribed prior to arriving at the Jail, resulting in significant physical pain and discomfort, as well as increased anxiety and panic. For example, one prisoner repeatedly requested colostomy reversal surgery for three months, but was informed by Defendants that he could not receive the surgery because it was an "elective," as opposed to emergency, procedure. During these three months, this prisoner suffered from infections, bloody discharge, fainting, and vomiting. Another prisoner was not timely provided with appropriate colostomy supplies, and when he appeared in court, he was leaking feces over his body. The judge ordered him to be sent immediately to the hospital in an ambulance.

118. Plaintiff HOBBS suffers from asthma and has been prescribed an Albuterol inhaler during his current and past terms in the Jail. In late-February 2014, his Albuterol inhaler ran out. Despite numerous sick call slips and other requests to medical staff, was not refilled for more than a month. Without his inhaler, he suffered asthma attacks on a near-nightly basis. Defendants also failed to provide Plaintiffs ESQUIVEL and MEFFORD with the inhalers they require to treat their asthma. Plaintiff ESQUIVEL

requires two inhalers—Albuterol and Flovent. During a previous stay in the Jail from January to February 2014, he was allowed to bring in his own inhalers, which were almost empty. When they ran out after a couple of weeks, he was not given replacements, despite orally requesting new inhalers from the staff. During his current stay in the Jail, Plaintiff ESQUIVEL is only receiving Flovent, not Albuterol. As a result, he is wheezing at night and experiencing increased fatigue. Plaintiff MEFFORD was provided with an inhaler during his initial days in the Jail in early December 2013. However, the Jail staff failed to mark the inhaler as his property. Custody staff thus confiscated it during a search as suspected contraband. Plaintiff MEFFORD requested a replacement inhaler from a nurse in January 2014. However, the nurse failed to find the doctor's order from December 2013 prescribing an inhaler for Plaintiff MEFFORD in his medical records. Thus, the nurse denied Plaintiff MEFFORD a new inhaler. Plaintiff MEFFORD had to again request to see the medical staff before a different staff member was able to find the order for an inhaler in his file and gave it to him. Without his inhaler, Plaintiff MEFFORD suffered increased chest pain and tightness and struggled to breathe normally.

119. Upon information and belief, CFMG medical staff inform prisoners that they will not receive medically necessary treatments, procedures, or medications while in the Jail because their release from the Jail or transfer to state prison or another institution is allegedly imminent. For example, notes in Plaintiff PEREZ's medical file made by a doctor employed by CFMG indicate that Defendants may have been attempting to delay his referral to an orthopedic oncologist at UCSF or Stanford in an attempt to avoid the expense involved in transporting Plaintiff PEREZ to the specialist. In addition, in response to Plaintiff PEREZ's inquiries to nurses at the Jail for information regarding when he might see an appropriate specialist, Plaintiff PEREZ has been asked by the nurses when he will getting out of custody.

120. Defendants have demonstrated that they are incapable of properly managing and treating severe chronic conditions suffered by many prisoners. For example, Plaintiff MILLER has severe type 1 diabetes. Staff of Defendants MONTEREY COUNTY and the

SHERIFF'S OFFICE wrote on an Intake Health Screening form dated January 8, 2013, that Plaintiff MILLER had diabetes; staff of Defendant CFMG noted on an Intake Triage Assessment form completed on that same date that Plaintiff MILLER took two different types of insulin. In nine months of incarceration Defendants have been unable to develop and implement a treatment plan to appropriately manage Plaintiff MILLER's diabetes. He suffers serious diabetic episodes resulting in periods of unconsciousness, and is experiencing diabetes-related vision loss and other serious and permanent side effects of his uncontrolled diabetes.

121. Plaintiff ESQUIVEL also has diabetes. In January 2014, Plaintiff ESQUIVEL entered the jail with a high blood sugar level over 280 mg/dl. After his intake forms noted his diabetic condition, it was ordered that he receive daily insulin. After initially providing one dose of insulin, the Jail failed to provide him with any insulin for 48 hours, after which time Plaintiff ESQUIVEL's blood sugar spiked above 330 mg/dl.

122. Another prisoner suffered a miscarriage immediately before being booked into the Jail, and experienced heavy vaginal bleeding for at least seven weeks afterward. Despite repeated requests, this prisoner did not see a women's health specialist for seven weeks. After seven weeks of bleeding and the filing of multiple grievances (most of which went unanswered), this prisoner was finally taken to Natividad Medical Center for an evaluation by a women's health specialist. This prisoner did not receive timely and appropriate care for her condition.

123. In interactions with medical staff, Defendants fail to ensure that hearing and speech impaired prisoners who use American Sign Language as their primary method of communication are provided with sign language interpreters to ensure effective communication. Without sign language, such prisoners are not able to explain to medical care providers the symptoms they are experiencing, and medical staff are not able to explain the benefits and risks of treatments, medications, and procedures such that prisoners can provide their informed consent. The lack of sign language interpretation services results in Defendants making medical treatment decisions without all of the

necessary and pertinent information they need, which increases the risk of misdiagnosis and mistreatment for the prisoner.

124. For example, Plaintiff YANCEY was examined by a Physician's Assistant ("PA") at the Jail on December 4, 2012, two days after he was discharged from the hospital with a fractured right arm and fractured left tibia. Defendants did not provide Plaintiff YANCEY with a sign language interpreter for the examination. Though Plaintiff YANCEY presented with multiple, complex trauma issues, the PA's Progress Note admits that the "[e]xam [was] limited due to decreased verbal communication ...." Because of Defendants' failure to provide Plaintiff YANCEY with a sign language interpreter, he was unable to explain the extent of his pain and other symptoms. As a result, he suffered from needless and unnecessary pain. Defendants also failed to provide sign language interpreters at other medical appointments for Plaintiff YANCEY. The lack of a sign language interpreter at other medical appointments similarly resulted in Plaintiff YANCEY's inability to communicate his symptoms to medical staff and to understand medical staff. Through their failure to provide sign language interpreters for medical appointments, Defendants are deliberately indifferent to the medical needs of prisoners who require assistance to communicate.

125. Upon information and belief, Defendants fail to ensure effective communication of critical medical information to prisoners with vision loss, such as Plaintiff MILLER. Defendants do not have a policy or protocol of implementing, tracking, or recording effective communication. Defendants provide written materials to vision-impaired prisoners without documenting that such materials were read aloud or otherwise communicated to the prisoners, and fail to ensure that vision-impaired prisoners are adequately informed of, among other things, the medications that are being administered. As a result of Defendants' failure to ensure effective communication in the provision of medical care, vision-impaired prisoners are subject to risk of serious medical harms, as was the case when Plaintiff MILLER was provided with an improper insulin injection and lapsed into unconsciousness.

126. Upon information and belief, Defendants fail to provide foreign language interpretation services to prisoners whose primary language is not English during medical clinical evaluations. This is particularly true for prisoners who cannot speak either English or Spanish. Without foreign language interpretation, such prisoners are not able to explain to doctors the symptoms they are experiencing, and medical staff are not able to explain the benefits and risks of treatments, medications, and procedures such that prisoners can provide their informed consent. The lack of foreign language interpretation services results in Defendants making medical treatment decisions without all of the necessary and pertinent information they need, which increases the risk of misdiagnosis and mistreatment for the prisoner. Through their failure to provide foreign language interpreters for medical appointments, Defendants are deliberately indifferent to the medical needs of prisoners who require assistance to communicate.

G. Defendants Fail to Continue Medically Necessary Treatments for Prisoners Upon Their Arrival at the Jail

127. Defendants fail to continue medically necessary treatments for prisoners who were in the process of undergoing care for chronic, serious, or other conditions immediately prior to being booked into the Jail, putting those prisoners at risk of harm. Defendants' policies and practices for continuing medically necessary treatments for prisoners who arrive at the Jail are inadequate. Upon information and belief, Defendants do not adequately train medical staff in how to evaluate and treat prisoners who were undergoing care for chronic or serious conditions immediately prior to being booked into the Jail.

128. Defendants routinely refuse to provide medications that prisoners have been using to treat conditions outside of the Jail, even when the prisoners themselves, doctors, family members, or other entities bring their medications and/or valid prescriptions to the Jail.

129. For example, one prisoner re-entered the Jail on June 15, 2013 following a period on which she had been released by the SHERIFF'S OFFICE to home confinement

in order for her to have necessary back surgery. On information and belief, this prisoner, who is an insulin-dependent diabetic, brought her insulin with her to the Jail on June 15, 2013. In the Diabetes section on this prisoner's Intake Triage Assessment form dated June 15, 2013, the Registered Nurse who completed the form wrote that the prisoner took seven units of Lantus twice a day. Although Defendants were aware of her diabetic condition and need for insulin, the "Diabetic Chart" in this prisoner's medical file indicates that she did not receive any insulin from June 15, 2013 through at least June 27, 2013. On information and belief, this prisoner did not begin to regularly receive insulin until on or after July 24, 2013.

130. Plaintiff GIST was prescribed the muscle relaxant Flexeril by her physician prior to entering the Jail in order to help manage the chronic back pain she experiences due to her scoliosis and congenital hip dislocation. The Jail is aware of her condition and has confirmed her prescription. Despite numerous requests, Plaintiff GIST has not received this pain medication while in the Jail, which has exacerbated the pain and swelling in her back. Due to her back pain Plaintiff GIST has difficulty walking, sitting, standing, and lying down in one position for a long time and has difficulty walking up stairs. Plaintiff GIST's condition also makes it difficult for her to balance and causes her to fall often. She has difficulty accessing programs and services, which are up a long flight of stairs, due to the pain.

131. Plaintiff WHITFIELD suffers from narcolepsy and cataplexy, two conditions that can be adequately controlled through the provision of two medications: Provigil and Xyrem. Plaintiff WHITFIELD was prescribed such medications by his outside specialist physician. Plaintiff WHITFIELD requested both drugs upon entering the Jail in November 2013. Plaintiff WHITFIELD saw a physician at the Jail on December 5, 2013, who then called Plaintiff WHITFIELD's outside specialist on December 6, 2013, to verify Plaintiff WHITFIELD's condition and medication regime. Immediately after this telephone call, the Jail physician ordered Provigil for Plaintiff WHITFIELD. However, Defendants did not provide Plaintiff WHITFIELD with Provigil for nearly two months, during which time

he was at risk for falling asleep at any time, without warning. He spent upwards of 20 hours a day in bed in an attempt to minimize his risk of falling and hurting himself. Plaintiff WHITFIELD eventually was forced to submit two grievances before Defendants finally provided him with Provigil on or around February 1, 2014. Defendants still refuse to provide him with Xyrem, which controls cataplexy. As a result, Plaintiff WHITFIELD has had four cataplexic episodes in the Jail since November 30, 2013—which is a far more frequent rate of attacks than he normally experiences.

132. Defendants place many prisoners who arrive at the Jail and who are prescribed pain and other medications on what Defendants call a "detoxification treatment." The detoxification treatment involves taking prisoners off of their prescribed medications "cold turkey" without any tapering, and refusing, for up to 90 days, to provide prisoners with the pain and other medications they were taking pursuant to prescription before they were booked into the Jail. This practice of removing prisoners from prescribed medications is dangerous, inhumane, and does not meet the standard of care. Prisoners placed on the detoxification treatment and removed from prescribed pain medications suffer extreme pain, withdrawal symptoms, and degeneration of conditions the medication was designed to treat.

133. For example, one prisoner was placed on a detoxification treatment when she re-entered the Jail on June 15, 2013, following significant spinal surgery on June 3, 2013. As treatment for the pain associated with the surgery, her treating physician outside of the Jail had prescribed for her various pain medications, including hydrocodone and diazepam. On June 15, 2013, Defendants refused to provide this prisoner any of her prescribed pain medications and gave her only ibuprofen and anti-anxiety medications until she was seen by a physician at the Jail almost two weeks later. Staff of Defendant CFMG placed this prisoner on detoxification treatment solely because she was taking prescribed pain medications and not because she was taking other substances, such as alcohol or illegal or non-prescribed drugs. As a result, the prisoner experienced extreme pain and physical and emotional distress, as well as significant mobility impairment as a result of her pain and

back injuries.

134. Another prisoner was taking significant dosages of prescription pain medications for injuries stemming from gunshot wounds, including a Fentanyl patch, Oxycontin, and Oxycodone. However, when he arrived at the Jail in August 2012, Defendants refused to provide him with any of his prescribed pain medications and subjected him to the detoxification treatment. As a result of the detoxification treatment, this prisoner suffered through an extremely painful withdrawal. Yet another prisoner was subjected to the formulaic detoxification treatment in March 2013, even though her intake form clearly indicates that she was receiving methadone under the supervision of a physician at Natividad Medical Center for treatment of her heroin dependency.

135. Prior to her incarceration, Plaintiff HUNTER was taking various prescription medications to treat her diabetes, fibromyalgia, high blood pressure, chronic back pain, bone cancer, seizures, bipolar disorder, manic depression, anxiety, and panic attacks. Plaintiff HUNTER had many of these medications with her upon her arrival at the Jail, but they were confiscated during the booking process. Defendants refused to provide her with all of her necessary medications for two weeks.

136. Prior to his incarceration, Plaintiff MURPHY was taking various prescribed pain medications at least four times a day as treatment for the nerve damage in his back. However, despite his repeated requests, Plaintiff MURPHY has not received the necessary medications at the appropriate times, and he is in constant pain.

H. Defendants Fail to Provide Adequate Care in Emergency Situations

137. Defendants fail to provide adequate medical care when confronted with prisoners who require emergency medical attention. Defendants' policies and practices for providing emergency treatment to prisoners are inadequate. Upon information and belief, Defendants do not adequately train custody or medical staff regarding how to respond to emergency medical situations and requests for emergency medical treatment from prisoners.

138. Plaintiff HERNANDEZ experienced two serious emergencies while in the

Jail in the month following his ileostomy reversal surgery in December 13, 2012. In both instances, Defendants' emergency response placed Plaintiff HERNANDEZ's life in jeopardy. The discharge instructions from his surgery indicated that he should either call the hospital or be taken to the emergency department if he had pain uncontrolled by pain medication, bleeding, inability to urinate, a fever, vomiting, or if his wounds became red or drained fluid. On December 22, 2012, his first day back in the Jail, he saw a nurse in the early afternoon and complained of extreme pain in his abdomen near the site of his surgery. Instead of immediately returning him to the hospital, the nurse called a PA, who ordered Tylenol, Milk of Magnesium, and Colace, and instructed that she should be called if his condition worsened. By 2:15 P.M., his condition had worsened. The nurse paged the PA, but did not send Plaintiff HERNANDEZ to the emergency department. When the PA did not respond, the nurse paged her again at 3:15 P.M.; still, the nurse did not send Plaintiff HERNANDEZ to the emergency department, even though his symptoms persisted and had possibly worsened. Finally, at 3:50 P.M., one of the Jail doctors called and ordered that he should be sent to the hospital. Ultimately, Plaintiff HERNANDEZ was transported to Natividad, where he remained for eight days to treat a bowel obstruction. The December 30, 2012 discharge note from the hospital stated that he should be returned to the emergency room if he had a fever, increased pain, vomiting, inability to have a bowel movement, or for any other problem.

139. On January 7, 2013, Plaintiff HERNANDEZ complained early in the morning to a nurse that he had a fever, that he woke up in a sweat, that he had diarrhea, that he was experiencing nausea, and that he had vomited one time. Rather than sending Plaintiff HERNANDEZ to the emergency department, the nurse ordered that he be provided Imodium and Phenergan and be evaluated by the PA later that day. Plaintiff HERNANDEZ was never seen by the PA that day. When he saw a nurse at 6:00 P.M. to change his dressing, he told her that he felt like he had a fever. She measured his temperature, which was 101.0 degrees. The nurse did not contact a doctor or the PA or send Plaintiff HERNANDEZ to the emergency department. Instead, she entered an order

to provide him with Tylenol, have his temperature checked regularly for a day, and set him up to be seen by the PA the next day.

140. That night, at about 1 A.M., Plaintiff HERNANDEZ started experiencing unbearable pain in his abdomen, which he describes as the worst pain of his life. At the time, he was single-celled in J-Pod. He collapsed on his bunk and could not move. He pleaded with another prisoner to get the attention of staff, but there was no custody staff around for the prisoner to notify for about 15 minutes. Staff finally made their rounds of the pods and the prisoner spoke with the staff. Without entering the pod or looking at Plaintiff HERNANDEZ, the officer stated that medical staff wouldn't be able to come for 30 minutes. The other prisoner said "But he's already been down for 15 minutes." The officer said, "I'll see what I can do." About a half hour passed and the same officer passed by J-Pod to conduct a regular check. The same prisoner banged on his door to get the guard's attention. The prisoner said that Plaintiff HERNANDEZ still hadn't been seen by medical staff. The guard then entered the pod for the first time and observed Plaintiff HERNANDEZ. He said "I'll be right back, let me get a hold of my Sergeant." He then left the pod. Another 10-15 minutes passed and still no medical staff came to see Plaintiff HERNANDEZ. Other prisoners started banging on their doors and yelling "Man down!" to try to get staff attention. Finally, medical staff finally arrived at around 2:50 A.M. on January 8, 2013. Plaintiff HERNANDEZ was transported to Natividad at 3:00 A.M., and remained in the hospital for treatment of multiple abscesses until February 27, 2013.

141. Plaintiff DOBBS sustained a fractured nose, a permanent post-traumatic tremor in her right hand from mild traumatic brain injury, and nerve damage, pain, and numbness in her left leg, knee, and ankle when she fell at the courthouse while shackled at the ankles, waist, and wrist. In addition to the permanent damage, she also suffered two black eyes and bruises on her elbows, knees, and ankles. Plaintiff DOBBS did not receive timely medical attention, proper pain medication, or proper follow-up tests after the incident despite the serious nature of the fall. For example, although she was given an ice pack and one dose of pain medication immediately after the incident, she did not see a

nurse until later that night despite being in severe pain. When Plaintiff DOBBS did see the nurse, the nurse simply gave her an ibuprofen prescription and recommended she go to sick call three days later with the PA. In fact, Plaintiff DOBBS had fractured her nose. The injury was not diagnosed for more than a week. She also experienced the onset of a tremor in her right hand, but was not taken to see a specialist for more than a month. This specialist concluded she had a post-traumatic tremor from a mild traumatic brain injury sustained from her fall. Medical staff should have, but did not, recognize the seriousness of her injuries when they occurred and provided more timely and appropriate treatment.

142. In emergency situations, prisoners sometimes request health care from custody staff when medical staff are not available. Rather than immediately contact health care staff to determine whether emergency care is required, custody staff often dismiss the prisoner's request and instruct prisoners to fill out a sick call slip. Plaintiff HERNANDEZ's experience, discussed above, in which it took approximately 60 minutes for custody staff to summon emergency medical care, is one example of this problem.

143. Upon information and belief, another prisoner in the Jail suffered a miscarriage due to the Jail's failure to timely respond to her emergency medical situation. While pregnant, this prisoner began to experience uterine cramping and bleeding, but was informed by medical staff to go on bed rest. The Jail staff did not transport her to a hospital until at least two days later, and by that time she had lost her baby. Between 2012-2013, at least two women in the Jail suffered from miscarriages.

