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UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CLAY MURRAY, DAVID FRANCO,
SHAREEN WINKLE, MARIA TRACY,
ERIC BROWN, on behalf of themselves
and all others similarly situated,

Plaintiffs,

v.

COUNTY OF SANTA BARBARA, and
SANTA BARBARA COUNTY
SHERIFF'S OFFICE,

Defendants.

Case No.:

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

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Forthcoming

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NATURE OF ACTION

1
2 1. This civil rights class action lawsuit seeks declaratory and injunctive
3 relief to remedy the unconstitutional, discriminatory, unlawful and dangerous
4 conditions in the Santa Barbara County Adult Detention Facilities (“Santa Barbara
5 County Jail” or “Jail”). Defendants County of Santa Barbara and Santa Barbara
6 Sheriff’s Office systematically and knowingly (1) fail to provide adequate medical
7 and mental health care to the people housed in the jail; (2) overuse isolation and
8 solitary confinement; (3) discriminate against and fail to accommodate people with
9 disabilities; and (4) provide inhumane, unsanitary, and unsafe living conditions.

10 2. These failures have caused and continue to cause widespread harm,
11 including unnecessary pain and injury, in violation of prisoners’ rights under the
12 Eighth and Fourteenth Amendments to the United States Constitution, the
13 Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and
14 California State law.

15 3. Defendants have been deliberately indifferent to the substantial risk of
16 pain and suffering and harm to prisoners, including serious injury, clinical
17 deterioration, and death, caused by their inadequate, unlawful, and unconstitutional
18 policies and practices. Defendants have been aware of the chronic and systemic
19 problems at the Jail and their causes for years, and have failed to take the actions or
20 commit the resources necessary to ameliorate the unconstitutional and illegal
21 conditions that expose Santa Barbara County Jail prisoners to a substantial risk of
22 harm.

23 4. Defendants regularly confine a population of prisoners that far
24 exceeds the Jail’s rated capacity of approximately 818 people. The average
25 population hovers at 120% of the Jail’s capacity, and frequently exceeds 1,100
26 people. At least ten (10) people, many with serious and inadequately treated
27 medical and mental health conditions, have died at the Jail since 2011. On any
28 given day, Defendants hold hundreds of people with serious mental health,

1 medical, and disability-related needs in the Jail. Every day, many prisoners –
2 including those with serious health conditions and disabilities – must sleep on the
3 floor due to overcrowding at the Jail. Defendants hold scores of people, many with
4 serious mental illness, indefinitely in solitary confinement cells, and on most days
5 deny them *any* time out of their cell for exercise, recreation, or sunlight. Suicide
6 attempts are common in these solitary confinement settings. In one recent five-
7 month period alone, at least twelve (12) prisoners attempted suicide while in
8 solitary confinement, more than one attempted suicide every two weeks, including
9 one man who died.

10 5. In 2016, after a detailed investigation, Disability Rights California
11 issued a Report (attached as Appendix A) on conditions in the Santa Barbara
12 County Jail. The Report documented findings of harmful policies, practices, and
13 conditions that impact prisoners, in particular prisoners with serious mental illness,
14 medical conditions, and physical, sensory, or mental health disabilities. The Report
15 detailed the Jail’s inadequate mental health care system, excessive use of solitary
16 confinement, and violations of the Americans with Disabilities Act (ADA). Nearly
17 all of the deficiencies identified in the Report persist, and recommendations to
18 address those deficiencies remain largely unimplemented.

19 6. Plaintiffs, who are prisoners housed in the Jail, seek declaratory and
20 injunctive relief compelling Defendants to provide constitutionally adequate health
21 care, reasonable accommodations and equal access for prisoners with disabilities,
22 and protection from inhumane conditions of confinement, as well as attorneys’ fees
23 and costs under applicable law. Plaintiffs bring this action on behalf of themselves
24 and all others similarly situated.

25 **JURISDICTION**

26 7. The claims alleged herein arise pursuant to 42 U.S.C. § 1983 and the
27 Eighth and Fourteenth Amendments to the United States Constitution, the
28 Americans with Disabilities Act (ADA), 42 U.S.C. §12101 et seq., Section 504 of

1 the Rehabilitation Act, 29 U.S.C. § 794.6, and related state law.

2 8. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §§
3 1331, 1343, and 1367. Plaintiffs seek declaratory and injunctive relief under 28
4 U.S.C. §§ 1343, 2201, and 2202; 42 U.S.C. § 1983 and 12117(a); and California
5 Government Code § 11135.

6 **VENUE**

7 9. Venue is proper in the Central District of California, pursuant to 28
8 U.S.C. § 1391(b), because a substantial part or all of the acts and omissions giving
9 rise to this action occurred within Santa Barbara County and one or more
10 Defendants reside in this District.

11 **PARTIES**

12 **Plaintiffs**

13 10. Plaintiff CLAY MURRAY is a prisoner in pretrial detention at the
14 Santa Barbara County Jail. Plaintiff MURRAY is a U.S. Army veteran with
15 significant medical conditions, including cirrhosis, high blood pressure,
16 degenerative joint disease, spinal arthritis, and peripheral neuropathy. He also has
17 diagnosed post-traumatic stress disorder and other mental health needs. Plaintiff
18 MURRAY requires the use of a wheelchair for mobility. Defendants have failed to
19 provide Plaintiff MURRAY adequate medical and mental health care, with
20 inadequate screening, improper medication management, and delayed treatment.
21 Defendants have denied Plaintiff MURRAY reasonable accommodations for his
22 disability and access to services and programs based on his disability status.
23 Plaintiff MURRAY is a person with a disability as defined in 42 U.S.C. § 12102,
24 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

25 11. Plaintiff DAVID FRANCO is a prisoner in pretrial detention at the
26 Santa Barbara County Jail. Plaintiff FRANCO has been diagnosed with
27 schizophrenia and bipolar disorder. Defendants have failed to provide Plaintiff
28 FRANCO timely and adequate mental health care, resulting in significant

1 decompensation and psychiatric symptoms resulting in his becoming suicidal.
2 Defendants also failed to provide him a bed, forcing him to sleep on the floor for
3 an extended period of time, which exacerbated his psychiatric distress. Plaintiff
4 FRANCO is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C.
5 § 705(9)(B), and California Government Code § 12926(j) and (m).

6 12. Plaintiff SHAREEN WINKLE is a prisoner at the Santa Barbara
7 County Jail. Plaintiff WINKLE has been diagnosed with mental illness, including
8 bipolar disorder. Defendants have repeatedly placed Plaintiff WINKLE in solitary
9 confinement for long periods based on such infractions as not being prepared for
10 linen exchange on laundry day and not properly wearing her shirt. Plaintiff
11 WINKLE's mental health deteriorated significantly in solitary confinement, where
12 she suffered multiple serious panic attacks. Defendants further held Plaintiff
13 WINKLE in a safety cell for a period of more than four (4) consecutive days,
14 during which time she was forced to sleep on the floor and use a grate on the floor
15 as a toilet. Defendants have failed to provide Plaintiff WINKLE adequate mental
16 health treatment. In addition, Defendants have failed to accommodate Plaintiff
17 WINKLE, who Defendants are aware has a seizure disorder, by placing her in an
18 isolation cell that contains a single bunk that is elevated several feet above the
19 ground, a situation that placed her at risk of a serious fall from the bunk in the
20 event she has a seizure. Plaintiff WINKLE 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(j) and (m).

23 13. Plaintiff MARIA TRACY is a prisoner in pretrial detention at the
24 Santa Barbara County Jail. Plaintiff TRACY has been diagnosed with
25 schizophrenia and has a serious ophthalmological medical condition. Defendants
26 have failed to provide Plaintiff TRACY with adequate mental health and medical
27 care, resulting in the severe worsening of her health. Plaintiff TRACY is a person
28 with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and

1 California Government Code § 12926(j) and (m).

2 14. Plaintiff ERIC BROWN is a prisoner at the Santa Barbara County
3 Jail. He has been diagnosed with chronic lower back pain, anxiety, and major
4 depressive disorder. Plaintiff BROWN uses a wheelchair for mobility as a result of
5 his medical conditions. Defendants have denied Plaintiff BROWN reasonable
6 accommodations for his disability and access to services and programs based on
7 his disability status. Defendants have further denied Plaintiff BROWN adequate
8 medical and mental health treatment. Plaintiff BROWN is a person with a
9 disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California
10 Government Code § 12926(j) and (m).

11 **Defendants**

12 15. Defendant COUNTY OF SANTA BARBARA (“County”) is a public
13 entity, duly organized and existing under the laws of the State of California. The
14 County operates and manages the Jail and is and was at all relevant times
15 mentioned herein, responsible for the actions, inactions, policies, procedures, and
16 practices of the Santa Barbara County Sheriff’s Office and its respective
17 employees and/or agents. The County is responsible for providing a constitutional
18 level of health care for those in its custody, including funding, oversight, and
19 corrective action to ensure adequate conditions. The Board of Supervisors of the
20 County of Santa Barbara authorizes and approves the contract between Defendant
21 Santa Barbara County Sheriff’s Office (“Sheriff’s Office”) and the health care
22 service provider for prisoners in the Jail, which is currently California Forensic
23 Medical Group (“CFMG”). Previously, the Sheriff’s Office had contracted with
24 Corizon Health (“Corizon”) to provide medical and mental health care at the Jail;
25 that contract terminated on or around April 1, 2017. By law, the County retains
26 ultimate authority and responsibility for the health care, treatment, well-being, and
27 safekeeping of prisoners in the Jail.

28 16. Defendant SANTA BARBARA COUNTY SHERIFF’S OFFICE is a

1 public entity, duly organized and existing under the laws of the State of California.
2 Sheriff Bill Brown (“Sheriff”) is the elected Sheriff of the County of Santa
3 Barbara. The Sheriff’s Office is responsible for the operation and supervision of
4 custody operations in Santa Barbara County, including promulgating policies and
5 procedures for the operation of its Jail facilities. The Sheriff’s Office has
6 contracted with CFMG to provide health care services. The Sheriff’s Office by law
7 retains the ultimate authority and responsibility for the health care, treatment, well-
8 being, and safekeeping of prisoners in the Jail.

9 **FACTUAL ALLEGATIONS**

10 **I. THE SANTA BARBARA COUNTY JAIL IS OLD, DILAPIDATED, SEVERELY OVERCROWDED, AND PLAGUED BY**
11 **UNDERSTAFFING.**

12 **A. Defendants Hold Prisoners in Deficient Facilities That Fail to**
13 **Meet the Basic Needs of People with Health Problems and**
14 **Disabilities.**

15 17. Defendants maintain and operate the adult detention facilities within
16 the County’s jurisdiction, comprising the Main Jail and Medium Security Facility
17 located in the City of Santa Barbara.

18 18. The Main Jail is more than 50 years old, having been built in the
19 1960s. Jail staff and others regularly refer to the Main Jail as a “Frankenstein”
20 facility or the “Franken-Jail.” Over several decades, there have been numerous
21 modifications and expansions to the facility, which have resulted in a facility that
22 is haphazard, substandard, and riddled with architectural barriers, deficiencies, and
23 limitations.

24 19. The Main Jail has many linear hallways with dead-end corridors and
25 little or no natural light. The facility is old and difficult to maintain, and is
26 significantly dilapidated. Prisoners and staff are exposed to dust, mold, and other
27 unsanitary conditions. “Exercise areas” consist of small cell-like areas with cement
28 walls and extremely limited natural light. Prisoners, when they are permitted in
these areas, are unable to see outside other than a small portion of the sky. Sheriff

1 Brown himself has called the Main Jail “disgraceful, embarrassing and
2 unacceptable for Santa Barbara County.”

3 20. A 2017 Grand Jury Report, entitled *Santa Barbara Main Jail: An*
4 *Outdated and Inefficient Facility*, noted that according to the County’s General
5 Services Department, “the Main Jail is in failure mode,” including with respect to
6 its “plumbing and sewer systems that are over 60 years old,” “compliance with
7 current seismic standards,” and “compliance with ADA regulations.”

