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21 UNITED STATES DISTRICT COURT

22 FOR THE EASTERN DISTRICT OF CALIFORNIA

23 QUENTIN HALL, ROBERT MERRYMAN,
24 DAWN SINGH, and CARLTON FIELDS, on
25 behalf of themselves and all others similarly
26 situated,

27 Plaintiffs,

28 v.

MARGARET MIMS, Sheriff, Fresno County;
EDWARD MORENO, M.D., Director, Fresno
County Department of Public Health; GEORGE
LAIRD, Ph.D., Division Manager, Division of
Correctional Health, Fresno County Department of
Public Health; PRATAP NARAYEN, M.D.,
Medical Director, Division of Correctional Health,
Fresno County Department of Public Health;
RICK HILL, Captain of Detention, Fresno County
Sheriff's Office; MARILYNN WELDON, Captain
of Inmate Programs and Contracts, Fresno County
Sheriff's Office,

Defendants.

Case No.

CLASS ACTION

**CLASS ACTION COMPLAINT FOR
INJUNCTIVE AND DECLARATORY
RELIEF**

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NATURE OF THE ACTION

1. This civil rights class action lawsuit seeks declaratory and injunctive relief to remedy dangerous and unconstitutional conditions in the Fresno County Adult Detention Facilities (“Jail”). Plaintiffs, who are four prisoners in the Jail, bring this action on behalf of themselves and all other prisoners (pretrial and convicted detainees) in the Jail, because they have been and continue to be seriously injured as a result of Fresno County officials’ systemic failure to 1) provide minimally adequate health care, including medical, mental health, and dental care; and 2) protect prisoners from injury and violence from other prisoners. This failure to provide adequate care and safety in the Jail has caused widespread harm, including severe and unnecessary pain and injury, and violates prisoners’ rights under the Eighth and Fourteenth Amendments to the United States Constitution.

2. Defendant Sheriff Margaret Mims is ultimately responsible for the health care and safety of prisoners in the Jail, but she has failed to meet this responsibility. Sheriff Mims and the other Defendants have been deliberately indifferent to the unreasonable risk of harm caused by policies and practices that result in an ineffective health care screening process, an ineffective health care request and referral system, delayed access to health care, under-qualified and insufficient numbers of health care staff, and the delivery of substandard health care. One consequence of such policies and practices is that prisoners with serious mental health conditions are housed in dungeon-like conditions of extreme sensory deprivation where correctional officers attempt to control their untreated mental symptoms with force. Another consequence is that prisoners with serious and chronic medical conditions have suffered from life-threatening symptoms that could have been avoided if they had received timely and adequate medical care.

3. Sheriff Mims and the other Defendants have also been deliberately indifferent to the level of violence among prisoners that is caused, at least in part, by exceedingly low staff-to-prisoner ratios, inadequate classification procedures, and dangerous jail construction design flaws. As a result of this deliberate indifference, prisoners are frequently harmed by assaults or fights with other prisoners in the Jail.

4. Because Defendants know that prisoners live under conditions creating an

1 unreasonable risk of harm but have not responded reasonably to this dire situation, Plaintiffs seek
2 an injunction compelling Defendants to immediately provide them and the class members they
3 represent with constitutionally adequate care and protection from violence and assault from other
4 prisoners.

5 **JURISDICTION**

6 **5.** The jurisdiction of this Court is invoked pursuant to 28 U.S.C. Sections 1331,
7 1343, and 1367. Plaintiffs seek declaratory and injunctive relief under 28 U.S.C. Sections 1343,
8 2201, and 2202; 42 U.S.C. Section 1983; 42 U.S.C. Section 12101 et seq.; and 29 U.S.C. Section
9 794.

10 **VENUE**

11 **6.** Venue is proper in the Eastern District of California under 28 U.S.C. Section
12 1391(b) because Plaintiffs' claims for relief arose in this district, and one or more of the
13 defendants reside in the district.

14 **PARTIES**

15 **7.** Plaintiff Quentin Hall is a prisoner in the Fresno County Jail. Mr. Hall has
16 suffered from hallucinations, delusions, manic and depressive episodes, and severe anxiety as a
17 result of Defendants' failure to provide him with minimally adequate mental health care. After
18 five months of not receiving medically necessary anti-psychotic medications, Mr. Hall was found
19 incompetent to stand trial and sent to Atascadero State Hospital (ASH). Upon his return to the
20 Jail three months later, the ASH discharge summary notified Defendants that he suffered from
21 Schizoaffective Disorder and he needs an anti-psychotic medication to adequately treat his
22 symptoms. Defendants discontinued his anti-psychotic medication within the first 24 hours of his
23 arrival, and they continue to refuse to provide this medically necessary psychotropic medication.
24 As a result, Mr. Hall is suffering from recurring psychosis, depression, anxiety, and insomnia. He
25 has submitted several written requests and grievances for mental health treatment to no avail. Mr.
26 Hall has exhausted his administrative remedies.

27 **8.** Plaintiff Robert Merryman is a prisoner in the Fresno County Jail. Mr. Merryman
28 suffers from serious and chronic diseases including Chronic Obstructive Pulmonary Disease

1 (COPD), and hypertension. Mr. Merryman has described his untreated symptoms in several
2 written requests for medical care and grievances. Medical specialists hired by Defendants have
3 also notified Defendants that Mr. Merryman requires medical care. Nonetheless, Defendants
4 have failed to provide him with even minimally adequate medical care, including, but not limited
5 to, timely access to qualified medical professionals, medically necessary diagnostic testing,
6 medically necessary specialty care, and essential medications. Mr. Merryman was also attacked
7 and injured by another prisoner as a result of Defendants' pattern and practice of understaffing
8 correctional officers and failing to provide adequate supervision. Mr. Merryman has exhausted
9 his administrative remedies.

10 **9.** Plaintiff Dawn Singh is a prisoner in the Fresno County Jail. Prior to her
11 incarceration, Ms. Singh was diagnosed with Crohn's disease. Since her incarceration, Ms. Singh
12 has suffered from excruciating medical symptoms for two years as a result of Defendants' failure
13 to adequately treat her Crohn's Disease. These symptoms include hemorrhaging, abdominal pain
14 and cramping, diarrhea, fevers, dehydration and fatigue. Ms. Singh has written dozens of
15 requests for health care and filed grievances describing these symptoms. Medical specialists
16 hired by Defendants have also notified Defendants that Ms. Singh requires medical care.
17 Regardless, Defendants have failed to provide her with timely access to qualified professionals,
18 medically necessary diagnostic testing, and medically necessary specialty and follow-up care.
19 Ms. Singh has exhausted her administrative remedies.

