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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

SACRAMENTO DIVISION

Estate of NATHAN PRASAD, deceased, by and through MARY PRASAD; MARY PRASAD; T.P., a minor; and A.P, a minor, Plaintiffs, v. COUNTY OF SUTTER; J. PAUL PARKER, Sutter County Sheriff's Department Sheriff; DAVID SAMSON, Sutter County Jail Division Commander; NORMAN BIDWELL, Sutter County Jail Corrections Lieutenant; DORIS BROWN, Sutter County Jail Advanced Registered Nurse Practitioner; MELODY YOUNG, Sutter County Jail Licensed Vocational Nurse; BALJINDER RAI, Sutter County Jail Deputy Officer; SHANE DICKSON, Sutter County Jail Deputy Officer; UNKNOWN JAIL EMPLOYEE I; FREMONT-RIDEOUT HEALTH GROUP; MICHAEL FRATERS, M.D.; and DOES I through XL, Defendants.	Case No. **COMPLAINT** **JURY TRIAL DEMANDED**

[579099-7]

INTRODUCTION

1. This case involves NATHAN PRASAD, a young man denied basic emergency life-saving treatment for a serious infection while detained at Sutter County Jail on minor, non-violent charges. In the course of his approximately one-week detention, NATHAN PRASAD's condition deteriorated from an infection wholly treatable through basic and timely medical attention to an extraordinarily painful death as a result of Sutter County Jail's failure to provide treatment. Sutter County Jail's failure was despite documented observation of his emergent medical problems, including coughing up blood, deteriorating vital signs, and desperate pleas for help by NATHAN PRASAD and other jail inmates.

2. After reporting to jail staff that he was experiencing enormous pain in his lower extremities, he was brought to Rideout Memorial Hospital on January 26, 2011 for further evaluation. Following diagnostic testing on his lower extremities, hospital staff discharged NATHAN PRASAD back to the jail. Doctors provided to jail staff Defendants explicit direction that NATHAN PRASAD be returned to the emergency room *immediately* if his symptoms worsen or new symptoms develop. Hospital staff knew or should have known, however, that the jail's policies and procedures made such immediate return extremely unlikely if not impossible. Hospital staff knew or should have known that jail policies prohibited custody staff from summoning medical attention when jail medical staff were not present, and that jail medical staff were not present during lengthy periods of the day and night.

3. Upon his return to Sutter County Jail, NATHAN PRASAD's symptoms worsened dramatically, and new alarming symptoms developed. Jail staff observed and documented that NATHAN PRASAD was experiencing tremendous pain, coughing up blood, and telling them that he was afraid he would die without medical care. Basic medical diagnostic evaluation at the jail showed that his vital signs indicated extreme danger. Fellow inmates desperately sought medical help for NATHAN PRASAD, going so far as to collect the blood he coughed up in a used milk carton.

4. Despite these facts, jail staff ignored NATHAN PRASAD's serious medical needs, instead ridiculing him and leaving him to continue to deteriorate in his cell and at the jail.

5. After almost two days of deterioration and suffering at the jail, NATHAN PRASAD's condition became so serious that his blood pressure could no longer be detected at all and he was losing consciousness. His condition was so deteriorated at this stage that subsequent life-saving measures could not revive him.

6. NATHAN PRASAD fell into a coma and died on January 28, 2011, at the age of 30. He left behind two young children, T.P. and A.P., with whom he had a close and loving relationship, and who he helped to support financially and emotionally. He further left behind his mother, MARY PRASAD, with whom he remained exceptionally close throughout his life and in the months prior to his death. Neither MARY PRASAD, nor T.P., nor A.P was able to make it to NATHAN PRASAD's bedside to see him before he passed away.

7. Defendants acted with deliberate indifference to NATHAN PRASAD's serious medical needs, and in violation of their duties under federal and state law, causing NATHAN PRASAD's tragic and preventable death.

JURISDICTION AND VENUE

8. This case is brought pursuant to 42 U.S.C. § 1983. Jurisdiction is based on 28 U.S.C. §§ 1331 and 1343. With respect to those claims brought pursuant to California law, Plaintiffs have complied with the administrative claim requirement.

9. The court has supplemental jurisdiction over Plaintiffs' state claims pursuant to 28 U.S.C. § 1367.

10. The claims alleged herein arose in the County of Sutter, California. Therefore, venue in the Eastern District of California is proper pursuant to 28 U.S.C. § 1391(b)(2).

PARTIES

11. Plaintiffs' decedent is NATHAN PRASAD, who, at the time of his death,

1 was a 30-year old citizen of the United States. He was a citizen and resident of County of
2 Sutter in the State of California.
3 12. Plaintiff MARY PRASAD, as Administrator of the Estate of NATHAN
4 PRASAD, brings this action pursuant to California Code of Civil Procedure §§ 377.10 *et*
5 *seq.* The survival causes of action in this matter are based on violations of NATHAN
6 PRASAD's rights under the First and Fourteenth Amendments, and on violations of
7 California state law as against COUNTY OF SUTTER and all individual Sutter County
8 Defendants. MARY PRASAD is the mother of NATHAN PRASAD, and is also suing
9 individually for violations of her civil rights under the First and Fourteenth Amendments.
10 13. Plaintiffs T.P. and A.P. are the children of NATHAN PRASAD. They are
11 suing for violations of their civil rights under the First and Fourteenth Amendments. They
12 are further suing for violations of California state law as against COUNTY OF SUTTER
13 and all individual Sutter County Defendants. As minors, T.P. and A.P. are suing through
14 MARY PRASAD, their grandmother, as Guardian *Ad Litem*.
15 14. Plaintiffs MARY PRASAD, T.P., and A.P. are residents of the County of
16 Colusa, California.
17 15. Defendant COUNTY OF SUTTER is a public entity, duly organized and
18 existing under the laws of the State of California. Under its authority, Defendant
19 COUNTY OF SUTTER operates and manages Sutter County Jail and is, and was at all
20 relevant times mentioned herein, responsible for the actions and/or inactions and the
21 policies, procedures and practices/customs of the Sutter County Sheriff's Department and
22 its respective employees and/or agents. Sutter County Sheriff's Department operates
23 Sutter County Jail, and is and was responsible for ensuring the provision of emergency and
24 basic medical care services to all Sutter County Jail inmates.
25 16. Defendant J. PAUL PARKER is, and was at all relevant times mentioned
26 herein, the Sheriff of the COUNTY OF SUTTER, the highest position in the Sutter County
27 Sheriff's Department. As Sheriff, Defendant PARKER is and was responsible for the
28 hiring, screening, training, retention, supervision, discipline, counseling, and control of all

Sutter County Sheriff's Department custodial employees and/or agents and DOES I through XL. Defendant PARKER is and was charged by law with the administration of the Sutter County Jail, with the assistance of a small group of executive officers. Defendant PARKER is and was also responsible for the promulgation of the policies and procedures and allowance of the practices/customs pursuant to which the acts of the Sutter County Sheriff's Department alleged herein were committed. Defendant PARKER is being sued in his individual capacity.

17. Defendant DAVID SAMSON is, and was at all relevant times mentioned herein, the Sutter County Jail Division Commander. Defendant SAMSON is and was responsible for the hiring, screening, training, retention, supervision, discipline, counseling, and control of all Sutter County Sheriff's Department custodial employees and/or agents and DOES I through XL. Defendant SAMSON is and was responsible for the administration of the Sutter County Jail. Defendant SAMSON is and was also responsible for the promulgation of the policies and procedures and allowance of the practices/customs pursuant to which the acts of the Sutter County Sheriff's Department alleged herein were committed. Defendant SAMSON is being sued in his individual capacity.

18. Defendant NORMAN BIDWELL, is, and was at all relevant times mentioned herein, the Sutter County Jail Corrections Lieutenant. Defendant BIDWELL is and was second-in-command at Sutter County Jail. He is and was responsible for the hiring, screening, training, retention, supervision, discipline, counseling, and control of all Sutter County Sheriff's Department custodial employees and/or agents and DOES I through XL. Defendant BIDWELL is and was responsible for the administration of the Sutter County Jail. Defendant BIDWELL is and was also responsible for the promulgation of the policies and procedures and allowance of the practices/customs pursuant to which the acts of the Sutter County Sheriff's Department alleged herein were committed. Defendant BIDWELL is being sued in his individual capacity.

19. Defendant DORIS BROWN was at all relevant times mentioned herein a

Registered Nurse Practitioner at Sutter County Jail. Defendant BROWN had direct contact with NATHAN PRASAD in the hours and/or days leading up to his death, had actual notice of NATHAN PRASAD's serious and life-threatening condition and need for emergency medical treatment, and acted with deliberate indifference by failing to take necessary steps to provide such treatment. Defendant BROWN is being sued in her individual capacity.

20. Defendant MELODY YOUNG was at all relevant times mentioned herein a Licensed Vocational Nurse at Sutter County Jail. Defendant YOUNG had direct contact with NATHAN PRASAD in the hours and/or days leading up to his death, had actual notice of NATHAN PRASAD's serious and life-threatening condition and need for emergency medical treatment, and acted with deliberate indifference by failing to take necessary steps to provide such treatment. Defendant YOUNG is being sued in her individual capacity.

21. Defendant BALJINDER RAI was at all relevant times mentioned herein a Deputy Officer at Sutter County Jail. Defendant RAI had direct contact with NATHAN PRASAD in the hours and/or days leading up to his death, had actual notice of NATHAN PRASAD's serious and life-threatening condition and need for emergency medical treatment, and acted with deliberate indifference by failing to take necessary steps to provide such treatment. Defendant RAI is being sued in his individual capacity.

22. Defendant SHANE DICKSON was at all relevant times mentioned herein a Deputy Officer at Sutter County Jail. Defendant DICKSON had direct contact with NATHAN PRASAD in the hours and/or days leading up to his death, had actual notice of NATHAN PRASAD's serious and life-threatening condition and need for emergency medical treatment, and acted with deliberate indifference by failing to take necessary steps to provide such treatment. Defendant DICKSON is being sued in his individual capacity.

