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14 Attorneys for Plaintiffs

15 UNITED STATES DISTRICT COURT

16 NORTHERN DISTRICT OF CALIFORNIA

17  
18 JESSE HERNANDEZ, CAIN AGUILAR, HA  
COBB, SUSAN DILLEY, CONNIE DOBBS,  
19 SEAN ESQUIVEL, RAMONA GIST, MARTHA  
GOMEZ, GEORGE GREIM, DENNIS GUYOT,  
20 JASON HOBBS, GLENDA HUNTER, ALBERT  
KEY, BRANDON MEFFORD, WESLEY  
21 MILLER, RICHARD MURPHY, JEFF  
NICHOLS, ANGEL PEREZ, SARAB SARABI,  
22 CLYDE WHITFIELD, and ROBERT YANCEY,  
on behalf of themselves and all others similarly  
23 situated,

24 Plaintiffs,

25 v.

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

28 Defendants.

Case No. CV 13 2354 PSG

**SECOND AMENDED CIVIL CLASS  
ACTION COMPLAINT FOR  
DECLARATORY AND INJUNCTIVE  
RELIEF**

Judge: Paul S. Grewal

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

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- (3) **Failure to Provide Adequate Mental Health Care to Prisoners:** Violations of 8th and 14th Amendments of U.S. Constitution, and Article I, Sections 7 and 17 of California Constitution
- (4) **Failure to Provide Reasonable Accommodations to Prisoners with Disabilities:** Violations of Americans with Disabilities Act, Rehabilitation Act, and California Government Code § 11135

## NATURE OF ACTION

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

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

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

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

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

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

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

6         6. Defendants’ failure to protect prisoners from violence and failure to provide  
7 minimally adequate medical and mental health care are particularly egregious given that  
8 Defendants have been aware of these problems and their causes for years, yet have failed  
9 to take the necessary actions to ameliorate the unconstitutional and illegal conditions. In  
10 2007, the County commissioned a third-party evaluation of the Jail, which resulted in a  
11 report, dated June 19, 2007, entitled “County of Monterey, Office of the Sheriff, Needs  
12 Assessment” (hereinafter “2007 Needs Assessment” or “2007 Assessment”), which is  
13 attached hereto as **Exhibit A**. The 2007 report concluded that “[t]he current combination  
14 of insufficient beds, an inadequate detention facility and understaffing has resulted in an  
15 almost untenable situation.” 2007 Assessment at Ex. 1-2. In 2011, the County asked the  
16 third-party consultant to update the 2007 report to reflect amendments to state law and  
17 changes within the Sheriff’s Office and the Jail population. This updated report, dated  
18 December 30, 2011, reached the exact same, word-for-word conclusion: “The current  
19 combination of insufficient beds, an inadequate detention facility and understaffing has  
20 resulted in an almost untenable situation.” County of Monterey, Office of the Sheriff, Jail  
21 Needs Assessment, December 30, 2011 (hereinafter “2011 Jail Needs Assessment” or  
22 “2011 Assessment”), attached hereto as **Exhibit B**, at Ex. 2. Defendants’ deliberate  
23 indifference to prisoners’ safety and medical and mental health is unconscionable, and  
24 must be stopped to prevent additional unnecessary loss of life, pain, and suffering.

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



1 injunctive relief under 28 U.S.C. §§ 1343, 2201, and 2202, 29 U.S.C. § 794a, 42 U.S.C.  
2 §§ 1983 and 12117(a), California Government Code § 11135, and Article I, Sections 7 and  
3 17 of the California Constitution.

4 **VENUE**

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

8 **PARTIES**

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

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



1 County Jail on April 4, 2013. Following her arrival at the Jail, Defendants provided  
2 untimely and inadequate care for Plaintiff COBB's severe kidney stones, including failing  
3 to timely diagnose her condition, failing to provide appropriate pain management, failing  
4 to provide appropriate and timely post-operative care after Plaintiff COBB had a surgical  
5 drain inserted into her kidney, failing to timely schedule necessary surgery for the removal  
6 of Plaintiff COBB's kidney stones, and failing to provide appropriate and timely post-  
7 operative care. As a result of Defendants' inadequate medical care, Plaintiff COBB has  
8 suffered severe and unnecessary pain and was placed at risk of permanent loss of kidney  
9 function. Plaintiff COBB still has a number of kidney stones for which she will continue  
10 to require treatment. Plaintiff COBB is a person with a disability as defined in 42 U.S.C.  
11 § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(m).

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



1 long flight of stairs that she can only climb with great difficulty and pain. Plaintiff  
2 DILLEY is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C.  
3 § 705(9)(B), and California Government Code § 12926(j) and (m).