144. Often there is neither custody nor medical staff around. Prisoners are thus forced to provide needed care to each other. For example, Plaintiff ESQUIVEL started bleeding profusely from his leg wound in October 2013. As there were no custody staff nor medical staff in the area, other prisoners had to actively seek a guard's attention before any custody staff recognized the existence of an emergency. This delayed care for Plaintiff ESQUIVEL's leg considerably. As another example, Plaintiff WHITFIELD has collapsed in a cataplexic episode four times thus far during his incarceration. Twice, no one woke him up and he woke up on the floor by himself. The third time, other prisoners

saw him collapse and banged on their doors to alert the guards. The fourth time, he was awoken on the floor by medical staff coming by to bring him his medication. These staff members did nothing to respond to him being on the floor but merely asked if he was ready to take his medication.

I. Defendants Fail to Provide Adequate Diagnostic Care to Prisoners, Including Failing to Appropriately Refer Prisoners to Outside Specialists When Necessary

145. Upon information and belief, Defendants fail to order diagnostic testing when medically necessary, creating an unreasonable risk of harm to prisoners. Defendants' policies and practices for ordering diagnostic testing are inadequate. Upon information and belief, Defendants fail to adequately train medical staff in when it is appropriate to order diagnostic testing.

146. When Plaintiff COBB reported unusually cloudy and discolored urine and increasing pain over a period of nearly six weeks, CFMG personnel evidently performed no diagnostic tests other than taking urine samples, which yielded inconsistent results and failed to lead to a diagnosis of Plaintiff COBB's large kidney stones. No ultrasound was performed until Plaintiff COBB was taken by ambulance to Natividad Medical Center on June 1, 2013.

147. In September 2013, an outside neurologist treating Plaintiff DILLEY for her likely diagnosis of MS ordered that Plaintiff DILLEY receive a full neuropsychiatric assessment to evaluate her cognitive function. To date, Defendants have not provided Plaintiff DILLEY with a full neuropsychiatric assessment.

148. When Plaintiff KEY reported to a PA at the Jail that he had previously been treated for a salivary gland tumor and was experiencing a recurrence of that tumor, no appropriate diagnostic tests were performed. Rather, the PA told him, on the basis of no testing, that it was a fatty tumor and did not require further treatment. Plaintiff KEY was only seen by a doctor for proper evaluation of his complaint after he filed a grievance.

149. When Plaintiff SARABI sustained an injury to his right ankle/foot after he was attacked by another prisoner, he did not timely receive tests to determine the extent of

the muscle and nerve damage. Other prisoners do not receive medically indicated diagnostic tests such as colonoscopies or ultrasounds in a timely manner.

150. Defendants also fail to refer prisoners to medical specialists or to an outside medical center when medically necessary. Defendants' policies and practices for referring prisoners to specialists or outside providers are inadequate. Upon information and belief, Defendants fail to adequately train medical staff regarding when it is appropriate to refer prisoners to medical specialists or outside medical centers.

151. For example, Plaintiff GUYOT suffered a concussion when he was attacked by a group of other prisoners on March 15, 2013. On March 31, 2013, he filed the first of approximately 26 sick call slips in which he has complained of blurred vision, severe migraines, dizziness, and/or sensitivity to light. He was not sent for a CT scan until May 16, 2013 (by which time he had filed approximately seven sick call slips with similar complaints of post-concussion trauma), and was not seen by a neurologist until June 7, 2013. Since June 7, 2013, he has filed approximately 17 sick call slips continuing to report serious vision and neurologic issues, but on information and belief, he has not been seen by any other specialists.

152. Plaintiff COBB suffered a delay of more than two weeks between her diagnosis, at Natividad Medical Center, of severe kidney stones and her first follow up visit with an outside medical provider. This delay was in part due to the Defendant's failure to promptly ensure that the first provider to whom Plaintiff COBB was referred would accept prisoner patients, which resulted in the belated cancellation of an appointment and a delayed effort to find a willing provider. After Plaintiff COBB had a surgical drain inserted into her kidney, she then went more than six weeks without again seeing a specialist or having surgery to remove her kidney stones.

153. As is discussed above in Paragraph 114, in October 2013, outside medical specialists first instructed that Plaintiff PEREZ be seen by an expert in orthopedic oncology at a tertiary facility to evaluate a possibly-cancerous tumor on his foot. Upon information and belief, he still has not been seen by an orthopedic oncologist.

154. Plaintiff MILLER began to complain of extremely painful involuntary hand contractions in mid-April 2013. Defendants did not arrange for a necessary hand operation to occur until July 27, 2013, leaving Plaintiff MILLER in excruciating pain and with limited use of his hand for more than two months. Plaintiff MILLER also began to complain of blurred vision by February 27, 2013. Although vision loss is a common and well-known complication of diabetes, Plaintiff MILLER did not see an ophthalmologist until April 17, 2013, did not have a follow-up appointment until May 11, 2013, and did not have a final ophthalmology appointment until July 24, 2013. Despite the long delays between specialist visits, Jail medical staff deferred eye examinations during Plaintiff MILLER's check-ups on the grounds that he was under an ophthalmologist's care.

155. Upon information and belief, another prisoner in the Jail suffered a miscarriage due to the Jail's failure to timely take her to a hospital after this prisoner reports uterine cramping and bleeding. Defendants did not order any diagnostic testing or take her to see a specialist. Two days later she was transferred to the hospital, and by that time she had lost her baby.

J. Defendants Fail to Provide Adequate Post-Operative and Other Medically Necessary Follow-Up Care to Prisoners

156. Defendants fail to adequately treat prisoners discharged from the hospital or Jail infirmary. Defendants' policies and practices for treating prisoners discharged from the hospital or infirmary are inadequate. Upon information and belief, Defendants fail to adequately train employees regarding how to appropriately and effectively treat prisoners discharged from the hospital or infirmary.

157. For example, Plaintiff HERNANDEZ received colostomy reversal surgery in December 2012, and had to return to the hospital one day after surgery due to post-operative complications. Since his discharge from Natividad Medical Center, Plaintiff HERNANDEZ has received inadequate care from CFMG medical staff. Specifically, Plaintiff HERNANDEZ's gauze at the surgery site was not changed every 24 hours as is ordered, he did not receive his prescribed narcotics, and, when he experienced fever and

severe pain, Jail staff failed to contact staff at the Natividad Medical Center (as they had been instructed to do in the discharge summary).

158. Another prisoner suffered a ruptured colon and had to undergo colostomy surgery in August 2012. After he was discharged from the Jail infirmary following the surgery, Defendants failed to timely provide him with supplies to change his colostomy bag, and when such supplies were provided, they were often improper (e.g., the wrong size colostomy bag). In November 2012, because of the improper post-operative treatment and maintenance of the colostomy and Defendants' refusal to authorize a colostomy reversal procedure, an infection developed around his stoma from the colostomy surgery and the prisoner suffered from bloody discharge from his colon.

159. Plaintiff DOBBS suffers from Right Carpal Tunnel syndrome which may have been exacerbated by her fall at the courthouse in November 2012. Although her outside neurologist recommended a hard wrist splint over a year ago, and Jail medical staff orders her such a wrist splint seven months ago, she has still yet to receive the splint. Without the splint Plaintiff DOBBS continues to experience pain, numbness, and tingling in her right wrist and hand which keeps her up at night. In lieu of the wrist splint, Plaintiff DOBBS has been given an ACE bandage wrap, which is not effective. Plaintiff DOBBS has also had the ACE wrap taken twice in raids on her pod after which time it has taken her two weeks to a month to get the bandage back.

160. Plaintiff COBB was diagnosed with large kidney stones at Natividad Medical Center on June 1, 2013, and had a surgical drain inserted into her kidney on June 26, 2013. In the four weeks between her diagnosis and the insertion of the drain, Defendants failed to consistently provide her with the pain medications that she had been prescribed at Natividad. When she returned to the Jail after her June 26, 2013 surgery, she experienced several weeks of increasing pain, nightly fevers, and distress due to Defendants' failure to consistently provide her with prescribed post-operative pain medications.

161. Another prisoner had major spinal surgery shortly before she re-entered the

Jail on June 15, 2013. CFMG medical personnel made no arrangements to ensure continuity of post-operative care either within the Jail or by this prisoner's outside treating physicians. Although a CFMG physician noted on June 28, 2013, that post-operation appointments with her treating physician would be approved, the prisoner was required to submit multiple requests for temporary release in order to attend scheduled appointments with her treating physicians, none of which were approved by Jail staff until July 26, 2013, nearly six weeks after she returned to the Jail.

162. Plaintiff MILLER had surgery on his hand for diabetes-related complications on June 27, 2013. Following the surgery, Defendants failed to consistently provide Plaintiff MILLER with timely and appropriate pain medications. As a result, he has suffered severe and unnecessary pain and has had limited use of his hand.

163. Plaintiff AGUILAR had to receive surgery while in custody to fix the fractured cheekbone he suffered after he was attacked by another inmate. He was returned to the Jail the same morning as his surgery. Once back in the Jail, he did not receive adequate follow-up care. Despite orders from both the outside doctor and Jail medical staff that Plaintiff AGUILAR was to be on a soft diet, he did not receive the proper diet. Despite filing numerous sick call slips and two grievances about the diet, Plaintiff AGUILAR went nearly two weeks without medically appropriate food to eat. During this time Plaintiff AGUILAR lost significant weight, constantly felt dizzy, could not concentrate, and often lacked the energy to do anything other than lay on his bed.

164. In addition, Plaintiff AGUILAR experienced problems receiving prescribed pain medication after his surgery. Despite orders from Jail medical staff that he was to receive Norco for 10 days, the medication stopped after the first five days, requiring him to fill out a sick call slip and a grievance in order to be seen by a doctor and get back on the medication. During the time Plaintiff AGUILAR was without Norco, his pain spiked to nine out of 10 and it was back to nearly the same amount of pain as right after the injury had occurred. He had stitches on both the inside of his and the outside of his face, which gave him sharp stabs of pain in addition to the throbbing pain where the fracture had

occurred.

165. Upon information and belief, Defendants routinely release prisoners with serious medical conditions from the Jail without providing them with services to ensure that their medical care is not disrupted. Defendants' policies and practices for the provision of continuing medical care services upon a prisoner's release are inadequate. Upon information and belief, Defendants fail to adequately train custody and medical staff regarding how to appropriately release prisoners with serious medical concerns so that such prisoners can continue their medical care. Upon information and belief, for those prisoners who are prescribed medications in the Jail, they are released without either a supply of or a prescription for them to fill those medications at a community pharmacy. Defendants do not schedule follow-up appointments in the community, nor are prisoners provided with sufficient referrals or information about where they may receive medical care services or medications.

K. Defendants Fail to Maintain Adequate, Accurate, and Complete Medical Care Records

166. Upon information and belief, Defendants fail to maintain adequate, accurate, and complete medical care records. Defendants' policies and practices for maintaining adequate accurate and complete medical care records are inadequate. Upon information and belief, Defendants fail to adequately train medical staff in how to maintain adequate medical care records.

167. For example, physicians change prisoners' medications without documenting a rationale.

168. Many of the medical files for Plaintiffs are incomplete. For example, some are missing progress notes that were dictated but never placed in the medical file.

169. As a result of Defendants' failure to maintain adequate medical care records, prisoners suffer from a substantial risk of misdiagnosis, dangerous mistakes, and unnecessary delays in care.

170. For example, Plaintiff MEFFORD was denied his prescribed inhaler for a

few days because a nurse did not find the order prescribing it in his records. Another nurse was able to find the order a few days later.

171. Defendants do not appear to have any policy, procedure, or practice for tracking, recording, or storing sick call slips in prisoners' medical files. Rather, the sick call slips appear to be stored in a loose and disorganized stack of slips of paper.

172. On information and belief, prisoners' medical files do not contain any log of sick call slips submitted, what complaints were raised in the sick call slips, and whether or when the prisoner was seen with regard to the complaint raised. As a result, prisoners' medical records do not contain a complete record of the condition of the prisoner or the care he or she has been provided, which compromises the adequacy of care that prisoners receives.

173. Upon information and belief, Defendants fail to obtain medical files from outside providers for significant periods of time after the prisoner's arrival at the Jail (if at all). When prisoners who arrive at the Jail inform CFMG employees that they suffer from a condition or take certain prescription medications, medical providers often indicate in progress notes that they will not provide the prisoner with the requested care until they can confirm the condition or prescription medication through outside medical or pharmacy records. Defendants routinely fail to request and obtain outside records in a timely manner or at all. Nonetheless, Defendants use their lack of possession of outside medical records as a justification for denying prisoners the care they were receiving outside of the Jail and are requesting inside the Jail. Defendants' repeated failures to timely obtain medical records from outside providers or pharmacies reduce the quality of medical care, as medical staff treat prisoners without reviewing pertinent medication background information and history, and significantly increase the risk of misdiagnosis, mistreatment, and harm.

174. Plaintiff HERNANDEZ's medical file does not include any progress notes or discharge summaries for either his December 13, 2012 surgery to reverse his ileostomy or for his seven-week hospitalization for abscesses in his abdomen.

175. Plaintiff AGUILAR was prescribed Vicodin by an outside doctor to help manage his pain prior to surgery for his fractured cheek bone. He was placed back in custody prior to the surgery. Although he informed medical staff of his pain medication, medical staff said they would not give it to him because they had to verify his prescription. Defendants never provided him with the medication.

176. Plaintiff AGUILAR's file is missing complete outside medical records from the doctor's office who performed surgery to repair the fracture in his cheek. The Jail medical file does not contain progress notes of Plaintiff AGUILAR's February 13 and 15, 2013 appointments in which he was initially examined, given post-operative instructions, and scheduled for surgery.

177. Defendants also fail to provide complete and accurate medical records regarding treatment within the Jail to outside providers to whom prisoners are sent for specialty care. For example, one prisoner was sent to an orthopedic specialist for follow-up care for his severe dog bite. That specialist noted: "It is unclear at this point if he is on any medications. I do not have any records from the jail." Defendants' failure to ensure that outside providers have access to jail medical records subjects prisoners to unreasonable risks of harm, including, but not limited to, risks of fatal drug interactions.

178. MONTEREY COUNTY has contracted with the County of Alameda to house certain Monterey County Jail prisoners in Alameda County's Santa Rita Jail Facility. According to the terms of the contract between the counties, prisoners remain in the legal custody of MONTEREY COUNTY and may be returned to Monterey County Jail at any time. In addition, the agreement may be cancelled upon 30 days' notice of either party, which would result in the return of all prisoners to the Monterey County Jail. Under the contract between the counties, MONTEREY COUNTY retains the right to pre-approve outside medical care for prisoners it sends to Alameda County, and has contractual obligations to provide the medical records of Monterey County Jail prisoners to Alameda County. Dozens of Monterey County Jail prisoners have been sent to Alameda County pursuant to the contract between the counties, including Plaintiff GREIM. As described

above, however, they are subject to return to the Jail and its unconstitutional conditions at any time.

179. Upon information and belief, Defendants have not ensured that the medical and medication records of prisoners who are sent to Alameda County accompany those prisoners to Alameda County or follow in a timely manner. As a result, Monterey County prisoners, including Plaintiff GREIM, have experienced interruptions in care and delays in receiving necessary medications when transferred to the physical custody of Alameda County.

L. Defendants Fail to Adequately Train Staff to Provide Appropriate and Timely Medical Care

180. Upon information and belief, Defendants fail to adequately train custody and medical staff in how to provide appropriate and timely medical care. The lack of training is evident from the numerous incidents in which prisoners' health and lives were placed at risk as a result of the deficient medical care provided in the Jail. As a result of a lack of adequate training, custody and health care staff do not, among other failings: timely and appropriately identify medical and dental problems during the screening and intake process, properly process and timely respond to prisoners' requests for medical evaluation, evaluate and treat prisoners who were undergoing care for chronic or serious conditions prior to being booked into the Jail, appropriately respond to emergency medical situations and requests for emergency medical treatment from prisoners, timely order appropriate diagnostic testing, timely refer prisoners to appropriate medical specialists or outside medical centers, appropriately and effectively treat prisoners discharged from the hospital or infirmary, appropriately release prisoners with serious medical concerns so that such prisoners can continue their medical care, and maintain adequate medical care records.

III. DEFENDANTS FAIL TO PROVIDE MINIMALLY ADEQUATE MENTAL HEALTH CARE TO PRISONERS

181. Defendants MONTEREY COUNTY, MONTEREY COUNTY SHERIFF'S OFFICE, and CFMG are not meeting their constitutional obligation to provide adequate

mental health care to prisoners in the Jail. The mental health care provided by Defendants to prisoners in the Jail is woefully inadequate and falls far short of all of the minimum elements of a constitutional mental health system. Defendants are deliberately indifferent to the fact that their failure to provide adequate mental health care subjects prisoners to a substantial risk of deteriorating psychiatric conditions, extreme and unnecessary anguish and suffering, and, in some cases, even death.

182. All mental health care in the Jail, like medical care, is provided by Defendant CFMG and its employees. CFMG provides these services pursuant to its contract with Defendants MONTEREY COUNTY and the SHERIFF'S OFFICE. CFMG is a for-profit corporation.

183. Prisoners are entirely dependent on Defendants for all mental health care. Defendants provide and control all mental health care services. Accordingly, prisoners cannot receive any mental health care services—including psychotropic medication, group and individual therapy, and suicide intervention—unless Defendants provide them. Defendants control prisoners' access to mental health care professionals, inside or outside of the Jail, as well as their access to laboratory or other diagnostic testing.

A. Defendants Fail to Identify and Track Prisoners in Need of Mental Health Care

184. Defendants fail to adequately identify, track, and treat the mental health problems of newly arriving prisoners during the screening and intake process. Defendants' policies and practices for mental health screening and tracking are inadequate. Upon information and belief, Defendants fail to adequately train custody staff regarding how to timely and appropriately identify prisoners with mental health problems during the screening and intake process. The first step of the intake process involves custody staff completing a brief one-page general health screening form, called an Intake Health Screening form, through a cursory interview conducted with the prisoner in a non-confidential area of the Jail. The form itself fails to capture basic and essential data necessary to identify prisoners in need of mental health care, including those at risk of self-

harm. When a prisoner is newly booked into the Jail, mental health staff play no role in the initial screening of the prisoner. As a result, prisoners in need of mental health care at admission are either denied that care, or their care is delayed, causing them unnecessary suffering.

185. After the custody staff complete the Intake Health Screening form, newly booked prisoners are typically interviewed by a member of the medical staff employed by CFMG. The medical staff member, typically a Licensed Vocational Nurse ("LVN") or other medical staff not trained in mental health and without ability to order treatments or prescribe medications, complete a two-sided Intake Triage Assessment form. Mental health staff play no role in this process. Mental health staff only evaluate prisoners at intake if the medical care staff who complete the Intake Triage Assessment form refer the prisoner to mental health care staff. Upon information and belief, intake evaluations by mental health staff, when they occur at all, frequently do not take place until days or weeks after a prisoner is booked into the Jail.