23. Defendant UNKNOWN JAIL EMPLOYEE I was at all relevant times mentioned herein an employee at Sutter County Jail. Defendant UNKNOWN JAIL EMPLOYEE I had direct contact with NATHAN PRASAD in the hours and/or days

1 leading up to his death, had actual notice of NATHAN PRASAD's serious and life-
2 threatening condition and need for emergency medical treatment, and acted with deliberate
3 indifference by failing to take necessary steps to provide such treatment. Defendant
4 UNKNOWN JAIL EMPLOYEE I, whose name and identity is presently unknown to
5 Plaintiffs and is thus a DOE Defendant until such time that Plaintiffs discover his/her true
6 identity and amend the instant Complaint accordingly. Defendant UNKNOWN JAIL
7 EMPLOYEE I is being sued in his/her individual capacity.
8 24. Defendant FREMONT-RIDEOUT HEALTH GROUP was at all times
9 mentioned herein responsible for the operation of Rideout Memorial Hospital. Defendant
10 FREMONT-RIDEOUT HEALTH GROUP had and maintained a contractual agreement
11 with COUNTY OF SUTTER to provide medical treatment to Sutter County Jail inmates,
12 including for the purpose of providing ambulance and emergency services. The process by
13 which Rideout Memorial Hospital provided treatment to Sutter County Jail inmates
14 involved significant, ongoing coordination and cooperation between COUNTY OF
15 SUTTER, the Sutter County Sheriff's Department, and Defendant FREMONT-RIDEOUT
16 HEALTH GROUP. On information and belief, Defendant FREMONT-RIDEOUT
17 HEALTH GROUP's Rideout Memorial Hospital is the only facility made available to Jail
18 inmates for the delivery of emergency medical services. Defendant FREMONT-
19 RIDEOUT HEALTH GROUP established and follows a policy, procedure and practice of
20 receiving jail inmates from Sutter County Jail, and discharging them to Sutter County Jail
21 in a manner that is deliberately indifferent to the known risk of serious or lethal injury in
22 the event, as in the case of NATHAN PRASAD, where the discharge instructions depend
23 on a capacity for emergency medical response that Fremont-Rideout Health Group knew
24 or should have known did not exist at Sutter County Jail.
25 25. Defendant MICHAEL FRATERS was at all relevant times mentioned herein
26 a physician at Rideout Memorial Hospital and employee of FREMONT-RIDEOUT
27 HEALTH GROUP. Defendant FRATERS treated NATHAN PRASAD pursuant to the
28 COUNTY OF SUTTER-FREMONT-RIDEOUT HEALTH GROUP agreement to treat

Sutter County Jail inmates in need of medical care. Defendant FRATERS had direct contact with NATHAN PRASAD on January 26, 2010, had actual notice of NATHAN PRASAD's serious and life-threatening condition and need for access to emergency medical treatment, and acted with deliberate indifference to the known risk of serious or lethal injury to NATHAN PRASAD given that a safe discharge from the hospital depended on the capacity for emergency medical response that he knew or should have known did not exist at Sutter County Jail. Defendant FRATERS is being sued in his individual capacity.

26. The true names and identities of Defendants DOES I through XX are presently unknown to Plaintiffs. Plaintiffs allege that each of Defendants DOES I through XX was employed by the COUNTY OF SUTTER and/or the Sutter County Sheriff's Department at the time of the conduct alleged herein. Plaintiffs allege that each of Defendants DOES I through XX was deliberatively indifferent to NATHAN PRASAD's medical needs and safety, failed to provide necessary care to him or to take other measures to violated his civil rights, wrongfully caused his death, and/or encouraged, directed, enabled and/or ordered other defendants to engage in such conduct. Plaintiffs further allege that Defendants DOES I through XX violated Plaintiffs' First and Fourteenth Amendment rights, and rights under California state law. Plaintiffs will seek to amend this Complaint as soon as the true names and identities of Defendants DOES I through XX have been ascertained.

27. The true names and identities of Defendants DOES XXI though XL are presently unknown to Plaintiffs. Plaintiffs allege that each of Defendants DOES XXI through XL was employed by the COUNTY OF SUTTER and/or the Sutter County Sheriff's Department at the time of the conduct alleged herein. Plaintiffs allege that each of Defendants DOES XXI through XL was responsible for the hiring, screening, training, retention, supervision, discipline, counseling, and control of medical, mental health, and jail custody employees and/or agents involved in the conduct alleged herein. Plaintiffs allege that each of Defendants DOES XXI through XL was also responsible for and caused

1 the acts and injuries alleged herein. Plaintiffs will seek to amend this Complaint as soon as
2 the true names and identities of Defendants DOES XXI through XL have been ascertained.
3 28. Defendant COUNTY OF SUTTER is a political subdivision of the State of
4 California, created and existing by virtue of the laws of the State of California. At all
5 times relevant to the instant complaint, Defendant COUNTY OF SUTTER employed
6 Defendants J. PAUL PARKER, DAVID SAMSON, NORMAN BIDWELL, DORIS
7 BROWN, MELODY YOUNG, BALJINDER RAI, SHANE DICKSON, UNKNOWN
8 JAIL EMPLOYEE I, and DOES I through XL.
9 29. Defendants J. PAUL PARKER, DAVID SAMSON, NORMAN BIDWELL,
10 DORIS BROWN, MELODY YOUNG, BALJINDER RAI, SHANE DICKSON,
11 UNKNOWN JAIL EMPLOYEE I, FREMONT-RIDEOUT HEALTH GROUP,
12 MICHAEL FRATERS, and DOES I through XL, and each of them, to the extent they
13 engaged in any acts or omissions alleged herein, engaged in such acts or omissions under
14 color of state law.
15 30. Plaintiffs are informed and believe and thereon allege that at all times
16 mentioned in this Complaint, Defendants, and each of them, were the agents, employees,
17 servants, joint venturers, partners and/or co-conspirators of the other Defendants named in
18 this Complaint and that at all times, each of the Defendants was acting within the course
19 and scope of said relationship with Defendants.
20 **EXHAUSTION OF PRE-LAWSUIT PROCEDURES**
21 31. Plaintiffs MARY PRASAD, T.P., and A.P. filed state governmental tort
22 claims with the State and Defendant COUNTY OF SUTTER, including on behalf of the
23 ESTATE of NATHAN PRASAD, on July 21, 2011. By correspondence dated September
24 7, 2011, their governmental tort claims were rejected.
25 **FACTUAL ALLEGATIONS**
26 **Nathan Prasad's Life and the Circumstances of His Detention in Sutter County Jail**
27 32. NATHAN PRASAD was born on April 10, 1980 in Cedarville, California.
28 33. NATHAN PRASAD had a close relationship with his family, helping to

raise his young children and assisting his mother and grandmother with various daily and household tasks. Despite a history of mental illness, NATHAN PRASAD had made great strides in the time before his death towards becoming independent and self-sufficient. After several years struggling with mental illness, he had moved into his own apartment for the first time in his life and was working towards gainful employment. He spent most days with his family, including his elderly grandmother, his mother and step-father, and his children.

34. COUNTY OF SUTTER officials and employees – including individual Defendants, county mental health staff, county law enforcement, and county jail staff, had extensive contact with NATHAN PRASAD. NATHAN PRASAD had been involuntarily hospitalized to receive emergency mental health treatment pursuant to Cal. Welf. & Inst. Code § 5150, and had been placed in the custody of the Sheriff's Department multiple times, generally during periods in which he was manifesting serious mental illness and in light of alleged non-violent parole and probation violations. COUNTY OF SUTTER produced and maintained significant documentation of his mental health and medical needs. This documentation was included in his Sutter County Jail inmate records, and, upon information and belief, reviewed by Defendants PARKER, SAMSON, BIDWELL, BROWN, YOUNG, RAI, DICKSON, and UNKNOWN JAIL EMPLOYEE I.

35. COUNTY OF SUTTER arrested NATHAN PRASAD on or about January 21, 2011, based on non-violent misdemeanor and parole-related charges. He was taken to Sutter County Jail, where he was detained for the next week. During that time period, NATHAN PRASAD developed a medical condition which, as a result of the denial of plainly necessary treatment, led to great suffering and his painful death on January 28, 2011.

36. At the time of NATHAN PRASAD's death, T.P. was seven (7) years old, and A.P. was six (6) years old. NATHAN PRASAD died just two (2) days before A.P.'s seventh birthday.

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Medical Problems, Pain, and Suffering While Detained in Sutter County Jail

37. Soon after Defendant COUNTY OF SUTTER's arrest of NATHAN PRASAD, NATHAN PRASAD reported to jail staff that he was experiencing significant pain in his lower extremities. He was further manifesting symptoms of mental illness. Jail staff, including Defendants BROWN, YOUNG, RAI, DICKSON, and UNKNOWN JAIL EMPLOYEE I observed him on multiple occasions and documented that he was experiencing pain, swelling, and other serious medical symptoms.

38. While detained at Sutter County Jail, NATHAN PRASAD completed and submitted to jail staff multiple written requests to receive medical treatment. In these reports, he reported that he was suffering "extreme pain," was concerned that he had a staph infection, and stated that he required "emergency" medical attention.

39. After several days of reported and documented medical concerns, jail staff transported NATHAN PRASAD to Rideout Memorial Hospital for what was a brief medical evaluation. A short time after his admission to the Emergency Department on January 26, 2011, emergency room physicians discharged NATHAN PRASAD with specific discharge instructions that if his symptoms worsen or new symptoms develop, he was to be returned to the Emergency Department ***immediately***. He was discharged on the afternoon of January 26, and returned to Sutter County Jail.

40. Defendant FREMONT-RIDEOUT HEALTH GROUP's Rideout Memorial Hospital staff, acting pursuant to a COUNTY OF SUTTER contract to provide medical treatment to Sutter County Jail inmates, acted with deliberate indifference by discharging NATHAN PRASAD to a notoriously dangerous setting at Sutter County Jail. Hospital staff knew or should have known that NATHAN PRASAD would not possibly receive the observation, supervision, and access to emergent medical treatment he would likely need given his serious medical complaints and condition.

41. Defendant FRATERS, NATHAN PRASAD'S physician at Rideout Memorial Hospital, evaluated and treated NATHAN PRASAD at the hospital on January 26, as pursuant with the Hospital's agreement to treat Sutter County Jail inmates.

Defendant FRATERS ordered and/or approved the discharge of NATHAN PRASAD. At the time, he knew or should have known that NATHAN PRASAD had a serious and life-threatening condition and would need access to emergency medical treatment if his symptoms worsened or new symptoms developed.

42. Defendant FRATERS acted with deliberate indifference to the known risk of serious or lethal injury to NATHAN PRASAD given that his safe discharge from the hospital depended on timely access to emergency medical response, which he knew or should have known did not exist at Sutter County Jail, a setting that is notoriously dangerous for individuals with serious medical needs and that does not provide sufficient around-the-clock access to medical care.

43. On information and belief, Defendants PARKER, SAMSON, and BIDWELL were informed and aware of, or should have been aware of, NATHAN PRASAD's evaluation at Rideout Memorial Hospital and the discharge instructions providing that if his symptoms worsened or new symptoms developed, he must be taken to the emergency room immediately.

44. On information and belief, Defendants BROWN, YOUNG, RAI, DICKSON, and UNKNOWN JAIL EMPLOYEE I each reviewed and/or were aware of, or should have been aware of, NATHAN PRASAD's custody file, including the medical documentation indicating his medical status and need to be taken to the emergency room immediately if his symptoms worsened or new symptoms developed.