20 **10.** Plaintiff Carlton Fields is a prisoner in the Fresno County Jail. Mr. Fields suffered
21 from a severely painful, swollen, and infected tooth for at least two weeks as a result of
22 Defendants' failure to provide him with adequate dental care. During that two-week period, he
23 made several written requests for dental care, spoke with several correctional officers, and
24 submitted a grievance describing his symptoms. Although he belatedly received dental care for
25 his infection, he is still suffering from painful and bleeding gums, and he is at risk of serious and
26 irreversible tooth decay as a result of Defendants' failure to provide him with adequate dental
27 hygiene tools. Mr. Fields has exhausted his administrative remedies.

28 **11.** Defendant Sheriff Margaret Mims is the Sheriff of the County of Fresno. She is

1 sued in her official capacity. In her capacity as Sheriff, she is ultimately responsible for the
2 safekeeping of all prisoners in the Jail. These responsibilities include, but are not limited to, the
3 operation and administration of all of the Jail facilities. Sheriff Mims has contracted with the
4 Fresno County Department of Public Health to provide all health care services in the Jail, but by
5 statute retains the ultimate county authority over the health care and treatment of the plaintiff
6 class.

7 **12.** Defendant Edward Moreno is the Director of the Department of Public Health. He
8 is sued in his official capacity. He is responsible for the provision of health care services,
9 including medical, dental, and mental health care, to all prisoners in the Jail. His responsibilities
10 include, but are not limited to, approving all policies and procedures for the delivery of health
11 care in the Jail.

12 **13.** Defendant George Laird is the Division Manager of the Division of Correctional
13 Health in the Fresno County Department of Public Health. He is sued in his official capacity. He
14 is responsible for supervising the operation and administration of health care services in the Jail.

15 **14.** Defendant Pratap Narayan is the Medical Director of the Division of Correctional
16 Health in the Fresno County Department of Public Health. He is sued in his official capacity. He
17 is responsible for the delivery of health care services to all prisoners in the Jail.

18 **15.** Defendant Rick Hill is the Captain of Detention in the Jail. He is sued in his
19 official capacity. His responsibilities include, but are not limited to, custody operations, prisoner
20 classification, correctional officer training, security emergency response, and prisoner grievances.

21 **16.** Defendant Marilyn Weldon is the Captain of Inmate Programs and Contracts.
22 She is sued in her official capacity. Her responsibilities include, but are not limited to, the
23 oversight of the contract with the Department of Public Health for the delivery of health care in
24 the Jail.

25 **CLASS ACTION ALLEGATIONS**

26 **17.** Plaintiffs bring this action on their own behalf and, pursuant to Rule 23(a), b(1),
27 and (b)(2) of the Federal Rules of Civil Procedure, on behalf of all adult men and women
28 (“prisoners”) who are now, or will be in the future, in the custody of the Fresno County Sheriff

1 and who are now, or will be in the future, subject to an unreasonable risk of harm due to the
2 following policies and practices:

- 3 (a) Denial of minimally adequate medical care,
- 4 (b) Denial of minimally adequate mental health care,
- 5 (c) Denial of minimally adequate dental care, and
- 6 (d) Denial of protection from injury and violence from other prisoners.

7 **18.** The class is so numerous that joinder of all members is impracticable. There are
8 currently more than 2,300 prisoners in the Jail, and the population is expected to grow to more
9 than 2,700 prisoners in April 2012 due to AB 109, which is a legislative measure designed to
10 reduce the state prison population by housing more prisoners in county jails (“realignment”). All
11 prisoners are at risk of developing serious medical, dental, or mental health conditions while in
12 the Jail, and while the exact number is unknown, plaintiffs believe there are hundreds of prisoners
13 at any given time who already have serious medical, dental, and/or mental health conditions. All
14 prisoners in the Jail are at risk of injury and violence from other prisoners. Finally, although the
15 exact number is unknown, plaintiffs believe there are scores of prisoners with disabilities who are
16 unable to receive reasonable accommodations.

17 **19.** There are questions of law and fact common to the class including 1) whether the
18 failure to provide minimally adequate medical, dental, and mental health care violates the Due
19 Process Clause of the Fourteenth Amendment and the Cruel and Unusual Punishment Clause of
20 the Eighth Amendment to the United States Constitution; and 2) whether the failure to protect
21 prisoners from injury and violence from other prisoners violates the Due Process Clause of the
22 Fourteenth Amendment and the Cruel and Unusual Punishment Clause of the Eighth Amendment
23 to the United States Constitution.

24 **20.** Since the number of class members is more than 2,300, separate actions by
25 individuals would in all likelihood result in inconsistent and varying decisions, which in turn
26 would result in conflicting and incompatible standards of conduct for the defendants.

27 **21.** Defendants have acted on grounds that apply generally to the class, so that final
28 injunctive or corresponding declaratory relief is appropriate respecting the class as a whole.

1 conscientiously train and supervise the conduct of such persons after their employment, and to
2 provide timely access to minimally adequate care. Defendants' conduct demonstrates deliberate
3 indifference and a reckless disregard for prisoners' Eighth and Fourteenth Amendment rights.

4 **A. Defendants Maintain Insufficient Health Care Staffing to Provide Adequate**
5 **Health Care to Prisoners.**

6 **26.** Defendants' have a policy and practice of maintaining fewer health care positions
7 than are necessary to adequately treat the number of prisoners in the jail. There are insufficient
8 medical, dental, and mental health clinicians (i.e., physicians, psychiatrists, psychologists,
9 therapists, social workers, and registered nurses) to provide adequate care to over 2,300 prisoners.
10 This is a major contributing factor in the woefully inadequate health care delivery system in the
11 Jail. For example, there are not enough staff to timely respond to prisoners' requests for health
12 care, or to adequately screen, monitor, and provide follow-up care to prisoners who are suffering
13 from serious and chronic illnesses. This problem is exacerbated between the hours of 11 p.m. and
14 7 a.m. when the most prisoners are booked into the Jail and the only medical providers serving
15 2,300 prisoners located in three different buildings (North Jail, South Annex Jail, and Main Jail)
16 are four nurses.