186. Defendants also fail to provide adequate treatment to prisoners who arrive at the Jail and have been prescribed psychotropic medications. Defendants' policies and practices for prisoners who have been taking prescribed psychotropic medications are inadequate. Upon information and belief, Defendants fail to adequately train mental health staff regarding how to evaluate and treat prisoners who arrive at the Jail and have been taking prescribed psychotropic medications. Defendants sometimes place prisoners who arrive at the Jail and who are prescribed psychotropic medications on what Defendants call a detoxification treatment. The detoxification treatment involves refusing, for up to 90 days, to provide prisoners with the psychotropic medications they were taking before they were booked into the Jail. This practice of removing prisoners from prescribed medications is dangerous, inhumane, and does not meet the standard of care. Prisoners placed on the detoxification treatment and removed from psychotropic medications experience unnecessary pain and increases in psychiatric symptoms including paranoia, hallucinations, and suicidality. Such individuals are at increased risk of attempting to

commit suicide. They are also at heightened risk of failing to respond to medications once they are restarted.

187. Defendants fail to identify and initiate adequate mental health treatment via the Jail's intake process. As a result, prisoners arriving at the Jail with mental health needs are at a significant risk of serious harm. For example, Plaintiff MURPHY was booked into the Jail on January 18, 2013. Both his Intake Health Screening Form (completed by custody staff) and his Intake Triage Assessment form (completed by medical staff of CFMG) indicated that he self-reported mental health problems. Moreover, medical records in CFMG's possession from a prior term that Plaintiff MURPHY had spent in the Jail indicated the Plaintiff MURPHY suffered from mental illness and had received psychiatric medications. Despite this information, no mental health care staff met with Plaintiff MURPHY until January 21, 2013, at which point he had an appointment with a Licensed Psychiatric Technician who lacked authority to prescribe treatment or medication. On January 21 and 22, Plaintiff MURPHY submitted sick call slips stating, among other things, "need psych meds – seeing and hearing things" and "need psych meds or psych hospital, Attn: head psych please." On January 24, 2013, he submitted another sick call slip, this one addressed to Dr. Fithian, stating "I take varies physch medication ... for hearing voices and seeing demons coming out of the walls driving me crazy, can't sleep or eat right at all. Ive been trying to see a physch doctor, PLEASE help if possible." (Typographical errors and misspellings in original).

188. On another day on or around January 24, 2013, Plaintiff MURPHY submitted another sick call slip stating that the staff were "placing my life in serious danger and possible death after many attempts to receive my medications during and after intake. I'm a disabled vet who served my country with honorable discharge and should not be treated like trash over a officers attitude." Despite these pleas for help, Plaintiff MURPHY was not seen by mental health care staff with authority to prescribe treatment until January 29, 2013. Plaintiff MURPHY was only seen by a psychiatrist on that day because on January 28, 2013 he informed staff that he was hearing demonic voices that

were telling him to kill himself. Consequently, Defendants placed Plaintiff MURPHY in a rubber room, from which he was not released until January 30, 2013. Between the time that Plaintiff MURPHY was booked in the Jail and January 29, 2013, when a psychiatrist finally saw him and prescribed psychiatric medication, Plaintiff MURPHY was exposed to an extraordinary risk of harm and suffered extreme, unnecessary pain and mental anguish.

189. Plaintiff HUNTER arrived at the Jail on March 16, 2013, with psychiatric medications to treat her bipolar disorder, manic depression, anxiety, and panic attacks. Plaintiff HUNTER also brought with her a hard copy of her medical history, which documents the medications she requires. However, during the booking process, Plaintiff HUNTER's psychiatric medications were confiscated, and she did not receive any of her needed psychiatric medications for at least three weeks, despite repeated requests and grievances asking for the medications. She did not see any mental health care staff until March 19, 2013, and did not see any staff with the authority to prescribe psychiatric medications until March 21, 2013. As a result of not receiving appropriate attention from mental health care staff, Plaintiff HUNTER ultimately did not begin to receive her prescribed medications until three weeks after being booked into the Jail; during that period, she suffered from unnecessary and avoidable pain and symptoms, including, but not limited to, nightmares, anxiety, panic attacks, and hallucinations for this three-week period.

190. Plaintiff GREIM was booked into the Jail on September 13, 2012. He reported to custody staff that he had psychiatric problems, was bipolar, and took Remeron; the custody officer recorded this information on Plaintiff GREIM's Intake Health Screening form. The following day, September 14, 2012, Plaintiff GREIM reported to medical staff that he was bipolar and had been prescribed Remeron. Plaintiff GREIM was not seen by any mental health care staff until September 17, 2012, even though during a previous term in the Jail in August 2012 he had been placed in a rubber room because he expressed suicidal thoughts to Jail staff. Even after seeing this staff member, he was not provided with any medication for his serious mental health conditions. As a result of the

lack of attention from mental health care staff during his booking into the Jail, Plaintiff GREIM was placed at an unreasonable risk of deterioration in his mental health.

191. Plaintiff GIST has been subjected to the detoxification treatment at least twice. Plaintiff GIST was booked into the Jail on March 15, 2012. She informed medical and custody staff that she was taking a number of psychotropic medications, including Risperidone, Fluoxetine, Benztropine, and Trazodone. Four days later, on March 19, 2012, her relatives brought those psychotropic medications to the Jail for her. That same day, the Jail obtained pharmacy records that confirmed that she was prescribed the same medications. On March 20, 2012, a psychologist at the Jail consulted with Dr. Fithian about whether Plaintiff GIST should be provided with her prescription medication. Dr. Fithian instructed that "due to history of alcoholism, … we should hold off medicating her for now to allow her to detox from alcohol while in custody." On March 27, Plaintiff GIST was again seen by the psychologist. In a progress note, the psychologist wrote that "[p]rior to seeing inmate, writer conferred with Dr. Fithian. It was agreed that she is to remain medication free and clean and sober for 90 days." Similarly, when Plaintiff GIST was booked in the Jail in November 2012, despite Defendants' knowledge of her mental health conditions and medications, medical staff again denied her the prescribed medications for 90 days. Upon information and belief, there was no clinical justification for denying Plaintiff GIST psychotropic medications for 90 days because of a history of alcohol abuse. Without her medications, Plaintiff GIST began experiencing auditory hallucinations, talking to herself, feeling increased depression, and having trouble organizing her thoughts, expressing herself, and focusing.

192. Plaintiff KEY has been subjected to the detoxification treatment on multiple occasions, even though Defendants themselves have an extensive medical record documenting his history of receiving psychotropic medications. Defendants appear unable to review even their own files to determine whether psychiatric medications are indicated, as one progress note for a psychiatric consult states in the **same note** that "Mr. Key … has been seen in the past by Dr. Fithian [director of Defendant CFMG] and placed on

trazodone" and also states that Plaintiff KEY "has no history of any psychiatric medications."

193. By custom and policy, there is poor coordination of care for prisoners with mental health needs. Upon information and belief, neither medical nor corrections staff appropriately refer to mental health staff prisoners who exhibit symptoms of mental illness during encounters with medical and corrections staff. As a result, prisoners who exhibit symptoms of mental illness are not timely treated. Upon information and belief, by custom and policy, neither medical nor corrections staff is adequately trained to recognize signs and symptoms of mental illness, and to refer to mental health staff prisoners exhibiting such signs and symptoms. Upon information and belief, medical and mental health care staff do not adequately coordinate their care of prisoners with co-existing medical and mental health conditions.

194. Upon information and belief, Defendants do not maintain any central list, electronic or otherwise, of prisoners with mental illness and the treatment they require. Defendants do not maintain adequate information about prisoners' mental health needs in the prisoners' custody and/or medical files. Moreover, upon information and belief, to the extent that Defendants maintain information about a prisoner's mental health needs in any form, custody, medical, and clerical staff are not provided with access to the information in a manner that would timely and effectively inform them of a prisoner's mental health concerns and treatment needs.

195. For example, one prisoner was noted to have "pressured speech" and a "paranoid" presentation when he was booked into the Jail on July 17, 2013. During his incarceration, this prisoner filed several grievances that demonstrated paranoid and possibly delusional thinking, which received only cursory responses from custody staff. This prisoner also had to be removed from at least one medical appointment due to aggressive and abusive behavior. Nevertheless, a psychiatric consult note in the prisoner's filed dated August 9, 2013, states that he was on no psychiatric medications and that his "mental status is perfectly clear." This note does not appear to take into account any

information about this prisoner's mental state that is present elsewhere in his medical and custody records.

196. One prisoner waited nearly three months after entering the Jail for an appointment with the Jail's psychiatrist even though she had a significant history of mental health crises, including episodes of self-harm and suicidal ideation, during prior incarcerations at the Jail. Although this prisoner had asked for medication at her first screening appointment on the day after her arrival, Dr. Fithian denied her medication when he saw her three months after her arrival because she was pregnant and without evident regard for the severity of this prisoner's mental health symptoms. Upon information and belief, no effort was made to consult with this prisoner's obstetrician to determine whether any appropriate psychotropic medications could be prescribed.

197. Plaintiff WHITFIELD, who was forced to spend almost all of his time in bed for the first two months of his incarceration after the Jail failed to provide him with Provigil to treat his narcolepsy, requested treatment for depression and anxiety via sick call slips submitted on January 26 and 27, 2014. Plaintiff WHITFIELD has previously been treated—both inside and outside the Jail—for depression and has attempted suicide in the past. Spending upwards of 20 hours a day in bed had a deleterious effect on Plaintiff WHITFIELD's mental health, but upon information and belief, medical and mental health care staff failed to coordinate their care of Plaintiff WHITFIELD to ensure that his co-existing medical and mental health conditions were adequately treated. A psychiatrist came to see him, but only to inform him that the Jail would do nothing to treat his depression or anxiety.

198. Upon information and belief, Defendants fail to adequately train mental health staff in how to track and monitor prisoners with mental illness and the treatment they require.

B. Defendants Fail to Ensure That Prisoners Raising Mental Health Complaints Are Timely Seen and Adequately Treated

199. As discussed in Section II.E, the sick call process does not provide prisoners

with a timely and effective means for requesting medical care. Prisoners must use the same inadequate sick call process to request mental health care services, and are thus placed at risk of harm. Upon information and belief, Defendants fail to ensure that requests for mental health care reach mental health care staff in a timely manner, if at all. Upon information and belief, there is no policy in place to ensure that requests for mental health care are forwarded to mental health care staff. As a result, prisoners with serious mental health complaints are not timely seen or adequately treated.

C. Defendants Fail to Timely Identify, Adequately Treat, or Effectively Track and Supervise Prisoners at Risk for Suicide

200. Defendants fail to identify, treat, track, and supervise prisoners who are at risk for suicide. Defendants' policies and practices for screening, supervising, and treating prisoners at risk for suicide are inadequate. These shortcomings in the suicide prevention and treatment program have had tragic consequences. Over the past four years, there have been three completed and more than a dozen attempted suicides. The rate of completed suicides at the Jail is nearly twice the national average for jail facilities.

201. The very design of the Jail itself presents a risk to suicidal prisoners. As noted in the 2011 Jail Needs Assessment, "The older design of the cells and dormitories constructed prior to 1993 does not meet today's minimum standards for detention facilities. Examples include: Suicide hazard elimination is not as stringent as it should be to prevent self-harm and the attendant liability." 2011 Assessment at Ex. 3.

202. Upon information and belief, Defendants do not adequately train custody staff to identify prisoners who are at risk of suicide and respond adequately to prisoners who are exhibiting suicidal tendencies. This is especially problematic because custody staff, both during the intake process and for the duration of a prisoner's time in the Jail, have the primary responsibility for alerting mental health staff when a prisoner is suicidal.

203. Defendants routinely fail to identify and track prisoners who are at risk for suicide. For example, a prisoner named Joshua Claypole was suicidal when he arrived at the Jail on May 1, 2013, and his attorney asked Jail staff to place Mr. Claypole on suicide

watch on the day of his arrest. Mr. Claypole was initially placed on suicide watch, but was soon taken off and cleared to go into the Jail's general population. He was then housed in a single cell, and, upon information and belief, did not receive any increased monitoring or effective treatment. On May 4, 2013, Mr. Claypole attempted suicide by hanging in his cell, and was air-lifted to a San Jose hospital where he was placed on life support. Five days later, he was taken off life support and died.

204. A prisoner named Daniel Lariviere committed suicide on July 8, 2011. Upon his arrest, he was initially placed in a rubber room, but after a few hours he was released to a booking cell without having been evaluated by any mental health care staff.
Mr. Lariviere informed custody and medical staff during the intake process that he had serious mental health issues, was having auditory hallucinations, and had been released from a psychiatric hospital just four days earlier. Despite these numerous indicia of suicide risk, Defendants decided to house Mr. Lariviere in an administrative segregation unit. The conditions in this segregation unit place prisoners at increased risk of suicide. Defendants also did not schedule Mr. Lariviere to see any mental health care staff at the Jail until three days after his booking. On the morning of the day he was supposed to be seen by mental health care staff, Mr. Lariviere committed suicide by hanging in his cell.

205. Another prisoner had attempted suicide at least twice before his incarceration and spent 6-8 months at Atascadero State Hospital, a state inpatient psychiatric hospital, before coming to the Jail. Despite this prisoner's attempted suicide and mental health history, about which Defendants were well aware, the Jail failed to identify him as at risk for suicide and failed to take steps to safely house, track, and treat him to reduce the risk of suicide. This prisoner attempted suicide by jumping off the second floor of the housing pod, and had to be airlifted to Santa Clara Hospital, where he was treated for trauma to his head and broken ribs.

206. Defendants routinely house suicidal and seriously mentally ill prisoners in conditions that result in further deterioration of their mental health, that violate notions of minimally adequate mental health care and basic human dignity, and that are incompatible

with civilized standards of humanity and decency. Defendants' policies and practices for housing suicidal prisoners are inadequate. Rather than individually determining the most integrated environment in which a suicidal prisoner can be safely housed, Defendants have a policy and practice of placing prisoners with serious mental health concerns in the "rubber rooms." The rubber rooms are single cells with no furnishings, toilets, or (in most cases) windows for outside light. The only features of the cell are the door, which has a slot through which food can be delivered, and a grate in the floor that serves as the toilet for feces and urine. When housing a prisoner in a rubber room, Defendants routinely remove all of the prisoner's clothing, leaving the prisoner naked in the room. In some instances, Defendants permit a prisoner to have a tear-proof smock for clothing and nothing else. There is no mattress or pad, let alone a bed, in any of the rubber rooms for prisoners to sit or sleep on. Prisoners are thus forced to sit, sleep, and eat on the same cold, dirty floor in which the grate for the toilet is located. Upon information and belief, when prisoners act out in rubber rooms, Jail staff place them in restraints, including in restraint chairs. However, upon information and belief, Defendants fail to properly use restraints on mentally ill prisoners or adequately monitor restrained prisoners. Defendants' improper use of restraints and seclusion places seriously mentally ill prisoners at an unreasonable risk of harm.

207. For example, in May 2012, a prisoner was placed in a rubber room because he had been kicking his cell door, yelling and screaming. While serving the afternoon meal, a deputy noticed the prisoner was bleeding from the head in his safety cell. While removing the prisoner from the safety cell, the prisoner was placed in a safety chair which was inoperative. As deputies moved him to an operative safety chair, the prisoner was able to throw himself to the ground head first, and had to be transported to the emergency room.

208. The rubber rooms are rarely cleaned when a prisoner is being housed in one of the cells and are not cleaned sufficiently once a prisoner is released from the cell. The walls and floor of the rubber rooms are soiled by feces because of the inadequate toilet and

non-existent sink. These conditions are traumatic for all prisoners, but especially for those who are already experiencing mental health symptoms. Voluminous psychiatric literature spanning nearly two hundred years has documented the adverse mental health effects of isolation, particularly on the mentally ill, and Monterey County Jail prisoners are no exception. Moreover, suicidal prisoners may perceive the rubber rooms as a method of punishment (as opposed to treatment), which may dissuade them from self-identifying as suicidal.

209. Plaintiff MEFFORD has been placed on suicide watch and put in a rubber room at least five separate times since entering the Jail after engaging in self-harming behavior. Plaintiff MEFFORD was able to continue engaging in self-harming behavior inside the rubber room, by banging his head repeatedly against the door until he was bleeding. Custody staff's only response to these episodes of self-mutilation has been to place Plaintiff MEFFORD in a restraint chair. Plaintiff MEFFORD was able to free himself from the restraint chair at least once, and began again hurting himself. Each time, he has been placed in a rubber room for varying lengths of time. Custody staff has routinely failed to conduct safety checks twice every thirty minutes as required by the Jail's own policies. The Jail has also failed to provide him with adequate food and water during these periods of time.

210. Plaintiff MEFFORD has informed the Jail medical and custody staff repeatedly that sensory deprivation and particularly a lack of light make his anxiety and other psychiatric conditions much worse. He has also stated a reluctance to express his true level of suicidality to staff because of fear of being placed in a rubber room. Despite this, custody staff continues to place him in rubber rooms.

211. Defendants placed Plaintiff MURPHY in a rubber room at least five times between January 2013 and October 31, 2013. When Plaintiff MURPHY was placed in a rubber room, the conditions were horrific, with feces on the walls and floor of the room. Defendants stripped Plaintiff MURPHY naked, provided him only with a safety smock, and forced him to eat and sleep on the same floor where the toilet grate is located. In

January 2013, during the more than 38 hours for which he was in the rubber room, Defendants' own documents show that they did not provide Plaintiff MURPHY a single meal and only offered him water on three occasions.

212. Defendants exacerbate the psychological trauma experienced by seriously mentally ill prisoners who are housed in rubber rooms by failing to provide them with necessary mental health care. These prisoners do not receive sufficient contact with mental health providers (if they receive mental health care at all). And, the harsh conditions of their confinement render less effective the minimal treatment they do receive. As a result, there is an unreasonable risk that their symptoms, including suicidality, will escalate and Defendants may force them to stay in the rubber rooms even longer.

213. For example, in January 2012, one prisoner woke up screaming from a nightmare, and was sent to the rubber room. She was given a filthy blanket, and forced to use a bathroom consisting of a grate in the floor as she was simultaneously vomiting green bile. During her time in the rubber room, the mental health staff did not visit this prisoner or provide her with any mental health treatment, aside from asking her if she was suicidal. Upon information and belief, during the time she was in the rubber room, all of the prisoner's interactions with mental health care staff took place at the cell front door; none of the interactions were face to face without barriers. While Defendants may consider rubber rooms "safe" for suicidal and seriously mentally ill prisoners, in fact the rubber rooms lack any therapeutic value, and certainly do not replace the need for psychiatric hospitalization and treatment.

214. Defendants fail to sufficiently observe prisoners who have been identified as being at risk of suicide, including prisoners who have been placed in rubber rooms. Specifically, Defendants lack any policy or procedure for, and therefore fail to provide, constant observation of prisoners who are actively suicidal, either threatening to or engaging in the act of suicide.

215. Defendants fail to ensure by policy and practice that mental health care staff

are consulted prior to placing a prisoner in a rubber room and before a prisoner is released from a rubber room. Upon information and belief, by not adequately involving mental health care staff in the decision to put prisoners in a rubber room, Defendants overuse the rubber rooms and place prisoners who do not require exposure to the punitive conditions of the rubber rooms to those conditions. Upon information and belief, by not adequately involving mental health care staff in the decision to release prisoners from rubber rooms, Defendants increase the risk that a prisoner who still requires enhanced monitoring will be placed back into housing conditions where they are not monitored as closely and are more able to engage in self-harm.