8 21. The Medium Security Facility is adjacent to the Main Jail, and is also
9 more than 50 years old. Prisoners housed at the Medium Security Facility
10 participate in work programs, such as jail laundry, kitchen, and landscaping.

11 22. A 2016-17 Grand Jury Report identified the need for extensive repairs
12 and remediation at the Jail, with an estimated cost over \$15 million. Such work
13 remains undone. Notably, the Grand Jury’s estimate does not take into account the
14 significant deficiencies in the treatment of prisoners with mental health needs,
15 medical needs, and disabilities.

16 23. The Jail’s housing units were not designed for prisoners with serious
17 health care and disability-related needs. As a result, Defendants house such
18 prisoners in inadequate spaces, as discussed below.

19 **B. Defendants Operate a Jail System Long Plagued by Severe**
20 **Overcrowding That Causes Serious Risks of Harm to Prisoners.**

21 24. The Jail has a long history of being severely overcrowded. Such
22 overcrowding has contributed to significant deficiencies in the provision of health
23 care, to the failures to accommodate and provide access to individuals with
24 disabilities, and to dangerous and harmful conditions of confinement. A 2012
25 Grand Jury *Detention Facilities Report* noted that “More than 20 previous Santa
26 Barbara County Grand Juries filed reports on overcrowding at the main jail. This
27 overcrowding condition still exists, and its effects are increasingly obvious.”

28 25. In 2008, the Santa Barbara County Sheriff’s Blue Ribbon Commission

1 documented that the Jail was rated to hold 818 inmates, but regularly detained
2 approximately 1,000, meaning that the Jail was running at 120% of its rated
3 capacity. Nearly a decade later, the situation is no better. The 2017 Grand Jury
4 found that the Jail's average daily population frequently exceeds 1,100, or nearly
5 135% of its rated capacity.

6 26. Defendants have resorted to housing prisoners in basement areas,
7 closets, and various rooms not designed for such purposes. There are not enough
8 beds to accommodate the number of prisoners in some units. Many prisoners must
9 sleep in plastic structures, commonly called "boats," that sit directly on the floor.
10 Other prisoners may not even get these "boats," and are forced to sleep on bedding
11 on the floor.

12 27. For example, when Plaintiff FRANCO arrived at the Jail in July 2017,
13 Defendants failed to assign him a bed for six (6) days. While he remained on "No
14 Bed Available" status, his mental health deteriorated significantly and he attempted
15 suicide. Upon his return to a dorm unit after his attempted suicide, Plaintiff
16 FRANCO spent another ten (10) days sleeping on the floor.

17 28. Indeed, a writ regarding prisoners being forced to sleep on the floor
18 due to lack of beds has been pending for more than 35 years in the Santa Barbara
19 County Superior Court. For almost three decades, the County has been under a
20 state court order to reduce the jail population to its approved bed capacity so that
21 prisoners do not need to sleep on the floor. But the issue has not improved, and
22 appears to be getting worse. The Sheriff's Office provides "No Bunk Available
23 (NBA)" reports to the state court. These reports show that, in 2016 and 2017, there
24 are generally at least 30 prisoners for whom no bed is available on any given day,
25 with as many as 70 or more prisoners without a bed on some days. The state court
26 judge stated at a May 2016 hearing that the "bottom line is that you can't have
27 floor sleepers. . . . [E]very time I look at one of these graphs and one of these
28 charts that reflects not one or two or single digit number of floor sleepers, but you

1 know 71, 59, 62 . . . that’s a pretty significant number of floor sleepers on a daily
2 basis . . . it’s a pretty clear violation of a previous court order.” Such overcrowding
3 has a deeply negative and harmful impact prisoner health and safety, particularly
4 for those individuals with medical or mental health care needs as well as disability
5 accommodation needs.

6 **C. The County’s Planned Construction of the Northern Branch Jail**
7 **Will Not Address Deficiencies at the Existing Facilities.**

8 29. The 2008 Sheriff’s Blue Ribbon Commission examined Jail
9 overcrowding and deficiencies at the Jail facilities. The Commission recommended
10 that the County make a significant investment in community programs that provide
11 drug and alcohol treatment, mental health treatment, homelessness prevention, and
12 other measures to safely reduce incarceration rates and Jail overcrowding. The
13 Commission also recommended the building of a new jail facility. The
14 recommendations in the report went unimplemented for years.

15 30. In 2016, the County approved the Northern Branch Jail Project, a
16 construction project that broke ground in October 2016 and is scheduled for
17 occupancy in 2019. The project scope is for 376 beds, with 32 “special use” beds.

18 31. Building the new facility, however, will *not* remedy the existing
19 deficiencies at today’s Jail facilities, which will remain in use even after the new
20 facility is opened. The 2017 Grand Jury report, *Santa Barbara Main Jail: An*
21 *Outdated and Inefficient Facility*, found that measures to address deficiencies at
22 the Main Jail remain “paramount,” but the Grand Jury “could find no concrete plan
23 to fund the multimillion dollars needed for repairs and upgrades to the Main Jail.”

24 32. Even if and when the Northern Branch Jail Project is completed, there
25 will remain insufficient facilities to meet the needs of prisoners with mental illness,
26 serious medical conditions, and disabilities. Notably, Sheriff Brown advocated for
27 the creation of additional beds for prisoners with mental illness as part of a
28 Sheriff’s Transition and Reentry (STAR) wing of the Northern Branch County Jail

1 Project. Despite a conditional award of \$38.9 million from the State Public Works
2 Board to fund the project, the County did not approve funding for the STAR
3 complex. Defendants have provided no plan to serve the mental health and other
4 critical needs of the County's incarcerated population.

5 33. As the 2017 Grand Jury noted: "This leaves the County with an
6 outdated and inefficient Main Jail, still in urgent need of repair, replacement and
7 repurposing to house its approved capacity. Many unanswered questions remain,
8 including how to satisfy current State and Federal requirements."

9 **D. Defendants' Systemic Understaffing Creates Additional Safety**
10 **Risks and Undermines Delivery of Necessary Care and Programs.**

11 34. The Jail has for years been extremely understaffed with respect to
12 custodial and clinical staff, which has a severely negative impact on prisoner health
13 and safety.

14 35. Two separate staffing studies conducted at the Jail in recent years
15 identified the need for substantial increases in staffing, noting that understaffing
16 poses significant dangers to both prisoners and staff. A 2013 Santa Barbara
17 County Sheriff's Office Jail Staffing Assessment completed by Crout & Sida
18 Criminal Justice Consultants, Inc. found significant issues related to the Jail's
19 staffing.

20 36. The Crout & Sida report found that understaffing due to insufficient
21 funding had become a serious problem, noting that "[w]hen we reduce staffing of
22 the jail in response to economic needs, there comes a tipping point where the jail
23 becomes a dangerous place for both staff and inmates. We believe that if the Santa
24 Barbara jail system has not already reached this point, it is very close."

25 37. Almost three years later, a 2015-2016 Grand Jury found that the Jail
26 remained "understaffed, underfunded, and not well designed to carry out all of
27 their required responsibilities." The Sheriff's Office 2015 Triennial Report
28 described a "critical shortage of trained staff" at the Jail, and reliance on

1 mandatory overtime to maintain basic Jail operations. And in 2017, the Grand Jury
2 found in its report on *Detention Facilities in Santa Barbara County* that the Jail
3 was “45 custody officers short” of the staffing level “considered adequate for the
4 current inmate population.” The Santa Barbara County Deputy Sheriffs’
5 Association has been seeking an increase to minimum staffing at the Jail for years,
6 noting safety concerns and the “excessive workload” for custody staff.

7 38. Health care staffing, as detailed below, also remains insufficient to
8 deliver adequate care to the Jail population, resulting in delays in treatment, denials
9 of treatment, and treatment that does not meet modern standards of care.

10 **II. DEFENDANTS FAIL TO PROVIDE ADEQUATE HEALTH CARE**
11 **TO PRISONERS.**

12 39. Defendants have a policy and practice of failing to provide adequate
13 health care, including mental health care, medical care, and dental care, to
14 prisoners in the Jail.

15 40. Defendants have a policy and practice of inadequately screening for
16 serious health care conditions and disabilities, delaying access to clinicians and
17 medications, understaffing health care professionals, delaying or denying access to
18 specialty care, and failing to provide health services necessary to meet minimum
19 standards of care. Defendants have been deliberately indifferent to the risk of harm
20 caused by these deficiencies.

21 41. There have been at least ten (10) deaths of individuals detained at the
22 Jail since 2011, including two (2) suicides and eight (8) deaths stemming from
23 serious medical conditions, many of which raise concerns about adequacy of care.

24 **A. Defendants Fail to Maintain Sufficient Numbers of Health Care**
25 **Professionals and Custody Staff to Deliver Adequate Care.**

26 42. The current level of staffing at the Jail is insufficient to deliver
27 constitutionally adequate and timely health care to prisoners.
28

1 43. Defendants fail to maintain sufficient numbers of medical care
2 professionals to provide minimally adequate care. The number of nurses on staff is
3 below the Jail's stated plan and does not meet minimum standards. The Jail's
4 physician staffing is only a 0.4 Full-Time Equivalent (FTE) position (or 16 hours
5 per week), with a physician on-site only three days per week. This is inadequate
6 given the size and health needs of the Jail's population and creates serious risks to
7 patient health. In addition, the current Jail physician is not board certified in
8 internal medicine, family medicine, or emergency medicine. The understaffing of
9 medical providers causes dangerous delays in the delivery of care.

10 44. Defendants also fail to maintain sufficient numbers of mental health
11 care professionals to provide minimally adequate treatment to the population of
12 prisoners with serious mental illness. Currently, there is no psychiatrist regularly
13 on site at the Jail. This results in long and unnecessary delays in treatment. Nor do
14 Defendants employ an on-site mental health coordinator to ensure that mental
15 health care operations are adequate.

16 45. Current mental health care staffing at the Jail, though increased since
17 Corizon served as the contracted health care provider, remains insufficient to
18 perform all necessary functions in a timely fashion, including screening and
19 assessment, crisis services, treatment programming, sick call requests, needs
20 assessments and discharge planning, treatment planning, and monitoring and
21 counseling of suicidal prisoners.

22 46. Defendants have failed to undertake a comprehensive analysis to
23 determine actual health care staffing needs, and whether the contracted number of
24 positions is adequate, preventing them from working productively towards an
25 adequate system.

26 47. There is currently only one discharge planner on staff to assist
27 prisoners preparing for release. Upon information and belief, Defendants release
28 prisoners with serious health conditions from the Jail without providing them with

1 adequate referrals, resources, or linkages to community services to ensure that their
2 medical care is not disrupted. In many cases, prisoners must specifically request
3 discharge planning assistance, meaning that individuals who are too sick or who do
4 not have the ability to make a request are unlikely to receive such assistance.

5 48. Custody staffing shortages further contribute to deficiencies in health
6 care delivery at the Jail. For example, each time a prisoner must be transported to
7 or from a housing unit to a health care appointment, at least one deputy must
8 accompany the prisoner. Prisoners are unable to get to, and often miss, scheduled
9 health care appointments due to an insufficient number of custody staff.

10 **B. Defendants Fail to Maintain Adequate, Accurate, and Complete**
11 **Health Care Records.**

12 49. Defendants have a policy and practice of failing to maintain accurate,
13 complete, and organized health care records. This lack of appropriate record-
14 keeping has a severely detrimental effect on patient care, creating a substantial risk
15 of misdiagnosis, dangerous mistakes, and unnecessary delays in care.

16 50. Defendants and their contracted provider maintain health care records
17 using an unorganized, inefficient paper system. When health history or other
18 information is needed during a health care appointment, staff must manually
19 retrieve health care records stored in paper form in the medical unit, if they can be
20 accessed at all.