17 **27.** The Jail has not always been so severely understaffed. Over the last few years, in
18 response to Fresno County budget cuts, Defendants have systematically eliminated staffing
19 positions for health care providers in the Jail, including physicians, nurse practitioners, registered
20 nurses, and psychiatric technicians. They have eliminated these positions in the face of dire
21 warnings from health care providers during budget hearing testimony that prisoner-patients would
22 suffer serious harm or death from delayed access to care, delayed response time to emergencies,
23 poor medication management practices, and entry-level providers practicing outside the scope of
24 their licensure. Defendants ignored these warnings, and prisoner-patients are now suffering from
25 inadequate health care as a result of their deliberate indifference.

26 **28.** As a result of these staffing shortages, Licensed Vocational Nurses (LVNs) and
27 Psychiatric Technicians (LPTs) make sole determinations about whether prisoners should be seen
28 by clinicians in response to requests or referrals for health care. But, according to the California

1 Board of Vocational Nurses and Psychiatric Technicians, LVNs and LPTs are entry level health
2 care providers who must only practice under the direct supervision of physicians, psychologists,
3 registered nurses, social workers, or other qualified professionals, and are not qualified to do their
4 own patient evaluations or assessments. Nonetheless, the LVNs and LPTs are tasked with
5 independently assessing and responding to prisoners' health care requests and correctional
6 officers' referrals for health care, and therefore serve as de facto gatekeepers for further
7 treatment.

8 **29.** For example, Defendants rely upon these entry-level providers to act as
9 gatekeepers for mental health treatment. In many instances, LPTs erroneously determine that
10 prisoners with documented histories of mental illness and serious ongoing mental health
11 conditions do not warrant treatment by mental health clinicians. These same low-level employees
12 also make unsupervised decisions about whether and where mentally ill prisoners who are
13 potentially a danger to themselves or others should be housed in the Jail, decisions that can have
14 serious or even life-threatening consequences.

15 **B. The Screening and Intake Process for Serious Illnesses, Mental Health**
16 **Conditions, and Communicable Diseases Is Inadequate.**

17 **30.** Defendants have a policy and practice of failing to adequately identify and treat
18 the health care problems of newly arriving prisoners during the screening and intake process. As
19 prisoners are booked into the Jail, they are placed in an open holding cell with other prisoners. A
20 nurse, sitting on the other side of a glass window, asks the prisoners a series of questions about
21 any medical symptoms or treatment. In front of other prisoners, the newly arriving prisoners
22 must divulge personal and private information about their health loudly enough so that the nurse
23 can hear them through the window. Not only is this process humiliating and demeaning, it is
24 dangerous because many prisoners reasonably do not want other prisoners to know about their
25 private health care, especially their mental health histories, and therefore fail to divulge all of the
26 information needed to house them safely and provide adequate health care.

27 **31.** Defendants have a policy and practice of failing to identify prisoners with
28 communicable diseases and serious illnesses during the screening and intake process. For

1 example, medical staff do not adequately screen for tuberculosis. Although tuberculosis is highly
2 contagious and potentially deadly, prisoners do not receive testing for this disease until several
3 weeks or even sometimes several months after they arrive, if they are ever tested at all.

4 **32.** Defendants have a policy and practice of failing to adequately identify prisoners
5 who are experiencing mental health symptoms and who are at risk of suicide during the screening
6 and intake process. The form used during all screenings does not even prompt the nurse
7 conducting the admission interview to ask any questions about current mental health symptoms or
8 past mental health treatment. Instead, the form only asks two questions related to mental health:
9 “Have you ever tried to commit suicide?” and “Are you currently taking any prescription drugs?”
10 These questions fall far short of eliciting the requisite screening information about whether the
11 prisoner has serious mental health needs.

12 **C. The Process for Prisoners to Request Health Care Is Inadequate.**

13 **33.** Defendants have a policy and practice of failing to provide a reliable way for
14 prisoners to alert health care staff of their need for evaluation of medical, mental health, or dental
15 problems. To request health care, prisoners are instructed to use the Medical Request for Services
16 form, which is a green form commonly called a “green slip.” If prisoners tell health care
17 providers who happen to be in their housing units about their symptoms, they are told to “fill out
18 a green slip.” After filling out green slips, prisoners must give them to correctional officers, who
19 do not always forward those completed green slips to the appropriate health care providers. In
20 some instances, correctional officers refuse to give prisoners green slips to fill out when prisoners
21 request them, or they mock prisoners for their symptoms, whether written on a green slip or told
22 to them directly.

23 **34.** When and if health care providers receive green slips from prisoners, they often do
24 not provide a timely response. For example, Plaintiff Dawn Singh never received a response to
25 seven green slips she submitted from September through December 2009 complaining of rectal
26 bleeding, abdominal cramping, and frequent bowel movements. In June 2011, health care
27 providers failed to evaluate another prisoner in response to her green slips describing symptoms
28 related to uncontrolled high blood pressure, including blurred vision, arm pain, and heart

1 palpitations.

2 **35.** The failure to timely respond to green slips is caused, at least in part, by
3 Defendants' failure to create an effective tracking and scheduling system for health care
4 appointments. Another contributing factor is there are no standardized protocols dictating when
5 prisoners should receive a face-to-face appointment with a nurse or other medical, dental, or
6 mental health care clinician. Consequently, health care providers arbitrarily determine whether
7 the content of a green slip, often written by a prisoner who can barely read or write, warrants an
8 examination.

9 **36.** In some instances, medical staff members respond to green slips solely in writing.
10 For example, in response to green slips from one prisoner dated January 3 and 6, 2011, describing
11 headaches and dizziness after a head injury, the sole response from medical staff was a written
12 note telling him to buy Motrin and Tylenol from the canteen. In another example, medical staff
13 failed to respond to a prisoner's green slips describing alarming and serious high blood pressure
14 symptoms, and instead admonished her in a written response to take medications she had already
15 explained were not helping and may have been worsening her symptoms.

16 **D. Prisoners Suffer from Unreasonably Delayed Access to Health Care.**

17 **37.** Defendants have a policy and practice of failing to provide timely access to health
18 care. If prisoners are seen by health care providers at all, they often experience unreasonable
19 delays in receiving those appointments. Prisoners commonly wait several weeks, sometimes
20 several months, before they are evaluated by clinicians for medical, mental health, or dental
21 symptoms. For example, one prisoner waited at least six months before he was evaluated by a
22 physician in response to at least nine green slips and a grievance describing debilitating
23 migraines. While he waited, he spent days at a time curled up in a fetal position on his bed with
24 his head under the blankets trying to manage the pain. Another prisoner is still waiting to be
25 evaluated by a physician in response to green slips requesting asthma and seizure medications
26 that he submitted over five months ago. In fact, since he arrived in April 2011, he has never been
27 examined by a health care provider even though Jail medical staff verified four months after
28 admission that he has been provided seizure and psychiatric medications by the state prison

1 medicine, but Defendants do not consistently follow that standard of care.