216. Defendants fail to adequately follow up with, monitor, and treat prisoners who have been released from the rubber room. For example, Plaintiff MURPHY was placed in a rubber room on February 11, 2013, at approximately 4 p.m. and was released at 5 a.m. the following day. No health care staff conducted any evaluation of Plaintiff MURPHY's physical or mental status until February 18, 2013. In fact, the psychiatric progress note for his February 18, 2013 appointment with Dr. Fithian does not even acknowledge that Plaintiff MURPHY had been placed in a rubber room. Another prisoner was kept in the rubber room for five full days, and described feeling as though the walls were closing in on him the entire time. After he was released from the rubber room, this prisoner did not receive adequate follow-up to evaluate his mental health state and risk of suicidality.

217. Defendants have knowledge of the substantial risk of harm caused by inadequate suicide prevention and treatment policies and practices in the Jail, but have failed to take steps to prevent, or even to diminish, the harmful effects of these unlawful policies and practices. Defendants are thus deliberately indifferent to the risk of harm to prisoners created by their failure to operate a constitutionally adequate suicide prevention and treatment program.

D. Defendants Lack Sufficient Facilities to Provide Adequate Mental Health Care

218. The outdated facility and overcrowding at the Jail only exacerbate the inadequate mental health conditions and treatment at the Jail. As the 2011 Jail Needs Assessment found, "Medical/mental health treatment spaces are not adequate for the rated beds, let alone the actual number of inmates held…. Overcrowding forces the entire facility to operate as an indirect supervision facility. Mental health issues are considerably more difficult to recognize, manage and treat in an indirect supervision facility." 2011 Assessment at Ex. 3. The Assessment further noted the direct impact of overcrowding on prisoners' mental health conditions: "Overcrowding affects inmates' mental and physical health by increasing the level of uncertainty with which they regularly cope." 2011 Assessment at Ex. 9. The lack of sufficient treatment space places prisoners at an unreasonable risk of harm from inadequate mental health care. Inadequate mental health offices and treatment spaces compromise the delivery of mental health care, and fail to address the confidentiality and safety concerns that arise in delivery of such care. Defendants have not sufficiently eliminated suicide hazards through the Jail.

219. Plaintiff MEFFORD, who has serious mental health conditions that require significant and sustained psychiatric care, was seen by a psychiatrist at his cell in G-Pod. Plaintiff MEFFORD was forced to share private and personal information about himself and his condition publically through the tray slot in his cell door, while the psychiatrist stayed in the public hallway, allowing any prisoner or custody staff member who might have been close by to overhear their conversation.

220. Plaintiff AGUILAR suffers from depression and anxiety and has trouble sleeping. In the Jail, he saw a psychiatrist who referred him to a therapist. The therapist came to speak with Plaintiff AGUILAR, but in the presence of a custody officer and not in a confidential treatment space. The therapist told Plaintiff AGUILAR to put in a sick call slip to see her another time so they could talk alone. He put in a sick call slip to do so, but was not seen in response to the sick call slip.

E. Defendants' Mental Health Treatment Program Involves Little More than Segregation and Supervision

221. Defendants provide little to no individual or group treatment to prisoners with mental health problems, even for prisoners who are acutely or chronically mentally ill. Therapy in an individual or group setting is almost never offered or provided to prisoners, regardless of whether prisoners were receiving therapy as a part of their treatment for mental illness outside of the Jail.

222. For acutely and chronically mentally ill prisoners, the standard of care includes, and they should be provided with, psychosocial rehabilitation services, which include structured out-of-cell programming that addresses their symptoms of mental illness, reduces their isolation, and promotes compliance with treatment and medications. Without this care, seriously mentally ill prisoners are at an unreasonable risk of decompensating and of not responding fully to the treatment they do receive. This deterioration can take many damaging forms, including increased symptoms and non-adherence to treatment. Defendants fail to provide adequate psychosocial rehabilitation services to seriously mentally ill prisoners in need of this care.

223. Defendants house prisoners with some of the most serious mental health problems in A and B Pods for men and in R and S pods for women. A, B, R, and S Pods are administrative segregation units. Defendants offer group therapy to prisoners in these pods once every other week for one hour. That amount of structured out of cell time falls far below the standard of care, and thus places prisoners at substantial risk of serious harm.

224. Upon information and belief, Defendants fail to train staff regarding when and how to provide therapy to prisoners with mental illness as a component of mental health care.

225. Plaintiff MURPHY had been seeing an outside psychiatrist who provided him with therapy, but the Jail failed to transport him to his April 2013 appointment with his outside psychiatrist. On information and belief, he repeatedly missed appointments with his outside psychiatrist due to errors on the part of Jail staff. Defendants informed

Plaintiff MURPHY that the provider will no longer see him, but appear to have made no attempt to provide Plaintiff MURPHY with therapy or to arrange that a different outside psychiatrist provide Plaintiff MURPHY with therapy. As a result of the total lack of therapy, at least as of October 31, 2013, Plaintiff MURPHY was not receiving adequate mental health care.

226. Plaintiff HUNTER suffered from anxiety and panic attacks that were exacerbated when she was in the overcrowded Jail environment, but she was denied therapy sessions during her time at the Jail. Another prisoner, who had attempted suicide twice prior to his arrival at the Jail and once while at the Jail in December 2012, did not receive one-on-one therapy sessions, but rather only medications (provided by nurses to the prisoner in his isolation cell).

F. Defendants Do Not Adequately Prescribe, Monitor, and Evaluate the Provision of Psychotropic Medications

227. Defendants routinely fail to provide medically necessary psychotropic medications to prisoners with psychiatric illnesses. Defendants' policies and practices for providing psychotropic medications to prisoners are inadequate. Upon information and belief, Defendants fail to adequately train mental health staff in the proper administration of psychotropic medications. Defendants fail to provide psychotropic medications even when provided with valid prescriptions from the California Department of Mental Health, community providers, or family members. Especially during the first 90 days of incarceration, prisoners are at risk of being labeled by medical staff as drug seekers and malingerers, and those labels are then used to deny needed medications.

228. Upon information and belief, Defendants fail to evaluate prisoners before making treatment decisions, including whether to prescribe psychotropic medications. Upon information and belief, Defendants fail to adequately train mental health staff regarding how to appropriately evaluate prisoners before making mental health treatment decisions.

229. As is discussed in Paragraph 187, *supra*, Plaintiff GIST has been denied

access to her prescribed antipsychotics, antidepressants, and sleep aids for up to 90 days when booked into the Jail. During these prolonged periods without her medication, Plaintiff GIST's mental health deteriorates. She hears voices, talks constantly to herself, has trouble organizing her thoughts and expressing herself, gets easily distracted and experiences depression. The back and forth of being on her medications on the outside and then abruptly off them for a long period in custody is further damaging to her long-term mental health and well-being.

230. Plaintiff KEY has experienced many different incarcerations at the Jail. He has repeatedly been subjected to Defendants' detoxification treatment during which he is denied all medications for 90 days. One psychiatric progress note in Plaintiff KEY's file offers this rationale for denying Plaintiff KEY psychiatric medications upon which he has depended for many years: "I was not going to put him on medication until he had been clean and sober for a while." After that initial 3-month period of denial, which each time causes Plaintiff KEY to suffer auditory hallucinations, severe depression, and other serious mental health problems, Defendants have repeatedly failed to provide Plaintiff KEY with appropriate psychiatric medications—even with the same psychiatric medications that they have previously provided him.

231. One pregnant prisoner was denied psychotropic medication because of her pregnancy, with the notation made that she could discuss the issue with her obstetrician at an appointment scheduled for a month after Defendants denied her medication.

232. As a result of Defendants' failure to provide medically necessary psychotropic medications, prisoners with mental illness suffer from the following: (1) withdrawal symptoms when the medications they were prescribed before admission to the Jail are abruptly terminated; (2) recurrence of debilitating symptoms such as hallucinations and suicidality; and (3) in some cases, decompensation to the point of being found incompetent to stand trial and/or being sent to the state hospital until they are stable enough to return to the Jail. In addition, pursuant to what is known as the "kindling phenomenon," interruptions in prisoners' psychotropic medications can cause a prisoners'

underlying mental illness to worsen. This not only worsens the underlying condition, but makes it more difficult to treat the underlying condition.

233. Upon information and belief, Defendants lack adequate policies and practices for monitoring and treating the side effects or efficacy of psychotropic medications and their effect upon prisoners with mental health issues. Upon information and belief, Defendants also fail to order diagnostic tests necessary to measure the efficacy of medications, as well as potential side and adverse effects, and fail to prescribe medications to address potential side and adverse effects of psychotropic medications. These adverse effects include extrapyramidal symptoms (EPS), which are involuntary and often painful movements of the limbs and muscles, including tardive dyskinesia, a potentially permanent disabling condition. Upon information and belief, Defendants fail to track, monitor, and treat prisoners prescribed psychotropic medications for dangerous and potentially fatal drug interactions.

234. For example, Plaintiff MURPHY is taking a number of psychiatric medications to address his auditory and visual hallucinations. However, during his time in the Jail, he has not received the correct dosages of the medications, and has continued to see shadows and hear voices. The hallucinations have been so frequent and intense that he was unable to sleep more than a few hours at night. Despite his repeated requests, mental health staff did not adjust his dosages or otherwise follow up with him to evaluate the efficacy of the medications.

235. Defendants have, without adequate justification, refused to provide Plaintiff GIST with the same psychotropic medication regimen she was taking pursuant to prescription immediately prior to her arrest. Plaintiff GIST's medication regimen consisted of four drugs. During her current term in the Jail, Defendants have only provided her with two of the four drugs at any given time. As a result, she has experienced auditory hallucinations, significant trouble sleeping, and mood instability.

236. Plaintiff MEFFORD has received a variety of medication during his incarceration without effective follow up or measurement of its efficacy. Instead, mental

health care staff have changed his prescriptions without seeing him and/or without providing adequate clinical explanations for the change. Plaintiff MEFFORD has suffered, and continues to suffer, from serious psychiatric conditions that remain undertreated and under-evaluated.

237. Plaintiff MEFFORD has also at least twice complained about serious side effects from his psychotropic medication. On February 24, 2014, Plaintiff MEFFORD complained to a psychiatrist at the Jail that valporic acid—a drug prescribed for Plaintiff MEFFORD in lieu of Depakote, which Plaintiff MEFFORD received in prison—was upsetting his stomach sufficiently that he wished to try an alternative treatment. The psychiatrist began providing Plaintiff MEFFORD with Tegretol. Tegretol caused Plaintiff MEFFORD to experience blurred vision, confusion, headaches, as well as an upset stomach. In response to Plaintiff MEFFORD's report of these side effects, the psychiatrist merely switched his medication back to valporic acid, instead of the better tolerated Depakote.

238. Defendants also lack adequate policies and practices for ensuring the continuity of administration of psychotropic medications for prisoners transferred to Alameda County pursuant to the contract between MONTEREY COUNTY and Alameda County, discussed in Paragraph 178, *supra*. After late-July 2013 when Plaintiff GREIM was transferred to the physical custody of Alameda County, doctors there prescribed two psychiatric medications to Plaintiff GREIM, which he received and took until he was returned to Monterey County Jail on or around September 6, 2013. Plaintiff GREIM received these two medications for the first three nights after he was returned to Monterey County Jail. On or around September 9, 2013, he was seen by a female staff member of Defendant CFMG who discontinued both of the medications. The staff member informed Plaintiff GREIM that he would not receive any psychiatric medications because he had not received medication when he was at Monterey County Jail before being transferred to Alameda County. Plaintiff GREIM experienced increased depression, anxiety, anger, and racing thoughts as a result of being removed from the medications he had been taking in

Alameda County.

239. Upon information and belief, Defendants routinely release prisoners with serious mental health conditions from the Jail without providing them with any services to ensure that their mental health care is not disrupted. Defendants' policies and practices for the provision of continuing mental health care services upon a prisoner's release are inadequate. Upon information and belief, Defendants fail to adequately train custody and mental health staff in how to appropriately release prisoners with serious mental health concerns so that such prisoners can continue their mental health care. Upon information and belief, for those prisoners who are prescribed psychiatric medications in the Jail, they are released without either a supply of, or a prescription for them to fill, those medications at a community pharmacy. Defendants do not schedule follow-up appointments in the community, nor are prisoners provided with sufficient referrals or information about where they may receive mental health care services or medications.

240. Upon information and belief, Defendants lack any comprehensive system for monitoring the prescription, distribution, efficacy, and side effects of psychotropic medication and for ensuring continuity of care for prisoners with mental illness before, during, and after their incarceration at the Jail.

G. Defendants Fail to Transfer Prisoners to Facilities That Provide Higher Levels of Mental Health Care When Necessary

241. Upon information and belief, Defendants routinely fail, when necessary, to transfer prisoners who require inpatient care to outside facilities that provide such care. Defendants' policies and practices transferring prisoners to outside facilities that provide inpatient care are inadequate. Upon information and belief, Defendants fail to adequately train custody and mental health staff regarding how to, when necessary, transfer prisoners to facilities that provide inpatient mental health care.

242. Prisoners in the Jail may require care at an inpatient facility in a variety of circumstances, including, but not limited to, when they are in acute mental health crisis or if they have been found mentally incompetent to stand trial. Upon information and belief,

Monterey County Jail is not a facility licensed to provide inpatient mental health care treatment to any individuals, and the Jail does not provide an inpatient level of care.

243. Upon information and belief, Defendants lack adequate policies and procedures regarding when to transfer prisoners who require inpatient care to outside medical facilities that provide higher levels of care.

244. Upon information and belief, when Defendants identify or are ordered by the Superior Court to transfer prisoners to outside facilities that provide inpatient level of care, there are frequently delays in transferring these prisoners from Monterey County Jail. The delays result in prisoners being denied needed inpatient care, which could result in further deterioration in their mental health, and creates a risk to the long-term prognosis of these patients: the longer the inpatient care is denied to the patients in need of that level of care, the less likely they are to respond to appropriate treatment once it is initiated.

245. For example, in April 2013, Dr. Fithian recommended that a pretrial detainee in the Jail be found incompetent to stand trial because of her mental health status. The Superior Court judge ordered her to be placed in a competency program in the state hospital to receive inpatient care. Until at least October 11, 2013, the prisoner had not been transferred to the state hospital and remained at the Jail.

H. Defendants Place Prisoners with Mental Illness at Risk by Housing Them in Restrictive Administrative Segregation Units Without Adequate Supervision

246. Defendants house prisoners with mental illness in administrative segregation units in the Jail in ways that place such prisoners at substantial risk of serious harm. In the Jail, A through D Pods, G through J Pod, and R and S Pods are administrative segregation units. All of the beds in these units are located in locked cells. Collectively, approximately 200 prisoners are housed in administrative segregation units at any given time.

247. The conditions in the administrative segregation units are extremely punitive, isolating, and restrictive. Upon information and belief, Defendants permit prisoners in administrative segregation to have only one hour of out-of-cell time per day. During that

hour, prisoners are expected to shower, exercise, and use the telephone. Prisoners are generally released from their cells individually, meaning they are outside of their cells by themselves. As a result, there are very few opportunities for human interaction.

248. These conditions significantly increase the risk that prisoners with mental illness will have their condition decompensate when placed in administrative segregation. A significantly disproportionate percentage of suicides occur in administrative segregation units. Because of the risks posed by administrative segregation to prisoners with mental illness, a consensus has been reached in mental health correctional communities that prisoners with mental illness should only be placed in administrative segregation if absolutely necessary. In addition, if prisoners with mental illness are placed in administrative segregation, there must be limits on the amount of time they remain in such units, they must be monitored closely, and they must be provided with significant structured and unstructured out-of-cell time.

249. Upon information and belief, Defendants do not have adequate safeguards in place to ensure that prisoners with mental illness are only placed in administrative segregation when absolutely necessary. In fact, upon information and belief, Defendants have a policy and practice of placing prisoners with the most serious mental illness in A and B Pods for men and R and S Pods for women. As a result, rather than only placing prisoners with mental illness in administrative segregation when absolutely necessary, Defendants have a policy and practice of placing mentally ill prisoners there **because of** their mental illness. Upon information and belief, Defendants also lack policies and practices to reevaluate whether prisoners with mental illness placed in administrative segregation should remain in administrative segregation. The amount of unstructured out-of-cell time that Defendants provide to prisoners in administrative segregation—a maximum of seven hours per week—falls far below the standard of care. The amount of structured out-of-cell time provided to prisoners in administrative segregation—at most one hour every other week—falls even farther below the standard of care.

250. Upon information and belief, Defendants have a policy of conducting safety

checks once every hour in administrative segregation units. Upon information and belief, Defendants do not conduct safety checks at intermittent and unpredictable times. Defendants' policy for conducting safety checks is inadequate to ensure the safety of prisoners with serious mental illness in administrative segregation. Upon information and belief, Defendants sometimes even fail to conduct safety checks in administrative segregation units once per hour according to their inadequate policy. As a result, Defendants' policy and practice for conducting safety checks of prisoners in administrative segregation place prisoners at a substantial risk of serious harm.

251. Plaintiff MEFFORD has been housed in administrative segregation or in a safety cell since arriving at the Jail. He has repeatedly informed custody and medical staff, both orally and through a formal grievance, that the sensory deprivation caused by this housing assignment is making his psychiatric conditions much worse and causing him considerable anxiety. The Jail has not responded to his repeated requests for accommodation or alternative housing.

252. Defendants placed Plaintiff MURPHY in an isolation cell at least one time for a period of 10 days in April 2013. Upon information and belief, Plaintiff MURPHY's mental health decompensated during his time in isolation, at least in part because of his inability to talk with anyone else.

253. Jessie Crow and Daniel Lariviere committed suicide by hanging in administrative segregation in 2010 and 2011 respectively. Defendants' inadequate policies and procedures for monitoring prisoners with mental illness in administrative segregation units placed both Mr. Crow and Mr. Lariviere at risk prior to their suicides and may have contributed to their suicides. For example, if Defendants had conducted safety checks every half hour at intermittent and unpredictable times, they may have been able to prevent Mr. Crow or Mr. Lariviere from committing suicide.

I. Defendants Discriminate Against and Unfairly Punish Prisoners with Mental Illness

254. Defendants discriminate against prisoners with serious mental illness by

isolating them from and denying them privileges granted to other prisoners. Defendants' policies and practices for housing prisoners with serious mental illness are inadequate. Upon information and belief, Defendants fail to adequately train mental health staff in how to appropriately house prisoners with serious mental illness. Prisoners with serious mental illness are frequently housed by Defendants in administrative segregation units, as opposed to in dorm housing units. When housed in a cell, as opposed to dorm, prisoners have far less freedom to move around and to interact with other prisoners. *See* Section III.H. In contrast, prisoners in dorm housing units are free to access most areas of the dorm unit, including the common area, showers, telephones, and exercise yard during most of the day. Prisoners with severe mental health concerns may also be housed by Defendants in isolation cells. When housed in an isolation cell, prisoners have even less freedom to move around and interact with other prisoners, and they have extremely limited access to programs and services at the Jail. Accordingly, prisoners with serious mental illnesses are denied access to programs and services because Defendants place prisoners with serious mental illness in lockdown units or isolation cells.

255. Upon information and belief, prisoners with serious mental health conditions may be placed in rubber rooms as punishment for an inability to follow Jail rules. Many of these prisoners may not have violated Jail rules had they been receiving adequate mental health treatment.