4 14. PLAINTIFF CONNIE DOBBS has been detained at the Jail since September  
5 15, 2012. While in custody in November 2012, Plaintiff DOBBS sustained a fractured  
6 nose, a permanent post-traumatic tremor in her right hand from mild traumatic brain  
7 injury, and nerve damage, pain, and numbness in her left leg, knee, and ankle when she fell  
8 at the courthouse while shackled at the ankles, waist, and wrists. Defendants failed to  
9 provide Plaintiff DOBBS with timely and appropriate medical care, including, but not  
10 limited to, failing to receive timely diagnostic tests, proper pain medication, or follow-up  
11 tests after her serious injury. For example, Defendants did not diagnose the nasal fracture  
12 for nearly two weeks. As result of her fall and other chronic, pre-existing injuries, Plaintiff  
13 DOBBS has chronic pain, particularly in her left leg, hip, knee, and lower back.  
14 Defendants did not provide her proper pain management for over four months after her  
15 fall. Though she currently is prescribed Gabapentin and ibuprofen for her pain, she has  
16 experienced interruptions in these medication when her prescriptions are set to expire; she  
17 has been required to put in sick call slips and grievances to restart her medications. Even  
18 with the medication, Plaintiff DOBBS has impaired mobility and cannot access all of the  
19 programs and services of the Jail, such as religious services, because it is difficult for her  
20 to climb the stairs to get there. Plaintiff DOBBS also suffers from Right Carpal Tunnel  
21 syndrome which may have been exacerbated by her fall. Despite the recommendation by  
22 her outside neurologist for a hard wrist splint over a year ago, and despite Jail medical staff  
23 ordering her such wrist splint seven months ago, she has still yet to receive the splint.  
24 Without the splint Plaintiff DOBBS continues to experience pain, numbness, and tingling  
25 in her right wrist and hand which keeps her up at night. Plaintiff DOBBS is a person with  
26 a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California  
27 Government Code § 12926(m).

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

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

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

1 Plaintiff GIST has a history of mental health conditions and suffers from schizophrenia,  
2 bipolar disorder, anxiety, and insomnia. These conditions make it difficult for Plaintiff  
3 GIST to effectively communicate with Jail staff, to understand the rules and processes of  
4 the Jail, and to access Jail programs and services without accommodations. Defendants  
5 have repeatedly failed to provide Plaintiff GIST with appropriate and timely mental health  
6 care, including, but not limited to, denying her access to psychiatric medications  
7 prescribed by her outside physician. For example, Defendants previously denied  
8 prescribed psychiatric medications to Plaintiff GIST for up to 90 days upon her booking  
9 into the Jail. When Defendants deny Plaintiff GIST her medications, her mental health  
10 deteriorates and she suffers unnecessarily. Plaintiff GIST additionally has developmental  
11 disabilities, including fetal alcohol syndrome and mild Down syndrome. Plaintiff GIST  
12 encounters obstacles to participating in the Jail's educational programs due to these  
13 disabilities. Upon information and belief, she is unable participate in the Jail's GED  
14 program because she has difficulty understanding the classes. If there were special  
15 education opportunities she would participate. Plaintiff GIST also has a number of  
16 physical medical conditions, including scoliosis and congenital hip problems, from which  
17 she experiences chronic pain. Despite numerous requests, Defendants have failed to  
18 provide Plaintiff GIST with appropriate medical care for these conditions, including, but  
19 not limited to, failing to provide the muscle relaxant she is prescribed by her outside  
20 physician. Plaintiff GIST's conditions affect her balance, causing her to fall often and  
21 making it painful to walk for long periods or upstairs. Plaintiff GIST encounters numerous  
22 obstacles in the Jail that prevent her from accessing Jail activities, programs, and services,  
23 including the exercise yard, religious services, and Alcohol and Narcotics Anonymous  
24 classes, because of her cognitive impairments, mental illness, and physical disabilities.  
25 Plaintiff GIST is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C.  
26 § 705(9)(B), and California Government Code § 12926(j) and (m).

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

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

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

1 experienced significant mental health decompensation, with increasing anxiety, racing  
2 thoughts, depression, and insomnia. As a result, Plaintiff GREIM had difficulty  
3 communicating effectively with Jail staff, understanding the rules and processes of the Jail,  
4 and accessing Jail programs and services without accommodations. Plaintiff GREIM was  
5 also a victim of violence at the Jail in which custody staff did not intervene, due to  
6 Defendants' serious understaffing and lack of appropriate supervision of prisoners at the  
7 Jail. Additionally, Plaintiff GREIM has an injured right knee, which has caused him  
8 serious pain throughout his time in the Jail. Defendants have failed to provide adequate  
9 care for his knee. Plaintiff GREIM is a person with a disability as defined in 42 U.S.C.  
10 § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