21 51. Defendants fail to maintain health care records in a way that allows
22 providers to find essential information about their patients. The 2016 Grand Jury
23 found significant deficiencies in Defendants' Jail Management System, noting that
24 the paper system was "antiquated" and that "information is frequently limited and
25 insufficient to medically evaluate inmates with major medical issues." 2016 Grand
26 Jury Report at 4. The County's Jail grievance oversight coordinator discussed in a
27 2016 annual report "the substantial need for an electronic medical records system"
28 at the Jail (emphasis in original). Grievance Review, 2016 Annual Report at 2.

1 52. The paper-based health care records maintained by Defendants are
2 inadequate in a number of ways. The documentation of clinical visits by prisoners
3 is often brief and incomplete. There is little or no documentation by health care
4 staff regarding clinical contacts, lab or test results, or treatment plans.

5 53. Upon information and belief, key lab results are often filed without
6 acknowledgement by the physician or nurse practitioner, and without indication
7 that the results were provided to or discussed with the patient.

8 54. Upon information and belief, Defendants also have a policy or
9 practice of denying people copies of their own jail health care records, in violation
10 of 45 C.F.R. § 164.524.

11 **C. Defendants Violate Prisoners' Patient Confidentiality Rights.**

12 55. Health care contacts typically occur in non-confidential spaces in the
13 Jail housing units. Clinical contacts often occur at cell-front, within earshot of
14 custody staff and other prisoners. There is no confidential treatment space
15 available for mental health staff to use when they meet with patients. Plaintiffs
16 TRACY, and BROWN are forced to attend telepsychiatry appointments in a small
17 room with custody staff present. Such practices violate patients' confidentiality
18 rights and undermines delivery of care. Prisoners are understandably reluctant to
19 disclose personal health information in front of others, which may result in
20 stigmatization and abuse. For example, Plaintiffs FRANCO, TRACY, and
21 BROWN are not comfortable disclosing their mental health history and symptoms
22 to Jail clinicians with custody staff and other prisoners present to hear their
23 conversation.

24 56. Upon information and belief, when prisoners put in a sick call slip
25 describing a health care concern, the slips are collected by custody staff without
26 any method to protect privacy, and health care requests are often reviewed by non-
27 health care staff, a further violation of prisoners' privacy rights.

1 **D. Defendants Routinely and Systematically Fail to Supervise the**
2 **Delivery of Health Care, and Lack Institutional Policies and**
3 **Procedures to Correct Deficiencies and Ensure Adequate Care.**

4 57. Defendants' system fails to adequately review, document, or correct
5 deficiencies in the delivery of care. The process for review of in-custody deaths or
6 critical incidents, to identify problems and determine if changes should be made to
7 the health care delivery system, is inadequate. Thus, Defendants do not take
8 necessary steps to avoid similar treatment system failures, and the consequent risks
9 to human life, in the future.

10 58. Defendants failed to provide adequate monitoring of the former health
11 care contractor, Corizon. The 2016 Grand Jury found that Defendants did not
12 provide adequate oversight of Corizon. 2016 Grand Jury Report at 1. The 2017
13 Grand Jury again found that the "Santa Barbara County Sheriff's Office did not
14 conduct performance reviews of the medical service provider," an essential process
15 to ensure that prisoners receive adequate care and that the County is getting the
16 services it has paid for.

17 **E. Defendants Oversaw a Deeply Flawed Transition from Corizon to**
18 **CFMG as the Contracted Health Care Provider.**

19 59. After years of contracting with Corizon to provide medical and mental
20 health care at the Jail, it became clear that Corizon's performance was abysmal. In
21 2015, the County Board of Supervisors noted that Corizon was providing no
22 performance data and could not show whether prisoners with health care needs
23 were seen in a timely manner or given appropriate medications. Yet Defendants
24 extended the Corizon contract.

25 60. Finally, in or about April 2017, Defendants changed their contracted
26 health care provider from Corizon to CFMG. This transition was deeply flawed
27 and caused several failures with respect to the delivery and continuity of care for
28 prisoners with serious treatment needs. This flawed transition is a reflection of the

1 County's failure to properly monitor contract compliance by the for-profit vendor,
2 as described above.

3 61. Upon information and belief, as Corizon's contract with the County
4 came to an end, Corizon staff sent paper clinical tracking logs and other critically
5 important patient documentation to Corizon's national headquarters in Tennessee.
6 These paper records were thus not available to CFMG administrators and staff
7 when they assumed the role as the County's health care contractor, meaning that
8 there was insufficient information about patients' current medications, diagnosis,
9 and treatment needs.

10 62. Upon information and belief, Corizon staff did not file loose paper
11 health care records for the last several months of the contract. Instead, these hard
12 copy records were stored in numerous boxes, with no apparent system of
13 organization. It regularly took hours to locate individual patient charts, if staff were
14 able to find them at all. Clinical staff often saw patients without records available
15 to them, resulting in time inefficiencies because of the need to repeat historical
16 health diagnostic questioning and in missed identification of prior treatment. Upon
17 information and belief, Corizon created new charts for each individual entering the
18 Jail each year, ignoring files created for people when they were previously
19 incarcerated. This practice resulted in failures to track past diagnoses, treatment
20 needs, and other essential medical information, compromising patient care.

21 63. Upon information and belief, during the transition from Corizon to
22 CFMG, prescriptions for patients were abruptly changed, allowed to lapse, or
23 discontinued altogether without consultation with the patient, thereby
24 compromising care. A system-wide termination of Gabapentin (a drug used to treat
25 several patients with seizure disorders and neurological conditions), without
26 appropriate clinical consultation, individualized review of patients, or alternative
27 treatment planning, is one example of the dangerous breaks in treatment that
28 Plaintiff MURRAY and others experienced.

1 64. Several months after the transition to the new contracted health care
2 provider, Defendants do not have health care policies and procedures that are
3 specific to Santa Barbara County Jail's system. Rather, the only policies and
4 procedures that exist are the property of the contractor, formerly Corizon, and now
5 CFMG. Defendants' provision of health care is guided by generic CFMG policies
6 that are not site-specific and remain only in draft form. This makes it significantly
7 more difficult for Defendants to ensure that adequate health care is provided.

8 **F. Defendants' Medical Care Delivery System Is Inadequate.**

9 **1. Defendants Fail to Provide Adequate Intake Screening to**
10 **Identify and Address Prisoners' Medical Care Problems.**

11 65. Defendants' intake process fails to adequately identify and treat the
12 health care problems of newly arriving prisoners. The County's medical consultant
13 found multiple prisoners housed at the Jail for two weeks or more with no medical
14 screening at all. For example, Defendants failed to complete an initial medical
15 intake assessment for Plaintiff MURRAY until a month after he arrived at the Jail.

16 66. A 2016 Grand Jury report documented findings of inconsistencies in
17 the intake screening process that resulted in failures to determine if an arrestee has
18 major medical concerns.

19 67. Screening failures have had serious and even fatal consequences. Joel
20 Huerta died hours after being booked at the Jail on August 4, 2016, following
21 delays in the provision of obviously and critically needed medical treatment. On
22 information and belief, an emergency crew responded to a call in the community
23 reporting that Mr. Huerta expressed to a neighbor that he was having difficulty
24 breathing and requested medical help. Law enforcement instead arrested Mr.
25 Huerta on suspicion of public intoxication, placing him in restraints due to his level
26 of impairment. At the Jail, Mr. Huerta was unable to respond to medical staff
27 questions. Instead of summoning medical care or transporting him to a hospital,
28 staff placed Mr. Huerta in an observation cell. He became unresponsive while in

1 the observation cell, and died soon thereafter.

2 **2. Defendants Fail to Provide Adequate Facilities to House**
3 **Individuals with Medical Needs or to Provide Medical**
4 **Care.**

5 68. The Jail's facilities are inadequate to provide appropriate housing and
6 care to prisoners with serious medical needs.

7 69. For example, prisoners with medical conditions are typically housed
8 in the "South Dorm," which is filled with metal bunk beds, a few tables, and little
9 more. There is nothing "medical" about this housing unit. The South Dorm is one
10 of the filthiest, most unsanitary housing units in the Jail. A 2015-2016 Santa
11 Barbara County Grand Jury raised concerns about the "disarray" of this unit.
12 Prisoners with chronic medical conditions and physical disabilities (including
13 several wheelchair users) are crowded into this unit. There are regularly not
14 enough beds, particularly given that many of the men in this unit have disabilities
15 that make it dangerous or impossible to reach an upper bunk. Prisoners in the unit
16 regularly sleep in the plastic "boat" structures that sit directly on the floor.



27 *Photo: The "Medical Dorm," with prisoners sleeping on floor*

1 70. There is no designated medical unit for women who require a higher
2 level of care. Such women are placed in crowded housing units that are not
3 equipped to meet their needs.

4 71. The physical spaces in the Jail used for medical treatment are not
5 sufficient for the population of prisoners. The Jail lacks an adequate centralized
6 clinic space, and therefore treatment areas are dispersed throughout the facility,
7 impacting efficiency of care and requiring additional custody officers for transport.
8 There is inadequate office space to support existing or necessary medical staff, and
9 inadequate space to store medical supplies.

10 72. The physical structure of the Jail prevents adequate supervision in
11 case of a medical emergency. Several areas have insufficient monitoring
12 equipment and staff supervision. In some Main Jail units, for example, existing
13 cameras monitor only the hallways and not the housing units themselves. Staff are
14 located in spots where they cannot see or hear housing areas, and there are
15 substantial periods of time when there are no staff present in or near these housing
16 areas. These deficiencies create a serious risk to prisoners in the event of a medical
17 emergency. In one case, numerous female prisoners were forced to yell down the
18 tier of dorms while a woman experienced a medical emergency, with severe
19 vomiting, diarrhea, and an inability to support her own weight. Upon information
20 and belief, it took nearly 20 minutes for staff to respond.

21 **3. Defendants Subject Prisoners to Dangerous Delays And**
22 **Denials of Clinically Necessary Medical Treatment.**

23 73. Defendants often delay, or deny entirely, clinically necessary medical
24 care, causing unnecessary pain and suffering, as well as risks of death, for
25 prisoners at the Jail. Defendants' system fails to provide timely access to medical
26 evaluation and treatment from nursing staff, facility doctors, and outside specialty
27 care providers.

1 74. Many prisoners wait an unacceptably long time to see appropriate
2 health care staff after submitting a sick call slip. Such delays have serious and
3 damaging consequences.

4 75. For example, Defendants failed to provide necessary medical care to
5 Plaintiff TRACY. Plaintiff TRACY arrived at the Jail a few days after receiving
6 treatment at Cottage Hospital for an eye infection. The hospital prescribed
7 medicated eye drops and directed her to see an ophthalmologist. Plaintiff TRACY
8 notified Jail staff of her condition and prescribed treatment in multiple health care
9 requests, writing that “the whole right side of my face is numb” and “Please see me
10 ASAP.” Defendants failed to provide the necessary ophthalmologist assessment or
11 treatment for seven (7) days. By then, her condition had worsened significantly,
12 and she required a four-day admission back at Cottage Hospital. With the denial of
13 treatment at the Jail, she lost vision in her right eye and hearing in her right ear,
14 and the infection had spread to her left eye.

15 76. The delays and denials of treatment have had other tragic results.
16 Raymond Herrera, a 52 year old local painter and father, died in June 2015, while
17 serving a 10-day sentence at the Jail. Mr. Herrera suffered from a seizure disorder.
18 Jail staff failed to provide him his anti-seizure medications. After days of not being
19 provided his medication, Mr. Herrera experienced a seizure that resulted in severe
20 physical trauma, including damage to his spleen. Fellow prisoners called for
21 emergency medical attention after witnessing Mr. Herrera fall. He was handcuffed
22 before being transported to the hospital. He died soon thereafter, having suffered
23 multiple serious ruptures in his spleen.