2 **40.** Defendants have a policy and practice of making treatment decisions without
3 examining prisoners. In some instances, they rely solely on brief notes or reports from nurses or
4 medical assistants. For example, instead of examining Plaintiff Merryman after a nurse
5 documented that he was complaining of chest and abdominal pain, his physician simply ordered a
6 refill of his pain medications and an EKG. Due to Mr. Merryman's co-existing and serious
7 medical conditions, the minimum standard of care would have been for the physician to examine
8 him to ensure that the abdominal pain he experienced was not the result of an infection.

9 **41.** In other instances, physicians make treatment decisions even though there is no
10 recent medical information whatsoever in a prisoner's medical records. For example, Plaintiff
11 Merryman's physician prescribed a certain medication on May 23, 2011 without taking or
12 checking any laboratory tests, which is contrary to the standard practice when prescribing such
13 medication and put him at risk of conditions including cardiac arrhythmia. In some instances,
14 physicians prescribe medication based solely on correctional officers' description of prisoners'
15 symptoms. For example, a physician increased a prisoner's blood pressure medications on
16 January 26, 2011, based solely on a correctional officer's report that his legs were swollen.

17 **42.** Defendants have a policy and practice of failing to provide complete examinations,
18 including after significant illnesses have been identified and/or documented. For example, even
19 though Plaintiff Singh consistently complained of abdominal cramping, weight loss, watery
20 stools, and had a documented history of small bowel surgery, she did not receive a rectal
21 examination, which is the standard of care, for at least a year and a half after she began requesting
22 treatment. Also, although her physician did not complete a rectal examination or consult with a
23 gastrointestinal specialist, he prescribed a dangerous and aggressive course of steroid treatment
24 on October 18, 2010. Once Ms. Singh was finally seen by a specialist almost four months after
25 she was belatedly referred by the Jail physician, the medication regimen was immediately
26 discontinued.

27 **43.** Defendants have a policy and practice of failing to order diagnostic testing or refer
28 prisoners to specialists when medically necessary. For example, after a prisoner injured his head

1 in a fall on or around January 1, 2011, his physician failed to test for infection until his wound
2 was emitting a foul odor one month after the injury, even though it was showing signs of
3 infection for over two weeks. This prisoner has a compromised immune system due to cirrhosis,
4 and his physician should have known that he was at high risk of infection. After the delayed test
5 came back positive for a staph infection, the physician failed to refer him to a specialist to
6 determine the extent of the infection. His physician failed to make this referral even though the
7 infection was potentially life-threatening due to his compromised immune system and the
8 infection's proximity to his brain.

9 **44.** Plaintiff Dawn Singh was not referred to a specialist for her Crohn's disease for
10 over a year even though she had ongoing symptoms of severe abdominal pain, diarrhea,
11 dehydration, and fatigue. After she was referred on September 16, 2011, Jail medical staff failed
12 to follow-through and contact the specialist to schedule an appointment. The Jail physician did
13 not discover this failure until two months later in November 2011 when he evaluated Ms. Singh
14 for bloody diarrhea, a common symptom of a Crohn's Disease flare-up, and re-referred her to the
15 specialist. Ms. Singh was forced to wait almost two more months until she was finally seen by
16 the specialist on January 6, 2011.

17 **45.** Another prisoner told the screening nurse upon her arrival in May, 2011 that she
18 had a history of kidney failure. Contrary to the standard of care, Defendants failed to obtain her
19 community records or perform laboratory tests to determine the severity of her kidney disease.
20 Defendants failed to evaluate her in response to her repeated green slips describing blurred vision,
21 headaches, swelling in her extremities, difficulty urinating, nausea, vomiting, and high blood
22 pressure. Also contrary to the standard of care, Defendants failed to order urgent diagnostic tests
23 in response to these symptoms to determine whether her kidneys were functioning properly.
24 Blood tests were finally taken for the first time three months after her arrival on July 29, 2011.
25 These tests showed that she was at risk of death from kidney failure and a dangerously high
26 potassium level, but a physician did not review her blood test results until seven days later on
27 August 4, 2011, at which time she was hospitalized. She remained hospitalized until August 12,
28 2011, and put on dialysis three times a week. If Defendants had provided treatment according to

1 the standard of care, her worsening kidney failure would have been caught months earlier,
2 certainly delaying, if not averting the need for dialysis.

3 **46.** If physicians prescribe treatment, or when prisoners return from the hospital, or
4 when they are discharged from the Jail infirmary, Defendants have a policy and practice of failing
5 to monitor symptoms and provide follow-up treatment. For example, Plaintiff Dawn Singh
6 received a colonoscopy on July 20, 2011. Although her colonoscopy results were not normal, and
7 her specialist subsequently recommended additional diagnostic tests to rule out fungal infections
8 and tuberculosis, the Jail physician failed to order this follow-up care, and she was not re-
9 evaluated by a physician until her next specialty appointment two months later. The specialist
10 again ordered the same diagnostic tests because they are necessary before she can begin receiving
11 treatment for her active Crohn's Disease.

12 **47.** Plaintiff Bob Merryman was hospitalized for three days in July 2011, where he
13 was diagnosed with moderate to severely high blood pressure in his lungs, cirrhosis, and large
14 swollen blood vessels in his esophagus. The discharge summary recommended follow-up
15 appointments with a gastro intestinal (GI) specialist and pulmonary specialist in one week. Mr.
16 Merryman was not seen by the GI specialist until five months later on December 1, 2011, and he
17 has not been seen by the pulmonary specialist, despite the fact that more than five months have
18 elapsed since it was prescribed.

19 **48.** Defendants have a policy and practice of failing to prescribe medically necessary
20 medications, including for serious and chronic diseases such as Chronic Obstructive Pulmonary
21 Disease (COPD), hypertension, asthma, seizure disorders, and cirrhosis. Physicians fail to
22 prescribe these medications even after prisoners and their families have notified medical staff of
23 valid prescriptions written prior to the prisoner's arrival at the Jail, either in the community before
24 incarceration, in the state prison system, or during previous incarcerations in the Jail. Prisoners
25 are often labeled as "drug-seeking" even when they are requesting medications that have no street
26 value or intoxication effects.