256. Upon information and belief, Defendants place prisoners in a rubber room when they request mental health care from Defendants. For example, in late-Spring or early-Summer 2012, one prisoner was suffering from mental health symptoms because he had not been provided with prescribed medications for preexisting medical conditions. Rather than attempt to treat his psychiatric distress, Defendants placed him naked in the rubber room without even a blanket for the first few hours. A female prisoner who entered the Jail in a manic state was placed in a rubber room for a period of days without clothing, and was forced to tear her blanket to minimally cover herself.

257. Upon information and belief, Defendants exacerbate the psychological

trauma experienced by prisoners with serious mental health conditions who are housed in rubber rooms by failing to provide them with necessary mental health care. These prisoners do not receive sufficient contact with mental health providers. As a result, their nonconforming behaviors may escalate and they are forced to stay in the rubber room even longer.

258. Upon information and belief, Defendants' disciplinary process fails to take into account behavior which results from inadequate mental health care. Upon information and belief, as a result of Defendants' failure to provide adequate mental health care, prisoners with serious mental conditions may be unable to conform to Jail rules or be safely housed in cells with other prisoners. In response, rather than provide them with the medications or treatment they need, Defendants selectively house these prisoners in isolation in the rubber rooms.

259. When mental illness is inhibiting a prisoner's ability to follow directions or interact with others, many incident reports show no effort by staff to involve mental health professionals who might be able to calm the prisoner down and address the underlying psychiatric issue without resorting to use of physical force. Upon information and belief, staff who do not have adequate training regarding how to treat mental health issues attempt to interact with the prisoner on their own, and end up resorting to use of physical force, improper use of restraints, and/or violence to control the prisoners. Sometimes, the use of force results in larger prisoner-on-prisoner fights in the unit.

260. Upon information and belief, Defendants fail to provide adequate training to custody staff regarding how to respond to mentally ill prisoners whose non-conforming behaviors are a product of their mental illness.

261. For example, Plaintiff MEFFORD received a Disciplinary Action Report on December 15, 2013, for yelling at a guard. As punishment, Plaintiff MEFFORD lost four weeks of commissary, yard, and visiting privileges. Plaintiff MEFFORD was then brought to a safety cell where he remained overnight on suicide watch. After being released from the safety cell, Plaintiff MEFFORD appealed this Disciplinary Action Report on the

grounds that four weeks of punishment was too severe because his conduct had been caused by his mental illness. Plaintiff MEFFORD noted that these punishments would "lead to me being very depressed and or suicidal and self harmful." Defendants denied Plaintiff MEFFORD's appeal on January 2, 2014, because "in this facility we take serious [sic]" "threats against an officer…regardless of an inmate's medical condition."

262. Defendants fail to provide sign language interpretation services to prisoners whose primary language is American Sign Language during mental health clinical evaluations. Without sign language interpretation, such prisoners are not able to explain to mental health staff the symptoms they are experiencing, and mental health staff are not able to explain the benefits and risks of treatments and medications such that prisoners can provide their informed consent. The lack of sign language interpretation services results in Defendants making mental health treatment decisions without all of the necessary and pertinent information they need, which increases the risk of misdiagnosis and mistreatment for the prisoner.

263. Upon information and belief, Defendants fail to provide foreign language interpretation services to prisoners whose primary language is not English during mental health clinical evaluations. This is particularly true for prisoners who cannot speak either English or Spanish. Without foreign language interpretation, such prisoners are not able to explain to mental health staff the symptoms they are experiencing, and mental health staff are not able to explain the benefits and risks of treatments and medications such that prisoners can provide their informed consent. The lack of foreign language interpretation services results in Defendants making mental health treatment decisions without all of the necessary and pertinent information they need, which increases the risk of misdiagnosis and mistreatment for the prisoner.

J. Defendants Fail to Employ a Sufficient Number of Properly Trained Mental Health Professionals

264. Defendants fail to maintain sufficient numbers of mental health care professionals to provide minimally adequate care to the more than 900 prisoners in the Jail.

265. The Jail's low staffing levels result in mental health care staff being unable to timely respond to prisoners' requests for psychiatric evaluations and treatment, to adequately screen, track, monitor, and provide follow-up care to prisoners who are suffering from serious mental illnesses, and to provide adequate group and individual therapy. Upon information and belief, there are no mental health care staff on site at the Jail on the weekends or holidays. Prisoners who experience serious mental health problems over a weekend or holiday, including prisoners newly booked into the Jail, are not seen by mental health care staff until the next business day. Over certain holiday weekends, prisoners in need of acute mental health care treatment may not be seen for more than 72 hours. Upon information and belief, Defendants often place such prisoners in rubber rooms until mental health care staff are available to see them.

266. For example, Plaintiff MEFFORD experienced an acute psychiatric incident in January 2014 on a Friday afternoon when he began engaging in acts of self-harm. Plaintiff MEFFORD was housed in rubber rooms (sometimes while being placed in a restraint chair) and booking cells until Monday, when he was seen by mental health care staff. The psychiatrist at the Jail explicitly ordered that Plaintiff MEFFORD be kept in a rubber room or booking cell over the weekend until the doctor could evaluate Plaintiff MEFFORD on Monday. Because of his placement in rubber rooms and booking cells over the weekend without any evaluation by mental health care staff, Plaintiff MEFFORD's mental health deteriorated and he engaged in additional acts of self-harm.

267. As another example, during an attorney interview, one prisoner was incapable of conversation, had feces in his hair, ranted obscene comments, and frequently exposed his genitals. When alerted to this prisoner's deteriorated mental health state by the attorney, Jail staff informed the attorney that the prisoner would be seen the next day because mental health staff had gone for the day.

268. Upon information and belief, Defendants fail to adequately train mental health staff to timely respond to prisoners' requests for psychiatric evaluations and treatment, and to adequately screen, track, monitor, and provide follow-up care to

prisoners who are suffering from serious mental illness.

K. Defendants Fail to Maintain Accurate, Complete, and Confidential Mental Health Treatment Records

269. Upon information and belief, Defendants fail to maintain adequate, accurate, and confidential mental health care records. For example, upon information and belief, psychiatrists often change prisoners' medications without documenting a clinical rationale. Upon information and belief, psychiatrists also fail to document their justification and reasoning for changing the diagnoses and treatment plans for prisoners returning to the Jail from psychiatric hospitals. As a result of Defendants' failure to maintain adequate mental health care records, prisoners suffer from a substantial risk of misdiagnosis, dangerous mistakes, and unnecessary delays in care.

270. Plaintiff MEFFORD's psychiatric medications have been changed multiple times since he arrived at the Jail in the beginning of December 2013. Some of these shifts are documented by progress notes with a few words justifying the shift, but many are not. Plaintiff MEFFORD is a former CDCR prisoner. While in a CDCR prison, Plaintiff MEFFORD consistently received a set of psychiatric medications to treat his mental illness. Soon after Plaintiff MEFFORD arrived at the Jail, a psychiatrist at the Jail changed his medication regime by substituting one medication for a cheaper version and adding an additional medication. On information and belief, the psychiatrist failed to document any clinical explanation for this medication shift. Plaintiff MEFFORD has suffered a number of psychotic episodes since entering the Jail and has struggled with continuing anxiety, depression, and episodes of self-harm.

271. Upon information and belief, Defendants fail to obtain medical files from outside providers for lengthy periods of time after the prisoner's arrival at the Jail (if at all). This lack of information results in inadequate and delayed mental health care which places prisoners at an unreasonable risk of harm. For example, Plaintiff MURPHY was arrested and booked into the Jail on January 18, 2013. During an intake triage assessment that same day, Jail staff was informed that Plaintiff MURPHY's psychiatric medications

were prescribed by a physician at the Monterey County Veteran's Administration clinic. Plaintiff MURPHY was not seen by any mental health staff until January 21, 2013, when he had an appointment with a Licensed Psychiatric Technician, who could not and did not prescribe him medications. Upon information and belief, the Licensed Psychiatric Technician made only one request for Plaintiff MURPHY's medical records from the Monterey County Veteran's Affairs office ("VA") on January 21, 2013, and made no effort to follow up after that date. On January 28, 2013, at least in part because he was not provided with any psychiatric medications, Plaintiff MURPHY was placed in a rubber room where he remained until January 30, 2013. As of at least April 19, 2013, Defendants had not obtained Plaintiff MURPHY's psychiatric records from the VA.

272. Plaintiff GREIM arrived at the Jail in September 2012. He reported during an intake screening that he had received mental health care and psychiatric medications while incarcerated in a CDCR prison as recently as the spring of 2012. Defendants did not request his records until March 2013. These records confirmed that Plaintiff GREIM suffers from a mood disorder and was prescribed Remeron while in prison and on parole in 2012 immediately prior to his booking in Monterey County Jail. Plaintiff GREIM had received care at the enhanced outpatient level while in prison. Even after receiving these records, Defendants failed to provide Plaintiff GREIM with any treatment for his serious mental illness. And when Plaintiff GREIM again requested psychiatric medication in July 2013, Defendants noted in his file that they "would get" his prison records—records they had received months before. Plaintiff GREIM did not begin to regularly receive any psychiatric medications while in Monterey County Jail until on or around October 3, 2013.

273. Upon information and belief, Defendants fail to adequately train mental health staff regarding how to maintain accurate mental health records, including the timely request of prisoners' prior mental health records.

274. Upon information and belief, Defendants have not ensured that the psychiatric care records of prisoners who are sent to Alameda County pursuant to the contract described in Paragraph 178, *supra*, either accompany those prisoners to Alameda

County or follow in a timely manner. As a result, Monterey County prisoners including Plaintiff GREIM, have experienced interruptions in care and delays in receiving necessary medications when transferred to the physical custody of Alameda County. As a result, Plaintiff GREIM experienced severe anxiety and mental health distress upon his arrival at Alameda County Jail, and staff there lacked the necessary information to provide him with appropriate care.

275. Upon information and belief, Defendants also fail to prepare adequate discharge summaries and to take steps to ensure continuity of care for prisoners with mental health impairments who are released from the Jail or transferred to other institutions. These failures result in unnecessary decompensation and inability to receive appropriate medications for prisoners with mental health issues housed at the Jail.

L. Defendants Fail to Adequately Train Staff to Provide Appropriate and Timely Mental Health Care

276. Upon information and belief, Defendants fail to adequately train custody and health care staff in how to provide appropriate and timely mental health care. The lack of training is evident from the numerous incidents in which prisoners' health and lives were placed at risk as a result of the deficient mental health care provided in the Jail. As a result of a lack of adequate training, custody and health care staff do not, among other failings: timely and appropriately identify mental health problems during the screening and intake process, properly evaluate and treat prisoners who arrive at the Jail and have been taking prescribed psychotropic medications, recognize signs and symptoms of mental illness and refer prisoners exhibiting such signs and symptoms to mental health care staff, track and monitor prisoners with mental illness and the treatment they require, identify prisoners who are at risk of suicide and respond adequately to prisoners who are exhibiting suicidal tendencies, provide therapy to prisoners with mental illness as a component of mental health care, properly administer psychotropic medications, appropriately evaluate prisoners before making mental health treatment decisions, appropriately release prisoners with serious mental health concerns so that such prisoners can continue their mental health care,

appropriately house prisoners with serious mental illness, ensure that prisoners with mental illness are only housed in administrative segregation when absolutely necessary and are adequately monitored and treated when placed in such punitive and isolating units, appropriately respond to mentally ill prisoners whose non-conforming behaviors are a product of their mental illness, respond to prisoners' requests for psychiatric evaluations and treatment, provide follow-up care to prisoners who are suffering from serious mental illness, and maintain accurate mental health records, including the timely request of prisoners' prior mental health records.

IV. DEFENDANTS DISCRIMINATE AGAINST, FAIL TO ACCOMMODATE, AND VIOLATE THE RIGHTS OF PRISONERS WITH DISABILITIES

277. Defendants MONTEREY COUNTY and MONTEREY COUNTY SHERIFF'S OFFICE currently incarcerate in Monterey County Jail significant numbers of individuals with disabilities, as that term is defined in the ADA, the Rehabilitation Act, and California disability rights law. Together with Defendant CFMG, these Defendants fail to provide prisoners with disabilities with basic reasonable accommodations to ensure equivalent access to all of the programs, activities, and services offered at the Jail. Defendants' failure to accommodate prisoners with disabilities not only denies them access to prison programs and services, but also substantially increases the risk that they are injured in an emergency or are the victim of violence or abuse from other prisoners. Moreover, Defendants' refusal to accommodate prisoners with disabilities results in the provision of inadequate medical and mental health care and the trampling of prisoners' due process rights in Jail disciplinary proceedings.

A. Defendants Lack Adequate Policies and Practices to Identify and Track Prisoners with Disabilities and Provide Them with Needed Accommodations

278. Under the ADA, the Rehabilitation Act, and California disability rights law, Defendants must create and maintain a system to identify and track individuals with disabilities and the accommodations they require. Defendants, however, lack adequate policies and practices for identifying individuals with disabilities and the reasonable

accommodations they require.

279. Defendants fail to identify prisoners with disabilities. During the intake process, custody officers collect various pieces of information about new prisoners. Custody staff use the information to make a number of determinations, including how to classify a prisoner. A prisoner's classification determines with which other prisoners the new prisoner can share space and in what parts of the prison the new prisoner can be housed.

280. Upon information and belief, the custody officers who are responsible for conducting the intake process are not adequately trained by Defendants regarding how to identify and track individuals with disabilities, and therefore frequently fail to identify prisoners with disabilities or the accommodations they need to access Jail programs and services. Upon information and belief, the forms and system that the custody staff use to capture the information gathered during the intake process lack adequate fields and space to document if a prisoner has a disability and requires accommodations.

281. Defendants' failures to accurately identify new prisoners' disabilities and needed accommodations during the intake process result in the denial of accommodations mandated by the ADA, Rehabilitation Act, and California disability rights law, placing prisoners at risk of discrimination, injury, and/or exploitation. For example, during booking into the Jail in August 2012 and again in December 2012, custody staff completed Monterey County Sheriff's Office Intake Health Screening forms for Plaintiff YANCEY. Despite Plaintiff YANCEY's complete hearing impairment, staff did not indicate on the forms that he had a hearing disability. Accordingly, staff throughout the Jail were unable to identify Plaintiff YANCEY as hearing impaired, resulting in a lack of accommodations for his disability.

282. Plaintiff ESQUIVEL is a full-time wheelchair user. He is unable to get around at all without a wheelchair. Despite this, when Plaintiff ESQUIVEL entered the Jail in October 2013, on neither his Intake Health Screening form nor his Intake Triage Assessment did any custody or medical staff member note that he requires a wheelchair.

283. Plaintiff MURPHY was booked into the Jail in January 2013 with a permanent back injury that requires him to use a walker or cane to ambulate without pain. During the intake process, the Jail failed to identify him as having a mobility impairment requiring an accommodation, and he was not provided with a walker or a cane. Plaintiff MURPHY was eventually provided with a cane after many months' delay, during which he frequently was unable to leave his bed due to his inability to walk unassisted.

284. Plaintiff NICHOLS was detained at the Jail on June 20, 2013. Plaintiff NICHOLS has a permanent mobility impairment arising from a motor vehicle accident many years ago. Although he normally uses a cane to ambulate and visibly has trouble walking, when he arrived at the Jail he neither had nor was provided with any assistive devices. Because he did not receive any assistive device, Plaintiff NICHOLS presented to medical staff with complaints of falling on his head three times, after which he received a wheelchair.

285. Another prisoner who was booked into the Jail in January 2012 with a mobility impairment required a cane to help him safely ambulate and access his housing unit and also required a lower bunk housing assignment to safely access a bed. During the intake process, the Jail failed to identify him as having a mobility impairment requiring those accommodations; he was not provided with a cane and the only available bed in his housing unit was on the upper bunk of a triple bunk. Without a cane, the prisoner fell and injured himself on a number of occasions. He slept on the floor because it was too difficult for him to access his bunk.

286. Defendants do not maintain any central list, electronic or otherwise, of prisoners with disabilities and the accommodations they require. Defendants do not maintain adequate information about prisoners' disabilities and related accommodations in the prisoners' custody and/or medical files. Upon information and belief, to the extent that Defendants maintain information about a prisoner's disabilities in any form, custody, medical, and clerical staff are not provided with access to the information in a manner that would timely and effectively inform them of a prisoner's disabilities and required

accommodations. Upon information and belief, Defendants do not adequately train staff to maintain records or information about prisoners' disabilities and related accommodations.

287. The lack of an adequate disability and accommodation tracking system results in substantial injuries to prisoners with disabilities, and results in their being denied the benefits of programs, services, and activities at the Jail. Without an adequate tracking system, medical and custody staff have no easily accessible means to determine whether a prisoner has a disability, and what, if any, accommodations that prisoner requires. Consequently, Defendants fail to provide prisoners with accommodations or withdraw accommodations that have already been provided without justification.

288. For example, Plaintiff YANCEY is deaf, cannot hear, and uses American Sign Language as his primary form of communication. Plaintiff YANCEY was not provided with a sign language interpreter for his communications with Jail staff, including at medical appointments, at a disciplinary hearing, and during the booking and classification process.

289. Plaintiff SARABI was provided with crutches after he sustained an injury to his right leg when he was attacked by another prisoner on or around March 6, 2013. However, on or around April 8, 2013, Plaintiff SARABI was called in for an unsolicited medical exam at which his crutches were taken away from him with no explanation, despite the fact that he still required the crutches in order to ambulate. Plaintiff SARABI could not use the restroom or shower without his crutches, and had to crawl around or hop on one foot to get around the Jail until his attorney contacted the Jail to request that the crutches be provided.

290. Plaintiff MILLER suffers from vision loss as a complication of his severe Type 1 diabetes. He began complaining of blurred vision shortly after his arrival at the Jail; his vision limitations were confirmed by an ophthalmologist to which he was sent by Defendants. His custody file, however, contains no documentation of his vision limitation. Nor does the Jail provide any kind of vest or other visible means by which custody staff may identify Plaintiff MILLER as vision-impaired in event of an emergency.

291. Plaintiff ESQUIVEL had his wheelchair taken away from him for at least 14 hours in August 2012. As a result of being denied the needed assistive device, he was rendered immobile, was unable to access the showers and restrooms, was forced to rely upon other prisoners for assistance, and was therefore placed at increased risk of being manipulated or attacked by other prisoners.

B. Defendants Lack an Effective Grievance Procedure for Prisoners to Request Reasonable Disability Accommodations

292. Defendants do not provide an effective or functional grievance system for prisoners with disabilities as required by the ADA and Rehabilitation Act.

293. Defendants do not provide prisoners with adequate notice of how to request reasonable accommodations for their disabilities. Upon information and belief, the only formal notice prisoners receive regarding any Jail grievance procedure comes from the "Monterey County Adult Detention Facility Inmate Information Booklet" (hereinafter "Inmate Information Booklet"), which is provided to each prisoner when booked into the Jail. Yet the Inmate Information Booklet does not discuss disabilities or the process for requesting disability accommodations. As a result, prisoners are not informed of any specific process for complaining about disability discrimination or requesting disability accommodations.

294. Defendants routinely deny prisoners access to grievance forms. Each prisoner is provided with only one grievance form which is attached to the Inmate Information Booklet provided during booking. Upon information and belief, grievance forms are not freely available in the housing units.