24 77. Defendants also fail to provide timely and adequate dental care.
25 Defendants’ own grievance oversight coordinator reported in 2016 the reoccurring
26 issue of limited access to dental care, which caused delays in the delivery of
27 treatment.
28

1 78. For example, Defendants denied timely and adequate dental care to
2 Plaintiff WINKLE, resulting in months of extreme pain. At the time of her arrival
3 at the Jail in June 2017, Plaintiff WINKLE informed Jail Staff that she had a tooth
4 that was causing her great pain and needed attention. Defendants noted that she
5 had a cavity but did not take steps to provide necessary treatment. Plaintiff
6 WINKLE submitted multiple written requests for dental care, emphasizing the pain
7 she was experiencing, such as: “URGENT. My wisdom tooth on my right upper
8 side is breaking [through] & doesn’t have enough room. It’s cutting the inside of
9 my cheek. Extremely swollen & painful. Please help ASAP.” Defendants did not
10 provide treatment for nearly four months, until October when they extracted her
11 tooth after noting “massive ... decay.”

12 79. The primary method for people to request health care at the Jail is to
13 submit a “sick call” slip or grievance form. Prisoners must request these forms
14 from custody staff. But, upon information and belief, custody staff often refuse to
15 provide the forms, or fail to deliver them to medical staff for review.

16 **4. Defendants’ System of Chronic Disease Management is**
17 **Inadequate.**

18 80. Defendants systematically fail to adequately manage chronic diseases
19 of prisoners. Management of chronic diseases such as asthma, diabetes, HIV, and
20 hypertension, among others, is *ad hoc*, incomplete, inconsistent, and reactive.
21 Upon information and belief, staff do not follow accepted clinical guidelines when
22 managing these conditions.

23 81. Defendants fail to maintain a comprehensive list of patients with
24 chronic care conditions. Patients with serious chronic conditions do not receive
25 treatment based on clinically accepted protocols.

26 82. Deficiencies in the Jail’s provision of diabetes care is a case in point.
27 Prisoners with diabetes often do not receive timely or consistent blood sugar
28 monitoring or Hemoglobin A1C testing (a standard measure of diabetic control).

1 Many patients with diabetes are not permitted access to medications they had been
2 taking outside of jail. In some cases, patients are not provided prescribed insulin,
3 with life-threatening results. For example, Jonathan Kelly, a prisoner with Type I
4 insulin-dependent diabetes, faced serious failures with respect to his diabetes
5 management treatment regimen, resulting in dangerously high blood sugars (as
6 high as 500 mg/dl, approximately five times normal levels) for long periods of
7 time without adjustment to his insulin dosing or management plan. Failure to
8 manage hyperglycemia, as occurred here, leads to long-term damage, including
9 retinopathy, neuropathy, kidney damage, and cardiovascular disease.

10 83. There are also systemic deficiencies with respect to asthma care.
11 Prisoners with significant asthma histories are not evaluated by physicians unless
12 they present with an acute asthma attack. Keep-on-Person inhalers are restricted,
13 and prisoners must submit a request when they need to use an inhaler. These
14 practices create an increased risk of harm in situations where prisoners face
15 respiratory distress without access to an inhaler.

16 84. For example, on one occasion, Plaintiff MURRAY reported breathing
17 issues in the morning, but was not seen by medical staff for several hours, and was
18 not provided an albuterol inhaler. Instead, his condition worsened. Late that night,
19 another prisoner attempted to summon medical help over the intercom, stating that
20 Plaintiff MURRAY was “on the ground below his bunk having trouble breathing.”
21 He was only then provided with an inhaler treatment. Two days after this incident,
22 he was finally seen for follow-up by a health care provider, who diagnosed him
23 with a respiratory infection.

24 **5. Defendants Fail to Provide Adequate Medication** 25 **Administration and Management.**

26 85. Defendants have a policy and practice of failing to prescribe, provide,
27 and properly manage medications, and of providing incorrect, interrupted, or
28 incomplete dosages of medication.

1 86. Defendants' system does not consistently provide an adequate
2 evaluation before prescribing, changing, or discontinuing medications, and fails to
3 adequately monitor people on medications for side effects, drug interactions, and
4 effectiveness. For example, Defendants recently put a blanket, facility-wide stop
5 on the administration of Gabapentin, a prescription drug used to treat seizure
6 disorders and nerve damage, without consultation or individualized medical
7 justification. Several patients at the Jail, including Plaintiff MURRAY,
8 experienced withdrawal symptoms and panic about their health after their
9 medication was abruptly terminated without any discussion with a provider.

10 87. Defendants fail to appropriately monitor and address prisoners'
11 medication side effects. For example, on one occasion, Plaintiff MURRAY
12 complained of possible side effects to his pain medication, and nursing staff
13 observed him to be nauseous, cold, and shivering (all potential side effects of the
14 medication). He was not referred to a primary care provider, but rather continued
15 on the medication without meaningful follow-up.

16 88. Defendants have also run out of critical prescription medications at
17 the Jail. For example, in 2016, Defendants ran out of Lantus (long-acting) insulin
18 that had been prescribed to Jonathan Kelly, a prisoner with Type I, insulin-
19 dependent diabetes. Medical staff replaced it with a different kind of insulin that
20 has a different mechanism of action and requires different administration timing
21 and dosing. Yet medical staff continued the new insulin at the same dose as the
22 previous one, causing Mr. Kelly to experience extremely low blood sugars
23 (hypoglycemia), which can be life threatening. Mr. Kelly required transport to the
24 emergency room for treatment because of this medication administration failure.

25 89. Plaintiff MURRAY has been denied important medications, in some
26 cases for as long as five days, due to the Jail's failure to maintain an appropriate
27 stock. For example, in May 2017, Plaintiff MURRAY was denied his prescription
28

1 blood pressure medication because, according to a medical record notation, it was
2 “out of stock” at the Jail.

3 90. Prisoners who arrive at the Jail already taking a medication often do
4 not receive timely prescriptions or bridge orders to ensure continuity, even if it is
5 verified by the intake nurse.

6 **6. Defendants Fail to Provide Necessary Assistance to**
7 **Prisoners with Daily Care or Skilled Nursing Needs.**

8 91. There are many prisoners who have complex disabilities and medical
9 conditions, or who are elderly, and require skilled nursing assistance to address
10 their daily care needs. They may need assistance with daily care activities such as
11 using the toilet, showering, getting dressed, changing adult diapers, or changing
12 wound dressings. Staff fail to provide necessary assistance with such daily care
13 activities. Prisoners must instead rely on other prisoners to assist with basic daily
14 care needs, or forego such activities to the detriment of their health and well-being.

15 **G. Defendants’ Mental Health Care Delivery System Is Inadequate.**

16 **1. Defendants Fail to Ensure that Prisoners with Mental**
17 **Health Treatment Needs Are Timely and Adequately**
18 **Identified, Tracked, and Treated.**

19 92. Defendants have a policy and practice of failing to provide prisoners
20 with adequate mental health care, and are deliberately indifferent to the fact that
21 the systemic failure to do so results in significant injury and a substantial risk of
22 serious harm to prisoners, including death.

23 93. In 2011, Sheriff Brown told the Board of Supervisors in 2011, the Jail
24 has become the “de facto mental institution for the county.” Since then, the number
25 of prisoners with serious mental illness has only grown. There are approximately
26 200 prisoners identified as requiring psychiatric medication on any given day, and
27 additional individuals who require monitoring, counseling, and other services to
28 meet their mental health needs.

1 94. Defendants have long been without an adequate tracking system for
2 prisoners with serious mental illness to ensure appropriate follow-up, placement,
3 and provision of treatment.

4 95. The Jail's intake process is inadequate to ensure that prisoners with
5 serious mental illness are identified and receive appropriate care. For prisoners
6 who are unable to participate or who refuse the initial screening, there is
7 inadequate follow-up to ensure that their needs are identified. For newly-arrived
8 prisoners who are taking psychiatric medication, the Jail lacks an adequate
9 procedure to ensure timely verification and medication continuity. Prisoners have
10 had to wait up to 30 days or more to see a psychiatrist, resulting in breaks in
11 medication and insufficient monitoring.

12 96. For example, in July 2017, Defendants failed to continue Plaintiff
13 FRANCO's psychiatric medications after documenting at intake that he was
14 hearing voices and that he had a history of psychiatric hospitalization. Plaintiff
15 FRANCO, who was taking psychiatric medications up until his arrest, was denied
16 treatment for approximately five (5) days. His condition worsened, with staff
17 documenting his reports that "I haven't slept for like 4 days ... I feel like my heart
18 is going to explode ... I need something for this anxiety – it's making me crazy." A
19 few days later, Plaintiff FRANCO attempted suicide by cutting his wrist.

20 **2. Defendants Fail to Identify, Treat, and Appropriately**
21 **Supervise Prisoners Who Are at Risk for Suicide.**

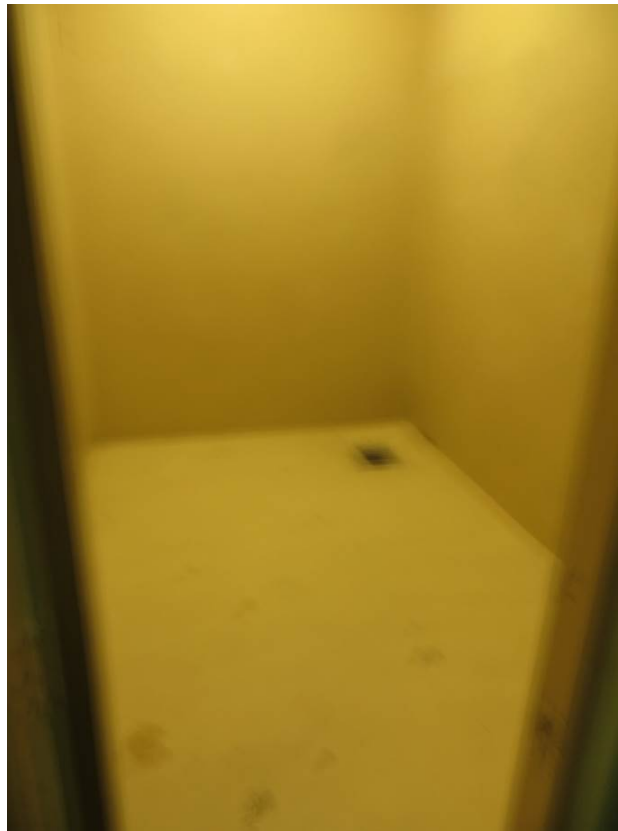
22 97. Defendants fail to identify, treat, and supervise prisoners who are at
23 risk for suicide, with inadequate suicide prevention policies and practices. There
24 have been at least two (2) completed suicides since 2011, and many attempted
25 suicides during that same time period.

26 98. On October 16, 2016, Hector Higareda, a 38-year old man died after
27 hanging himself in an isolation cell at the Jail. Despite the well-known fact that a
28 disproportionately high number of suicides occur in isolation units, the Jail's

1 isolation cells have dangerous attachment points, including prominent metal rungs
2 on the bunks, which serve as a ligature for hanging attempts (as in Mr. Higareda's
3 case). Defendants place prisoners known to be at risk of suicide in these dangerous
4 isolation units.

5 99. Defendants' response to suicidal prisoners is extremely harsh and
6 damaging to individual's psychological well-being. If Defendants identify an
7 individual to be at risk of suicide, staff force the individual to strip naked and to
8 put on a "safety smock," a heavy single-piece outer garment that provides little
9 cover, and then lock the individual in a "safety cell." There are four safety cells in
10 the facility. They have no furnishings, no windows for outside light, and no source
11 of water. There is only a door with a food slot and a grate in the floor that serves as
12 a toilet for feces and urine. Prisoners must sit, sleep, and eat on the same cold, dirty
13 floor in which the toilet grate is located. Prisoners receive no blanket or mattress.
14 These cells are filthy, with feces and dirt smeared on the walls. They often have
15 foul odors that make it difficult to breathe, given the lack of air circulation.