27 **49.** For example, Plaintiff Robert Merryman's physician labeled him as "drug-
28 seeking," even though he had not fully evaluated him for his complaints and the medications Mr.

1 Merryman sought were to treat his COPD, cirrhosis, and high blood pressure. His physician
2 inexplicably delayed for two months prescribing medications to control the swelling in his legs,
3 which is a clear departure from the standard of care. Another prisoner did not receive his
4 cirrhosis medications until he was hospitalized for internal bleeding and vomiting on March 26,
5 2011, despite the fact that Defendants were notified of a pre-existing prescription for cirrhosis
6 medications over two months earlier, on January 13, 2011.

7 Substandard Mental Health Care

8 **50.** Defendants have a policy and practice of failing to provide medically necessary
9 psychotropic medications to prisoners with serious mental health conditions. They fail to provide
10 these medications even when provided with valid prescriptions from the California Department of
11 Mental Health, community providers, family members, or the California Department of
12 Corrections and Rehabilitation (CDCR).

13 **51.** Prisoners with serious mental health conditions who have long and documented
14 histories of receiving anti-psychotic or mood-stabilizing medications are often labeled as “drug-
15 seeking” or “malingering” by mental health staff when they seek these medications in the Jail. In
16 some instances, they are prescribed medications which are known not to be effective in treating
17 their psychosis or mood disorders.

18 **52.** As a result of Defendants’ pattern and practice of failing to provide medically
19 necessary psychotropic medications, prisoners with psychotic and mood disorders suffer from the
20 following: 1) withdrawal symptoms when the medications they were prescribed before admission
21 to the Jail are abruptly terminated; 2) recurrence of debilitating symptoms such as hallucinations
22 and suicidality; and 3) in some cases, decompensation to the point of being found incompetent to
23 stand trial and/or being sent to the State Hospital until they are stable enough to return to the Jail.

24 **53.** For example, after five months in the Jail, Plaintiff Quentin Hall was sent to
25 Atascadero State Hospital (ASH) to receive mental health treatment after two court-appointed
26 psychologists found him to be incompetent to stand trial due to untreated mental health
27 symptoms. While at ASH, Plaintiff Quentin Hall was diagnosed as suffering from
28 Schizoaffective Disorder. They also worked with him to find the right anti-psychotic medication

1 to effectively manage both the mood and psychotic symptoms he experienced and that are
2 commonly associated with this diagnosis. Despite these efforts, the Jail psychiatrist discontinued
3 this medication within 24 hours of Mr. Hall's discharge from ASH to the Jail.

4 **54.** The Jail psychiatrist claimed he discontinued Mr. Hall's anti-psychotic medication
5 at least in part because he believed that the treatment providers at ASH had not ruled out that Mr.
6 Hall was faking his symptoms. The psychiatrist made this determination even though the ASH
7 mental health providers had observed and evaluated Mr. Hall far more extensively than any
8 treatment providers had ever done in the Jail. He also made this determination in the face of two
9 independent findings from court-appointed psychologists that Mr. Hall was too mentally ill to
10 understand his criminal proceedings and/or to assist his attorneys with his defense. After
11 discontinuing the anti-psychotic medication that had proven effective in treating Mr. Hall's
12 rapidly alternating manic and depressive moods, persecutory delusions, and auditory
13 hallucinations, the Jail psychiatrist prescribed him the same class of anti-depressant medications
14 that had led to his decompensation in the Jail before he was sent to ASH.

15 **55.** Defendants have a policy and practice of failing to evaluate prisoners before
16 making treatment decisions, including whether to prescribe psychotropic medications. For
17 example, in May 2011, a prisoner's psychiatrist prescribed an anti-depressant based solely on an
18 LVN's note stating that the prisoner wished to start an anti-depressant and a mood stabilizer.
19 Also, Plaintiff Hall's psychiatrist has repeatedly increased and decreased his anti-depressants
20 without evaluating him.

21 **56.** Defendants also have a policy and practice of failing to monitor and provide
22 follow-up treatment, even after they have prescribed anti-depressant medications. In fact, after a
23 Jail psychiatrist prescribes an anti-depressant, it is common practice for psychiatrists to rely
24 solely on nurses' and LPTs' treatment notes, as opposed to personally evaluating prisoners, to
25 monitor for side effects, effectiveness, and/or to determine whether medications should be
26 adjusted, renewed, or discontinued. This practice is dangerous because nurses and LPTs are not
27 qualified to adequately identify, assess, and diagnosis complications, side effects, or symptoms
28 that may be caused by anti-depressant medications.

Substandard Dental Care

1
2 **57.** Defendants have a policy and practice of failing to provide medically necessary
3 dental services. As a general rule (with only very limited exceptions), the only dental service
4 available in the Jail is tooth extraction, even if a much less invasive procedure may be medically
5 appropriate and necessary. Most prisoners are not even permitted to see a dentist until after they
6 tell a dental assistant they are willing to have a tooth extraction.

7 **58.** Prisoners are therefore faced with a horrible dilemma—they can either lose a tooth
8 that might otherwise be saved, or suffer unbearable pain and discomfort. Some prisoners deal
9 with this dilemma by initially refusing to have minor conditions such as cavities treated with
10 extractions, but then eventually acquiescing after they suffer from long periods of time without
11 treatment. In some instances, after prisoners refuse to have minor conditions treated with
12 extractions, their conditions worsen until extractions become the only treatment option available.
13 Many prisoners are so terrified of having their teeth pulled that they refuse to seek any dental
14 services and instead suffer in pain, which puts them at risk of serious complications and
15 additional health risks from infection.

16 **59.** The failure to provide medically necessary dental care is aggravated by
17 Defendants' pattern and practice of failing to provide adequate tools to prisoners to clean their
18 teeth. For those prisoners who are incarcerated for long periods of time, it is inevitable that their
19 teeth deteriorate given the inadequate dental hygiene tools and lack of dental care provided. One
20 prisoner has had six teeth pulled over the seven consecutive years he has been in the Jail, and he
21 is currently experiencing pain in two more untreated teeth. This prisoner is only 44 years old and
22 never had any problems with his teeth before he was arrested.

23 **F. Defendants Fail to Keep Complete and Adequate Health Care Records.**

24 **60.** Defendants have a policy and practice of failing to maintain adequate, accurate,
25 and complete health care records. For example, physicians and psychiatrists often change
26 prisoners' medications without documenting any explanations. Psychiatrists fail to document
27 adequate justification and reasoning for changing the diagnoses and treatment plans for prisoners
28 returning to the Jail from psychiatric hospitals. Dental providers fail to keep x-ray results in

1 prisoners' health care files. Defendants also fail to maintain prisoners' written requests for health
2 care ("green slips") in their health care files. As a result of Defendants' failure to maintain
3 adequate health care records, prisoners suffer from an unreasonable risk of misdiagnosis,
4 dangerous mistakes, and unnecessary delays in care.