11         19. PLAINTIFF DENNIS GUYOT was detained at Monterey County Jail on  
12 March 3, 2013. On March 15, 2013, Plaintiff GUYOT was assaulted by a group of other  
13 prisoners at the Jail, outside of the visual and audio supervision of any staff. Defendants  
14 unreasonably failed to protect Plaintiff GUYOT and failed to timely intervene in the  
15 attack. As a result of the assault, Plaintiff GUYOT experienced serious dental trauma for  
16 which he had to undergo invasive oral surgery. Plaintiff GUYOT also suffered a  
17 concussion, and continues to suffer from blurred vision, sensitivity to light, and serious  
18 migraines. Defendants failed to provide adequate medical care for his post-concussion  
19 medical needs, including, but not limited to, egregiously delaying in referring him for  
20 necessary specialist evaluations. Plaintiff GUYOT is a person with a disability as defined  
21 in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code  
22 § 12926(m).

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

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

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



1 back problems, which cause him constant pain, were severely aggravated when another  
2 prisoner in the Jail attacked him, without provocation, on November 17, 2013. The  
3 damage he sustained in the attack has caused him serious problems with walking and  
4 balance, and significant pain. After the attack, Defendants failed to provide Plaintiff  
5 HOBBS with adequate medical treatment, including, but not limited to, adequate pain  
6 medication, rehabilitative services, and access to outside medical specialists. In addition,  
7 Defendants did not timely provide him with a cane which he needed and requested to  
8 ensure his balance when walking. Moreover, because of the lack of a safe and adequate  
9 shower chair in his housing unit, on December 22, 2013, Plaintiff HOBBS fell while  
10 showering and further aggravated his back condition. Finally, in July 2013 during a prior  
11 term in the Jail, despite Plaintiff HOBBS's requests, Defendants refused to provide him  
12 with a lower bunk housing assignment; that same month, forced to sleep in the middle  
13 bunk of a triple bunk, Plaintiff HOBBS fell and injured his back attempting to climb down  
14 from his bed. Plaintiff HOBBS is a person with a disability as defined in 42 U.S.C.  
15 § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

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



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

13         23.     PLAINTIFF ALBERT KEY was detained at Monterey County Jail on  
14 March 17, 2013. Plaintiff KEY is a Vietnam War veteran with a long history of post-  
15 traumatic stress syndrome and bipolar disorder, and has received psychiatric care and  
16 medications from various providers including doctors employed by Defendants and by the  
17 California Department of Corrections and Rehabilitation ("CDCR") for over a decade.  
18 Nevertheless, on multiple occasions when he has arrived at Monterey County Jail,  
19 Defendants have subjected him to their inhumane and medically unjustified  
20 "detoxification" process, during which he is denied prescribed psychiatric medication for  
21 90 days. During each incarceration, Plaintiff KEY has experienced extreme delays in  
22 obtaining correct and appropriate psychiatric medications, and other necessary mental  
23 health interventions and care, and as a result suffers auditory hallucinations, racing  
24 thoughts, severe depression, nightmares, and periods of suicidal ideation. Plaintiff KEY  
25 also has a recurrent tumor on his neck for which Defendants have failed to provide  
26 appropriate medical care. As a result of Defendants' inadequate medical and mental health  
27 care, Plaintiff KEY has experienced unnecessary and avoidable pain and symptoms during  
28 his incarceration. Plaintiff KEY is a person with a disability as defined in 42 U.S.C.

1 § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

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

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

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

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

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

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

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

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

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

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

1 Narcoleptics may fall asleep at any time, and, without treatment, may sleep for upwards of  
2 20 hours a day. Cataplexy is a sudden loss of muscle control that may occur anywhere  
3 without warning, causing Plaintiff WHITFIELD to collapse and risk serious injury. When  
4 not in the Jail, Plaintiff WHITFIELD controls these conditions with a combination of  
5 medications, Provigil and Xyrem, prescribed for him by a doctor. Defendants have failed  
6 to provide Plaintiff WHITFIELD with appropriate and timely treatment for his narcolepsy.  
7 Defendants have not provided Plaintiff WHITFIELD with Xyrem, which controls  
8 cataplexy. As a result, Plaintiff WHITFIELD has experienced four cataplexic attacks since  
9 being detained on November 30, 2013. Normally, Plaintiff WHITFIELD experiences one  
10 such attack approximately every six months. Defendants also did not provide Plaintiff  
11 WHITFIELD with Provigil for approximately two months after his arrest, despite knowing  
12 he was prescribed the medication prior to incarceration. During that time, Plaintiff  
13 WHITFIELD was unable to leave his bed most hours of the day and spent 20 hours a day  
14 asleep. As a result, Plaintiff WHITFIELD experienced serious depression and anxiety and  
15 was put at increased risk for violence and theft from other prisoners. Plaintiff  
16 WHITFIELD also has sleep apnea. Plaintiff WHITFIELD is a person with a disability as  
17 defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code  
18 § 12926(j) and (m).