45. Throughout NATHAN PRASAD's detention at Sutter County Jail, Defendants BROWN, YOUNG, RAI, DICKSON, and UNKNOWN JAIL EMPLOYEE I failed to provide sufficient medical screening, evaluation, and observation of his medical condition and emergent treatment needs.

Defendants' Failure to Provide Clearly Necessary Life-Saving Emergency Treatment

46. Shortly upon his return from the brief hospital admission, it became readily apparent that NATHAN PRASAD's condition and symptoms were in fact getting significantly worse. His symptoms included vomiting, shortness of breath, severe chills,

1 and extreme pain. NATHAN PRASAD began coughing and/or vomiting up blood. On the
2 evening of January 26, 2011, jail staff documented speaking with Defendant BROWN that
3 NATHAN PRASAD was suffering from "uncontrollable pain." Yet no follow-up
4 evaluation or medical treatment was provided that night.
5 47. From January 26 to January 28, NATHAN PRASAD stated aloud repeatedly
6 that he was in extreme pain and having trouble breathing. He reported to staff that he
7 thought he was going to die unless he received immediate medical attention. He was
8 manifesting numerous symptoms indicating a serious and life-threatening condition and an
9 immediate need for emergency medical treatment.
10 48. Several fellow inmates observed NATHAN PRASAD's worsening condition
11 and notified staff at the jail. Staff responded that NATHAN PRASAD was faking his pain
12 and other symptoms and that he and the inmates needed to "get over it."
13 49. Fellow inmates collected the blood that NATHAN PRASAD was coughing
14 up in an empty milk carton, and, upon information and belief, showed it to Defendants
15 RAI, BROWN, YOUNG, DICKSON, UNKNOWN JAIL EMPLOYEE I, and other staff in
16 an effort to obtain emergency medical help for NATHAN PRASAD.
17 50. Jail staff, including Defendants BROWN, YOUNG, RAI, DICKSON, and
18 UNKNOWN JAIL EMPLOYEE I observed NATHAN PRASAD's suffering and heard his
19 and his fellow inmates' pleas for immediate medical help. Defendants BROWN,
20 YOUNG, and RAI documented NATHAN PRASAD's complaints and worsening
21 symptoms. In spite of the alarming reports and the observations of Defendants, they failed
22 to provide adequate evaluation or timely emergency treatment for a period of 36 hours or
23 more.
24 51. Defendant BROWN observed NATHAN PRASAD's condition and
25 reviewed the Emergency Department records and discharge instructions to return him to
26 the hospital ***immediately*** if his symptoms worsened or new symptoms developed. She
27 observed and documented that he was continuing to experience pain and other serious, and
28 worsening, symptoms, but took no steps to obtain the emergency medical care he

1 obviously needed.

2 52. Defendant DICKSON, after observing NATHAN PRASAD screaming in
3 pain and begging to be taken to the hospital for treatment, ridiculed NATHAN PRASAD.
4 Defendant DICKSON stated that he was the type of person who comes to jail because he
5 wants to get free medical care. Defendant DICKSON ignored NATHAN PRASAD's
6 serious medical condition, and took no steps to address his medical needs.

7 53. Defendant UNKNOWN JAIL EMPLOYEE I, after observing NATHAN
8 PRASAD screaming in pain and begging to be taken to the hospital for treatment.
9 Defendant UNKNOWN JAIL EMPLOYEE I stated that he was getting what he deserved
10 for whatever he had done, and would have to wait until later to see a doctor. Defendant
11 UNKNOWN JAIL EMPLOYEE I ignored NATHAN PRASAD's serious medical
12 condition, and took no steps to address his medical needs.

13 54. In the pre-dawn hours of January 28, 2011, Defendants RAI and YOUNG
14 observed and documented that NATHAN PRASAD's blood pressure and blood-oxygen
15 saturation were dangerously low, that he was coughing and/or vomiting up blood, dizzy,
16 sweating, cold, and clammy. On information and belief, he reported to Defendants RAI
17 and YOUNG that he felt like he was "going to die."

18 55. After several hours during which NATHAN PRASAD was exhibiting
19 worsening symptoms and significant suffering and was pleading with jail staff for help,
20 Defendants RAI and YOUNG placed NATHAN PRASAD in a Sutter County Jail office.
21 However, they held him in a jail office *but provided him no medical treatment*, and failed
22 to properly monitor his deteriorating condition, for a period of nearly four (4) hours or
23 more. Defendants RAI and YOUNG did not call an ambulance or make other
24 arrangements for NATHAN PRASAD to be taken to the hospital emergency room for
25 emergency and life-saving medical care.

26 56. Instead, NATHAN PRASAD was made to sit in a jail office room, without
27 medical attention of any kind, even as his condition got worse, including further coughing
28 up of blood and deteriorating vital signs. Not until *nearly four hours later* on January 28

1 was an ambulance summoned. By that time, NATHAN PRASAD's condition had
2 deteriorated dramatically and his skin had turned blue due to severe oxygen deficiency and
3 cyanosis. His blood pressure could no longer be detected.
4 57. The failure of correctional officer Defendants RAI, DICKSON, UNKNOWN
5 JAIL EMPLOYEE I to contact emergency medical services was consistent with a policy in
6 effect at Sutter County Jail such that correctional officers did not have authority to
7 determine who goes to the hospital or to call for an ambulance in an emergency situation,
8 despite the lack of 24-hour medical staff availability at the jail. Defendants PARKER,
9 SAMSON, and BIDWELL created, were aware of, and enforced this policy, knowing that
10 it would endanger inmates like NATHAN PRASAD who require emergency medical
11 attention.

12 **NATHAN PRASAD's Painful and Preventable Death**

13 58. NATHAN PRASAD suffered severe bronchopneumonia and multiple organ
14 failure as a result of Defendants' failure to provide timely medical treatment. He was
15 deemed to be in critical condition and was unconscious, leading to his placement in the
16 Intensive Care Unit (ICU) at Rideout Memorial Hospital.
17 59. Defendants failed to timely contact NATHAN PRASAD's family. As a
18 result, his mother MARY PRASAD, his children T.P. and A.P., and other family members
19 were unable to make it to the hospital in time to see NATHAN PRASAD while he was still
20 alive.
21 60. Meanwhile, Defendants PARKER, SAMSON, and BIDWELL took steps to
22 drop all pending charges and to release NATHAN PRASAD "on his own recognizance"
23 after he was placed in the ICU and was in critical condition.
24 61. At approximately 4:19 pm on January 28, NATHAN PRASAD was
25 pronounced dead by hospital staff.
26 62. Had NATHAN PRASAD not been placed in a jail setting known to be
27 dangerous and ill-equipped to ensure timely emergency medical treatment, and had such
28 emergency treatment been summoned and provided to NATHAN PRASAD, his condition

could have been effectively treated. He would not have experienced severe pain and suffering, and his life would have been saved.

Longstanding and Systemic Deficiencies in Sutter County Jail's Provision of Emergency Treatment to Inmates, Medical Staffing, and Policies and Procedures in Violation of Existing Court Order

63. Defendant COUNTY OF SUTTER has knowingly maintained and tolerated longstanding and systemic deficiencies in the Sutter County Jail's provision of emergency treatment to seriously ill inmates. It has also knowingly had inadequate medical staffing as well as policies and procedures that were likely in violation of an existing court order directing minimum standards of medical treatment at the jail. Defendants PARKER, SAMSON, and BIDWELL were aware of and tolerated these serious deficiencies in Sutter County Jail's medical care system, policies, and procedures.

64. As identified by a Sutter County Grand Jury in its 2010-2011 Final Report, Sutter County Jail has had several known deficiencies in its system of providing treatment to inmates. (The Sutter County Grand Jury Report is appended as **Attachment A**.)

65. Identified deficiencies included inadequate medical staffing, non-compliant medical policies and procedures, and a medical program that was long out-of-compliance. The Grand Jury noted that such deficiencies were "unacceptable," and may have caused Sutter County to be out of compliance with an existing court order in *Haller v. Sutter County*, Case No. CIV-S-93-1256, which mandates certain jail conditions, policies, and procedures for providing medical treatment to Sutter County Jail inmates.

66. The Grand Jury found that medical staffing at Sutter County Jail has been inadequate, and that the hiring of additional staff is required.

67. The Grand Jury noted a report that training of staff had not occurred in more than five (5) years as of 2011, and that such training was necessary to maintain proficiency in emergency response procedures. The Grand Jury found that Sutter County Jail had failed to offer staff required training pursuant to court order and the jail's own Medical Policies and Procedures.

68. The Grand Jury found that Sutter County Jail's health care policies and

procedures were significantly out of date, and that conditions at the jail had been allowed to "deteriorate."

69. The Grand Jury found that Sutter County Jail's nursing program was "completely out of compliance with annual nurse training updates and standard nursing procedures," and found "unacceptable that the program is out of compliance, lack of training for the nursing staff, [and] not having the [policies and procedures] up-to-date," among other problems.

70. The systemic deficiencies regarding the provision of emergency and other medical treatment at Sutter County Jail, as well as the inadequate staffing, policies, and procedures, as identified in the Grand Jury Report and in violation of the existing *Haller v. Sutter County* court order, directly caused the woefully inadequate emergency medical attention and treatment that NATHAN PRASAD required between January 26 and January 28, 2011, leading to his untimely and preventable death on January 28, 2011.

71. Defendants maintained insufficient policies and procedures, and provided inadequate staff training or no training at all, on the provision of emergency medical care to Sutter County Jail inmates with a serious and/or life-threatening medical condition. These deficiencies include, but are not limited to, insufficient direction as to what circumstances require emergency medical care and the procedure for summoning emergency medical care. These failures directly caused the denial of emergency medical attention and treatment that NATHAN PRASAD required between January 26 and January 28, 2011, leading to his untimely and preventable death on January 28, 2011.

72. Sutter County Jail has recently experienced several likely preventable inmate deaths in custody, indicating a culture of deliberate indifference to inmates' serious treatment needs at the Jail. In addition to NATHAN PRASAD's death, there have been disturbing reports of inmate deaths in April 2010 and September 2011.

NATHAN PRASAD's Mother and Young Children Have Been Profoundly Harmed by Defendants' Misconduct Leading to NATHAN PRASAD's Death

73. Plaintiffs MARY PRASAD, T.P., and A.P. have been profoundly harmed by

Defendant's conduct leading to NATHAN PRASAD's untimely and avoidable death.

74. As NATHAN PRASAD's mother, MARY PRASAD has experienced the painful loss of her eldest son. She has been denied the regular contact that she and NATHAN PRASAD had. She has lost the loving mother-son relationship that she and NATHAN PRASAD maintained, including regular contact, a warm relationship, and the assistance that NATHAN PRASAD regularly provided her, including home maintenance and improvement projects.