5 **G. Defendants' Failure to Provide Minimally Adequate Health Care Directly**
6 **Causes Other Unconstitutionally Harmful Policies and Practices.**

7 **61.** Defendants' policy and practice of denying minimally adequate health care give s
8 rise to other policies and practices that result in significant harm and injury to prisoners, in
9 violation of their Constitutional rights.

10 **Solitary Confinement for Prisoners with Serious Mental Health Conditions**

11 **62.** As a result of Defendants' policy and practice of denying medically necessary
12 psychotropic medications, many prisoners with serious mental conditions are unable to conform
13 to Jail rules or be safely housed in cells with other prisoners. In response, rather than provide
14 them with the medications they need, Defendants have a policy and practice of housing these
15 prisoners in isolation in the FF units of the Main Jail and Unit 2D of the South Annex Jail.
16 Prisoners in these maximum security housing units experience conditions of extreme isolation
17 and reduced environmental stimulation. Defendants are deliberately indifferent to how these
18 conditions exacerbate mental health symptoms.

19 **63.** In Unit 2D of the South Annex Jail, prisoners with serious mental health
20 conditions are housed by themselves in small cells at least 23 hours a day. There is no natural
21 light in the cells, and they do not have clocks. Thus, prisoners lose track of time and often have
22 no idea whether it is day or night, or how much time has passed. The inability to keep track of
23 time exacerbates these prisoners' already existing mental health symptoms.

24 **64.** The only type of human contact the prisoners on Unit 2D have on most days is
25 when they are given their food through a slot in the door, or when they hear other prisoners (who
26 may be psychotic, incoherent, and distressed themselves) yelling from their cells. They are not
27 touched by another human being unless they are being shackled. The single window they have to
28 the corridor outside is covered so no one can see in or out of the cells. The conditions in Unit 2D

1 are so bleak that staff and prisoners commonly refer to it as “the dungeon.” These conditions are
2 traumatic for all prisoners, but especially for those who are already suffering from mental health
3 symptoms.

4 **65.** Many of the prisoners with serious mental health conditions are placed in isolation
5 in Unit 2D and the FF pods as punishment for an inability to follow Jail rules. But many of these
6 prisoners would not have violated Jail rules had they been receiving adequate mental health
7 treatment, especially psychiatric medications. For example, one prisoner requested mental health
8 treatment and anti-psychotic medications to help control his psychotic symptoms and impulses
9 for several weeks in July and August of 2010 without any response. On September 3, 2011, he
10 could no longer control his impulses, and he threw his food tray and responded violently to
11 correctional officers’ attempts to restrain him. He was subsequently moved to Unit 2D where he
12 has been housed ever since.

13 **66.** Defendants exacerbate the psychological trauma experienced by prisoners with
14 serious mental health conditions who are housed in isolation by failing to provide them with
15 necessary mental health care. These prisoners do not receive regular contact with mental health
16 providers (if they receive mental health care at all), nor do they receive the group therapy that is
17 periodically provided to prisoners in other housing locations. As a result, their nonconforming
18 behaviors escalate and they are forced to stay in isolation even longer with very little prospect of
19 release to the general population.

20 **Force Used on Prisoners with Serious Mental Health Conditions**

21 **67.** As a result of Defendants’ policy and practice of failing to prescribe medically
22 necessary psychotropic medications, some prisoners with serious mental conditions exhibit
23 nonconforming and erratic behaviors that correctional officers attempt to control with force.
24 They use force without regard to the traumatic impact of such measures, and without first
25 attempting clinical intervention.

26 **68.** Correctional officers fire nonlethal bullets at close range at prisoners who are
27 obviously in psychiatric distress. They aim their nonlethal rifles and weapons at prisoners with
28 mental health conditions even when it is not necessary and results in psychological trauma.

1 cut his arm with a razor in May, 2011. Just before he cut his arm, correctional officers in his unit
2 notified Jail mental health providers that he was making suicidal comments. A Licensed
3 Psychiatric Technician, who is not licensed or qualified to diagnose or treat prisoners, evaluated
4 him in response and determined he was not suicidal. He was taken to the emergency room 40
5 minutes later with deep, self-inflicted cuts to his arm. From the emergency room, he was
6 admitted directly into a psychiatric facility for five days where he was given the psychotropic
7 medications he required. Upon his return from the hospital, Defendants failed to continue his
8 psychotropic medications and did not provide follow-up treatment. They also gave him access to
9 another razor.

10 **73.** About a week later, this prisoner cut his arm and leg with a razor, except this time
11 the cuts were so deep he required 19 staples in his wounds to help them heal. He was
12 hospitalized again, this time for four days, where he received medically necessary psychotropic
13 medications. Upon his second return to the jail, Defendants again failed to continue his
14 psychotropic medications and housed him in maximum security isolation for four weeks, where
15 correctional officers could not provide direct supervision due to the window to his cell being
16 covered. After he was removed from isolation, he was housed in the South Annex Jail where he
17 had access to razors and tools to hang himself on the bars. He has finally been prescribed a
18 psychotropic medication in the Jail, although it is a different medication than he had been
19 prescribed at the psychiatric facility and has proved ineffective in treating his symptoms. He
20 then cut his arm with a razor and had to be emergently hospitalized for the third time in
21 November, 2011.

22 **74.** Due to the construction design of the South Annex Jail and the inadequate custody
23 staffing patterns discussed in detail in Section II below, it is nearly impossible for custody staff to
24 witness a suicide attempt unless they happen to be walking down the line at the right moment.
25 And since there are only two officers on each floor with many custodial responsibilities
26 supervising over 200 prisoners, the chances are slim that they will be able to prevent a suicide.
27 Defendants are deliberately indifferent to how the failure to provide minimally adequate health
28 care heightens the already existing risk of suicide caused by inadequate staffing patterns and

1 construction design flaws in the Jail.