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*Photo: Inside a "Safety Cell": View of cell with grate in floor
for person to use as a toilet*

100. Prisoners have been left in these safety cells for hours and even days. They are not provided with access to showers, telephones, outdoor recreation, visitation, or any out-of-cell time. Contacts with mental health staff occur through the food port in the metal door, without privacy. The Jail does not place a firm time limit on how many days or weeks a prisoner can spend in a safety cell.

101. Defendants placed Plaintiff WINKLE in one of these safety cells for more than four (4) consecutive days after she expressed thoughts about self-harm and suicide. During that time period, she was stripped, placed in the heavy smock, forced to sleep on the ground, and required to use the grate on the floor to urinate and defecate.

102. A 2012 report by a Santa Barbara County correctional care consultant, Health Management Associates, found that the Jail's safety cells "should be

1 eliminated. All concur that these sensory-deprivation cells will cause seriously
2 mentally ill to further decompensate.” Analysis of Inpatient Mental Health
3 Delivery Services for the County of Santa Barbara, October 2012, at 28-29. Yet
4 these same safety cells continue to exist today, with little to no changes. For many
5 prisoners at risk of suicide, the harsh conditions in these safety cells deter them
6 from reporting suicidal thoughts or psychiatric symptoms and seeking help, for
7 fear that they will be placed back in a safety cell and still not get the help they
8 need.

9 103. After returning from a safety cell to a housing unit, prisoners are not
10 provided clinically necessary mental health treatment to address their needs and
11 avoid decompensation or renewed suicidal ideation. Many prisoners who have
12 decompensated or become suicidal in a solitary confinement cell are returned to
13 the same isolation setting after spending time in a safety cell. Many individuals
14 cycle between solitary confinement and safety cells over and over again.

15 104. The Jail lacks a functional process for reviewing suicides and
16 attempted suicides, to identify systemic problems and to ensure that necessary
17 corrective action takes place. Defendants’ suicide prevention training for staff is
18 also inadequate. These deficiencies put the safety of all prisoners at serious risk.

19
20 **3. Defendants Fail to Provide Adequate Facilities to Provide
Mental Health Care.**

21 105. Despite the Sheriff’s statement that the Jail is the “*de facto* mental
22 institution for the county,” there is no mental health treatment unit in the Jail.
23 Prisoners with serious mental illness are generally housed in solitary confinement
24 units scattered throughout the facility. There is one dorm unit, called “South
25 Tank,” that houses approximately 15-20 prisoners with mental health needs. South
26 Tank is a severely cramped and dirty dorm setting with insufficient space for
27 meaningful treatment, socialization, or other activities.

1 106. There is no designated unit at all for women with significant mental
2 health treatment needs. These women are generally housed in solitary confinement.

3 107. It is the established practice that mental health staff do not have access
4 to treatment space for confidential individual contacts or group therapy. Mental
5 health staff rarely, if ever, have access to treatment rooms used by medical staff in
6 order to meet confidentially with their patients. Nearly all mental health clinical
7 contacts occur in locations with many other people in the immediate area and with
8 limited or no visual or auditory privacy. Plaintiff TRACY, Plaintiff BROWN, and
9 other patients must attend telepsychiatry appointments in a small room with
10 custody staff present, preventing doctor-patient confidentiality. In the isolation
11 units, clinical contacts are exceedingly brief, and occur at cell-front through the
12 bars or solid doors. The lack of confidentiality compromises the delivery of care,
13 and deters many patients from seeking treatment or sharing private information.

14 108. The 2012 Health Management Associates report documented the
15 inadequacy of facilities for prisoners with mental illness. It recommended creation
16 of a mental health treatment and observation unit where prisoners with mental
17 illness would receive appropriate programming and supervision. Five years later,
18 this recommendation has not been implemented.

19
20 **4. Defendants' Mental Health Treatment Program Involves
21 Little More than Responding to Emergencies.**

22 109. Defendants provide little to no treatment to prisoners with mental
23 health needs, even for those with acute or high-risk mental illness. Defendants do
24 not develop individualized treatment plans to prisoners with mental illness, in
25 violation of Section 1210 of Title 15 of the California Code of Regulations.

26 110. Correctional mental health standards dictate that prisoners with
27 serious mental illness should receive, at a minimum, ten (10) hours per week of
28 out-of-cell structured therapeutic group and individual programming and an

1 additional ten (10) hours per week of out-of-cell recreational or other unstructured
2 time. Defendants do not come close to meeting this standard.

3 111. The only treatment program in the Jail is the recently initiated Project
4 BRACE (Breaking Recidivism and Creating Empowerment). Under Project
5 BRACE, a local organization meets periodically with a limited number of
6 prisoners with mental illness or substance abuse disorders. Many of the prisoners
7 with the most significant treatment needs are not permitted to participate in the
8 program. Jail mental health staff and administrators do not oversee or direct the
9 program. Outside BRACE providers and the in-house treatment providers do not
10 coordinate or share information about patients' treatment planning and delivery.

11 112. Plaintiff MURRAY, who has an extensive history of post-traumatic
12 stress disorder and has reported to staff that he suffers from flashbacks,
13 nightmares, anxiety, and depression, has received no structured group or individual
14 therapy in the approximately three years he has been at the Jail. Defendants have
15 denied Plaintiff MURRAY the opportunity to participate in the BRACE program
16 because his medical conditions and disabilities require that he be housed in the
17 medical dorm, which the BRACE providers generally do not serve. Plaintiff
18 MURRAY requested treatment after his mental health condition worsened on a
19 number of occasions, with long delays in response from clinicians and a consistent
20 failure to monitor and follow up. Absent timely and appropriate care, his mental
21 health condition has worsened during his time in detention.

22 **5. Defendants Fail to Provide Prisoners Access to Higher**
23 **Levels of Mental Health Care When Necessary.**

24 113. The Jail does not have a mental health unit and lacks the staff, space,
25 and program to provide treatment to individuals with significant treatment needs.
26 Prisoners with mental health conditions are generally housed in the "South Tank"
27 dorm or in solitary confinement units; there is no therapeutic treatment unit in the
28 system, despite the considerable need within the prisoner population. If individuals

1 decompensate to the point that they are suicidal or actively psychotic, essentially
2 the only option is to place individuals in the Jail’s barren safety cells.

3 114. Prisoners who require emergency or acute psychiatric care are
4 referred for evaluation for inpatient placement in the County’s 16-bed Psychiatric
5 Health Facility (PHF) that is up the street from the Jail. Historically, it has been
6 nearly impossible for a prisoner requiring an inpatient level of care to receive a
7 timely transfer – or any transfer at all – to the PHF. Following DRC’s 2016
8 investigation report, Defendants designated one PHF bed for prisoners requiring
9 inpatient care. But the practice has been inconsistent, and this single bed does not
10 meet the needs of the Jail population. Santa Barbara Undersheriff Bernard
11 Melekian has acknowledged the insufficient availability of inpatient psychiatric
12 treatment in the County, and the resulting placement of patients in non-therapeutic
13 jail settings. He has stated that “what we have is a facility that is absolutely
14 archaic” and acknowledged that the County jails people who need an inpatient
15 facility level of care.

16 115. Given the unavailability of inpatient psychiatric beds, prisoners who
17 are suicidal or actively psychotic are left in safety cells or isolation units at the Jail,
18 without an individualized treatment plan and without meaningful, clinically
19 necessary care.

20 116. In addition, there are many prisoners with serious mental illness who
21 have been deemed incompetent to stand trial and ordered to a California
22 Department of State Hospitals competency restoration treatment program. Such
23 individuals can wait for months to be transferred to a competency restoration
24 treatment program. During that time, they generally remain in safety cells or
25 isolation units, where their condition deteriorates without necessary treatment.

1 **6. Defendants Fail to Adequately Prescribe, Monitor, and**
2 **Evaluate the Provision of Psychiatric Medication.**

3 117. Defendants fail to provide clinically necessary psychiatric
4 medications to prisoners with serious mental illness. Defendants' policies and
5 practices for providing psychiatric medications to prisoners, and for monitoring
6 and treating the side effects or efficacy of medications, are inadequate.

7 118. As a result of Defendants' failure, prisoners with mental illness suffer
8 withdrawal symptoms, recurrence of debilitating symptoms such as hallucinations
9 and suicidality, and decompensation to the point of not being competent to stand
10 trial in their criminal proceeding and/or requiring emergency or acute care.

11 119. Defendants fail to provide adequate medication management for
12 prisoners with mental illness. Prisoners have gone for weeks and months without
13 the psychiatric medications (or comparable medications) that they had been taking
14 prior to detention, resulting in decompensation.

15 120. Prisoners taking medication may wait for long periods for their
16 psychiatric prescriptions to be filled. It has been common for medications to take
17 several days or more to arrive at the Jail. The County's Jail grievance oversight
18 coordinator identified that the lack of a full-time psychiatrist on site was an "on-
19 going issue creating delayed service delivery." Q3 2016 Grievance Review at 2.

20 121. For example, Defendants' failure to timely continue Plaintiff
21 FRANCO's medication regimen when he arrived at the Jail led to his experiencing
22 increased hallucinations and suicidal thoughts, as described above. He attempted
23 suicide and was placed in a safety cell twice during his first two weeks at the Jail.

24 122. Defendants do not provide a comprehensive evaluation or consultation
25 before prescribing or changing psychiatric medications and fail to adequately
26 monitor side effects, drug interactions, and effectiveness. Medication dosages are
27 often changed abruptly or missed entirely without explanation.

1 **7. Defendants Discriminate Against and Unfairly Punish**
2 **Prisoners with Mental Illness.**

3 123. Defendants discriminate against prisoners with serious mental illness
4 by isolating them from and denying them privileges granted to other prisoners.
5 Prisoners with serious mental illness are denied access to programs and services
6 because Defendants place them in the most restrictive settings in the system, a
7 violation of federal disability law, 28 C.F.R. § 35.152.

8 124. Defendants unfairly subject prisoners with mental health conditions to
9 discipline where the conduct at issue is a direct result of the individual's (generally
10 untreated) mental health condition. Defendants lack a policy allowing mental
11 health input into disciplinary procedures for prisoners with serious mental illness.
12 The prevalence of individuals with serious mental illness in solitary confinement,
13 such as Plaintiff WINKLE, illustrate this systemic problem.

14 125. Defendants further fail to adequately train staff regarding how to
15 respond to prisoners with mental illness whose non-conforming behaviors stem
16 from their mental illness. Upon information and belief, when prisoners' psychiatric
17 condition inhibits their ability to follow directions or interact with others, staff too
18 often fail to involve mental health professionals or to otherwise address the
19 underlying psychiatric needs, instead relying on disciplinary measures or referral
20 for additional criminal charges. Plaintiff WINKLE's experience illustrates this
21 problems. Defendants have repeatedly placed Plaintiff WINKLE in solitary
22 confinement for long periods based on disciplinary infractions, including not being
23 prepared for linen exchange on laundry day and not properly wearing her shirt, as
24 well as verbal outbursts likely relate to her mental health condition. In late summer
25 2017, Defendants placed Plaintiff WINKLE in segregation housing for nearly a
26 month following one such incident. During that time, her mental health condition
27 deteriorated significantly – she experienced increased anxiety and multiple serious
28 panic attacks in the solitary confinement setting.

1 **H. Overcrowding at the Jail Contributes to a Significant Health**
2 **Crisis and Causes Additional Risks of Harm.**

3 126. Because of overcrowding at the Jail, prisoners are housed in tightly
4 packed housing units and are forced into close contact with others. Such conditions
5 raise the risk of transmission of infectious diseases, including common respiratory
6 and gastrointestinal viruses, bacterial infections, scabies, or lice infestations, and
7 other serious conditions.

8 127. For example, a recent outbreak of Methicillin-resistant
9 Staphylococcus aureus (MRSA), a skin infection caused by drug-resistant bacteria
10 causing painful wounds and posing major health risks, was likely related to
11 overcrowding. Numerous patients in the South Dorm, where prisoners with serious
12 medical needs are clustered, have developed MRSA infections since being placed
13 in that unit.