75. As NATHAN PRASAD's young children, T.P. and A.P. have experienced the traumatic loss of their father, who remained close to them throughout their lives until his tragic death. They have taken the loss of their father extremely hard, asking when they will be able to see him again. They have had and will continue to have great difficulty coping with his death during their most formative years. T.P. and A.P. have further suffered the loss of NATHAN PRASAD's financial support, his care and supervision of them, and his paternal guidance.

FIRST CLAIM FOR RELIEF
Cruel and Unusual Punishment in Violation of the Fourteenth Amendment to the Constitution of the United States – Deliberate Indifference to Serious Medical Needs, Health and Safety
(Survival Action – 42 U.S.C. § 1983)
(Against Defendants COUNTY OF SUTTER, J. PAUL PARKER, DAVID SAMSON, NORMAN BIDWELL, DORIS BROWN, MELODY YOUNG, BALJINDER RAI, SHANE DICKSON, UNKNOWN JAIL EMPLOYEE I, FREMONT-RIDEOUT HEALTH GROUP, DAVID FRATERS, and DOES I through XL)

76. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 75 of this complaint as though fully set forth herein.

77. Defendants knew that NATHAN PRASAD was in danger of serious personal harm because:

a. Based on NATHAN PRASAD's previous contact with COUNTY OF SUTTER and Sutter County Jail officers and employees, including all individual Defendants, Defendants had substantial documentation of his medical needs, and his need for consistent supervision and prompt medical attention when warranted.

b. NATHAN PRASAD completed and submitted multiple written requests to receive medical treatment, reporting "extreme pain," a staph infection, and the need for "emergency" medical attention.

c. Emergency room physicians documented clear instructions that were placed in NATHAN PRASAD's custody file and reviewed by Defendants, that if his symptoms worsened or new symptoms developed, he needed to be returned to the hospital for emergency treatment ***immediately***. Upon information and belief, Defendants PARKER, SAMSON, and BIDWELL were informed and aware of NATHAN PRASAD's evaluation at Rideout Memorial Hospital and the discharge instructions providing that if his symptoms worsened or new symptoms developed, he must be taken to the Emergency Department immediately. Upon information and belief, Defendants BROWN, YOUNG, RAI, DICKSON, and UNKNOWN JAIL EMPLOYEE I each reviewed and/or were informed of NATHAN PRASAD's custody file, including the medical documentation indicating his medical status and need to be taken to the emergency room immediately if his symptoms worsened or new symptoms developed.

d. Defendants FREMONT-RIDEOUT HEALTH GROUP and FRATERS, who treated NATHAN PRASAD pursuant to a COUNTY OF SUTTER contractual agreement to provide medical treatment to Sutter County Jail inmates, discharged NATHAN PRASAD to a notoriously dangerous setting at Sutter County Jail on January 26, 2011. They knew or should have known that NATHAN PRASAD had or could have had a serious and life-threatening condition and would need access to emergency medical treatment if his symptoms worsened or new symptoms developed. Defendants further knew or should have known, and thus acted with deliberate indifference, to the known risk of serious or lethal injury to NATHAN PRASAD given that his safe discharge from the hospital depended on the capacity for timely emergency medical response, which they knew or should have known did not exist at Sutter County Jail, given the hospital's service agreement and their experience treating Sutter County Jail inmates.

e. From January 26 to January 28, 2011, NATHAN PRASAD reported to each of Defendants BROWN, YOUNG, RAI, DICKSON, and UNKNOWN JAIL EMPLOYEE I that he was in extreme pain, having trouble breathing, and afraid that he was going to die.

f. Defendants BROWN, YOUNG, and RAI, each observed and documented that NATHAN PRASAD's condition and symptoms were clearly getting worse, including but not limited to vomiting, shortness of breath, severe chills, coughing and/or vomiting up blood, and "uncontrollable pain."

g. Defendants DICKSON and UNKNOWN JAIL EMPLOYEE I each observed that NATHAN PRASAD's condition and symptoms were clearly getting worse, heard his and his fellow inmates' pleas for medical help.

h. Inmates housed with NATHAN PRASAD collected the blood that NATHAN PRASAD was coughing up in an empty milk carton, showing it to Defendants BROWN, YOUNG, RAI, DICKSON, and UNKNOWN JAIL EMPLOYEE I in a desperate effort to obtain medical attention and treatment for him.

i. In the pre-dawn hours of January 28, 2011, Defendants RAI and YOUNG observed and documented NATHAN PRASAD's significant suffering and life-threatening symptoms, including dangerously low blood pressure and blood-oxygen saturation, coughing and/or vomiting up blood, dizziness, sweats, and reports that NATHAN PRASAD feared that he was "going to die."

j. Not until *several hours* after these observations and documented reports did Sutter County Jail staff contact emergency medical services and summon an ambulance. At that time, NATHAN PRASAD's condition had deteriorated so substantially that his condition was dire. He died soon thereafter at the hospital.

78. Defendants failed to provide necessary evaluation and treatment for NATHAN PRASAD while he was detained at Sutter County Jail.

79. Defendants' acts and/or omissions as alleged herein, including but not limited to their failure to provide NATHAN PRASAD with timely or adequate medical

care and/or to take other measures to protect him from serious harm, along with the acts and/or omissions of the Defendants in failing to train, supervise and/or promulgate appropriate policies and procedures at Sutter County Jail in order to prevent NATHAN PRASAD's and other inmate deaths, constituted deliberate indifference to NATHAN PRASAD's serious medical needs, health and safety.

80. As a direct and proximate result of Defendants' conduct, NATHAN PRASAD experienced physical pain, severe emotional distress, mental anguish, loss of his life, and the damages alleged herein.

81. The aforementioned acts and/or omissions of the individually named Defendants were malicious, reckless and/or accomplished with a conscious disregard of decedent's rights thereby entitling Plaintiffs to an award of exemplary and punitive damages according to proof, to punish the wrongful conduct alleged herein and to deter such conduct in the future.

SECOND CLAIM FOR RELIEF
Municipal Liability for in Violation of the Fourteenth Amendment to the Constitution of the United States
(Survival Action - 42 U.S.C. § 1983)
(Against Defendant COUNTY OF SUTTER)

82. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 81 of this complaint as though fully set forth herein.

83. The aforementioned acts and/or omissions of Defendants in being deliberatively indifferent to NATHAN PRASAD's serious medical needs, health and safety and violating NATHAN PRASAD's civil rights were the direct and proximate result of customs, practices and policies of Defendants COUNTY OF SUTTER, by and through their agencies, employees and/or agents, as alleged herein.

84. Such policies, customs and/or practices include but are not limited to an ongoing pattern of deliberate, including the following: the failure to ensure implementation of appropriate medical and emergency treatment plans; the failure to act upon clearly life-threatening symptoms and reports; the failure to provide appropriate staffing and training

at Sutter County Jail to provide minimally adequate medical treatment for seriously ill inmates; and the failure to implement a policy to ensure that staff would contact and summon emergency medical treatment in a timely manner.

85. Defendant COUNTY OF SUTTER tacitly encouraged, ratified and/or approved of the acts and/or omissions alleged herein, and knew that such conduct was unjustified and would result in violations of constitutional rights.

86. The customs, policies and/or practices of Defendants COUNTY OF SUTTER were a direct and proximate cause of Plaintiffs' injuries and the death of the NATHAN PRASAD in that Defendant COUNTY OF SUTTER failed to adequately train and supervise its employees and/or agents to prevent the occurrence of the constitutional violations suffered by Plaintiffs and NATHAN PRASAD, and by other inmates at Sutter County Jail. Defendant COUNTY OF SUTTER also failed to promulgate appropriate policies or procedures or take other measures to prevent the constitutional violations suffered by Plaintiffs and NATHAN PRASAD, and by other inmates at Sutter County Jail.

87. As a direct and proximate result of the aforementioned customs, policies and/or practices of Defendant COUNTY OF SUTTER, NATHAN PRASAD and Plaintiffs suffered injuries and damages as alleged herein.

THIRD CLAIM FOR RELIEF
Supervisory Liability
(Survival Action - 42 U.S.C. § 1983)
(Against Defendants J. PAUL PARKER, DAVID SAMSON, NORMAN BIDWELL, and DOES XXI through XL)

88. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 87, as though fully set forth herein.

89. The aforementioned acts and/or omissions of Defendants in being deliberatively indifferent to NATHAN PRASAD's serious medical needs, health and safety and violating decedent's civil rights were the direct and proximate result of customs, practices and policies of Defendants PARKER, SAMSON, BIDWELL, and DOES XXI through XL as alleged herein.

90. Such policies, customs and/or practices include but are not limited to an ongoing pattern of deliberate indifference, including the following: the failure to ensure implementation of appropriate medical and emergency treatment plans; the failure to act upon clearly life-threatening symptoms and reports; the failure to provide appropriate staffing and training at Sutter County Jail to provide minimally adequate medical treatment for seriously ill inmates; and the failure to implement a policy to ensure that staff would contact and summon emergency medical treatment in a timely manner.

91. Defendants PARKER, SAMSON, BIDWELL and DOES XXI through XL tacitly encouraged, ratified and/or approved of the acts and/or omissions alleged herein, and knew that such conduct was unjustified and would result in violations of constitutional rights.

92. The customs, policies and/or practices of said Defendants were a direct and proximate cause of Plaintiffs' injuries and the death of the NATHAN PRASAD in that Defendants failed to adequately train and supervise their employees and/or agents to prevent the occurrence of the constitutional violations suffered by Plaintiffs and NATHAN PRASAD, and by other inmates at Sutter County Jail. Defendants also failed to promulgate appropriate policies or procedures or take other measures to prevent the constitutional violations suffered by Plaintiffs and NATHAN PRASAD, and by other inmates at Sutter County Jail.

93. As a direct and proximate result of the aforementioned customs, policies and/or practices of Defendants, NATHAN PRASAD and Plaintiffs suffered injuries and damages as alleged herein.

94. The aforementioned acts of Defendants PARKER, SAMSON, BIDWELL and DOES XXI through XL were willful, wanton, malicious, and oppressive, thereby justifying an award of exemplary and punitive damages to punish the wrongful conduct alleged herein and to deter such conduct in the future.

FOURTH CLAIM FOR RELIEF
Substantive Due Process in Violation of First and Fourteenth Amendments to the Constitution of the United States – Loss of Parent/Child Relationship
(42 U.S.C. § 1983)
(Against Defendants COUNTY OF SUTTER, J. PAUL PARKER, DAVID SAMSON, NORMAN BIDWELL, DORIS BROWN, MELODY YOUNG, BALJINDER RAI, SHANE DICKSON, UNKNOWN JAIL EMPLOYEE I, FREMONT-RIDEOUT HEALTH GROUP, DAVID FRATERS, and DOES I through XL)

95. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 94, as though fully set forth herein.