295. Even when prisoners are able to submit grievances, Defendants frequently do not provide any response. One prisoner submitted multiple grievances following her re-entry to the Jail on June 15, 2013, but received no responses. A housing deputy told her that one of her grievances had been "lost" and would not be returned to her. This prisoner then filed a grievance with regards to this purportedly lost grievance, which also did not receive a response. Plaintiff HERNANDEZ submitted at least four grievances to which he

never received responses. Plaintiff MURPHY submitted a grievance on April 4, 2013, requesting a cane or walker as an accommodation for his mobility impairment; he did not receive a response to the grievance either. Plaintiff SARABI submitted a grievance on April 4, 2013, requesting to see a doctor for the intense pain he was experiencing in his foot (the source of his mobility impairment), but he also did not receive a response to the grievance. Plaintiff WHITFIELD submitted multiple grievances to which he received no response or was told that the issue was resolved, even when it was not. These include at least two grievances informing the Jail that he was still not receiving his needed and prescribed Provigil. On both of these grievances, Jail staff members wrote that the issue was resolved, but he had not yet received his medication. Plaintiff YANCEY submitted a grievance on December 20, 2012, requesting a number of accommodations relating to his serious hearing impairment, but he did not receive a response to the grievance.

296. Even when prisoners are able to submit a grievance and Defendants provide a response, the responses are not adequate or comprehensive, and may be arbitrary and counterproductive. One prisoner filed three successive grievances concerning the Jail's failure to provide her with necessary medications, none of which provided a satisfactory response or resulted in her receiving medication. The Jail's response to the first grievance was that she should have received her medication; to the second, that her issue had been addressed (it had not); and the third, that she should file a sick call slip for a refill of a medication the Jail had never given her. As another example, a prisoner filed a grievance requesting a walking cane to assist him in moving around the dorm, shower, and going to court. The response stated only that "you did not have a 'cane' when you came in to the facility. If you are having problems go on sick call."

297. Defendants lack adequate policies and procedures instructing health care or correctional officers how to respond if prisoners request accommodations through means other than the grievance process.

298. Defendants do not adequately train staff in how to provide, appropriately process, and timely respond to grievance forms.

299. Defendants do not make available to prisoners in the Jail information regarding their rights and the protections against discrimination under the American with Disabilities Act.

C. Defendants Fail to Accommodate Prisoners with Disabilities That Affect Communication

300. Prisoners with hearing, speech, developmental disabilities, mental illness, and other communication impairments have problems effectively communicating with Jail staff. Prisoners with disabilities that impair communication require accommodations to ensure effective communication with prison staff and equal access to programs and services offered by Defendants. Defendants fail to provide such accommodations. As a result, prisoners with communication disabilities are denied the benefits of programs, services, and activities at the Jail. Upon information and belief, Defendants fail to adequately train staff in how and when to provide such accommodations.

301. Defendants fail to provide prisoners with hearing and speech impairments with sign language interpreters, hearing aids, or other auxiliary aids. Plaintiff YANCEY has been booked into the Jail numerous times over the past three to five years. Plaintiff YANCEY is completely deaf, and also has a speech impairment that makes it difficult or impossible for him to communicate through spoken words. He uses American Sign Language (ASL) as his primary form of communication, but was not provided with a sign language interpreter by Defendants during his incarcerations in the Jail.

302. Defendants do not provide prisoners with hearing, speech, and other communication impairments with sign language interpreters, hearing aids, staff assistants, or other auxiliary aids during the booking and intake process, which harms these prisoners by preventing them from communicating specific concerns, including emergency medical issues, and understanding Jail policies and practices.

303. For example, Defendants never provided Plaintiff YANCEY with a sign language interpreter during the booking process. When he was booked into the Jail for his most recent term, Plaintiff YANCEY's right arm was in a cast, making it impossible for

him to communicate through written notes. Accordingly, he essentially lacked any means of communicating with the custody officers conducting the intake process.

304. Defendants fail to provide equal access to telephone services to prisoners who require the use of a Telecommunications Device for the Deaf/Teletype ("TDD/TTY"). Non-TDD/TTY telephones are located in the housing units. Upon information and belief, prisoners without disabilities have access to non-TDD/TTY telephones any time the prisoner is permitted in the common area of his or her housing unit. Upon information and belief, telephone calls are limited to 30 minutes in length, though there is no limit to the number of telephone calls a prisoner may make so long as he or she does not abuse or monopolize the telephone.

305. In contrast, there is one TDD/TTY for the entire Jail. Prisoners who require the use of the TDD/TTY must ask a custody officer to transport them to the office where the TDD/TTY is located. Officers frequently refused to transport Plaintiff YANCEY to the TDD/TTY, claiming that they were too busy to do so. Even when allowed to use the TDD/TTY, Plaintiff YANCEY was denied sufficient time to conduct a conversation, since using a TDD/TTY takes longer than using a telephone.

306. Defendants' policies and practices for equal access to telephone services are inadequate. Upon information and belief, Defendants fail to adequately train staff in how to provide equal access to telephone services.

307. Defendants fail to provide prisoners with hearing, speech, or other communication impairments with sign language interpreters, hearing aids, staff assistants, or other auxiliary aids to permit participation in other Jail programs and services, including religious services and educational and vocational classes. For example, Plaintiff YANCEY was not provided with a sign language interpreter when attending religious services at the Jail. As a result, he was not able to understand what was being said by the chaplain and other participants, and could not participate in the services himself.

308. Defendants do not provide equal access to television to prisoners who are hearing impaired. Upon information and belief, most non-disciplinary housing units have

televisions installed for prisoners to watch, but Defendants have either not installed televisions with the capability to display closed captioning or they fail to alter the settings to the televisions to display closed captioning.

309. Defendants fail to provide sign language interpreters, hearing aids, staff assistants, and other auxiliary aids at disciplinary hearings even though prisoners risk a loss of credits and privileges if they are found guilty of disciplinary infractions. For example, Plaintiff YANCEY was charged with a rule violation on December 16, 2012. At the disciplinary hearing, he was found guilty of the violation and punished with two weeks without visitation, canteen, or yard privileges. Plaintiff YANCEY was not provided with a sign language interpreter at the disciplinary hearing, and therefore was not able to defend himself or explain his version of the events. Without an interpreter, Plaintiff YANCEY also had difficulty understanding what the hearing officer and other Jail staff were saying.

310. By failing to provide Plaintiff YANCEY and other hearing impaired prisoners with sign language interpreters, hearing aids, or other auxiliary aids at disciplinary hearings, Defendants deny such prisoners the same opportunity to participate in the hearing regarding their guilt or innocence of the disciplinary charge and to present their views to the hearing officer that prisoners without disabilities have.

311. Similarly, as is discussed in Paragraph 261, *supra*, Plaintiff MEFFORD received a Disciplinary Action Report on December 15, 2013, for yelling at a guard. Despite knowing of his serious mental illness, Defendants did not provide and did not even consider whether they should provide Plaintiff MEFFORD with a staff assistant to help him understand the disciplinary proceedings. As punishment, Plaintiff MEFFORD lost four weeks of commissary, yard, and visiting privileges. Plaintiff MEFFORD appealed this Disciplinary Action Report on the grounds that four weeks of punishment was too severe because his conduct had been caused by his mental illness. Plaintiff MEFFORD noted that these punishments would "lead to me being very depressed and or suicidal and self harmful." Defendants denied Plaintiff MEFFORD's appeal on January 2, 2014, because "in this facility we take serious [sic]" "threats against an officer…regardless of an

inmate's medical condition." Defendants failed to ensure that they effectively communicated their response to Plaintiff MEFFORD's grievance.

312. Upon information and belief, Defendants fail to communicate effectively with prisoners with disabilities that affect cognitive functions, including prisoners with learning disabilities, developmental disabilities, mental illness, and brain injuries. Plaintiff NICHOLS has a brain injury that affects his cognitive function. Defendants noted his brain injury multiple times in his medical file. Nonetheless, neither his custody nor his medical files have any indication that any staff at the Jail ever used any method of effective communication to ensure that Plaintiff NICHOLS understood any of his interactions with staff, including during medical appointments and the booking process.

D. Defendants Routinely Fail to Provide Prisoners with Disabilities with Needed Assistive Devices

313. Defendants lack policies and practices to ensure that prisoners with disabilities who require assistive devices, including, but not limited to, wheelchairs, walkers, crutches, canes, braces, tapping canes, hearing aids, and pocket talkers, as accommodations are provided with and are allowed to retain those devices. Upon information and belief, Defendants fail to adequately train staff in how to timely and appropriately provide assistive devices to prisoners with disabilities.

314. Because of Defendants' deficient disability screening procedure and inadequate grievance process, prisoners who require assistive devices to access Jail programs are frequently not identified. As a result, those prisoners do not receive needed assistive devices and cannot access the programs and services offered at the Jail.

315. Upon information and belief, Defendants deny prisoners certain assistive devices, claiming that such items are not permitted in the Jail. For example, Plaintiff MURPHY, who uses a cane to ambulate and required a lower bunk housing assignment while at CDCR facilities, requested during the booking process that he be provided with a cane or walker. He was informed by Jail staff that canes and walkers were not allowed in the Jail. Despite this initial assertion, Plaintiff MURPHY has now been provided with a

cane. Other prisoners' files indicate that canes are sometimes allowed if approved by custody staff, rather than if deemed medically necessary as accommodations for documented disabilities.

316. Upon information and belief, Defendants have refused to provide some prisoners with assistive devices as an accommodation for a disability, even after Defendants have identified the person as a qualified individual with a disability and as needing a particular assistive device. Upon information and belief, Defendants have informed such prisoners that they are permitted to possess certain assistive devices, but only if someone from outside of the Jail, like a family member, friend, or community organization provides the assistive device. Unless the assistive device is provided by a third party, such prisoners may be denied reasonable accommodations necessary for them to access programs and services offered by Defendants.

317. Even when the Jail provides a prisoner with an assistive device, Defendants unjustifiably remove these devices from prisoners, as alleged in Paragraphs 289-291, *supra*.

318. Defendants fail to consider prisoners' specific needs and abilities in assigning assistive devices, to the detriment of those prisoners' overall health and safety. For example, Plaintiff NICHOLS normally uses a cane to ambulate, but was provided with a wheelchair by Defendants because he did not have a cane with him at time of arrest. Because Defendants have provided Plaintiff NICHOLS with a wheelchair rather than his accustomed cane, he is less physically active at the Jail than he is able to be and would like to be, and has suffered deterioration of his overall physical condition. He is also denied equal access to Jail programs, services, and activities as a result of his confinement to a wheelchair.

319. Defendants also fail to provide properly operational assistive devices to prisoners. Plaintiff ESQUIVEL received a wheelchair in October 2013 with a broken right wheel and a missing foot bed. Plaintiff ESQUIVEL was thus only able to get around by performing a "wheelie" to lift up the broken wheel and move himself forward. Even after

he complained about this wheelchair to medical staff, he was not provided with an operational wheelchair. It was only after he complained to the CFMG Program Manager that he was provided with a functioning wheelchair.

E. Defendants Fail to Provide Prisoners with Disabilities with Equal Access to Programs and Services, Including Safe and Accessible Housing

320. Defendants fail to ensure that prisoners with disabilities have equal access to all programs and services offered at the Jail.

321. Defendants fail to ensure that prisoners with disabilities are assigned to and are actually housed in housing units and bed assignments that are accessible and safe. Upon information and belief, Defendants fail to adequately train staff in how to house prisoners with disabilities in accessible and safe housing.

322. The Jail consists of five main housing areas—the Rehabilitation Center, the Men's Section, K-Pod, the Dorm Section, and the Women's Section—located in two buildings.

323. Each housing area is separated into a number of smaller housing units. The housing units differ in their design, and importantly, in their accessibility to prisoners with disabilities. Some of the housing units are dorm housing units, where many beds, including triple bunks, are placed in an open area that is shared by the prisoners. Other housing units consist of celled housing, where the unit is divided into a number of cells with doors in which one or two prisoners are housed. Cells that house two prisoners typically have bunk beds in them.

324. Some of the housing units in the Jail are located up flights of stairs, while others are on the ground floor.

325. Defendants control housing unit assignments. In housing units with celled housing, Defendants also assign prisoners to a particular cell.

326. Upon information and belief, Defendants make decisions regarding where to house a particular prisoner without taking into account the prisoner's disability-related limitations. Because of Defendants' general failure to identify and track prisoners with

disabilities, Defendants decide where to house a prisoner without sufficient information regarding the prisoner's limitations; this practice significantly increases the risk that a prisoner will be assigned to a housing unit that is not accessible to him or her, because, for example, it lacks adequate toilets or grab bars in the shower, is up a flight of stairs, lacks space for a wheelchair.

327. One prisoner who was housed in the Jail for a significant period of time was a full-time wheelchair user. Defendants generally permitted this prisoner to retain his wheelchair in the Jail, meaning that Defendants were aware of his mobility impairment. Nonetheless, Defendants housed this prisoner in the C-Dorm and D-Dorm within the Dorm Section. The C-Dorm and D-Dorm were not then wheelchair accessible in that they did not have toilets and showers with grab bars, did not have shower chairs, and had structural lips between the housing areas and the showers. Upon information and belief, C-Dorm and D-Dorm still do not have shower grab bars and lack adequate shower chairs. This prisoner fell four times while housed in those dorms when attempting to access the toilets and showers, injuring himself each time he fell. He also was frequently forced to rely on other prisoners for assistance to access the toilets and showers.

328. Plaintiff ESQUIVEL has previously been housed in both C-Dorm and D-Dorm. While there, he was unable to use the shower or toilet without assistance from other prisoners or serious concern for his own safety.

329. Another prisoner who was a full-time wheelchair user was permitted to retain his wheelchair, indicating that Defendants were aware of his mobility impairment. Nevertheless, Defendants housed this prisoner in the B-Dorm for 30-45 days. This prisoner had difficulty accessing almost every feature of B-Dorm, including the bathroom. Specifically, this prisoner was forced to shower while sitting in his wheelchair due to the lack of a shower chair, and had to rely on other prisoners to press the shower button for him because he could not reach it. This prisoner also had to rely on other prisoners to lift him onto the toilet.

330. One prisoner was known to have a mobility impairment and provided with

crutches to use within the Jail. Nevertheless, he was housed in J-Pod, which has a shower without any minimal accessibility features such as a grab bar or shower chair. As a result, he suffered several serious falls while attempting to use a shower that was not accessible to him, but was the only shower available to him.

331. Upon information and belief, Defendants lack policies and practices for ensuring the prisoners who require lower bunk bed assignments actually receive lower bunk bed assignments. Upon information and belief, in many housing units, Defendants have essentially no system for assigning particular prisoners to specific beds. Instead, especially in dorm housing units, Defendants typically abdicate the assignment and selection of beds in the housing unit to the prisoners themselves, who will be assigned to the newly-vacated bed. In some dorm housing units, bed assignments and selection are determined by who has been in the unit for the longest period of time. In units that include a significant number of gang members, bed assignments may be determined by the leaders of the gang within the unit.

332. Plaintiff WHITFIELD, who is at serious risk for falling off of his bunk due to his narcolepsy and cataplexy, was inappropriately housed on an upper-level bunk of a triple bunk in C-Wing upon first entering the Jail in November 2013. Jail staff did not assign him to a lower bunk and thus he was forced to accept the empty bed offered to him by the other prisoners. It took repeated requests to medical and custody staff for him to be moved to the Rotunda, where he was finally provided with a single bed.

333. Upon information and belief, Defendants have no means for ensuring that prisoners who require lower bunk bed assignments are actually able to sleep in lower bunks, and have no mechanism for guaranteeing that prisoners who should not be housed in triple bunks avoid such bed placements. As a result, prisoners who require lower bunk and non-triple bunk bed assignments as accommodations for their disabilities may be forced to sleep on upper bunks and in triple bunks rather than experience the pain and danger of sleeping in an inaccessible bed. For example, Plaintiff NICHOLS was housed for many weeks in a dorm where he was required to sleep in a middle bunk, although that

bunk was difficult and painful for him to access.

334. A prisoner booked into the jail in January 2012 with a mobility impairment required a lower bunk housing assignment to safely access a bed. During the intake process, Defendants failed to identify him as having a mobility impairment requiring that accommodation. In the housing unit to which he was assigned, the only available bed was on the upper bunk of a triple bunk. No prisoner in the unit would agree to switch bed assignments with him. Rather than sleep on the upper bunk, he slept on the floor because it was too difficult and dangerous for him to access the available bed.

335. On information and belief, Defendants' general practice is to house prisoners with disabilities, mobility impairments, and/or significant medical needs in the Rotunda of the Jail, a space designed for use as a programmatic area and not as a housing unit. One prisoner who uses a wheelchair and was housed in the Rotunda in July 2013 fell and was injured while attempting to use the Rotunda shower, which is not properly equipped for use by prisoners with disabilities.

336. The recreation yards for the Men's Section (including the Rotunda), the Women's Section, and K-Pod are located on the roof of the Jail. In order to access the yards, prisoners must walk up one long flight of stairs and then down a smaller flight of stairs. The stairways are the only means of reaching the yard. Because the yard is located on the roof, prisoners who are housed in the Men's Section, Women's Section, or K-Pod and who have mobility or vision impairments that make walking up or down stairs difficult, painful, impossible, or dangerous are denied access to the recreation yard.

337. One such prisoner, due to her use of a walker, was thus denied access to the rooftop recreation yard used by female prisoners. Mobility-impaired prisoners housed in the Rotunda, such as Plaintiff NICHOLS, are also unable to access the recreational yard. Because of his mobility impairment, Plaintiff MURPHY has rarely accessed the yard since he arrived at the Jail on January 18, 2013. If the yard for their housing units was not up a flight of stairs, all three prisoners would have gone to the yard most times that it was offered to them.

338. Plaintiff DILLEY can only climb the stairs to access the exercise yard if she is willing to endure great pain in her legs. As a result, she has not been able to access the exercise yard for the entire duration of her time in the Jail. While incarcerated, Plaintiff DILLEY has not been outside except when she has been escorted to medical appointments at outside medical specialists and to go to court. She had not been outside at all between mid-December 2013 and late-March 2014.

339. Plaintiff GIST would like to attend the religious services and substance abuse treatment classes, Narcotics Anonymous and Alcoholics Anonymous, but in order to access the programs and services she must climb the same long staircase that provides the Women's Section with access to the exercise yard. There is no alternative means of accessing these programs and services. Plaintiff GIST does not attend these programs due to the pain caused by climbing the stairs. Plaintiff GIST could likely access the class if Defendants offered the class in an area of the Jail that could be reached without having to climb stairs.

340. As a permanent wheelchair user, Plaintiff ESQUIVEL was not able to access the exercise yard while he was housed in the Rotunda

341. Another prisoner who has a mobility impairment that makes walking up stairs extremely difficult and painful was assigned to F-Pod. This prisoner declined to go to yard every time that it was offered because the pain and difficulty of climbing the stairs was too great. On at least one occasion, despite this prisoner's mobility impairments, Defendants forced him to climb the stairs to the yard when Defendants were conducting searches of cells in F-Pod. The prisoner specifically requested that he be excused from the need to go to the yard; Defendants denied his request. When he had to walk up to the yard, it caused him great pain and placed him at serious risk of falling and further injuring himself.