14 128. Plaintiff WINKLE also developed an infection in a women's housing
15 unit. She notified Defendants of a painful and swollen area on her neck, and
16 expressed concern that she had developed an infection through contact with
17 another prisoner in her unit. Medical staff failed to provide treatment for several
18 weeks, at which time they finally diagnosed it as a MRSA infection.

19 129. The overcrowding in the Jail also means that health care staff are
20 unable to timely see prisoners who require evaluation or treatment, an issue further
21 complicated by the problem of insufficient treatment space to deliver care.

22 **III. DEFENDANTS ROUTINELY OVERUSE AND IMPROPERLY USE**
23 **SOLITARY CONFINEMENT**

24 130. Defendants have a policy and practice of overusing and improperly
25 using prolonged isolation in the Jail. On a given day, approximately 75 or more
26 prisoners are locked in small solitary confinement cells for 23 and even 24 hours
27 per day. These cells are prevalent throughout the Jail.
28

1 131. Many isolation cells are windowless, dimly lit, filthy, and lack fresh
2 air. There are dozens of isolation cells located down dark, dead-end corridors,
3 outside of any staff sight line and inaudible to staff. The conditions in these cells
4 are defined by deprivation and extreme social isolation. Defendants place no
5 limitation on the amount of time a prisoner can spend in solitary confinement.



22 *Photos: At Left: View inside an Isolation Cell*

23 *At Right: Dark corridor containing 6 windowless Isolation Cells*

24 132. Placement in isolation housing at the Jail results in severe restriction
25 of movement for prisoners, particularly given the exceedingly small size of the
26 cells and the lack of access to a dayroom. Dozens of isolation cells are 60 square
27 feet or less, an area that includes an affixed bed, toilet, and water basin. These cells
28 were purportedly built pursuant to jail construction standards more than half a

1 century old. They do not come close to meeting current American Correctional
2 Association standards, which require that cells like these provide at least 80 square
3 feet of total floor space.

4 133. Many solitary confinement cells are repurposed spaces that were
5 never intended to house prisoners – some were designed to serve as closets or
6 small storage areas, not to house human beings.

7 134. Prisoners in solitary confinement have strikingly little stimulation or
8 opportunity for meaningful social interaction. They are not permitted radios or
9 televisions to pass the time. By policy, prisoners in isolation units are permitted out
10 of their cells for recreation and exercise only *three hours per week*. Many do not
11 even receive that amount of time out of their cell. The Jail’s schedule provides that
12 these individuals receive out-of-cell time for recreation and exercise just two days
13 per week, meaning that they essentially spend five days per week confined entirely
14 to their isolation cell. Due to staffing shortages and other operational challenges,
15 many prisoners do not get out of their cells for days or weeks at a time.

16 135. The “yards” for prisoners in isolation units are exceedingly small and
17 inadequate, and do not provide meaningful opportunity for exercise or recreation.

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11 *Photo: The small concrete “Yard” where prisoners in solitary confinement*
12 *receive 3 hours or less of out-of-cell time per week*

13 136. These harsh isolation conditions affect both physical and mental health.
14 Plaintiff WINKLE suffered multiple panic attacks while housed for several weeks
15 in a solitary confinement cell.

16 137. The features of some isolation cells create an even more extreme sense
17 of isolation. One cell, called “South 20,” is located by itself down a long and
18 winding hallway behind an additional door. An individual can spend weeks or
19 months in this cell without any normal or meaningful interaction with another
20 person. Other cells are designed such that the prisoner is separated by two doors –
21 a locked, solid, essentially sound-proof metal door and a second locked door that is
22 barred. It is common for individuals with serious mental illness and actively
23 psychotic symptoms to be placed in ultra-isolation units, like the ISO-21 cell,
24 below.

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Photos: The solid door and bars of Ultra-Isolation Cell "ISO-21"

138. The devastating effects of these conditions of extreme social isolation and environmental deprivation are well known to Defendants. A vast body of literature has documented the adverse mental health effects of isolation. Santa Barbara County Jail prisoners are no exception. Even prisoners who have no mental illness when first placed in isolation often experience a significant deterioration in their mental health, developing symptoms such as paranoia, anxiety, depression, and post-traumatic stress disorder.

139. Isolation is even more damaging to prisoners with a pre-existing mental illness. For these prisoners, isolation poses a significant risk of exacerbation of mental health symptoms, emotional trauma, self-harm, and suicide. Deprived of the social interaction that is essential to keep them grounded in reality, many prisoners with mental illness experience dangerous psychiatric deterioration. Yet Defendants place numerous prisoners with serious mental illness in isolated, solitary confinement settings not simply in spite of their psychiatric condition, but *because* of their psychiatric condition. Even short stays in such conditions of extreme isolation are likely to worsen prisoners' mental health symptoms.

140. Defendants' Northwest Isolation and "New East" Isolation units specifically house numerous individuals who are suffering acute mental illness, in

1 austere cells that are barren, often with only a metal bunk, a metal desk, a toilet,
2 and a thin blanket.



14 *Photos: Prisoners in barren Isolation Cells at Santa Barbara County Jail*

15 141. Defendants' solitary confinement practices place people with
16 psychiatric disabilities and serious mental illness at grave risk of harm. According
17 to the American Psychiatric Association: "Prolonged segregation of adult inmates
18 with serious mental illness, with rare exceptions, should be avoided due to the
19 potential for harm to such inmates." The National Commission on Correctional
20 Health Care has issued a position statement asserting that "mentally ill individuals
21 . . . should be excluded from solitary confinement of any duration." The United
22 States Department of Justice issued a report on the use of restrictive housing in
23 2016, in which it states that "[g]enerally, inmates with serious mental illness (SMI)
24 should not be placed in restrictive housing."

25 142. Defendants do not have policies and procedures to ameliorate the
26 serious risk of harm stemming from placing individuals with mental illness in
27 solitary confinement. Contrary to established correctional mental health standards,
28 mental health staff do not assess people with mental illness before placing them in

1 solitary confinement to ensure that such a placement is not contraindicated or
2 otherwise dangerous. Defendants do not provide treatment or adequate out-of-cell
3 time to mitigate the negative effects of solitary confinement. Defendants do not
4 provide any established criteria or programming to transition prisoners out of
5 solitary confinement.

6 143. Upon information and belief, Defendants do not conduct sufficient
7 mental health, medical, or custody welfare checks of those in solitary confinement,
8 to ensure that the prisoners in these units are safe and to timely identify psychiatric
9 or medical emergencies. Defendants do not sufficiently monitor prisoners in
10 isolation settings to identify any signs of decompensation or new onset of
11 symptoms. Many isolation cells lack an in-cell emergency call button, placing the
12 occupants at high risk should there be a medical emergency.

13 144. Defendants' policy and procedures allows and in fact encourage the
14 isolation of prisoners with mental illness. Defendants knowingly hold prisoners
15 that they know have mental illness in isolation for extended periods of time.

16 145. In 2011, Juan Rodriguez- Zepeda, a 29-year-old prisoner with mental
17 health needs died in an isolation cell, having been housed in solitary confinement for
18 more than one month at the time of his death. He had made numerous requests for
19 medical attention and expressed fear for his safety. A Santa Barbara County Grand
20 Jury found that the man had been dead for several hours by the time paramedics
21 arrived, and his body was in *rigor mortis*. The 2011-2012 Grand Jury identified several
22 deficiencies related to this case. It found that the Jail's isolation cells, which were
23 designed and built under 1963 construction standards, contained hidden alcove
24 areas that prevented visibility into the cell. This layout impedes staff from
25 monitoring whether an inmate is alive or in need of medical attention. The Grand
26 Jury recommended steps be taken to address the lack-of-visibility problem in these
27 cells. In its response, the Sheriff's Office agreed with the Grand Jury's finding but
28 declined to implement the recommendation.

1 146. The harm to prisoners in isolation is worsened by Defendants' policy
2 and practice of failing to provide adequate mental health care staffing and
3 treatment, as detailed above. Prisoners in isolation do not receive regular and
4 meaningful contact with psychiatrists or mental health clinicians.

5 147. Attempts to commit suicide remain frighteningly common in the
6 solitary confinement units at the Jail. During the five-month period between
7 September 2016 and January 2017, at least twelve (12) prisoners attempted suicide
8 inside an isolation cell, more than one every two weeks, including the case of Mr.
9 Higareda, who died as a result, as discussed above.

10 **IV. DEFENDANTS DISCRIMINATE AGAINST AND FAIL TO**
11 **ACCOMMODATE PEOPLE WITH DISABILITIES.**

12 148. Defendants incarcerate significant numbers of individuals with
13 disabilities, as that term is defined in the ADA, the Rehabilitation Act, and
14 California State law. Defendants fail to provide prisoners with disabilities with
15 reasonable accommodations to ensure equivalent access to all of the programs,
16 activities, and services offered at the Jail. Defendants' system discriminates against
17 people with disabilities with respect to classification, housing, access to programs
18 and services, and physical access barriers. Defendants systematically fail to
19 evaluate the needs of people with disabilities and fail to meet those needs through
20 appropriate accommodations.

21 149. Defendants have failed to create and implement adequate policies and
22 procedures to ensure the rights of prisoners with disabilities to reasonable
23 accommodations and equal access. Existing disability-related policy is incomplete
24 and insufficient to ensure that all staff are aware of the required procedures and
25 responsibilities. Numerous custody, operational, and health care policies and
26 procedures lack sufficient guidance with respect to their application to prisoners
27 with disabilities.
28

1 150. Defendants have not provided adequate training to correctional staff
2 to prevent discrimination against people with disabilities, and to ensure that each
3 prisoner with a disability has appropriate accommodations and access to programs,
4 services, and activities at the Jail.

5 **A. Defendants Lack Adequate Policies and Practices to Identify and**
6 **Track Prisoners with Disabilities.**

7 151. Defendants do not have an effective or automated system to identify
8 and track the accommodation and other needs of persons with disabilities, or to
9 ensure that reasonable accommodations are provided. The existing manual system
10 frequently fails to capture, substantiate, and address important disability
11 accommodation and accessibility needs.

12 152. The lack of an effective tracking system results in substantial risk of
13 injury and actual injuries to prisoners with disabilities, and results in them being
14 denied the benefit of programs, services, and activities at the Jail.

15 **B. Defendants Place Prisoners with Disabilities in More Restrictive**
16 **Settings and Deny Them Meaningful Access to Jail Programs,**
17 **Services, and Activities.**

18 153. Individuals with disabilities end up in higher security, more restrictive
19 housing units and are denied access to several programs, services, and activities
20 *because* of their disability status, in violation of federal law.

21 154. Defendants' policy and practice of denying prisoners with physical or
22 psychiatric disabilities the opportunity to be housed or participate in programming
23 at the Medium Security Facility is an example. The Medium Security Facility has
24 many unique benefits, including the most freedom, access to an outdoor exercise
25 area, and access to a library. It is also the housing unit for prisoners who receive
26 job assignments at the Jail. As Defendants describe in their policy, the Medium
27 Security Facility offers "several educational and self-enhancement programs,"
28 which "allow inmates to improve themselves, learn vocational and life skills, and

1 serve the community.” But Defendants do not permit prisoners with disabilities to
2 be housed or participate in programs in the Medium Security Facility.

3 155. Prisoners with disability needs are segregated based on their
4 disabilities. Although there are no functional medical or mental health treatment
5 units, prisoners who have mobility disabilities are routinely segregated in the South
6 “Medical” Dorm and prisoners with mental illness are either segregated into the
7 South “Mental Health” Tank or solitary confinement units. There is no meaningful
8 clinical reason for these placements.