96. The aforementioned acts and/or omissions of Defendants in being deliberatively indifferent to NATHAN PRASAD's serious medical needs, health and safety and violating NATHAN PRASAD's civil rights, and their failure to train, supervise and/or take other measures at Sutter County Jail to prevent the conduct that caused the untimely and wrongful death of NATHAN PRASAD and deprived Plaintiffs MARY PRASAD, T.P., and A.P. of their liberty interest in the parent-child relationship in violation of their substantive due process rights as defined by the First and Fourteenth Amendments to the United States Constitution.

97. As a direct and proximate result of the aforementioned acts and/or omissions of Defendants, Plaintiffs suffered injuries and damages as alleged herein.

98. The aforementioned acts and/or omissions of the individually named Defendants were willful, wanton, malicious, and oppressive, thereby justifying an award of exemplary and punitive damages to punish the wrongful conduct alleged herein and to deter such conduct in the future.

FIFTH CLAIM FOR RELIEF
Failure to Furnish/Summon Medical Care
(Survival Action – Cal. State Law)
(Against Defendants DORIS BROWN, MELODY YOUNG, BALJINDER RAI, SHANE DICKSON, UNKNOWN JAIL EMPLOYEE I, and DOES I through XL)

99. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 98, as though fully set forth herein.

100. Defendants owed NATHAN PRASAD a duty of care to provide him

immediate medical care.

101. The conduct of Defendants alleged herein, including but not limited to the facts that Defendants knew or had reason to know that NATHAN PRASAD was in need of immediate medical treatment, and that Defendants failed to take reasonable action to summon such care or to provide that care, resulting in NATHAN PRASAD's death as alleged herein, violated California state law, including Cal. Govt. Code Sections 844.6 and 845.6.

102. The alleged conduct of Defendants was committed within the course and scope of their employment.

103. As a direct and proximate result of Defendants' breach, NATHAN PRASAD and Plaintiffs suffered injuries and damages causing great pain and leading to his death, as alleged herein.

104. The aforementioned acts of Defendants were willful, wanton, malicious, and oppressive, thereby justifying an award of exemplary and punitive damages to punish the wrongful conduct alleged herein and to deter such conduct in the future.

SIXTH CLAIM FOR RELIEF
Wrongful Death, Cal. Code Civ. Proc. § 377.60
(Against Defendants COUNTY OF SUTTER, J. PAUL PARKER, DAVID SAMSON, NORMAN BIDWELL, DORIS BROWN, MELODY YOUNG, BALJINDER RAI, SHANE DICKSON, UNKNOWN JAIL EMPLOYEE I, FREMONT-RIDEOUT HEALTH GROUP, DAVID FRATERS, and DOES I through XL)

105. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 104, as though fully set forth herein.

106. NATHAN PRASAD's death was a direct and proximate result of the aforementioned wrongful and/or negligent acts and/or omissions of Defendants. Defendants' acts and/or omissions thus were also a direct and proximate cause of Plaintiffs' injuries and damages, as alleged herein.

107. As a direct and proximate result of Defendants' wrongful and/or negligent acts and/or omissions, Plaintiffs incurred expenses for funeral and burial expenses in an amount to be proved.

108. As a direct and proximate result of Defendants' wrongful and/or negligent acts and/or omissions, Plaintiffs suffered the loss of the services, society, care and protection of the decedent, as well as the loss of the present value of his future services to his family. Plaintiffs are further entitled to recover prejudgment interest.

109. Plaintiff Estate of NATHAN PRASAD is entitled to recover punitive damages against individual Defendants who, with conscious disregard of NATHAN PRASAD's rights, failed to provide NATHAN PRASAD with medical treatment meeting the professional standard of practice and failed to adhere to the legal mandates of prisoner supervision and care.

110. The aforementioned acts of Defendants were willful, wanton, malicious, and oppressive, thereby justifying an award to Plaintiffs of exemplary and punitive damages to punish the wrongful conduct alleged herein and to deter such conduct in the future.

PRAYER FOR RELIEF

WHEREFORE Plaintiffs pray for judgment against Defendants as follows:

1. For compensatory, general and special damages against each Defendant, jointly and severally, in the amount proven at trial;

2. For damages related to loss of familial relations as to Plaintiffs MARY PRASAD, T.P., and A.P.

3. Funeral and burial expenses, and incidental expenses not yet fully ascertained;

4. General damages, including damages for physical and emotional pain, emotional distress, hardship, suffering, shock, worry, anxiety, sleeplessness, illness and trauma and suffering, the loss of the services, society, care and protection of the decedent, as well as the loss of financial support and contributions, loss of the present value of future services and contributions, and loss of economic security;

5. Prejudgment interest;

6. For punitive and exemplary damages against each individually named Defendant in an amount appropriate to punish Defendants and deter others from engaging

in similar misconduct, in amounts according to proof;

7. For lost wages, employment opportunities, and other losses in an amount according to proof;

8. For costs of suit and reasonable attorneys' fees and costs pursuant to 42 U.S.C. § 1988, and as otherwise authorized by statute or law;

9. For restitution as the court deems just and proper;

10. For such other and further relief as the court deems just and proper.

DATED: March 6, 2012

Respectfully submitted,

ROSEN, BIEN & GALVAN, LLP

By: */s/ Aaron J. Fischer*
Michael W. Bien
Aaron J. Fischer

Attorneys for Plaintiffs

1 **DEMAND FOR JURY TRIAL**

2 Plaintiffs hereby demand a jury trial.

3

4 DATED: March 6, 2012 Respectfully submitted,

5 ROSEN, BIEN & GALVAN, LLP

6

7 By: */s/ Aaron J. Fischer*
Michael W. Bien
8 Aaron J. Fischer

9 Attorneys for Plaintiffs

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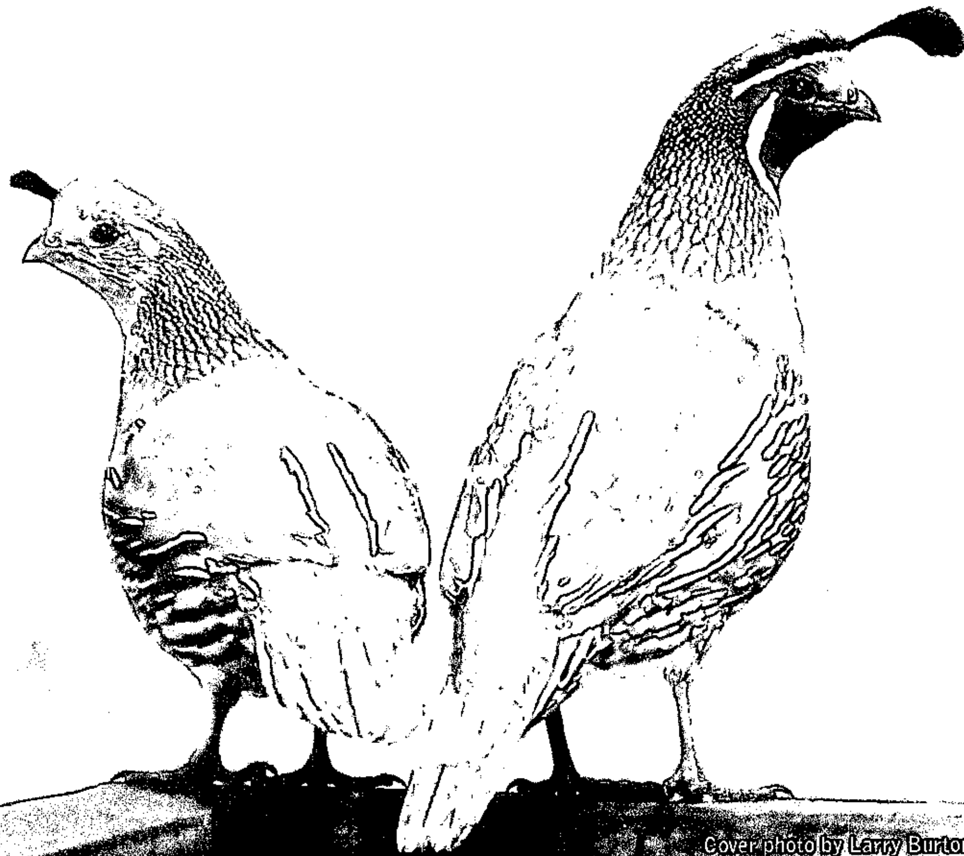
Attachment A

2010-2011
Sutter County Grand Jury Final Report



Cover photo by Larry Burton

ENDORSED FILED

JUL 13 2011

SUPERIOR COURT OF CALIFORNIA
COUNTY OF SUTTER
CLERK OF THE COURT
By JACKIE LASWELL Deputy

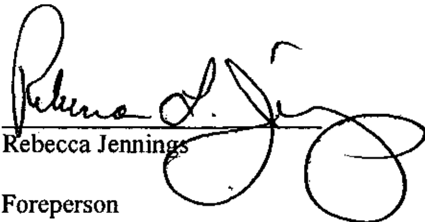
Final Report

of the

2010-2011

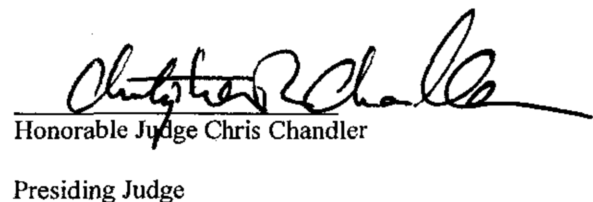
Sutter County

Grand Jury



Rebecca Jennings

Foreperson



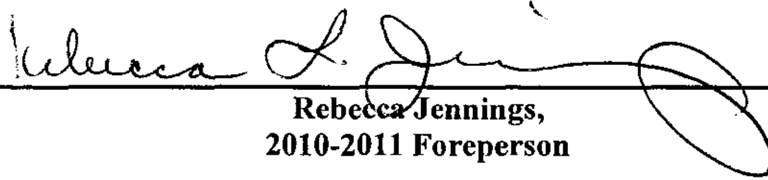
Honorable Judge Chris Chandler

Presiding Judge

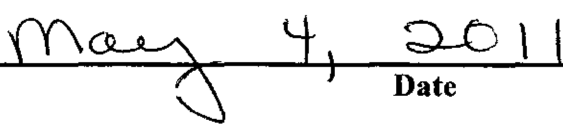
Report
Of the
2010-2011
Sutter County Grand Jury

Rebecca Jennings-Foreperson, Bob Benton, Carol Guidera, Dale Palmer, Don Pope, Glen Davis, Hal Beeso, Harjeet Singh, Jimi Hans, Karen LaRose, Linda Peterson, Megan Saavedra, Nancy Romero, Sue Countryman, Tammie Putman, Theresa McFall, Tom Bethards, Vera Crabtree

Final Report [pursuant to Penal Code 933 (a)

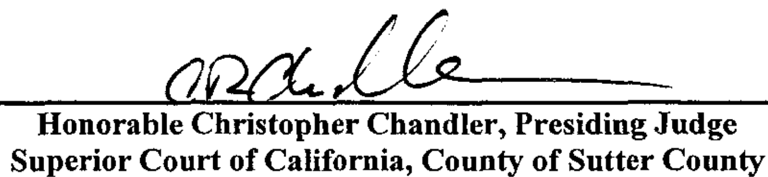


Rebecca Jennings,
2010-2011 Foreperson

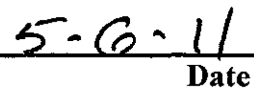


Date

Pursuant to Penal Code Section 933(a), the Presiding Judge makes the finding that the foregoing report is in compliance with the Title 4, Chapter 3 of the Penal Code ("Powers and Duties of the Grand Jury".