342. Defendants offer an educational program to some prisoners called Choices and Pride. Prisoners who complete the more than 20 sessions of Choices and Pride, conducted over a period of weeks, receive a five-day reduction of their sentence. Choices

and Pride is only offered to women in the Jail in a room that is located up the same long staircase that provides the Women's Section with access to the exercise yard. There is no alternative means of accessing the classroom. Plaintiff DILLEY desires to complete the class to receive a reduction in her sentence. She was able to access the classroom for the first session of the class, but did so by suffering through the extraordinary pain caused by climbing up and down the stairs. By forcing Plaintiff DILLEY to climb the stairs to access the class, and suffer significant, unnecessary pain, Defendants discriminate against Plaintiff DILLEY. Plaintiff DILLEY could access the class without any unnecessary pain if Defendants offered the class in an area of the Jail that could be reached without having to climb stairs.

343. Plaintiff GIST would like to participate in the Jail's educational programs but cannot because of her developmental and physical disabilities, which prevent her both from accessing the classroom space (which is located up a long flight of stairs that she cannot access without difficulty and pain) and understanding the classes. If there were special education opportunities offered in a more accessible area, she would participate.

344. Defendants use segregated isolation units to house prisoners with disabilities whom they are unable to properly accommodate. One prisoner, who is mobility impaired due to permanent spinal injuries and uses a walker, was housed in the general population for approximately one month after she returned to the Jail following surgery. On July 12, 2013, she had a dispute with a deputy because that deputy would not allow her to leave her cell to pick up her dinner tray, "as she uses a walker and [it] would be hard for her to walk up and down the stairs with trays and her walker." She received a Disciplinary Action Report as a result of this conflict. Rather than accommodating this prisoner to ensure that she could remain in the least restrictive possible housing environment and have equal access to dining services, Defendants moved her to the "holding" area of the women's facility, a segregated and isolated single-cell unit. Defendants moved this prisoner to the holding area at least in part because of her disability. On a July 13, 2013 Lockdown/Inmate Movement form Defendants wrote that they "moved [this prisoner] to

holding so this incident [not being able to safely navigate the stairs with a tray] does not occur again." In the holding area, this prisoner slept on a mattress on the floor and had limited access to toilet facilities and running water. On information and belief, this prisoner was housed in the holding area for approximately six weeks.

345. Defendants routinely discriminate against prisoners with serious mental illness by isolating them from and denying them privileges granted to other prisoners, as described in Paragraphs 254-256, *supra*. When housed in lockdown units, isolation cells, or rubber rooms, prisoners with serious mental illnesses are denied access to programs and services.

346. Plaintiff MEFFORD has only been housed in lockdown, isolation, and safety cells while at the Jail. In addition, he has repeatedly lost yard privileges due to disciplinary actions where the custody staff failed to consider the effect of his mental illness. As such, he has been essentially denied access to the even limited recreational and therapeutic opportunities offered to prisoners housed in these cells.

347. Defendants have placed Plaintiff MURPHY in an isolation cell at least one time for a period of 10 days in April 2013. Upon information and belief, Plaintiff MURPHY's was denied access to programs, services, and activities at the Jail during his time in isolation.

F. Defendants Subject Prisoners with Disabilities to Dangerous Conditions in the Jail

348. Defendants fail to accommodate prisoners with disabilities that affect communication for interactions with medical and mental health care staff, despite the grave importance of the interactions. Specifically, Defendants fail to provide sign language interpreters, hearing aids, staff assistants, and other auxiliary aids, or use other methods of effective communication, for prisoners with disabilities that affect communication. Defendants fail to provide these accommodations despite knowledge that such prisoners cannot effectively communicate with staff without the accommodations and that the failure to communicate effectively places such prisoners at an increased risk that

medical or mental health issues will not be not be diagnosed or will be misdiagnosed.

349. For example, during his most recent booking in the Jail, Plaintiff YANCEY had at least six medical appointments. He was not provided with a sign language interpreter at any of his appointments. Because there was no sign language interpreter to help him communicate with the medical staff, Plaintiff YANCEY was not able to explain that the pain medication he was being provided was insufficient to treat his pain. Accordingly, his pain symptoms were not adequately treated.

350. Plaintiff NICHOLS had at least eight interactions with medical staff during his time in the Jail. None of the notes from those interactions indicate that medical staff used any method of effective communication to ensure that Plaintiff NICHOLS understood the information conveyed to him.

351. Defendants endanger prisoners with hearing impairments by failing to institute any system for visually identifying prisoners with hearing impairments (e.g., vests). If a fight breaks out in a housing unit, Jail staff may order all prisoners to get down on the ground or to line up against a wall. For any number of reasons, Jail staff may also order a specific prisoner to cease or engage in certain behavior. Upon information and belief, Jail staff are authorized to initiate disciplinary proceedings and/or use force against prisoners who fail to comply with orders. Upon information and belief, the use of force for failure to comply with an order can include the use of Tasers, non-lethal firearms (like "flash bang" grenades) and lethal firearms.

352. Prisoners with communication impairments like Plaintiff YANCEY, Plaintiff NICHOLS, or Plaintiff MEFFORD are not capable of understanding and therefore are less likely to comply with alarms and oral orders from jail staff. Without a visual identification system by which staff can identify prisoners with communication impairments (*e.g.*, vests), there is an increased risk that staff will not recognize that a prisoner has an impairment and will interpret such prisoner's actions as a failure to comply with an order, rather than as a failure to hear and/or understand the order. As a result, prisoners with hearing and other communication impairments are at increased risk that staff will initiate disciplinary

proceedings and/or use force for failure to comply with an order that they have not heard or understood.

353. Defendants lack any policy, practice, or system for notifying prisoners with disabilities of emergencies, including alarms, fires, and earthquakes. Upon information and belief, Defendants fail to adequately train staff in how to notify prisoners with disabilities of emergencies. Upon information and belief, the Jail does not have a visual or tactile alarm system installed to alert prisoners with disabilities. Because Defendants lack a system for identifying prisoners with disabilities, including those with hearing and communication impairments, or notifying prisoners with disabilities of an emergency, these prisoners may not be aware of an emergency, or may need assistance during the emergency, and are therefore at increased risk of injury or death should one occur.

354. Defendants lack any policies or practices to ensure that prisoners with difficulty walking, including prisoners in wheelchairs, are safely evacuated from the Jail in the event of an emergency. Upon information and belief, Defendants fail to adequately train staff in how to ensure that prisoners with mobility impairments are safely evacuated from the Jail in an emergency. Upon information and belief, the emergency exits in the Jail, to the extent they exist, are not accessible to prisoners in wheelchairs. As a result, prisoners with difficulty ambulating are at increased risk of injury or death if an emergency, like a fire or earthquake, were to occur.

355. Defendants endanger prisoners with mobility impairments by failing to institute any system for staff to visually identify prisoners with mobility impairments. Upon information and belief, Defendants fail to adequately train staff in how to visually identify prisoners with mobility impairments. Upon information and belief, in response to alarms or other incidents in the Jail, custody staff frequently order prisoners to "prone out," *i.e.*, lay down on the ground, face down. Upon information and belief, Jail staff are authorized to initiate disciplinary proceedings and/or use force against prisoners who fail to prone out when ordered to do so. Upon information and belief, the use of force for failure to comply with an order to prone out can include the use of Tasers, non-lethal

firearms (like "flash bang" grenades) and lethal firearms.

356. Some prisoners with mobility impairments are incapable of complying with an order to prone out because of their mobility impairments. Without a visual identification system by which staff can identify prisoners with such mobility impairments (*e.g.*, a vest or certain color of clothing), there is an increased risk that custody staff will not recognize that a prisoner has a mobility impairment and will interpret such a prisoner's failure to prone out as a failure to comply with an order, rather than an inability to comply with the order. As a result, prisoners with mobility impairments are at increased risk that staff will initiate disciplinary proceedings and/or use force for failure to comply with an order to prone out with which they cannot comply because of their disability.

357. Prisoners with disabilities that are not accommodated are susceptible to exploitation by other prisoners. For example, in exchange for help getting to the toilet, shower, or meals, or communicating with prison staff, prisoners with disabilities may be required to pay other prisoners, potentially leading to increased risk of violence or even rape.

G. Defendants Fail to Adequately Train Staff to Accommodate Prisoners with Disabilities

358. Upon information and belief, Defendants fail to adequately train custody and health care staff in how to provide appropriate and timely accommodations to prisoners with disabilities. The lack of training is evident from the numerous failures to accommodate prisoners with disabilities, and exclusion of prisoners with disabilities from equal access to programs, services, and activities offered by Defendants, and placement of prisoners with disabilities at risk of injury and exploitation. As a result of a lack of adequate training, custody and health care staff do not, among other failings: identify and track individuals with disabilities and the accommodations they require, maintain records or information about prisoners' disabilities and related accommodations, appropriately process and timely respond to grievance forms, provide accommodations necessary for effective communication, including sign language interpreters, hearing aids, staff

assistants, and other auxiliary aids, provide equal access to telephone services for prisoners with communication disabilities, notify prisoners with disabilities of emergencies, ensure that prisoners with mobility impairments are safely evacuated from the Jail in an emergency, and provide equal access to Jail services and programs.

CLASS ACTION ALLEGATIONS

Prisoner Class

359. All Plaintiffs bring this action on their own behalf and, pursuant to Rule 23(a), (b)(1), and (b)(2) of the Federal Rules of Civil Procedure, on behalf of a class of all adult men and women who are now, or will be in the future, incarcerated in Monterey County Jail ("Prisoner Class"). All prisoners incarcerated in the Jail are at substantial risk of serious harm due to the policies and practices of Defendants MONTEREY COUNTY, MONTEREY COUNTY SHERIFF'S OFFICE, and CFMG ("Defendants"), including:

a. Denial of protection from injury and violence from other prisoners,

b. Denial of minimally adequate medical care, and

c. Denial of minimally adequate mental health care.

Numerosity: Fed. R. Civ. P. 23(a)(1)

360. The proposed class as defined is sufficiently numerous that joinder of all members of the class is impracticable and unfeasible. Currently, there are more than 900 prisoners in the Jail, as well as thousands of individuals either in CDCR custody or in the community on probation, mandatory supervision, home confinement, and Post-Release Community Supervision ("PRCS"), all of whom are subject to being returned to the Jail at any time on an alleged violation or revocation of their supervision or to participate in civil or criminal court proceedings. Due to Defendants' policies and practices, all prisoners in Monterey County Jail are at risk of being harmed by violence from other prisoners. Due to Defendants' policies and practices, all prisoners at Monterey County Jail receive or are at substantial risk of receiving inadequate medical, dental, and mental health care.

361. The plaintiff class members are identifiable using records maintained in the ordinary course of business by Defendants.

Commonality: Fed. R. Civ. P. 23(a)(2)

362. There are questions of law and fact common to the Prisoner Class, including, but not limited to:

a. Whether Defendants' failure to protect prisoners from violence from other prisoners violates the Due Process Clause of the Fourteenth Amendment and the Cruel and Unusual Punishment Clause of the of the Eighth Amendment to the United States Constitution, and Article I, Sections 7 and 17 of the California Constitution;

b. Whether Defendants' failure to provide minimally adequate medical care to prisoners violates the Due Process Clause of the Fourteenth Amendment and the Cruel and Unusual Punishment Clause of the Eighth Amendment to the United States Constitution, and Article I, Sections 7 and 17 of the California Constitution; and

c. Whether Defendants' failure to provide minimally adequate mental health care to prisoners violates the Due Process Clause of the Fourteenth Amendment and the Cruel and Unusual Punishment Clause of the Eighth Amendment to the United States Constitution, and Article I, Sections 7 and 17 of the California Constitution.

363. Defendants are expected to raise common defenses to these claims, including denying that their actions violate the law.

Typicality: Fed. R. Civ. P. 23(a)(3)

364. The claims of the named Plaintiffs are typical of the claims of the members of the proposed class. Plaintiffs and all other members of the class have sustained similar injuries arising out of and caused by Defendants' common course of conduct and policies in violation of the law as alleged herein.

Adequacy: Fed. R. Civ. P. 23(a)(4)

365. Plaintiffs are members of the class and will fairly and adequately represent and protect the interests of the putative class members because they have no disabling conflict(s) of interest that would be antagonistic to those of the other class members. Plaintiffs, as well as plaintiff class members, seek to enjoin the unlawful acts and omissions of Defendants. Plaintiffs have retained counsel who are competent and

experienced in complex class action litigation and prisoner's rights litigation.

Fed. R. Civ. P. 23(b)(1)(A) and (B)

366. Since the number of class members is more than 900, separate actions by individuals could result in inconsistent and varying decisions, which in turn would result in conflicting and incompatible standards of conduct for Defendants.

Fed. R. Civ. P. 23(b)(2)

367. This action is also maintainable as a class action pursuant to Federal Rule of Civil Procedure 23(b)(2) because Defendants have acted and refused to act on grounds that apply generally to the class, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the class and will apply to all members of the class.

Prisoners with Disabilities Subclass

368. All Plaintiffs bring this action on their own behalf and, pursuant to Rule 23(a), (b)(1), and (b)(2) of the Federal Rules of Civil Procedure, on behalf of a subclass of all qualified individuals with a disability, as that term is defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m), and who are now, or will be in the future, incarcerated in Monterey County Jail ("Prisoners with Disabilities Subclass"). All prisoners with disabilities who are incarcerated in the Jail are at risk of being discriminated against or denied access to programs, services and activities offered at the Jail as a result of the policies and practices of Defendants MONTEREY COUNTY, MONTEREY COUNTY SHERIFF'S OFFICE, and CFMG ("Defendants").

Numerosity: Fed. R. Civ. P. 23(a)(1)

369. The proposed subclass as defined is sufficiently numerous that joinder of all members of the subclass is impracticable and unfeasible. The exact number of members of the Prisoners with Disabilities Subclass is unknown. According to data regarding the incidence of disabilities among the general population, at least 30% of the prisoners in the Jail are qualified individuals with disabilities as that term is defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

370. The Prisoners with Disabilities Subclass members are identifiable using

records maintained in the ordinary course of business by Defendants.

Commonality: Fed. R. Civ. P. 23(a)(2)

371. There are questions of law and fact common to the Prisoners with Disabilities Subclass, including, but not limited to: Whether Defendants' failure to reasonably accommodate prisoners with disabilities violates the Americans with Disabilities Act, Section 504 of the Rehabilitation Act, and California Government Code § 11135.

372. Defendants are expected to raise common defenses to these claims, including denying that their actions violate the law.

Typicality: Fed. R. Civ. P. 23(a)(3)

373. The claims of the named Plaintiffs are typical of the claims of the members of the proposed subclass. Plaintiffs and all other members of the subclass have sustained similar injuries arising out of and caused by Defendants' common course of conduct and policies in violation of the law as alleged herein.

Adequacy: Fed. R. Civ. P. 23(a)(4)

374. Plaintiffs are members of the subclass and will fairly and adequately represent and protect the interests of the putative subclass members because they have no disabling conflict(s) of interest that would be antagonistic to those of the other subclass members. Plaintiffs, as well as Prisoners with Disabilities Subclass members, seek to enjoin the unlawful acts and omissions of Defendants. Plaintiffs have retained counsel who are competent and experienced in complex class action litigation and prisoner's rights litigation.

Fed. R. Civ. P. 23(b)(1)(A) and (B)

375. Since the subclass consists of more than 30% of the prisoner population in the Jail, separate actions by individuals could result in inconsistent and varying decisions, which in turn would result in conflicting and incompatible standards of conduct for Defendants.

Fed. R. Civ. P. 23(b)(2)

376. This action is also maintainable as a class action pursuant to Fed. R. Civ. P. 23(b)(2) because Defendants have acted and refused to act on grounds that apply generally to the subclass, so that final injunctive relief or corresponding declaratory relief is appropriate respecting the subclass and will apply to all members of the class and subclass.

FIRST CAUSE OF ACTION

(Eighth Amendment to the United States Constitution, 42 U.S.C. § 1983)

By Plaintiffs HERNANDEZ, AGUILAR, COBB, DILLEY, DOBBS, ESQUIVEL, GIST, GOMEZ, GREIM, GUYOT, HOBBS, HUNTER, KEY, MEFFORD, MILLER, MURPHY, NICHOLS, PEREZ, SARABI, WHITFIELD, and YANCEY and the Prisoner Class Against Defendants MONTEREY COUNTY, MONTEREY COUNTY SHERIFF'S OFFICE, and CALIFORNIA FORENSIC MEDICAL GROUP

377. Plaintiffs re-allege and incorporate by reference herein all allegations previously made in paragraphs 1 through 376 above.

378. By their policies and practices described above, Defendants MONTEREY COUNTY, MONTEREY COUNTY SHERIFF'S OFFICE, and CFMG ("Defendants") subject Plaintiffs AGUILAR, COBB, DILLEY, DOBBS, ESQUIVEL, GIST, GOMEZ, GREIM, GUYOT, HERNANDEZ, HOBBS, HUNTER, KEY, MEFFORD, MILLER, MURPHY, NICHOLS, PEREZ, SARABI, WHITFIELD, and YANCEY, and the Prisoner Class they represent, to a substantial risk of harm and injury from violence from other prisoners and inadequate medical and mental health care. These policies and practices have been, and continue to be, implemented by Defendants and their agents or employees in their official capacities, and are the proximate cause of Plaintiffs' and the Prisoner Class's ongoing deprivation of rights secured by the United States Constitution under the Eighth Amendment.

379. Defendants have been and are aware of all of the deprivations complained of herein, and have condoned or been deliberately indifferent to such conduct.

WHEREFORE, Plaintiffs and the Prisoner Class they represent request relief as outlined below.

SECOND CAUSE OF ACTION

(Fourteenth Amendment to the United States Constitution, 42 U.S.C. § 1983)

By Plaintiffs HERNANDEZ, AGUILAR, COBB, DILLEY, DOBBS, ESQUIVEL, GIST, GOMEZ, GREIM, GUYOT, HOBBS, HUNTER, KEY, MEFFORD, MILLER, MURPHY, NICHOLS, PEREZ, SARABI, WHITFIELD, and YANCEY and the Prisoner Class Against Defendants MONTEREY COUNTY, MONTEREY COUNTY SHERIFF'S OFFICE, and CALIFORNIA FORENSIC MEDICAL GROUP

380. Plaintiffs re-allege and incorporate by reference herein all allegations previously made in paragraphs 1 through 379, above.

381. By their policies and practices described above, Defendants subject Plaintiffs AGUILAR, COBB, DILLEY, DOBBS, ESQUIVEL, GIST, GOMEZ, GREIM, GUYOT, HERNANDEZ, HOBBS, HUNTER, KEY, MEFFORD, MILLER, MURPHY, NICHOLS, PEREZ, SARABI, WHITFIELD, and YANCEY, and the Prisoner Class they represent, to a substantial risk of harm and injury from violence from other prisoners and inadequate medical and mental health care. These policies and practices have been, and continue to be, implemented by Defendants and their agents or employees in their official capacities, and are the proximate cause of Plaintiffs' and the Prisoner Class's ongoing deprivation of rights secured by the United States Constitution under the Fourteenth Amendment.

382. Defendants have been and are aware of all of the deprivations complained of herein, and have condoned or been deliberately indifferent to such conduct.

WHEREFORE, Plaintiffs and the Prisoner Class they represent request relief as outlined below.