2 **Substandard Housing Conditions**

3 75. Defendants have a pattern and practice of housing and segregating prisoners with
4 serious mental health conditions in the facility with the worst living conditions, the South Annex
5 Jail. This facility has been deemed unfit for housing prisoners (see para graph 84 below) and is
6 especially traumatic for prisoners with serious mental health conditions. It is extraordinarily hot
7 with poor circulation in the summer and so frigid on cold winter days that prisoners spend most of
8 their time shivering under their blankets in bed because they are not permitted extra clothing.
9 There is very little access to natural light throughout this facility. There are serious problems
10 with the plumbing, and the water is often shut off. Nonetheless, Defendants have chosen to locate
11 the “psychiatric housing” on the third floor of this dilapidated facility without regard for how
12 these conditions especially traumatize prisoners with serious mental health conditions.

13 **Inadequate Pre-Release Planning**

14 76. Defendants have a policy and practice of releasing prisoners with serious health
15 care conditions from the Jail without providing them with any services to ensure that their health
16 care is not disrupted. For those prisoners who are prescribed medications in the Jail, they are
17 released without either a supply or a prescription for them to fill those medications at a
18 community pharmacy. Defendants do not schedule follow-up appointments in the community,
19 nor are prisoners provided with any referrals or information about where they may receive health
20 care services or medications.

21 77. Defendants have knowledge of the unreasonable risk of harm caused by
22 inadequate health care in the Jail and the derivative harmful policies and practices including, but
23 not limited to, inadequate suicide precautions, and housing prisoners with serious mental
24 conditions in isolation. Defendants have failed to take steps to prevent, or even to diminish, the
25 harmful effects of these unlawful policies and practices.

26 **II. FAILURE TO PROTECT PRISONERS FROM VIOLENCE**

27 78. Prisoners face an unreasonable risk of harm from violence at the hands of other
28 prisoners due to Defendants’ policy and practice of understaffing the Jail and failing to

1 adequately classify prisoners. In all of the Jail facilities, large group fights between prisoners
2 break out regularly and smaller fights between prisoners occur daily. Prisoners regularly assault
3 and victimize vulnerable prisoners. Defendants are deliberately indifferent to the danger of
4 assault faced by prisoners in the Jail.

5 **79.** The Fresno County Adult Detention Facilities include three jails—the Main Jail,
6 North Jail, and South Annex Jail.

7 **Main Jail**

8 **80.** In the Main Jail, most prisoners are housed on the third through sixth floors. The
9 second floor houses 37 prisoners who are medically infirm. The third through sixth floors consist
10 of six “pods,” each containing sixteen small cells. Each cell houses at least three prisoners. There
11 is a common dayroom in each of the pods. The doors to each cell in the pods are left open for
12 most of the day, and prisoners are free to go in and out of the dayroom and other prisoners’ cells.
13 In addition to the six pods, there are ten administrative segregation cells arranged in a line ar
14 fashion.

15 **81.** There is one officer on each floor who sits in an upraised and enclosed viewing
16 station. He or she has no direct contact with prisoners. This officer can see into all of the
17 dayrooms, but cannot see into all of the prisoners’ cells.

18 **82.** There are only two officers on the floor (“floor officers”) providing supervision to
19 over 200 prisoners in the six pods. These officers cannot and do not provide line of sight
20 supervision to more than two pods at any one time, leaving a minimum of over 130 prisoners
21 without direct supervision at any given time. To reach prisoners in a particular pod or
22 administrative segregation cell, the floor officers must typically go through at least two locked
23 doors.

24 **North Jail**

25 **83.** In the North Jail, prisoners are housed on the second through fifth floors. Each
26 floor consists of six pods of dormitories with 72 beds (triple bunks), although each pod is
27 designed to house only 48 prisoners. There is one officer on each floor who sits in an upraised
28 and enclosed viewing station. He or she has no direct contact with prisoners. This officer has

1 limited visibility between and around the triple bunks and in certain corners of the dorms. There
2 are only four floor officers providing direct supervision to over 400 prisoners. These officers
3 cannot and do not provide line of sight supervision to more than four pods at any one time,
4 leaving at least 140 prisoners without direct supervision at any given time.

5 South Annex Jail

6 **84.** The South Annex Jail was built in 1947 and is the oldest facility in the Jail.
7 According to a Fresno County Jail Needs Assessment and Master Plan, dated September 24,
8 2008, “this facility is no longer functional for the housing of inmates.” Nonetheless, there are
9 over 200 prisoners housed on each of the upper three floors of this jail, and there are only two
10 floor officers providing direct supervision on each floor.

11 **85.** Each floor is broken up into separate housing units that contain cells and adjoining
12 dayrooms. Each cell houses four prisoners. The doors to the cells are left open periodically
13 during the daytime, and prisoners are free to go in and out of the dayroom when the cell doors are
14 open. However, when the cell doors are closed, before officers can enter a cell, they must first
15 operate an antiquated system of door controls.

16 **86.** The housing units in the South Annex Jail are located off long corridors. The
17 “control rooms” on each floor, where one officer sits and watches monitors showing limited areas
18 of the jail, have no visibility into the housing units. Officers must walk down the corridors to
19 observe the prisoners in the housing units, and it is easy for prisoners to cease illegal activity
20 before officers can see them. Also, visibility into the cells is severely limited due to the use of
21 steel bars to separate the cells from the dayrooms and corridors. All of the conditions in the
22 South Annex Jail described above make it extremely difficult for officers to prevent and quickly
23 respond to fights or emergencies, and to transport injured or combative prisoners.

24 **87.** In all of the facilities, besides providing general safety and security for 200-400
25 prisoners, the floor officers must supervise and coordinate all prisoner movement to the yard,
26 infirmary, legal visits, and court dates. They must shackle and escort any prisoners in
27 administrative segregation who are removed from or brought back to their cells. They must
28 provide security for nursing staff when prisoners receive their medications. They must also

1 provide security when meal trays, canteen items, and laundry are distributed. These officers are
2 unable to perform all these duties and also protect prisoners from violence.

3 **88.** In all of the facilities, there are blind spots or places out of view of correctional
4 officers for prisoners to hide illegal activity, including assaults. In the Main Jail, to stay out of
5 view, prisoners assault other prisoners in their cells. In the North Jail, prisoners go into dark
6 corners of the dorms, or between the triple bunks. In the South Annex Jail, prisoners in the
7 dayrooms wait until there are no officers present in the corridors or they go into cells to fight or
8 assault others. They also fight or assault each other in the showers.

9 **89.** Indeed, each day prisoners are assaulted by other prisoners, whether it stems from
10 a large drawn-out group fight in the dayroom or the yard, or a quick and vicious assault in a
11 hidden pocket of the Jail. Prisoners know they can fight and engage in violent behaviors in the
12 Jail with impunity because there are not enough correctional officers to supervise and prevent
13 such violence.