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



1 Plaintiff YANCEY is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C.  
2 § 705(9)(B), and California Government Code § 12926(j) and (m).

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

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

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



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

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

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

## 15 FACTUAL ALLEGATIONS

### 16 I. DEFENDANTS FAIL TO PROTECT PRISONERS FROM INJURY OR 17 VIOLENCE FROM OTHER PRISONERS

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

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

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

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

27  
28

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

3           40. Defendants staff the Jail in a manner that creates an unreasonable risk of  
4 prisoners being assaulted by other prisoners. For the past few years the Jail has routinely  
5 housed more than 1,100 prisoners. Defendants generally staff the Jail with as few as 24  
6 and no more than 26 officers. A significant number of officers are required to staff areas  
7 of the Jail other than the housing units, like the booking area, visitor processing areas, and  
8 kitchen. Thus, usually no more than a handful of officers are responsible for directly  
9 supervising the prisoners in the jail. In 2011, outside consultants (TRG) notified  
10 Defendants that the current authorized staffing for the Jail was "woefully inadequate."  
11 2011 Assessment at Ex. 7.

12           41. The minimum staffing plan utilized by the SHERIFF'S OFFICE does not  
13 provide for a sufficient number of officers to safely operate the Jail. As the 2011 Jail  
14 Needs Assessment explained, "[i]t appears that the staffing provided by the County salary  
15 ordinance is based on the rated capacity of [the Jail], not on how many inmates are actually  
16 in custody." 2011 Assessment at Ex. 6. Currently, the population in the Jail is more than  
17 15% above the facility's rated capacity.

18           42. Though the staffing plan being used by Defendants is not sufficient on its  
19 face, Defendants have not even hired staff to fill all of the authorized positions. As the  
20 2011 Jail Needs Assessment stated, "[v]acancies, extended periods of leave, and normal  
21 staff attrition have resulted in a significant amount of vacant ... positions. The jail has an  
22 increased reliance on overtime to meet minimum staffing." 2011 Assessment at Ex. 7.  
23 Upon information and belief, these staffing shortfalls identified at the end of 2011 continue  
24 to exist today.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2011 Assessment at Ex. 2.

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



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

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

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

5         57. According to the Monterey County Community Corrections Partnership  
6 AB109 Statistical Report for Fiscal Year 2013/2014, Second Quarter: October 2013-  
7 December 2013, since the inception of the County's pretrial release program in October  
8 2012, there have been more than 17,000 prisoners booked into the Jail. The County has  
9 only interviewed and assessed 491 prisoners for eligibility for pretrial release and has  
10 actually released only 209 individuals. At the same time, the population of pretrial  
11 defendants in the Jail rose to approximately 77 percent during the last quarter of 2013, up  
12 from 71 percent during the last quarter of 2012.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

20 68. The 2011 Jail Needs Assessment further noted that, "[i]t is obvious that the  
21 system is dangerously out of balance in terms of the types of beds available and the  
22 classification of inmates held.... In Monterey County there is the possibility of  
23 misclassifying inmates based on space rather than security level. Overcrowding reduces  
24 the ability to classify. This is further compounded by the dormitory design. Normally,  
25 10%-15% of the beds should be empty and available for classification spikes and  
26 maintenance.... Proper separation and segregation of inmates as envisioned in the  
27 Sheriff's classification plan is very difficult because of insufficient staff, an inadequate  
28 physical plant layout and ... severe overcrowding ...." 2011 Assessment at Ex. 4-5.

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

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

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

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

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



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

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

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

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

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

1 19 incidents, while in the C-Wing of the Rehabilitation Center, there were 15 incidents.  
2 Violent incidents also occurred in the booking area, the kitchen where prisoners work, the  
3 infirmary, and the visiting area.

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

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

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

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

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

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

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

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

8 **II. DEFENDANTS FAIL TO PROVIDE ADEQUATE MEDICAL CARE TO**  
9 **PRISONERS**

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

15 84. CFMG is a for-profit corporation. CFMG provides medical, mental health,  
16 and dental services to prisoners in the Jail pursuant to its contract with Defendants  
17 MONTEREY COUNTY and the SHERIFF'S OFFICE. The term of the agreement is from  
18 April 1, 2012, through June 30, 2015. The COUNTY and the SHERIFF'S OFFICE  
19 compensate CFMG for providing health care to prisoners with a flat fee payment made  
20 annually for the term of the contract. In the first year of the contract, CFMG was paid  
21 \$4,826,195. In the second and third years of the contract, the amount paid to CFMG is  
22 supposed to be increased according to the Medical Consumer Price Index for San  
23 Francisco/Oakland. In addition, CFMG receives an additional \$4.02 each day for each  
24 prisoner housed in the Jail in excess of a population of 1,065. The COUNTY has the right  
25 to terminate the agreement if CFMG violates any of the material terms of the agreement.  
26 The material terms of the agreement include that CFMG "shall perform all work in a safe  
27 and skillful manner and in compliance with all applicable laws and regulations."