Honorable Christopher Chandler, Presiding Judge
Superior Court of California, County of Sutter County



Date

SUTTER COUNTY GRAND JURY

Honorable Judge Chris Chandler
Sutter County Superior Court
446 2nd Street
Yuba City, CA 95991

Dear: Judge Chandler

In accordance with the California Penal Code Section 933, the 2010-2011 Sutter County Grand Jury has completed its duties with the release of the Final Report to the Court and to the citizens of Sutter County. We were privileged to be selected a year ago to serve on the Sutter County Grand Jury as "a voice of the people and conscience of the community." We took our work seriously and did our best to approach our reviews and investigations objectively and thoroughly.

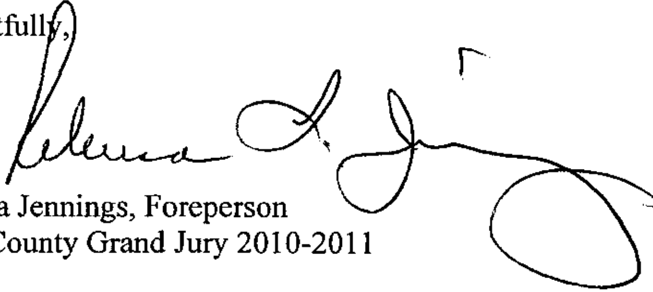
It has been a year of learning and hard work in gaining new insights; some were frustrations, and some were fun. We have all had personal growth in this Grand Jury experience. As is with any new Grand Jury, eighteen independent individuals with distinctive talents and skills successfully formed cohesive efforts to make their contribution to the citizens of this county. Members of this Jury have dedicated countless hours of work investigating, compiling, debating, and writing these reports. Each member of this Grand Jury contributed greatly to this report. I am proud of my fellow jurors and all they have accomplished.

This year was Judge Brian Aronson second year as the supervising judge for the Grand Jury. We would like to thank Judge Aronson, together we have learned a lot. To complete our work, we had the assistance of the county's court staff, particularly Christine Dagnino and Jackie Laswell. Each staff member we encountered was friendly and helpful. Our thanks to District Attorney Carl Adams and his staff who assisted us along the way taking our phone calls and providing us with the information we needed to perform our duties as members of the Grand Jury. We commend District Attorney Carl Adams dedication of time as the legal advisor for the Grand Jury for the past twenty-eight years**.** The Court Security Staff was very helpful as we navigated unfamiliar territory around the courthouse. Many individuals from the various agencies we visited were also helpful in countless ways.

In Conclusion I would like to thank this year's Grand Jurors for their conscientious effort and commitment. I would also like to thank Tammie Putman for her dedication and service as the Pro-tem and Secretary of the 2010-2011 Sutter County Grand Jury. Her dedication has made our job much easier. In closing, I would also like to express my

gratitude to the families of my fellow jurors in their unwavering support of their family members as they dedicated many hours away from home in performance of their Grand Jury duties. I believe that each member of this year's Sutter county Grand Jury will echo my sentiments, that this has been a priceless learning experience and opportunity to serve our County. I consider it a privilege to have served with the many individuals who demonstrate concern about the welfare of their county and the citizens who reside in it.

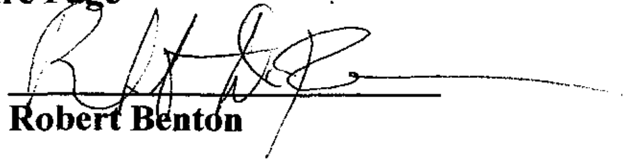
Respectfully,



Rebecca Jennings, Foreperson
Sutter County Grand Jury 2010-2011

2010-2011 Signature Page

Harold Beeso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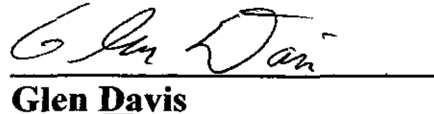
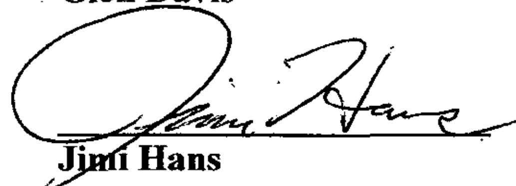
Tom Bethards

Susan Countryman

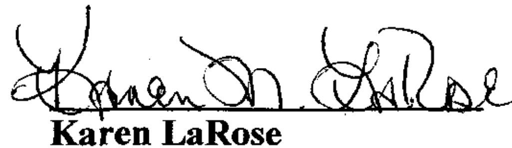
Vera D. Crabtree

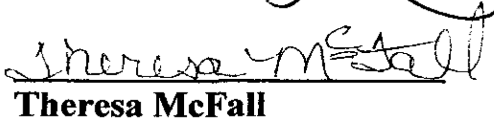

Glen Davis

Carol Guidera


Jimi Hans

Rebecca L. Jennings


Karen LaRose

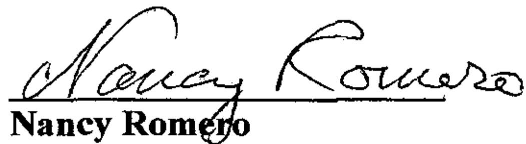

Theresa McFall

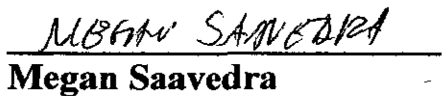
Dale D. Palmer

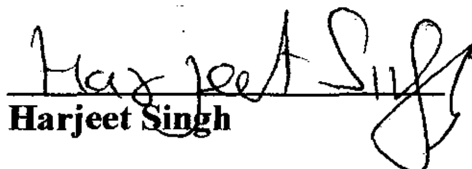
Linda Peterson

Donald Pope

Tammie Putman


Nancy Romero


Megan Saavedra


Harjeet Singh

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AD-HOC Committee

Sutter County Jail Nurses Program
Citizens Complaint

Introduction

The 2010-2011 Sutter County Grand Jury (SCGJ) received a citizen's complaint on the Sutter County Jail Nurses Program. The complaint alleged illegal practices, lack of training, out of compliant policies/procedures and poor inmate medical care.

The Grand Jury established an Adhoc Committee to undertake an investigation to determine these allegations on the complaint. Interviews were held with supervisors, managers, and staff of the Sutter County Jail. The Adhoc Committee completed an investigation of this complaint and made a number of recommendations resulting from that investigation.

Discussion

The Sutter County Jail Nurses program is to ensure provision of emergency and basic health care services to individuals who are in custody. Nursing Staff provides health care to the incarcerated from booking until the time of release. Along with the Physician and Nurse Practitioner, there is a Jail Nurse Manager, a Supervising Registered Nurse (SRN), three Licensed Vocational Nurses (LVN)'s and 7-8 contract LVN's. Since November 2010, the county has an open position for a second SRN.

The Grand Jury felt the allegations in the complaint were serious and needed to be investigated.

The complaint alleges the following:

Inadequate R.N. Coverage

According to the complaint, per Legal Decree #CIV-S-93-1256 DFL JFM (P) of Dempsey W. Haller, et al. vs. The County of Sutter, et al. (see attachment, A) states in part:

E. 2. Staffing: "Jail medical staffing is the responsibility of the County's Human Services Department and shall consist of at least one registered nurse on site during either the day shift or the evening shift seven days per week, and either one registered nurse or one LVN on site during the other day shift or evening shift as appropriate, seven days per week..."

Prior to the resignation of a SRN, there was one SRN and LVN on the day shift or one SRN and LVN on the night shift. There was an incident when the SRN on the night shift became ill while on duty. The SRN called in a LVN for backup. The SRN was reprimanded by the Jail Nurse Manager in an email that there should have been a Registered Nurse on duty. The SRN was referred to legal decree #CIV-S-93-1256 DFL

JFM (P) against Sutter County, which states the requirement. The SRN was not told of this legal decree prior to this incident. According to the staff, there had been 20 days so far that year that this had occurred. During the investigation, it was noted that this was a common occurrence since there were only two SRNs.

Lack of Training

According to the complaint training of staff nurses has not occurred in more than five (5) years. Annual onsite training is necessary to maintain proficiency in emergency response procedures.

Before the SRN resigned, the SRN requested onsite training. The SRN's request was refused by the Jail Nurse Manager. The SRN put together training on Emergency Response in the jail. The SRN asked for a review of the materials and the Jail Nurse Manager refused to even look at the class outline. The SRN held the class with a few nurses and correctional staff in attendance.

Out of Compliant Policies and Procedures

The complaint alleged the Jail Nurses Program is out of compliance with California State correctional code – Title 15 sec 1206 Policy and Procedures (P&P) are to be reviewed annually. Standardized Nursing Procedures (SNP) have not been reviewed or updated since 1995. The SNP has been changed with pencil marks.

The nursing staff has inquired as to why these P&P's and the SNP's are outdated. The Jail Nursing Manager's answer is lack of time prevents him from completing the task.

Finding

Inadequate R.N. Coverage

The Nurse staffing at the Jail has been directed by a court order in Dempsey W. Haller vs. Sutter County, et al. No. CIV-S-93-1256 DFL JFM (P). Failure to comply with this order Sutter County can be found out-of-compliance and could be liable for additional action by the Court.

Recommendation

Every effort should be made to hire an additional SRN and ensure one is available for either the AM shift or the PM shift. The Nursing Program Manager needs to take a more active role in managing the Jail Nursing Program. Once the SRN position is filled, the Nursing Program Manager, who is also an RN, must be utilized to ensure the Jail Nursing Program is in compliance with the court order.

The Assistant Director of Health and Human Services should provide oversight to insure the Jail Nursing Program is in full compliance with court order Legal decree #CIV-S-93-1256 DLF JFM (P).

Finding

Lack of Training

Legal decree #CIV-S-93-1256 DLF JFM (P)
E19. Training: "Jail custody staff shall receive periodic update training in First Aid, CPR, intake screening, blood borne pathogens and suicide prevention..."

Sutter County Jail Medical Policies and Procedures #3 Section 6. "Oversees training of nurses and/or officers in areas where improvement is needed, as identified by QA audits, including regular and continued joint staff development activities. These will be documented as to date given, content, attendees and comments."