THIRD CAUSE OF ACTION

(Article I, Section 7 of the California Constitution)

By Plaintiffs HERNANDEZ, AGUILAR, COBB, DILLEY, DOBBS, ESQUIVEL, GIST, GOMEZ, GREIM, GUYOT, HOBBS, HUNTER, KEY, MEFFORD, MILLER, MURPHY, NICHOLS, PEREZ, SARABI, WHITFIELD, and YANCEY and the Prisoner Class Against Defendants MONTEREY COUNTY, MONTEREY COUNTY SHERIFF'S OFFICE, and CALIFORNIA FORENSIC MEDICAL GROUP

383. Plaintiffs re-allege and incorporate by reference herein all allegations

previously made in paragraphs 1 through 382, above.

384. By their policies and practices described above, Defendants subject AGUILAR, COBB, DILLEY, DOBBS, ESQUIVEL, GIST, GOMEZ, GREIM, GUYOT, HERNANDEZ, HOBBS, HUNTER, KEY, MEFFORD, MILLER, MURPHY, NICHOLS, PEREZ, SARABI, WHITFIELD, and YANCEY, and the Prisoner Class they represent, to a substantial risk of harm and injury from violence from other prisoners and inadequate medical and mental health care. These policies and practices have been, and continue to be, implemented by Defendants and their agents or employees in their official capacities, and are the proximate cause of Plaintiffs' and the Prisoner Class's ongoing deprivation of rights secured by the California Constitution, Article I, Section 7.

385. Defendants have been and are aware of all of the deprivations complained of herein, and have condoned or been deliberately indifferent to such conduct.

WHEREFORE, Plaintiffs and the Prisoner Class they represent request relief as outlined below.

FOURTH CAUSE OF ACTION

(Article I, Section 17 of the California Constitution)

By Plaintiffs HERNANDEZ, AGUILAR, COBB, DILLEY, DOBBS, ESQUIVEL, GIST, GOMEZ, GREIM, GUYOT, HOBBS, HUNTER, KEY, MEFFORD, MILLER, MURPHY, NICHOLS, PEREZ, SARABI, WHITFIELD, and YANCEY and the Prisoner Class Against Defendants MONTEREY COUNTY, MONTEREY COUNTY SHERIFF'S OFFICE, and CALIFORNIA FORENSIC MEDICAL GROUP

386. Plaintiffs re-allege and incorporate by reference herein all allegations previously made in paragraphs 1 through 385, above.

387. By their policies and practices described above, Defendants subject Plaintiffs AGUILAR, COBB, DILLEY, DOBBS, ESQUIVEL, GIST, GOMEZ, GREIM, GUYOT, HERNANDEZ, HOBBS, HUNTER, KEY, MEFFORD, MILLER, MURPHY, NICHOLS, PEREZ, SARABI, WHITFIELD, and YANCEY, and the Prisoner Class they represent, to a substantial risk of harm and injury from violence from other prisoners and inadequate medical and mental health care. These policies and practices have been, and continue to

be, implemented by Defendants and their agents or employees in their official capacities, and are the proximate cause of Plaintiffs' and the Prisoner Class's ongoing deprivation of rights secured by the California Constitution, Article I, Section 17.

388. Defendants have been and are aware of all of the deprivations complained of herein, and have condoned or been deliberately indifferent to such conduct.

WHEREFORE, Plaintiffs and the Prisoner Class they represent request relief as outlined below.

FIFTH CAUSE OF ACTION

(Americans with Disabilities Act, 42 U.S.C. § 12132)

By Plaintiffs HERNANDEZ, AGUILAR, COBB, DILLEY, DOBBS, ESQUIVEL, GIST, GOMEZ, GREIM, GUYOT, HOBBS, HUNTER, KEY, MEFFORD, MILLER, MURPHY, NICHOLS, PEREZ, SARABI, WHITFIELD, and YANCEY and the Prisoners with Disabilities Subclass Against Defendants MONTEREY COUNTY and MONTEREY COUNTY SHERIFF'S OFFICE

389. Plaintiffs re-allege and incorporate by reference herein all allegations previously made in paragraphs 1 through 388, above.

390. The ADA prohibits public entities, including the COUNTY and the SHERIFF'S OFFICE from denying "a qualified individual with a disability … the benefits of the services, programs, or activities of [the] public entity" because of the individual's disability. 42 U.S.C. § 12132.

391. Defendants MONTEREY COUNTY and SHERIFF'S OFFICE are legally responsible for all violations of the ADA committed by CFMG in the course of performing its duties under its contractual arrangement with the SHERIFF'S OFFICE to provide medical and mental health care services to prisoners in the Jail. *See* 28 C.F.R. § 35.130(b)(1).

392. The ADA defines "a qualified individual with a disability" as a person who suffers from a "physical or mental impairment that substantially limits one or more major life activities," including, but not limited to, "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working." 42 U.S.C.

§ 12102(1)(A), (2)(A). All Plaintiffs are qualified individuals with disabilities as defined in the ADA, as they have impairments that substantially limit one or more major life activities.

393. The programs, services, and activities that Defendants MONTEREY COUNTY and SHERIFF'S OFFICE provide to prisoners include, but are not limited to, sleeping, eating, showering, toileting, communicating with those outside the Jail by mail and telephone, exercising, entertainment, safety and security, the Jail's administrative, disciplinary, and classification proceedings, medical, mental health, and dental services, the library, educational, vocational, substance abuse, and anger management classes, and discharge services. Defendants MONTEREY COUNTY's and SHERIFF'S OFFICE's programs, services, and activities are covered by the ADA.

394. Under the ADA, Defendants MONTEREY COUNTY and SHERIFF'S OFFICE must provide prisoners with disabilities reasonable accommodations and modifications so that they can avail themselves of and participate in all programs and activities offered by Defendants.

395. Defendants MONTEREY COUNTY and SHERIFF'S OFFICE fail to accommodate the Plaintiffs and the Prisoners with Disabilities Subclass they represent as described above, including by:

a. failing to "ensure that qualified inmates or detainees with disabilities shall not, because a facility is inaccessible to or unusable by individuals with disabilities, be excluded from participation in, or be denied the benefits of, the services, programs, or activities of a public entity, or be subjected to discrimination by any public entity," 28 C.F.R. § 35.152(b)(1);

b. failing to "ensure that inmates or detainees with disabilities are housed in the most integrated setting appropriate to the needs of the individuals," 28 C.F.R. § 35.152(b)(2);

c. failing to "implement reasonable policies, including physical modifications to additional cells in accordance with the 2010 [accessibility] Standards, so

as to ensure that each inmate with a disability is housed in a cell with the accessible elements necessary to afford the inmate access to safe, appropriate housing," 28 C.F.R. § 35.152(b)(3);

d. failing or refusing to provide Plaintiffs and the Prisoners with Disabilities Subclass they represent with reasonable accommodations and other services related to their disabilities, *see generally* 28 C.F.R. § 35.130(a);

e. failing or refusing to provide equally effective communication, *see generally* 28 C.F.R. § 35.160(a);

f. denying Plaintiffs and the Prisoners with Disabilities Subclass they represent "the opportunity to participate in or benefit from [an] aid, benefit, or service" provided by Defendants, 28 C.F.R. § 35.130(b)(1)(i);

g. failing to make "reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability," 28 C.F.R. § 35.130(b)(7);

h. failing to make available information to the Prisoners with Disabilities Subclass about their rights under the ADA while detained in the Jail, *see* 28 C.F.R. § 35.106;

i. failing to "adopt and publish grievance procedures providing for prompt and equitable resolution of complaints alleging any action that would be prohibited by … [the ADA]," 28 C.F.R. § 35.107(b);

j. failing to "maintain in operable working condition those features of facilities and equipment that are required to be readily accessible to and usable by persons with disabilities by the [ADA]," 28 C.F.R. § 35.133(a); and

k. failing to "furnish appropriate auxiliary aids and services where necessary to afford individuals with disabilities … an equal opportunity to participate in, and enjoy the benefits of, a service, program, or activity of a public entity," 28 C.F.R. § 35.160(b)(1).

396. As a result of Defendants MONTEREY COUNTY and SHERIFF'S

OFFICE's policy and practice of discriminating against and failing to provide reasonable accommodations to prisoners with disabilities, Plaintiffs and the Prisoners with Disabilities Subclass they represent do not have equal access to Jail activities, programs, and services for which they are otherwise qualified.

WHEREFORE, Plaintiffs and the Prisoners with Disabilities Subclass they represent request relief as outlined below.

SIXTH CAUSE OF ACTION

(Americans with Disabilities Act, 42 U.S.C. § 12188)

By Plaintiffs HERNANDEZ, AGUILAR, COBB, DILLEY, DOBBS, ESQUIVEL, GIST, GOMEZ, GREIM, GUYOT, HOBBS, HUNTER, KEY, MEFFORD, MILLER, MURPHY, NICHOLS, PEREZ, SARABI, WHITFIELD, and YANCEY and the Prisoners with Disabilities Subclass Against Defendant CALIFORNIA FORENSIC MEDICAL GROUP

397. Plaintiffs re-allege and incorporate by reference herein all allegations previously made in paragraphs 1 through 396, above.

398. Defendant CFMG is a public accommodation that owns, leases, leases to, or operates a professional office of a health care provider, hospital, or other service establishment within the meaning of 42 U.S.C. § 12181(7)(F), and Title III of the ADA's implementing regulations, 28 C.F.R. § 36.104.

399. Plaintiffs are all individuals with a disability and covered by Title III of the ADA, 42 U.S.C. §§ 12102(1), 12182(b); 28 C.F.R. § 36.104.

400. By its policies and practices described above, Defendant CFMG violates Title III of the ADA, 42 U.S.C. §§ 12181-12189, by discriminating against individuals with disabilities on the basis of disability, in the full and equal enjoyment of Defendant CFMG's goods, services, facilities, privileges, advantages, or accommodations. 42 U.S.C. § 12182(a); 28 C.F.R., Part 36.

WHEREFORE, Plaintiffs and the Prisoners with Disabilities Subclass they represent request relief as outlined below.

SEVENTH CAUSE OF ACTION

(Rehabilitation Act, 29 U.S.C. § 794)

By Plaintiffs HERNANDEZ, AGUILAR, COBB, DILLEY, DOBBS, ESQUIVEL, GIST, GOMEZ, GREIM, GUYOT, HOBBS, HUNTER, KEY, MEFFORD, MILLER, MURPHY, NICHOLS, PEREZ, SARABI, WHITFIELD, and YANCEY and the Prisoners with Disabilities Subclass Against Defendants MONTEREY COUNTY and MONTEREY COUNTY SHERIFF'S OFFICE

401. Plaintiffs re-allege and incorporate by reference herein all allegations previously made in paragraphs 1 through 400, above.

402. At all times relevant to this action, Defendants MONTEREY COUNTY and SHERIFF'S OFFICE were recipients of federal funding within the meaning of the Rehabilitation Act. As recipients of federal funds, they are required to reasonably accommodate prisoners with disabilities in their facilities, program activities, and services, and to provide a grievance procedure.

403. Plaintiffs and the Prisoners with Disabilities Subclass they represent are qualified individuals with disabilities as defined in the Rehabilitation Act.

404. By their policy and practice of discriminating against and failing to reasonably accommodate prisoners with disabilities, Defendants MONTEREY COUNTY and SHERIFF'S OFFICE violate Section 504 of the Rehabilitation Act, 29 U.S.C. § 794.

405. As a result of Defendants MONTEREY COUNTY and SHERIFF'S OFFICE's discriminating against and failing to provide a grievance procedure and reasonable accommodations, Plaintiffs and the Prisoners with Disabilities Subclass they represent do not have equal access to Jail activities, programs, and services for which they are otherwise qualified.

WHEREFORE, Plaintiffs and the Prisoners with Disabilities Subclass they represent request relief as outlined below.

EIGHTH CAUSE OF ACTION

(Cal. Gov't Code § 11135)

By Plaintiffs HERNANDEZ, AGUILAR, COBB, DILLEY, DOBBS, ESQUIVEL, GIST, GOMEZ, GREIM, GUYOT, HOBBS, HUNTER, KEY, MEFFORD, MILLER, MURPHY, NICHOLS, PEREZ, SARABI, WHITFIELD, and YANCEY and the Prisoners with Disabilities Subclass Against Defendants MONTEREY COUNTY, MONTEREY COUNTY SHERIFF'S OFFICE, and CALIFORNIA FORENSIC MEDICAL GROUP

406. Plaintiffs re-allege and incorporate by reference herein all allegations previously made in paragraphs 1 through 405, above.

407. Defendants receive financial assistance from the State of California as part of Realignment Legislation, California Government Code §§ 30025, 30026, and 30029, and through other statutes and funding mechanisms. Plaintiffs and the Prisoner with Disabilities Subclass they represent are all persons with disabilities within the meaning of California Government Code § 11135.

408. As described in this Complaint, Defendants deny Plaintiffs full access to the benefits of the Jail's programs and activities which receive financial assistance from the State of California and unlawfully subject Plaintiffs and the Prisoners with Disabilities Subclass they represent to discrimination within the meaning of California Government Code § 11135(a) on the basis of their disabilities.

409. From February 2012 through October 2013, through their counsel and through grievances submitted to the Jail, Plaintiffs and the Prisoners with Disabilities Subclass they represent demanded that Defendants stop their unlawful discriminatory conduct described above, but Defendants refused and still refuse to refrain from that conduct.

WHEREFORE, Plaintiffs and the Prisoners with Disabilities Subclass they represent request relief as outlined below.

PRAYER FOR RELIEF

Plaintiffs and the class and subclass they represent have no adequate remedy at law to redress the wrongs suffered as set forth in this Second Amended Complaint. Plaintiffs

have suffered and will continue to suffer irreparable injury as a result of the unlawful acts, omissions, policies, and practices of the Defendants as alleged herein, unless Plaintiffs are granted the relief they request. Plaintiffs and Defendants have an actual controversy and opposing legal positions as to Defendants' violations of the constitutions and laws of the United States and the State of California. The need for relief is critical because the rights at issue are paramount under the constitutions and laws of the United States and the State of California.

WHEREFORE, Plaintiffs AGUILAR, COBB, DILLEY, DOBBS, ESQUIVEL, GIST, GOMEZ, GREIM, GUYOT, HERNANDEZ, HOBBS, HUNTER, KEY, MEFFORD, MILLER, MURPHY, NICHOLS, PEREZ, SARABI, WHITFIELD, and YANCEY, on behalf of themselves, the proposed class and subclass, and all others similarly situated, pray for judgment and the following specific relief against Defendants MONTEREY COUNTY, MONTEREY COUNTY SHERIFF'S OFFICE, CALIFORNIA FORENSIC MEDICAL GROUP, and DOES 1 through 20 as follows:

410. An order certifying that this action may be maintained as a class action pursuant to Federal Rule of Civil Procedure 23(a) and 23(b)(1) and (2);

411. A declaratory judgment that the conditions, acts, omissions, policies, and practices described above are in violation of the rights of Plaintiffs and the class and subclass they represent under the Eighth and Fourteenth Amendments to the United States Constitution, the ADA, the Rehabilitation Act, Article I, Sections 7 and 17 of the California Constitution, and California Government Code § 11135;

412. An order requiring Defendants, their agents, officials, employees, and all persons acting in concert with them under color of state law or otherwise to protect prisoners from substantial risk of harm from other prisoners, to provide minimally adequate medical care to prisoners, to provide minimally adequate mental health care to prisoners, and to cease discriminating against and failing to provide accommodations to prisoners with disabilities;

413. An order enjoining Defendants, their agents, officials, employees, and all

persons acting in concert with them under color of state law or otherwise, from continuing the unlawful acts, conditions, and practices described in this Complaint;

414. An order requiring Defendants and their agents, employees, officials, and all persons acting in concert with them under color of state law or otherwise to develop and implement, as soon as practical, a plan to eliminate the substantial risk of harm, discrimination, and statutory violations that Plaintiffs and members of the class and subclass they represent suffer due to the unlawful acts, omissions, conditions and practices described in this Complaint. Defendants' plan shall include at a minimum the following:

a. Population: Implement appropriate population management so that the number of prisoners is kept at a level that can be safely managed.

b. Staffing: Ensure adequate numbers of correctional staff to ensure the safety and security of the prisoner population.

c. Physical Plant: Remedy all physical plant problems that endanger the safety and security of the prisoner population.

d. Protection from Harm: Take all steps to ensure that prisoners are safe from harm from fellow prisoners.

e. Training: Ensure that corrections staff are adequately trained to carry out their duties to ensure the safety and security of the prisoner population.

f. Classification and Housing: Appropriately classify and house prisoners to ensure their safety and security.

g. Medical Care: Ensure timely access to medical care to treat the serious medical needs of the prisoner population.

h. Access to Care: Ensure timely access to appropriately trained providers and staff to adequately treat prisoners' serious medical needs.

i. Medical Staffing: Ensure adequate numbers of staff by discipline to ensure the timely and appropriate treatment of the prisoner populations' serious medical needs.

j. Emergency Care: Ensure timely access to appropriate emergency care

of prisoner's emergent medical needs.

k. Chronic Care: Ensure appropriate and timely monitoring and care of prisoners' chronic conditions.

l. Medical Records: Ensure appropriate and complete medical records are maintained as necessary to ensure adequate treatment of prisoners' serious medical needs.

m. Specialist and Outside Treatment: Ensure appropriate and timely access to specialists and outside treatment and hospitalization for prisoners who cannot be adequately treated at the Jail.

n. Mental Health Care: Ensure timely access to necessary treatment by qualified staff for serious mental illness, including appropriate medication practices, appropriate therapies, access to hospitalization and inpatient care, appropriate suicide prevention practices and policies, appropriate use of seclusion and restraints, appropriate disciplinary policies and practices regarding the mentally ill, and appropriate training of corrections and mental health staff to recognize and treat prisoners' mental illness.

o. Quality Assurance: Ensure a system that regularly assesses the performance of health care and custodial staff regarding the provision of health services at the Jail against a set of established and appropriate criteria, so that errors and deficiencies in the Jail's health care system are identified and corrected timely.

p. Accommodation for Prisoners with Disabilities: Ensure that the members of the Prisoners with Disabilities Subclass are not denied the benefits of, or participation in, programs, services, and activities at the Jail; that prisoners with disabilities are timely identified and tracked; have their disabilities accommodated; are provided with an effective grievance procedure; are provided with all needed assistive devices and other accommodations; and receive effective communication in all medical, mental health, and due process settings and encounters.

415. An award to Plaintiffs, pursuant to 29 U.S.C. § 794a, 42 U.S.C. §§ 1988, 12205, and California Code of Civil Procedure § 1021.5, of the costs of this suit and

reasonable attorneys' fees and litigation expenses;

416. An order retaining jurisdiction of this case until Defendants have fully complied with the orders of this Court, and there is a reasonable assurance that Defendants will continue to comply in the future absent continuing jurisdiction; and

417. An award to Plaintiffs of such other and further relief as the Court deems just and proper.

Respectfully submitted,

DATED: April 11, 2014

ROSEN BIEN GALVAN & GRUNFELD LLP

By: */s/ Gay Crosthwait Grunfeld*
Gay Crosthwait Grunfeld

DATED: April 11, 2014

OFFICE OF THE PUBLIC DEFENDER
COUNTY OF MONTEREY

By: */s/ James Egar*
James Egar
Public Defender

DATED: April 11, 2014

AMERICAN CIVIL LIBERTIES UNION
OF NORTHERN CALIFORNIA

By: */s/ Alan Schlosser*
Alan Schlosser

DATED: April 11, 2014

ACLU NATIONAL PRISON PROJECT

By: */s/ Eric Balaban*
Eric Balaban