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 **C. Defendants Lack Sufficient Facilities to Provide Adequate Medical Care**

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 booked into the Jail, he filed a sick call slip stating that he had been experiencing severe  
2 abdominal pains for the previous eight hours. The sick call slip was not reviewed by any  
3 staff at the Jail until 5 p.m. on July 29, 2012. Moreover, the prisoner was not seen by  
4 medical staff until 12 p.m. on July 30, 2012, at which time his temperature was 102  
5 degrees. The prisoner was rushed to the Emergency Department at Natividad Medical  
6 Center, where he was diagnosed with a perforated bowel and had an emergency colostomy  
7 procedure that same day. According to the medical records maintained by CFMG, at least  
8 36 hours passed between when the prisoner requested and received medical attention from  
9 staff at the Jail. The delay in response caused the prisoner considerable and unnecessary  
10 pain, and placed him at a significant risk of death.

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

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

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

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

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

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

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

1 and at times offering no treatment at all. On June 1, 2013 she was taken to Natividad  
2 Medical Center in an ambulance due to a high fever and severe pain. At Natividad, she  
3 was finally diagnosed as having large kidney stones. Doctors at Natividad instructed that  
4 she be seen by a urologist immediately. She was not seen by a urologist until June 19,  
5 2013, at which time the urologist was concerned about whether Plaintiff COBB had lost so  
6 much kidney function that her kidney would have to be removed. On June 25, 2013,  
7 Plaintiff COBB had a surgical drain inserted into her kidney, and shortly thereafter it was  
8 determined that her affected kidney only had approximately 31% remaining function. She  
9 did not receive any surgery to remove any kidney stones until September 13, 2013. She  
10 has suffered severe and unnecessary pain and risk of permanent loss of kidney function  
11 due to Defendants' failure to timely diagnose and appropriately treat her medical  
12 condition.

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 in order for her to have necessary back surgery. On information and belief, this prisoner,  
2 who is an insulin-dependent diabetic, brought her insulin with her to the Jail on June 15,  
3 2013. In the Diabetes section on this prisoner's Intake Triage Assessment form dated June  
4 15, 2013, the Registered Nurse who completed the form wrote that the prisoner took seven  
5 units of Lantus twice a day. Although Defendants were aware of her diabetic condition  
6 and need for insulin, the "Diabetic Chart" in this prisoner's medical file indicates that she  
7 did not receive any insulin from June 15, 2013 through at least June 27, 2013. On  
8 information and belief, this prisoner did not begin to regularly receive insulin until on or  
9 after July 24, 2013.

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

20 131. Plaintiff WHITFIELD suffers from narcolepsy and cataplexy, two conditions  
21 that can be adequately controlled through the provision of two medications: Provigil and  
22 Xyrem. Plaintiff WHITFIELD was prescribed such medications by his outside specialist  
23 physician. Plaintiff WHITFIELD requested both drugs upon entering the Jail in November  
24 2013. Plaintiff WHITFIELD saw a physician at the Jail on December 5, 2013, who then  
25 called Plaintiff WHITFIELD's outside specialist on December 6, 2013, to verify Plaintiff  
26 WHITFIELD's condition and medication regime. Immediately after this telephone call,  
27 the Jail physician ordered Provigil for Plaintiff WHITFIELD. However, Defendants did  
28 not provide Plaintiff WHITFIELD with Provigil for nearly two months, during which time

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

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

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

1 back injuries.

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

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

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

#### 21 **H. Defendants Fail to Provide Adequate Care in Emergency Situations**

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

28 138. Plaintiff HERNANDEZ experienced two serious emergencies while in the



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

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

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

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

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

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

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

15 143. Upon information and belief, another prisoner in the Jail suffered a  
16 miscarriage due to the Jail's failure to timely respond to her emergency medical situation.  
17 While pregnant, this prisoner began to experience uterine cramping and bleeding, but was  
18 informed by medical staff to go on bed rest. The Jail staff did not transport her to a  
19 hospital until at least two days later, and by that time she had lost her baby. Between  
20 2012-2013, at least two women in the Jail suffered from miscarriages.