9 156. These individuals are then denied access to programs, outdoor
10 recreational time, and other activities that are available to other prisoners in the
11 Jail, including at the Medium Security Facility. Such placement of individuals with
12 disabilities in units more restrictive than necessary, and the exclusion of such
13 individuals in services, programs, or activities, violates federal disability law. *See*
14 28 C.F.R. § 35.152(b)(1). Plaintiff MURRAY, Plaintiff FRANCO, Plaintiff
15 BROWN, and others have been denied the opportunity to participate in programs
16 offered only at the Medium Security Facility because of their disability, medical,
17 and mental health conditions.

18 157. Plaintiff MURRAY has requested the opportunity to participate in
19 structured programming and activities that take place in the classroom area in the
20 Jail’s basement. Defendants have denied his request based on his placement in the
21 South Dorm medical unit, indicating to him that prisoners in this unit are not
22 permitted to participate in such programs.

23 **C. Defendants Fail to Provide Reasonable Accommodations to**
24 **Prisoners Who Need Them.**

25 158. Defendants do not timely or consistently provide reasonable
26 accommodations to prisoners with disabilities, including but not limited to
27 wheelchairs, walkers, crutches, canes, braces, and hearing aids, to people who
28 require them, if they ever provide them at all.

1 159. Additionally, the provision of a reasonable accommodation, even if
2 initially provided, is often taken away based on Defendants' operational failures.
3 Defendants have taken mobility assistive devices away from individuals who
4 require them. For example, Defendants confiscated Plaintiff MURRAY's
5 wheelchair for an extended period when he was housed in an isolation cell.
6 Without his wheelchair, he was unable to reach the shower area from his cell.
7 Plaintiff MURRAY could not shower for several days, even as he repeatedly
8 requested that his wheelchair be returned to him. For other prisoners, Defendants
9 have taken away their mobility assistive devices when they are transported to court
10 or another outside facility, putting them at risk of falling. When they return to the
11 Jail, Defendants often fail to return the devices. In some cases, it has taken several
12 days for prisoners with significant mobility disabilities to get their device returned
13 to them, during which time they struggle to get around to the shower, toilet, meals,
14 and other daily activities.

15 160. Presently, *none of the cells* in the Jail meets ADA accessibility
16 standards, and there are significant physical accessibility deficiencies throughout
17 all housing units. Defendants' housing units are filled with bunks, telephones,
18 toilets, and shower facilities that are not ADA-compliant and are not accessible to
19 individuals with disabilities. Plaintiff BROWN and other prisoners with mobility
20 disabilities have had great difficulty using the toilets and showers at the Jail.

21 161. The lack of accessibility for prisoners with disabilities reaches nearly
22 all aspects of the Jail. For example, Plaintiff MURRAY, who requires a wheelchair
23 to get around safely, cannot access confidential attorney visiting booths in his
24 wheelchair because the booths do not accommodate a wheelchair. Plaintiff
25 MURRAY has had to collapse his wheelchair and hobble on his own into an
26 inaccessible seat to meet with his legal counsel. Plaintiff BROWN is regularly
27 placed in holding cells that are not wide enough to fit his wheelchair, requiring him
28 to hobble into those cells on his own. Plaintiff BROWN has had difficulty getting

1 safely on and off the bus transporting prisoners to and from court based on
2 accessibility barriers.

3 162. Physical plant deficiencies even extend to the South Dorm, where
4 medically infirm and mobility-limited men are housed. In the South Dorm, the
5 shower, toilet, and wash areas do not meet accessibility requirements, and there are
6 path of travel barriers and other deficiencies that impede access for many
7 individuals with mobility disabilities. For example, Plaintiff MURRAY has been
8 required to use showers and toilets that lack grab bars and other features necessary
9 for accessibility. Plaintiff MURRAY, and other prisoners with disabilities, have
10 fallen and suffered physical injury and humiliation because they were forced to use
11 the Jail's inaccessible facilities.

12 163. As a result of overcrowding at the Jail and the resulting lack of beds,
13 many prisoners with disabilities have been among those individuals forced to sleep
14 on the floor. Until recently, Defendants lacked any process to assign prisoners with
15 disabilities lower bunks. When these individuals are assigned a top bunk, they have
16 no choice but to sleep on the floor. Plaintiff MURRAY was forced to sleep on the
17 floor for several days, despite his having a degenerative back disease, spinal
18 arthritis, and peripheral neuropathy.

19 164. Even now, Defendants assign individuals with disabilities to
20 inaccessible or inappropriate beds. Plaintiff WINKLE, who has a seizure disorder,
21 was recently assigned to an isolation cell with only a high bunk, putting her at
22 significant risk of a dangerous fall from the upper bunk during a seizure.

23 165. Defendants use bunk beds in the crowded South Dorm "medical unit,"
24 even though a large number of the prisoners in the unit have disabilities and
25 medical conditions that make an upper bunk placement unsafe and inappropriate.
26 Defendants fail to provide many of these individuals a lower bunk bed. Many end
27 up sleeping on the floor.

1 166. Often, there are simply not enough beds in units housing people with
2 disabilities and serious medical conditions. The “No Bunk Available (NBA)”
3 reports submitted to the superior court as recently as July and August 2017 indicate
4 that Defendants have failed to provide a bed to as many as ten (10) prisoners
5 housed in the South Dorm “medical unit” on a given day. Several of these
6 medically fragile individuals went without a bed for more than 48 hours. Plaintiff
7 BROWN, who has a mobility disability and chronic back pain, and uses a
8 wheelchair to get around, was assigned to sleep on the floor at least twice in May
9 2017 – once for two (2) days and then again for five (5) days. During that time, he
10 reported to Jail staff that he was experiencing increased pain, and he refused to eat
11 in protest of the denial of treatment and poor conditions.

12 167. Holding, sobering, and safety cells also lack accommodations for
13 prisoners with disabilities. Holding and sobering cells lack grab bars to allow
14 prisoners with disabilities to access the sink and toilet. Prisoners with mobility
15 disabilities who are in psychiatric crisis have their wheelchairs or other assistive
16 devices confiscated when they are placed in the Jail’s safety cells, forcing them to
17 lie on the floor for hours or days at a time.

18 168. Upon information and belief, Defendants do not provide emergency
19 evacuation plans for people with disabilities, putting this group at serious risk of
20 harm in the event of an emergency at the Jail.

21 **D. Defendants Fail to Accommodate Prisoners with Disabilities that**
22 **Affect Communication.**

23 169. Prisoners with hearing, speech, or intellectual disabilities, mental
24 illness, and other conditions that impact communication have problems effectively
25 communicating. Such prisoners require accommodations to ensure effective
26 communication with staff and equal access to programs and services offered by
27 Defendants. Defendants fail to provide such accommodations, effectively denying
28 this group the benefits of programs, services, and activities at the Jail.

1 170. For prisoners who are deaf, access to reasonable accommodations
2 related to telephone use is inadequate. By policy, the Jail's TDD/TTY machine is
3 located only in the booking area, far from many of the housing units in the facility.
4 By policy, access to TDD/TTY equipment is furnished only when "reasonably
5 available accommodations can be made," a significant issue given the custody staff
6 shortages that limit the availability of a custody escort to get the deaf prisoner to the
7 equipment. Upon information and belief, there is no access to video relay services or
8 videophone provided for prisoners who communicate through sign language, which
9 is inconsistent with modern correctional and disability access practices.

10 171. Upon information and belief, the intercom system allowing a prisoner
11 to communicate with staff in an emergency situation is inaccessible to prisoners
12 with disabilities. Many of these intercoms are in disrepair and do not work for
13 prisoners with limited hearing ability, and are located in places not accessible to
14 prisoners with mobility disabilities – for example, too high on the wall for a person
15 who uses a wheelchair to reach.

16 **E. Defendants Lack an Effective Grievance Procedure for Prisoners**
17 **to Request Reasonable Disability Accommodations**

18 172. Defendants do not provide an effective or functional grievance system
19 for prisoners with disabilities to ensure that needs are timely met. For example, the
20 existing grievance procedure does not provide for an expedited review process
21 when a prisoner with a disability is at risk of physical or other serious harm based
22 on a denial of an accommodation. Prisoners, particularly those housed in solitary
23 confinement, have great difficulty obtaining accommodation request or grievance
24 forms. Responses are often delayed or fail to address the problem.

1 **V. DEFENDANTS FORCE PRISONERS TO LIVE IN DANGEROUS,**
2 **UNSANITARY CONDITIONS.**

3 173. Defendants' policies and practices deprive prisoners of sanitary and
4 humane living conditions. Much of the Jail is significantly run-down, dilapidated,
5 and unsanitary.

6 174. Recently, two of three wash basins and one of the three toilets in
7 South Tank (which houses prisoners with mental illness) were not in working
8 order, and the sole shower was missing tiles and had a visible mold. In the South
9 Dorm (the "medical unit"), there was mold in the lavatory and shower area, and on
10 the walls of the wash basin area. Air vents were covered with caked dirt. Housing
11 units regularly exist in a filthy condition and with a foul smell, including the
12 isolation cells housing prisoners with serious mental illness.

13 175. The makeshift basement dorms have significant mold growing in the
14 ceiling and shower areas. The air quality and ventilation in these units is especially
15 poor and causes significant breathing problems, particularly for individuals with
16 asthma or other respiratory conditions.

17 176. In isolation units, toilets overflow, with feces and urine pouring onto
18 the cell floors. Lighting and ventilation in the West, East, and South isolation cells
19 are inadequate and enhance the deprivation and suffering of people in those units.

20 177. Defendants have allowed a widespread custom and practice of
21 maintaining unsanitary living conditions. The filth, mold, and other unsanitary
22 conditions cause a serious risk of harm to human health and daily suffering for
23 prisoners. Prisoners like Plaintiff WINKLE have contracted dangerous infections,
24 like MRSA, and other serious medical problems in these units.

25 178. Prisoners have taken it upon themselves to use their personal soap and
26 towels to clean their living areas. Prisoners' grievances regarding these conditions
27 have been ignored, as staff tell them these issues are "not grieve-able."

28 179. There are further severe deficits with respect to the provision of food
and nutrition to prisoners. Prisoners report receiving foul-tasting food. Defendants

1 have a policy of punishing prisoners by denying them normal food and instead
2 serving them only a “disciplinary diet,” a tasteless and disgusting “meatloaf” with
3 two slices of bread, served twice daily for multiple consecutive days. Serving this
4 sort of disciplinary diet as punishment is banned in many jail and prison systems.

5 CLASS ACTION ALLEGATIONS

6 **Prisoner Class**

7 180. 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 all men
9 and women who are now or will in the future be incarcerated in the Santa Barbara
10 County Jail system (the “Prisoner Class”). All Prisoner Class members are subject
11 to an unreasonable risk of harm due to: Defendants’ policies and practices of
12 denying prisoners minimally adequate medical and mental health care; Defendants’
13 misuse and overuse of solitary confinement; and Defendants’ failure to maintain
14 safe and adequate conditions of confinement.

15 181. The Prisoner Class is so numerous that joinder of all members is
16 impracticable. Fed. R. Civ. P. 23(a)(1). There are approximately 1,000 prisoners in
17 Defendants’ custody. Due to Defendants’ policies and practices, all prisoners in the
18 Jail receive or are at risk of receiving harm due to Defendants’ harmful policies
19 and practices.

20 182. Prisoner Class members are identifiable using records maintained in
21 the ordinary course of business by Defendants.

22 183. There are questions of law and fact common to the class, including,
23 but not limited to, whether Defendants’ failure to provide minimally adequate
24 medical and mental health care, Defendants’ misuse and overuse of solitary
25 confinement, and Defendants’ failure to maintain safe and adequate conditions of
26 confinement, violate the Due Process Clause of the Fourteenth Amendment and the
27 Cruel and Unusual Punishment Clause of the Eighth Amendment to the United
28 States Constitution, and whether Defendants have been deliberately indifferent to

1 the serious needs of class members and the serious risks of harm to class members.
2 Defendants are expected to raise common defenses to these claims, including
3 denying that their actions violated the law.