14 **90.** Defendants have knowledge of these conditions. A report from the U.S.
15 Department of Justice (“DOJ Report”) warned that the construction design and crowding in the
16 South Annex and North Jails creates a risk of harm to prisoners. It described the risk due to
17 visibility problems, the antiquated door control systems, and the small doorframes in the South
18 Annex Jail. It stated that the “obsolete ‘linear type’ construction” of the South Annex Jail is
19 “very staff intensive and unsafe.” It also warned about the risk of triple bunking 72 prisoners in
20 the North Jail dorms designed to house only 48 prisoners. Finally, the DOJ Report also warned of
21 a risk of harm to prisoners from the bunk beds in the North Jail that are not “correctional grade”
22 fixtures. Thus, prisoners can tamper with the beds to create and hide weapons.

23 **91.** Despite the warnings in the DOJ Report, Defendants have assigned only one
24 officer to provide direct supervision for every 100 (or more) prisoners. This staffing pattern is
25 woefully inadequate to keep prisoners safe.

26 **92.** Defendants have a policy and practice of failing to adequately classify and assign
27 prisoners to housing locations in the Jail where they will be safe from injury and violence. Before
28 prisoners are assigned to certain housing locations in the Jail, they are “classified” based on a

1 number of factors including their criminal charges, gang affiliation, race, and history of violence.
2 These classification procedures are ineffective, however, and prisoners who are incompatible for
3 various reasons, including rival gang memberships and/or histories of assaultive behaviors, are
4 housed together in the Jail. Defendants are deliberately indifferent to how their inadequate
5 classification procedures create a risk of injury from assault.

6 **93.** As a result of Defendants' pattern and practice of understaffing the Jail and failing
7 to assign prisoners to safe housing locations, Plaintiff Merryman was attacked in a dayroom of
8 the Main Jail on June 30, 2011. Mr. Merryman is an older man who is frail due to Defendants'
9 failure to provide him with adequate medical care. The prisoner who attacked Mr. Merryman was
10 obviously experiencing acute mental health symptoms. For two days before the attack, Mr.
11 Merryman observed this prisoner talking to himself, randomly unplugging cords from electrical
12 outlets, and wearing garbage bags over his mouth. On the morning of June 30, 2011, while Mr.
13 Merryman was watching television, this prisoner attacked Mr. Merryman from behind and sliced
14 him two times in the face with a razor. There were no correctional officers inside or near the pod
15 before or during the attack.

16 **94.** After Mr. Merryman was attacked, a group of prisoners began beating the prisoner
17 who sliced his face. Correctional officers did not arrive in the day room until several minutes
18 later. Mr. Merryman went into his cell to stop the bleeding and stay out of the way of the
19 fighting. Before correctional officers came to his cell, he had filled up his jumpsuit and two
20 towels with blood. He subsequently received sutures to treat his wounds and he now has a
21 prominent scar on his cheek. This injury, and the beating of the prisoner with a psychiatric
22 disability who attacked Mr. Merryman, could have been prevented if Defendants had provided
23 adequate supervision and classification procedures in the Jail.

24 **CLAIMS FOR RELIEF**

25 **First Cause of Action** 26 **(Eighth Amendment)**

27 **95.** By their policies and practices described in paragraphs 23 - 94, Defendants subject
28 Plaintiffs and the Plaintiff class to an unreasonable risk of harm and injury from inadequate health

1 care and violence. These policies and practices have and continue to be implemented by
2 Defendants and their agents or employees in their official capacities, and are the proximate cause
3 of Plaintiffs' and the Plaintiff class's ongoing deprivation of rights secured by the United States
4 Constitution under the Eighth Amendment.

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

7 **Second Cause of Action**
8 **(Fourteenth Amendment)**

9 **97.** By their policies and practices described in paragraphs 23 - 94, Defendants subject
10 Plaintiffs and the Plaintiff class to an unreasonable risk of harm and injury from inadequate health
11 care and violence. These policies and practices have and continue to be implemented by
12 Defendants and their agents or employees in their official capacities, and are the proximate cause
13 of Plaintiffs' and the Plaintiff class's ongoing deprivation of rights secured by the United States
14 Constitution under the Fourteenth Amendment.

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

17 **PRAYER FOR RELIEF**

18 **99.** Plaintiffs and the class they represent have no adequate remedy at law to redress
19 the wrongs suffered as set forth in this complaint. Plaintiffs have suffered and will continue to
20 suffer irreparable injury as a result of the unlawful acts, omissions, policies, and practices of the
21 Defendants as alleged herein, unless Plaintiffs are granted the relief they request. The need for
22 relief is critical because the rights at issue are paramount under the Constitution of the United
23 States,

24 **100.** WHEREFORE, Plaintiffs, on behalf of themselves and the class they represent,
25 request that this Court grant them the following relief:

26 A. Declare the suit is maintainable as a class action pursuant to Federal Rule of Civil
27 procedure 23(a) and 23(b)(1) and (2);

28 B. Adjudge and declare that the conditions, acts, omissions, policies, and practices of

1 Defendants and their agents, officials, and employees are in violation of the rights of Plaintiffs
2 and the class they represent under the Eighth and Fourteenth Amendments to the Constitution;

3 C. Order Defendants, their agents, officials, employees, and all persons acting in
4 concert with them under color of state law or otherwise, to provide minimally adequate health
5 care to prisoners, and to protect prisoners from an unreasonable risk of harm.

6 D. Enjoin Defendants, their agents, officials, employees, and all persons acting in
7 concert with them under color of state law or otherwise, from continuing the unlawful acts,
8 conditions, and practices described in this Complaint, and from failing to provide minimally
9 adequate health care and protection to prisoners from an unreasonable risk of harm;

10 E. Award Plaintiffs, pursuant to 42 U.S.C. Sections 1988 and 12205, the costs of this
11 suit and reasonable attorneys' fees and litigation expenses;

12 F. Retain jurisdiction of this case until Defendants have fully complied with the
13 orders of this Court, and there is a reasonable assurance that Defendants will continue to comply
14 in the future absent continuing jurisdiction; and

15 G. Award such other and further relief as the Court deems just and proper.

16
17
18
19 Dated: December 13, 2011

Respectfully submitted,

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21 PRISON LAW OFFICE

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23 By: /s/ Kelly Knapp

24 DONALD SPECTER
25 KELLY KNAPP
26 Attorneys for Plaintiffs
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