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

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

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

7 145. Upon information and belief, Defendants fail to order diagnostic testing  
8 when medically necessary, creating an unreasonable risk of harm to prisoners.

9 Defendants' policies and practices for ordering diagnostic testing are inadequate. Upon  
10 information and belief, Defendants fail to adequately train medical staff in when it is  
11 appropriate to order diagnostic testing.

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

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

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

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

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

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

8 151. For example, Plaintiff GUYOT suffered a concussion when he was attacked  
9 by a group of other prisoners on March 15, 2013. On March 31, 2013, he filed the first of  
10 approximately 26 sick call slips in which he has complained of blurred vision, severe  
11 migraines, dizziness, and/or sensitivity to light. He was not sent for a CT scan until  
12 May 16, 2013 (by which time he had filed approximately seven sick call slips with similar  
13 complaints of post-concussion trauma), and was not seen by a neurologist until June 7,  
14 2013. Since June 7, 2013, he has filed approximately 17 sick call slips continuing to report  
15 serious vision and neurologic issues, but on information and belief, he has not been seen  
16 by any other specialists.

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

1 occurred.

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

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

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

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

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

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

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

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

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

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

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

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

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

6           176. Plaintiff AGUILAR's file is missing complete outside medical records from  
7 the doctor's office who performed surgery to repair the fracture in his cheek. The Jail  
8 medical file does not contain progress notes of Plaintiff AGUILAR's February 13 and 15,  
9 2013 appointments in which he was initially examined, given post-operative instructions,  
10 and scheduled for surgery.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

3         191. Plaintiff GIST has been subjected to the detoxification treatment at least  
4 twice. Plaintiff GIST was booked into the Jail on March 15, 2012. She informed medical  
5 and custody staff that she was taking a number of psychotropic medications, including  
6 Risperidone, Fluoxetine, Benztropine, and Trazodone. Four days later, on March 19,  
7 2012, her relatives brought those psychotropic medications to the Jail for her. That same  
8 day, the Jail obtained pharmacy records that confirmed that she was prescribed the same  
9 medications. On March 20, 2012, a psychologist at the Jail consulted with Dr. Fithian  
10 about whether Plaintiff GIST should be provided with her prescription medication.  
11 Dr. Fithian instructed that “due to history of alcoholism, ... we should hold off medicating  
12 her for now to allow her to detox from alcohol while in custody.” On March 27, Plaintiff  
13 GIST was again seen by the psychologist. In a progress note, the psychologist wrote that  
14 “[p]rior to seeing inmate, writer conferred with Dr. Fithian. It was agreed that she is to  
15 remain medication free and clean and sober for 90 days.” Similarly, when Plaintiff GIST  
16 was booked in the Jail in November 2012, despite Defendants’ knowledge of her mental  
17 health conditions and medications, medical staff again denied her the prescribed  
18 medications for 90 days. Upon information and belief, there was no clinical justification  
19 for denying Plaintiff GIST psychotropic medications for 90 days because of a history of  
20 alcohol abuse. Without her medications, Plaintiff GIST began experiencing auditory  
21 hallucinations, talking to herself, feeling increased depression, and having trouble  
22 organizing her thoughts, expressing herself, and focusing.

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

1 trazodone” and also states that Plaintiff KEY “has no history of any psychiatric  
2 medications.”

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

7 204. A prisoner named Daniel Lariviere committed suicide on July 8, 2011. Upon  
8 his arrest, he was initially placed in a rubber room, but after a few hours he was released to  
9 a booking cell without having been evaluated by any mental health care staff.

10 Mr. Lariviere informed custody and medical staff during the intake process that he had  
11 serious mental health issues, was having auditory hallucinations, and had been released  
12 from a psychiatric hospital just four days earlier. Despite these numerous indicia of  
13 suicide risk, Defendants decided to house Mr. Lariviere in an administrative segregation  
14 unit. The conditions in this segregation unit place prisoners at increased risk of suicide.  
15 Defendants also did not schedule Mr. Lariviere to see any mental health care staff at the  
16 Jail until three days after his booking. On the morning of the day he was supposed to be  
17 seen by mental health care staff, Mr. Lariviere committed suicide by hanging in his cell.

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

10       216. Defendants fail to adequately follow up with, monitor, and treat prisoners  
11 who have been released from the rubber room. For example, Plaintiff MURPHY was  
12 placed in a rubber room on February 11, 2013, at approximately 4 p.m. and was released at  
13 5 a.m. the following day. No health care staff conducted any evaluation of Plaintiff  
14 MURPHY's physical or mental status until February 18, 2013. In fact, the psychiatric  
15 progress note for his February 18, 2013 appointment with Dr. Fithian does not even  
16 acknowledge that Plaintiff MURPHY had been placed in a rubber room. Another prisoner  
17 was kept in the rubber room for five full days, and described feeling as though the walls  
18 were closing in on him the entire time. After he was released from the rubber room, this  
19 prisoner did not receive adequate follow-up to evaluate his mental health state and risk of  
20 suicidality.