Training is necessary to maintain proficiency in on-site activities. The Nursing Program Manager has failed to offer his nursing staff any of the required training. When one of his SRN's put together an emergency response training class he refused to review the course outline before the class was held.

Recommendation

The Grand Jury recommends the Nursing Program Manager along with the Medical Officer, develop a training program to ensure adequate on-site training be made available to the nursing staff on a regular basis. The Assistant Director of Health and Human Services should provide oversight to ensure this training program is implemented.

Finding

Out of Compliance Policies and Procedures

Title 15 Regulations 1206. Health Care Procedure Manual "The health authority shall in cooperation with the facility administrator, set forth in writing, policies and procedures in conformance with applicable State and Federal law, which are reviewed and updated at least annually..."

During the investigation, it was stated unanimously that the P&P's were significantly out-of-date. The County Medical Officer is responsible for making sure the P&P's are current by signing them annually. The Jail Nurse Program Manager has overall responsibility to see that the Nursing Program policies and procedures are operational and functioning in the scope as laid out in the Standard Nursing Procedures. The Jail Nurse Program Manager has not done this. When the Jail Nurse Program Manager was hired, the P&P's were not up to date. By not correcting these problems, his inaction has allowed this

situation to deteriorate further. The Jail Nurse Program Manager indicated it would take over a year to complete. This should be made a priority.

Recommendation

The County Medical Officer and the Jail Nurse Program Manager with oversight from the Assistant Director of Health and Human Services should ensure the Jail Nursing Program P&P's are reviewed, rewritten, and made current so they can be used and referred to by the jail staff. The Standard Nursing Procedures has been changed with pencil marks and needs to be corrected.

The Grand Jury recommends that these documents be completed by December 31, 2011. The Jail Nursing Program would also benefit from more active oversight by the Assistant Director of Health and Human Services to see that it is accomplished by the above date.

Finding

During this investigation the Grand Jury finds the Jail Nursing Program is completely out of compliance with annual nurse training updates and standard nursing procedures. This exposes Sutter County to numerous potential issues in the future.

Recommendation

The Grand Jury recommends that the Assistant Director of Health and Human Services actively take measures to ensure that this program is in full compliance with the law. It is unacceptable that the program is out of compliance, lack of training for the nursing staff, not having the P & P's up-to-date, and the pencil corrections in the SNP. The Grand Jury recommends that the Jail Nursing Program be in full compliance by December 31, 2011.

Respondents

Director of Health and Human Services, Tom Sherry
Assistant Director of Health and Human Services, Amerjit Bhattal
County Medical Officer, Dr. Cummings
Jail Nurse Program Manager, Brent Garbett

Attachment A

FILED

SEP 14 1994

CLERK, U. S. DISTRICT COURT
EASTERN DISTRICT OF CALIFORNIA
BY
DEPUTY CLERK

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Attorneys for Defendants COUNTY OF SUTTER
and SHERIFF ARTHUR R. BRANDWOOD

LODGED

DEPUTY CLERK

UNITED STATES DISTRICT COURT

FOR THE EASTERN DISTRICT OF CALIFORNIA

DEMPSEY W. HALLER, et al. Plaintiffs, vs. THE COUNTY OF SUTTER, et al.	No. CIV-S-93-1256 DFL JFM (P) AMENDED SETTLEMENT AGREEMENT

The parties hereby stipulate to settlement of the issues remaining in this case as follows:

A. Clothing Exchange: Defendants will provide Jail inmates with clothing upon intake, and periodic clothing exchanges pursuant to Title 15, section 1260, 1261, 1262, 1263, and 1264. All references to Title 15 in this agreement are to Title 15 as amended in 1994.

B. Recreation: Defendants will provide Jail inmates with outdoor recreation pursuant to Title 15, section 1065. Defendants will make best efforts to provide Main Jail inmates with outdoor recreation five times per week. In addition, defendants will provide, subject to security considerations, the following recreation equipment in the Jail's outdoor recreation yards [both male and female]: portable basketball hoops, volleyball nets and balls, handballs, and one Santa Clara County Hermo II exercise machine.[1]

C. Food: Defendants will complete the Jail's kitchen remodel project by September 1, 1994. Thereafter, defendants will comply with Title 15 standards, specifically sections 1240, 1241, 1242, 1243, 1245, 1246, 1247, 1248, and 1249 concerning food preparation in the Jail.

D. Law Library: Defendants will participate in an experiment to provide CD-Rom law library materials to Jail inmates effective September 1, 1994. There will be a CD-Rom library for inmates in the Jail.

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[1] A Hermo II is also provided to inmates housed in the Jail Dormitory housing unit.

1. All inmates will be provided with access to the CD-Rom library and hardbound law library regardless of sentenced or presentenced status, regardless of whether the inmate is represented by counsel.

2. CD-Rom library and hardbound law library access will be subject to reasonable security, staffing and time restrictions. Inmates facing court deadline and inmates proceeding "in pro per" in local courts will be afforded priority access.

3. Inmates who request access to the CD-Rom or hardbound law library will be provided direct access without staff present and will be allowed to browse among the available CD disks and law books and to work on their legal cases within the law library.

4. The Jail CD-Rom West Publishing inventory is attached as Exhibit A. The Jail hardbound book law library is attached as Exhibit B.

5. Inmates working with the CD-Rom legal system will have access to a computer, CD drive, dot matrix printer and written instructions explaining how to access CD-Rom materials will be provided by plaintiffs' counsel.

6. The above-referenced experiment will continue for at least a period of twelve [12] months. Counsel for the parties will communicate at least every six months concerning the status of this experiment. At the conclusion of this period the parties shall meet and confer in good faith concerning the long term use of CD-Rom and hardbound law books.

E. Medical Care: Defendants will modify their delivery of medical services system to provide medical, mental health, and dental care to the plaintiff class as set forth below, the implementation of which service systems will be commenced immediately and will be completed on or about January 1, 1995.

1. Intake Screening: Jail medical intake screening shall be performed by a Sheriff's custody staff trained in screening procedures by County medical and mental health personnel. The intake screening form shall meet the criteria established by Title 15 of the California Code of Regulations and the California Medical Association. Jail medical staff shall review all intake screening forms as soon as possible, in most cases the same day as booking, but in no event later than the next shift when nursing staff is available.

2. Staffing: Jail medical staffing is the responsibility of the County's Human Services Department and shall consist of at least one registered nurse on site during either the day shift or the evening shift seven days per week, and either one registered nurse or one LVN on site during the other day shift or evening shift as appropriate, seven days per week. Supplementing this nursing coverage shall be on-site visits by a nurse practitioner or physician's assistant two days per week for a total of approximately four hours per week, and on-site visits by a physician twice per week for approximately five hours. Excluding weekends and county holidays, there will be an on-site visit by either a nurse practitioner, physician's assistant, or a physician not less frequently than every other day. Further

supplementing this coverage shall be on-site visits by a County mental health staff crisis counselor for approximately 18 hours per week, for no less than 3 separate visits each week. On-site visits for physicians and mental health workers will take place, whenever possible, on established days and hours. Clerical support will be provided the Jail nurses as appropriate.

3. Sick Call: There shall be a screening process concerning inmate medical problems and complaints conducted by the Jail nursing staff or a nurse practitioner or a physician's assistant. To access sick call, inmates shall utilize a Jail Sick Call Request form. The triage for sick call slips shall take place daily, formal sick call shall be available five days per week.

4. Pill Call: Medications shall be distributed to Jail inmates by County medical and/or Jail staff based upon protocols established and approved by the County Department of Human Services. All medications shall be distributed the appropriate number of times per day deemed medically necessary by County medical/mental health staff.

5. Inmate Medical Records: Inmate medical/mental health/dental records shall be maintained in a confidential manner and in a secure setting. The Jail's medical staff shall maintain records on site at the Jail which document inmate medical problems and which include the information and documents deemed necessary by established protocols based upon Title 15 Minimum Jail Standards.

/////

6. Access to Specialized Clinics: Inmates shall have access to specialized clinics and care as deemed appropriate by County medical, dental, and mental health providers.

7. Inmates With Acute Illnesses: Inmates with acute illnesses shall be transferred to alternative sites for care as deemed appropriate by County medical and/or mental health staff.

8. Detoxification: The Jail shall maintain written detoxification procedures which are utilized by both Sheriff's and County medical staff. These procedures shall comply with the standards set forth in the Title 15 "Minimum Standards" for Local Detention Facilities in the California Code of Regulations.

9. Communicable Diseases: The Jail shall maintain its plan to detect, control, and treat inmates with priority communicable diseases. The program to detect, control and treat inmates with communicable diseases will describe how the identification, treatment, control, and follow-up management of inmates with communicable diseases will occur. Priority communicable diseases will include TB, HIV/AIDs, STD's, Hepatitis A and B, Rubella, Measles and other diseases identified by Jail staff and the Sutter County Public Health Officer.

10. Standardized Practices: The Jail's medical personnel shall follow established written treatment protocols prepared by the County's Department of Human Services. These treatment protocols, and the medical policies and procedures utilized by Jail medical staff shall be completely revised and approved by all of the involved County agencies. Jail policies, procedures, and treatment protocols shall follow the format established by the California Medical Association.

11. Suicide Prevention: The Jail shall maintain a suicide prevention program which includes instruction by County mental health staff [both classroom and video training] for Sheriff's personnel working with the Jail.

12. Dental Care: Inmates requiring dental care shall be referred to a private provider who shall provide the appropriate care necessary to alleviate pain, prevent infections, and treat emergency dental needs. Dental care shall be timely depending upon the pain and seriousness of the dental problem. Dental care shall not be limited to extractions, however, the dental care provided to Jail inmates is not intended to deal with years of personal neglect.

13. Management of Pharmaceuticals: Pharmaceutical practices will comply with section 1216 of the Title 15 Minimum Standards for Local Detention Facilities.

14. Sick Call Forms: The Jail's sick call form, including the form necessary to request mental health care, shall be printed in English, Spanish, and Punjabi. Inmates who request that a staff member act as a translator during the sick call or intake screening process shall be provided with language assistance as deemed appropriate by Jail staff. Access to forms shall include access to information concerning how to obtain medical, mental health, and dental care within the Jail.

15. Quality Assurance: The responsible County physician for the Jail under Title 15, section 1202 shall establish a mechanism to assure that the quality and adequacy of medical, dental, and mental health care is annually assessed. The plan

shall include a means for the correction of identified deficiencies of the medical/dental/mental health and pharmaceutical services provided and shall include the statistical gathering set forth in Title 15. In addition, and as part of this plan, monthly meetings shall be held between the Jail's custody and medical/mental health staff.

16. Informed Consent: The Jail has established procedures which conform to Title 15, section 1214 of the California Code of Regulations.

17. Food Handlers: The responsible physician shall develop procedures for medical screening of food handlers prior to working in the facility kitchen. Additionally, there shall be written procedures for education and ongoing monitoring and cleanliness of food service workers in accordance with section 27605 of the Health and Safety Code, California Uniform Retail Food Facilities Law.

18. Jail Medical Office: The Jail's medical office shall be renovated by March 1, 1995.

19. Training: Jail custody staff shall receive periodic update training in First Aid, CPR, intake screening, blood borne pathogens,and suicide prevention.

20. OSHA: The Jail will implement a program to address the OSHA blood borne pathogen requirements.

21. Women's Rights: The Jail will post as necessary the pregnancy related rights of female inmates as set forth by the California Penal Code.

22. <u>HIV Testing</u>: HIV testing will be provided in the Jail upon request. Pre and post test counselling will be provided.

F. Either party may seek to change the terms of this SETTLEMENT AGREEMENT pursuant to the standards set forth in <u>Rufo v. Inmates of Suffolk County Jail</u>, 502 U.S. ____, 112 S.Ct. 748 (1992).

G. In the event that an emergency threatens the Sheriff's ability to comply with these orders, counsel for defendants will notify counsel for plaintiffs no later than the next business day.

H. Defendants shall pay to plaintiffs' counsel attorney fees in the amount of $17,500 at the time of the filing of the Final Judgment.

I. The parties have previously stipulated to a permanent injunction filed on September 15, 1993 relating to any and all population issues, a copy of which is attached hereto and incorporated herein by reference as Exhibit C. This SETTLEMENT AGREEMENT is intended to resolve all matters not covered by the permanent injunction referred to above.

Upon the execution of this SETTLEMENT AGREEMENT, the parties request a dismissal of all matters not covered by the permanent injunction referred to above.

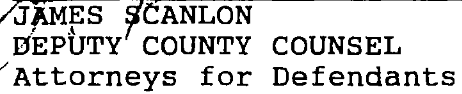
J. The parties stipulate and agree that the Magistrate Judge and District Court Judge assigned this case will issue any and all orders necessary for the dismissal of this action, including but not by way of limitation any orders deemed

necessary regarding posting of this agreement and any Fairness Hearing deemed necessary.

IT IS SO STIPULATED:

DARRELL W. LARSEN
SUTTER COUNTY COUNSEL

DATED: August 16, 1994



JAMES SCANLON
DEPUTY COUNTY COUNSEL
Attorneys for Defendants

DATED: August 17, 1994

PAUL COMISKEY
Attorney for Plaintiffs

EXHIBIT A -- CD-ROM LIBRARY

1. The system will provide access to the following legal authorities:

(a) Reported cases of the United States Supreme Court

(b) Federal 2d and Federal 3d Reporters

(c) All available California reported cases

(d) Annotated California Codes

2. The computer hardware system which will include a single work station terminal shall be selected by the Sutter County Sheriff with the concurrence with plaintiffs' counsel.

EXHIBIT B -- LAW LIBRARY - BOOKS

In addition to computerized legal research, the law library shall consist of at a minimum the following bound authorities or their substantial equivalents:

1. West California Rules of Court, State - latest edition

2. West California Rules of Court, Federal - latest edition

3. West Federal Rules of Civil and Criminal Procedure and Evidence - latest edition

4. Black's Law Dictionary - latest edition

5. Deerings California Penal Code - latest edition

6. Deerings California Civil Practice Code - latest edition

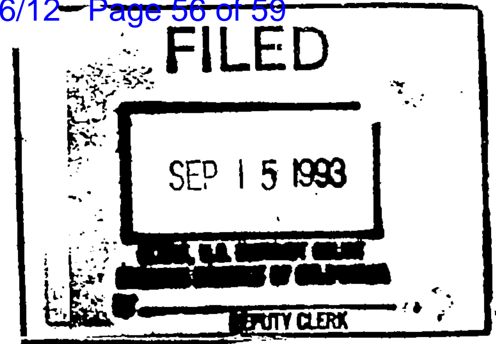
7. Federal Habeas Corpus - 2nd edition (Michie Company)

8. California Criminal Law

   Book No. 1
   - a. Introduction to Crimes
   - b. Elements of Crime
   - c. Defenses
   - d. Crimes Against the Person

   Book No. 2
   - a. Crimes Against Property
   - b. Crimes Against Decency and Morals
   - c. Crimes Against Public Peace and Morals
   - d. Crimes Against Governmental Authority

   Book No. 3
   - a. Punishment for Crimes



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Los Angeles, CA 90086-0935
7 (213) 626-2089

8 Attorneys for Defendants COUNTY OF SUTTER
and SHERIFF ARTHUR R. BRANDWOOD

EXHIBIT C

9

10 **UNITED STATES DISTRICT COURT**

11 **FOR THE EASTERN DISTRICT OF CALIFORNIA**

DEMPSEY W. HALLER, et al.)	NO. CIV-S-93-1256 DFL PAN (P)
)	
Plaintiffs,)	**STIPULATION RE POPULATION LIMITS, ORDER**
)	
vs.)	
)	
THE COUNTY OF SUTTER, et al.)	
)	
Defendants.)	
)	

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1 The parties hereby agree and stipulate to the following
2 injunctive orders:
3 1. This action shall proceed as a class action pursuant to
4 Federal Rules of Civil Procedure, Rule 23b.
5 2. Defendants are enjoined from bedding inmates on the floor.
6 3. The maximum assigned bed capacities for each housing unit
7 of the Sutter County Jail are set forth below:
8 Unit I - 8 beds
9 Unit MPS - 24 beds*
10 Unit MS - 24 beds*
11 Medical Sheltered Living - 3 beds
12 Kitchen Trustee Unit - 8 beds
13 FPC - 4 beds
14 FPS - 6 beds*
15 FS - 10 beds*
16 FJ - 4 beds
17 Jail Dormitory - 62 beds*
18 4. Defendants may operate, if conditions warrant, housing
19 units MPS, MS, FPS, and FS at two beds above the capacity defined
20 in paragraph 3. Defendants may operate, if conditions warrant, the
21 Jail Dormitory with as many as six beds above the capacity defined
22 in paragraph 3. Defendants shall not house inmates in MPS, MS,
23 FPS, FS, and the Jail Dormitory above the capacities agreed to in
24 paragraph 3 unless beds of like classification are not available in
25 other housing units. In the event units MPS, MS, FPS, FS, and the
26 Jail Dormitory are operated above the capacity set forth in
27 paragraph 3, outdoor recreation will be provided for those units
28

1 operating above the capacity set forth in paragraphs 3 for at least
2 one hour per day, five days per week. In no event will any housing
3 unit operate above its paragraph 3 capacity for more than 14
4 consecutive days and, in no event will the total Jail bed capacity
5 exceed by 14 beds the total capacity set forth in paragraph 3,
6 except that except that Defendants may operate the Jail Dormitory
7 at its existing bed capacity of 88 beds until the Minimum Facility
8 presently under construction is operational.[1]

9 5. The prohibition against floorsleepers is effective
10 immediately. The population limits set forth in paragraphs 3 and
11 4 shall be effective forty five [45] days from the date that this
12 Order is approved by the District Court.

13 6. Defendants are enjoined from adding beds to the Main Jail
14 in each and every housing unit which exists on the date that this
15 stipulation is executed.[2]

16 7. The Sheriff of Sutter County is authorized by this order
17 to release inmates from the Sutter County Jail whenever the Sutter
18 County Jail, or any specific housing unit therein, is within ten
19 percent [10%] of being filled. The Sheriff shall release inmates
20 or refuse to accept newly-committed inmates whenever all beds in
21 the Jail are filled, or whenever any specific housing unit within
22 the Jail is filled.

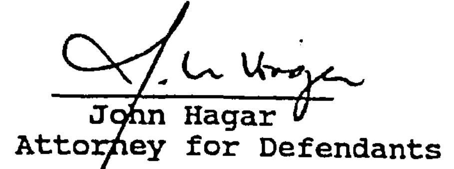
23

24 1. "Operational" is defined, for the purposes of this stipulation, as being 50% occupied under the rated capacity assigned by the California Board of Corrections.

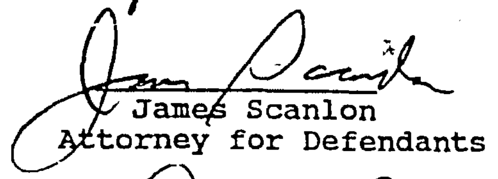
25

26 2. This stipulation does not encompass any additional jail structures to be built in the future, whether contiguous or
27 attached, that are not presently within the physical confines of the presently constructed Jail. This stipulation does not limit
28 the capacity of the Minimum Facility presently under construction.

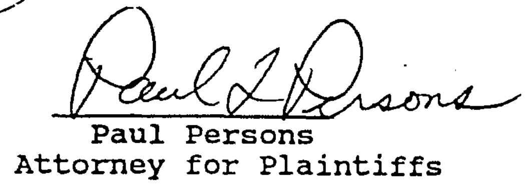
1 8. Either party may seek to modify or terminate this
2 stipulation pursuant to the standards set forth in <u>Rufo v. Inmates</u>
3 <u>of Suffolk County Jail</u>, ___ U.S. ___, 112 S.Ct. 748 (1992).
4 IT IS SO STIPULATED:
5
6 DATE: 9/8/93



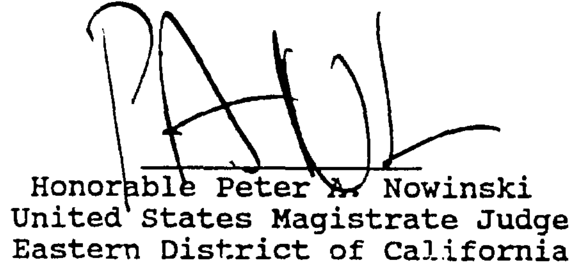
7 John Hagar
Attorney for Defendants
8
9 DATE: 9/13/93



10 James Scanlon
Attorney for Defendants
11
12 DATE: 9/9/93



13 Paul Persons
Attorney for Plaintiffs
14
15 ORDER
16 It is so recommended.



17
18 DATE: 9-15-93

Honorable Peter A. Nowinski
19 United States Magistrate Judge
Eastern District of California
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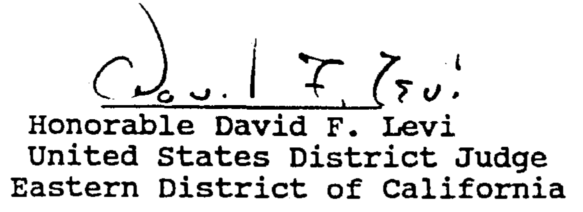
21 It is so ordered.
22



23 DATE: 9-15-93

Honorable David F. Levi
24 United States District Judge
Eastern District of California
25
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27
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