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

27  
28

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

1 Alameda County.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

28       254. Defendants discriminate against prisoners with serious mental illness by



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

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

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

28       257. Upon information and belief, Defendants exacerbate the psychological

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 prisoners who are suffering from serious mental illness.

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

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

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

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

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

11       272. Plaintiff GREIM arrived at the Jail in September 2012. He reported during  
12 an intake screening that he had received mental health care and psychiatric medications  
13 while incarcerated in a CDCR prison as recently as the spring of 2012. Defendants did not  
14 request his records until March 2013. These records confirmed that Plaintiff GREIM  
15 suffers from a mood disorder and was prescribed Remeron while in prison and on parole in  
16 2012 immediately prior to his booking in Monterey County Jail. Plaintiff GREIM had  
17 received care at the enhanced outpatient level while in prison. Even after receiving these  
18 records, Defendants failed to provide Plaintiff GREIM with any treatment for his serious  
19 mental illness. And when Plaintiff GREIM again requested psychiatric medication in July  
20 2013, Defendants noted in his file that they “would get” his prison records—records they  
21 had received months before. Plaintiff GREIM did not begin to regularly receive any  
22 psychiatric medications while in Monterey County Jail until on or around October 3, 2013.

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

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

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

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

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

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



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

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

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

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

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

1 accommodations they require.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



1 bunk was difficult and painful for him to access.

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

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

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

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

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

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

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

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

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

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

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

16       344. Defendants use segregated isolation units to house prisoners with disabilities  
17 whom they are unable to properly accommodate. One prisoner, who is mobility impaired  
18 due to permanent spinal injuries and uses a walker, was housed in the general population  
19 for approximately one month after she returned to the Jail following surgery. On July 12,  
20 2013, she had a dispute with a deputy because that deputy would not allow her to leave her  
21 cell to pick up her dinner tray, "as she uses a walker and [it] would be hard for her to walk  
22 up and down the stairs with trays and her walker." She received a Disciplinary Action  
23 Report as a result of this conflict. Rather than accommodating this prisoner to ensure that  
24 she could remain in the least restrictive possible housing environment and have equal  
25 access to dining services, Defendants moved her to the "holding" area of the women's  
26 facility, a segregated and isolated single-cell unit. Defendants moved this prisoner to the  
27 holding area at least in part because of her disability. On a July 13, 2013  
28 Lockdown/Inmate Movement form Defendants wrote that they "moved [this prisoner] to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1 firearms (like “flash bang” grenades) and lethal firearms.

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

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

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

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



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

### 5 CLASS ACTION ALLEGATIONS

#### 6 Prisoner Class

7 359. All Plaintiffs bring this action on their own behalf and, pursuant to Rule  
 8 23(a), (b)(1), and (b)(2) of the Federal Rules of Civil Procedure, on behalf of a class of all  
 9 adult men and women who are now, or will be in the future, incarcerated in Monterey  
 10 County Jail (“Prisoner Class”). All prisoners incarcerated in the Jail are at substantial risk  
 11 of serious harm due to the policies and practices of Defendants MONTEREY COUNTY,  
 12 MONTEREY COUNTY SHERIFF’S OFFICE, and CFMG (“Defendants”), including:

- 13 a. Denial of protection from injury and violence from other prisoners,
- 14 b. Denial of minimally adequate medical care, and
- 15 c. Denial of minimally adequate mental health care.

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

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

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

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

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

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

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

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

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

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

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

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

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

1 experienced in complex class action litigation and prisoner’s rights litigation.

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

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

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

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

11 **Prisoners with Disabilities Subclass**

12 368. All Plaintiffs bring this action on their own behalf and, pursuant to Rule  
13 23(a), (b)(1), and (b)(2) of the Federal Rules of Civil Procedure, on behalf of a subclass of  
14 all qualified individuals with a disability, as that term is defined in 42 U.S.C. § 12102, 29  
15 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m), and who are  
16 now, or will be in the future, incarcerated in Monterey County Jail (“Prisoners with  
17 Disabilities Subclass”). All prisoners with disabilities who are incarcerated in the Jail are  
18 at risk of being discriminated against or denied access to programs, services and activities  
19 offered at the Jail as a result of the policies and practices of Defendants MONTEREY  
20 COUNTY, MONTEREY COUNTY SHERIFF’S OFFICE, and CFMG (“Defendants”).

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

22 369. The proposed subclass as defined is sufficiently numerous that joinder of all  
23 members of the subclass is impracticable and unfeasible. The exact number of members of  
24 the Prisoners with Disabilities Subclass is unknown. According to data regarding the  
25 incidence of disabilities among the general population, at least 30% of the prisoners in the  
26 Jail are qualified individuals with disabilities as that term is defined in 42 U.S.C. § 12102,  
27 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

28 370. The Prisoners with Disabilities Subclass members are identifiable using

1 records maintained in the ordinary course of business by Defendants.

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

3 371. There are questions of law and fact common to the Prisoners with  
4 Disabilities Subclass, including, but not limited to: Whether Defendants' failure to  
5 reasonably accommodate prisoners with disabilities violates the Americans with  
6 Disabilities Act, Section 504 of the Rehabilitation Act, and California Government Code  
7 § 11135.

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

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

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

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

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

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

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

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

2 376. This action is also maintainable as a class action pursuant to Fed. R. Civ. P.  
3 23(b)(2) because Defendants have acted and refused to act on grounds that apply generally  
4 to the subclass, so that final injunctive relief or corresponding declaratory relief is  
5 appropriate respecting the subclass and will apply to all members of the class and subclass.

6 **FIRST CAUSE OF ACTION**

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

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

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

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

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

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

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**SECOND CAUSE OF ACTION**

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

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

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

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

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

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

**THIRD CAUSE OF ACTION**

**(Article I, Section 7 of the California Constitution)**

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

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

1 previously made in paragraphs 1 through 382, above.

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

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

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

15 **FOURTH CAUSE OF ACTION**

16 **(Article I, Section 17 of the California Constitution)**

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

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

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



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

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

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

8 **FIFTH CAUSE OF ACTION**

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

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

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

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

19 391. Defendants MONTEREY COUNTY and SHERIFF'S OFFICE are legally  
20 responsible for all violations of the ADA committed by CFMG in the course of performing  
21 its duties under its contractual arrangement with the SHERIFF'S OFFICE to provide  
22 medical and mental health care services to prisoners in the Jail. *See* 28 C.F.R.  
23 § 35.130(b)(1).

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

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

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

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

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

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

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

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

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

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

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

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

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

15 h. failing to make available information to the Prisoners with Disabilities  
16 Subclass about their rights under the ADA while detained in the Jail, *see* 28 C.F.R.  
17 § 35.106;

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

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

24 k. failing to “furnish appropriate auxiliary aids and services where  
25 necessary to afford individuals with disabilities ... an equal opportunity to participate in,  
26 and enjoy the benefits of, a service, program, or activity of a public entity,” 28 C.F.R.  
27 § 35.160(b)(1).

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

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

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

7 **SIXTH CAUSE OF ACTION**

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

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

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

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

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

22 400. By its policies and practices described above, Defendant CFMG violates  
23 Title III of the ADA, 42 U.S.C. §§ 12181-12189, by discriminating against individuals  
24 with disabilities on the basis of disability, in the full and equal enjoyment of Defendant  
25 CFMG's goods, services, facilities, privileges, advantages, or accommodations. 42 U.S.C.  
26 § 12182(a); 28 C.F.R., Part 36.

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

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**SEVENTH CAUSE OF ACTION**  
**(Rehabilitation Act, 29 U.S.C. § 794)**

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

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

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

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

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

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

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

1 **EIGHTH CAUSE OF ACTION**

2 (Cal. Gov't Code § 11135)

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

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

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

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

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

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

28 **PRAYER FOR RELIEF**

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

1 of prisoner's emergent medical needs.

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

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

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

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

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

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

27 415. An award to Plaintiffs, pursuant to 29 U.S.C. § 794a, 42 U.S.C. §§ 1988,  
28 12205, and California Code of Civil Procedure § 1021.5, of the costs of this suit and

1 reasonable attorneys' fees and litigation expenses;

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

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

7  
8 DATED: April 11, 2014

Respectfully submitted,

ROSEN BIEN GALVAN & GRUNFELD LLP

9  
10 By: /s/ Gay Crosthwait Grunfeld  
Gay Crosthwait Grunfeld

11  
12 DATED: April 11, 2014

OFFICE OF THE PUBLIC DEFENDER  
COUNTY OF MONTEREY

13  
14 By: /s/ James Egar  
James Egar  
15 Public Defender

16  
17 DATED: April 11, 2014

AMERICAN CIVIL LIBERTIES UNION  
OF NORTHERN CALIFORNIA

18  
19 By: /s/ Alan Schlosser  
Alan Schlosser

20  
21 DATED: April 11, 2014

ACLU NATIONAL PRISON PROJECT

22  
23 By: /s/ Eric Balaban  
Eric Balaban

24  
25  
26  
27  
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