4 184. This action is maintainable as a class action pursuant to Fed. R. Civ.
5 P. 23(b)(1) since there are several thousand class members, separate actions by
6 individuals would in all likelihood result in inconsistent and varying decisions,
7 which in turn would result in conflicting and incompatible standards of conduct for
8 the Defendants.

9 185. This action is maintainable as a class action pursuant to Fed. R. Civ.
10 P. 23(b)(2) since Defendants have acted and failed to act on grounds that apply
11 generally to the class, so that final injunctive or corresponding declaratory relief is
12 appropriate respecting the class as a whole.

13 186. The claims of the named Plaintiffs are typical of the claims of the
14 class and subclass, since their claims arise from the same policies, practices, and
15 courses of conduct and their claims are based on the same theory of law as the
16 class's claims. Fed. R. Civ. P. 23(a)(3).

17 187. The named Plaintiffs, through counsel, will fairly and adequately
18 protect the interests of the class. Fed. R. Civ. P. 23(a)(4). Plaintiffs do not have
19 any interests antagonistic to the class. Plaintiffs, as well as the class members, seek
20 to enjoin the unlawful acts and omissions of Defendants. Further, Plaintiffs are
21 represented by counsel experienced in civil rights litigation, prisoners' rights
22 litigation, and complex class action litigation.

23 **Disabilities Subclass**

24 188. The named Plaintiffs further bring this action on their own behalf and,
25 pursuant to Rule 23(a), b(1), and (b)(2) of the Federal Rules of Civil Procedure, on
26 behalf of all qualified individuals with disabilities, as that term is defined in 42
27 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code §
28 12926(j) and (m), who are now, or will be in the future incarcerated in the Jail

1 (“Disabilities Subclass”). All prisoners with disabilities who are incarcerated in the
2 Jail are at risk of being discriminated against or denied access to programs,
3 services, and activities offered at the Jail as a result of the policies and practices of
4 Defendants.

5 189. The Disabilities Subclass is so numerous that joinder of all members
6 is impracticable. The exact number of members of the Disabilities Subclass is
7 unknown. According to data gathered by the United States Department of Justice’s
8 Bureau of Justice Statistics regarding the incidence of disabilities among
9 individuals in jails, approximately 40% of Jail prisoners have one or more
10 disabilities, suggesting an estimated 400 members of the Disabilities Subclass.

11 190. There are questions of law and fact common to the Disabilities
12 Subclass, including whether Defendants’ violated the Americans with Disabilities
13 Act, Section 504 of the Rehabilitation Act, and California Government Code §
14 11135.

15 191. Defendants have acted and failed to act on grounds that apply
16 generally to the Disabilities Subclass, so that final injunctive or corresponding
17 declaratory relief is appropriate respecting the Disabilities Subclass as a whole.

18 192. The claims of the named Plaintiffs are typical of the claims of the
19 Disabilities Subclass, since their claims arise from the same policies, practices, and
20 courses of conduct and his claims are based on the same theory of law as the
21 Disabilities Subclass’s claims.

22 193. Plaintiffs, through counsel, will fairly and adequately protect the
23 interests of the Disabilities Subclass. Plaintiffs do not have any interests
24 antagonistic to the Disabilities Subclass. Plaintiffs, as well as the Disabilities
25 Subclass members, seek to enjoin the unlawful acts and omissions of Defendants.
26 Further, Plaintiffs are represented by counsel experienced in civil rights litigation,
27 prisoners’ rights litigation, and complex class action litigation.
28

1 **CLAIMS FOR RELIEF**

2 **First Cause of Action**

3 **(Eighth Amendment; 42 U.S.C. § 1983)**

4 194. Plaintiffs re-allege and incorporate by reference herein all allegations
5 previously made in paragraphs 1-193.

6 195. By their policies and practices described above, Defendants subject
7 Plaintiffs MURRAY, FRANCO, WINKLE, TRACY and BROWN and the
8 Prisoner Class to a substantial risk of serious harm and injury from inadequate
9 medical and mental health care and dangerous conditions of confinement. These
10 policies and practices have been and continue to be implemented by Defendants
11 and their agents or employees in their official capacities, and are the proximate
12 cause of Plaintiffs' and the Prisoner Class's ongoing deprivation of rights secured
13 by the United States Constitution under the Eighth Amendment.

14 196. Defendants have been and are aware of all the deprivations described
15 herein, and have condoned or been deliberately indifferent to such conduct, and
16 have failed to take reasonable steps to remedy the deprivations.

17 **Second Cause of Action**

18 **(Fourteenth Amendment; 42 U.S.C. § 1983)**

19 197. Plaintiffs re-allege and incorporate by reference herein all allegations
20 previously made in paragraphs 1-196.

21 198. By their policies and practices described above, Defendants subject
22 Plaintiffs MURRAY, FRANCO, WINKLE, TRACY and BROWN and the
23 Prisoner Class to a substantial risk of serious harm and injury from inadequate
24 medical and mental health care and dangerous conditions of confinement. These
25 policies and practices have been and continue to be implemented by Defendants
26 and their agents or employees in their official capacities, and are the proximate
27 cause of Plaintiffs' and the Prisoner Class's ongoing deprivation of rights secured
28 by the United States Constitution under the Fourteenth Amendment.

1 as defined in the ADA, as they have impairments that substantially limit one or
2 more major life activities.

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

11 207. Under the ADA, Defendants must provide prisoners with disabilities
12 meaningful access to programs, services, and activities, as well as reasonable
13 accommodations and modifications so that they can participate in all programs,
14 services, and activities offered by Defendants.

15 208. Defendants fail to accommodate Plaintiffs and the Disabilities
16 Subclass they represent as described above, including by:

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

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

25 c. failing to "implement reasonable policies, including physical
26 modifications to additional cells in accordance with the 2010 [accessibility]
27 Standards, so as to ensure that each inmate with a disability is housed in a cell with
28

1 the accessible elements necessary to afford the inmate access to safe, appropriate
2 housing,” 28 C.F.R. § 35.152(b)(3);

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

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

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

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

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

18 i. failing to make “reasonable modifications in policies, practices, or
19 procedures when the modifications are necessary to avoid discrimination on the
20 basis of disability,” 28 C.F.R. § 35.130(b)(7); and

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

24 209. As a result of Defendants’ policy and practice of discriminating
25 against and failing to provide reasonable accommodations, Plaintiffs and the
26 Disabilities Subclass they represent do not have equal access to Jail activities,
27 programs, and services for which they are otherwise qualified.

28 ///

1 **Fourth Cause of Action**

2 **(Rehabilitation Act, 29 U.S.C. § 794)**

3 210. Plaintiffs re-allege and incorporate by reference herein all allegations
4 previously made in paragraphs 1-209.

5 211. At all times relevant to this action, Defendants were recipients of
6 federal funding within the meaning of the Rehabilitation Act. As a recipient of
7 federal funds, they are required to reasonably accommodate prisoners with
8 disabilities in their facilities, program activities, and services. They are also
9 required to provide a grievance procedure.

10 212. Plaintiffs MURRAY, FRANCO, WINKLE, TRACY, and BROWN
11 and members of the Disabilities Subclass are qualified individuals with disabilities
12 as defined in the Rehabilitation Act.

13 213. By their policy and practice of discriminating against and failing to
14 reasonably accommodate prisoners with disabilities, Defendants violate Section
15 504 of the Rehabilitation Act, 29 U.S.C. § 794.

16 214. As a result of Defendants' discriminating against and failing to
17 provide a grievance procedure and reasonable accommodations, Plaintiffs
18 MURRAY, FRANCO, WINKLE, TRACY, and BROWN and members of the
19 Disabilities Subclass do not have equal access to Jail activities, programs, and
20 services for which they are otherwise qualified.

21 **Fifth Cause of Action**

22 **(California Government Code § 11135)**

23 215. Plaintiffs re-allege and incorporate by reference herein all allegations
24 previously made in paragraphs 1-214.

25 216. Defendants receive financial assistance from the State of California as
26 part of Realignment Legislation, California Government Code §§ 30025, 30026,
27 and 30029, and through other statutes and funding mechanisms.

1 policies, and practices of Defendants and agents, officials, and employees
2 are in violation of the rights of Plaintiffs and the class and subclass they
3 represent under the Eighth and Fourteenth Amendments to the U.S.
4 Constitution, the Americans with Disabilities Act, Section 504 of the
5 Rehabilitation Act, and California law;

6 C. Enjoin Defendants, agents, officials, employees, and all persons
7 acting in concert under color of state law or otherwise, from continuing the
8 unlawful acts, conditions, and practices described in this Complaint;

9 D. Order Defendants, agents, officials, employees, and all persons
10 acting in concert with them under color of state law or otherwise, to
11 immediately provide adequate medical and mental health care, including but
12 not limited to sufficient intake screening, sufficient staffing, timely access to
13 appropriate clinicians, timely prescription and distribution of appropriate
14 medications and supplies, timely access to specialty care, and timely access
15 to adequate therapy, inpatient treatment, and suicide prevention;

16 E. Order Defendants, agents, officials, employees, and all persons
17 acting in concert with them under color of state law or otherwise, to provide
18 equal access to programs, services, and activities for people with disabilities,
19 including but not limited to housing people with physical disabilities in
20 accessible housing appropriate to their needs, timely delivery of and
21 appropriate access to assistive devices and other accommodations, housing
22 people with disabilities in the least restrictive and most integrated settings
23 appropriate to their needs, and providing an effective grievance system to
24 contest disability discrimination;

25 F. Award Plaintiffs the costs of this suit and reasonable attorneys'
26 fees and litigation expenses, pursuant to 42 U.S.C. § 1988, 42 U.S.C. §
27 12205, 29 U.S.C. § 794, and other applicable law;

28 G. Retain jurisdiction of this case until Defendants have fully

1 complied with the orders of this Court and there is a reasonable assurance
2 that Defendants will continue to comply in the future absent continuing
3 jurisdiction;

4 H. Appoint the undersigned counsel as class counsel pursuant to
5 Federal Rule of Civil Procedure 23(g); and

6 I. Award such other and further relief as the Court deems just and
7 proper.
8

9 Dated: December 6, 2017

10 Respectfully submitted,

11 /s/ Julia E. Romano

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APPENDIX A



Report on Inspection of the Santa Barbara County Jail (*Conducted on April 2, 2015*)

EXECUTIVE SUMMARY

Disability Rights California (DRC) is the state and federally designated protection and advocacy agency charged with protecting the rights of people with disabilities in California. DRC has the authority to inspect and monitor conditions in any facility that holds people with disabilities. Pursuant to this authority, DRC is conducting inspections of conditions in six county correctional facilities in 2015. One of these facilities is the Santa Barbara County Jail ("Jail"). On April 2, 2015, three DRC attorneys and our authorized agent Kelly Knapp of the Prison Law Office, inspected the Jail. We appreciate that Sheriff Bill Brown met with us personally and that Sheriff Department staff was helpful and cooperative during our inspection.

We observed positive practices and programs during our inspection. Sheriff Brown is forward-looking, recognizes the physical limitations in the current jail facility, and has obtained funding and approval for construction of new jail in North County. The Department emphasizes the Sheriff's Treatment and Re-entry (STAR) Program for prisoners.

However, we also found evidence of the following violations of the rights of prisoners with disabilities:

- (a) Undue and excessive isolation and solitary confinement;
- (b) Inadequate mental health care; and
- (c) Denial of rights under the Americans with Disabilities Act (ADA).

Pursuant to our authority under 42 U.S.C. §10805(a)(1) and 29 U.S.C. § 794(f)(3) and as a result of this initial inspection, we find

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there is probable cause to conclude that prisoners with disabilities are subjected to neglect in the Santa Barbara County [Jail](#).¹ We will continue to work with you regarding these findings and the next steps in our investigation.

Background

The Santa Barbara County Jail houses pretrial detainees as well as sentenced inmates, and both male and female offenders. The Main Jail facility has 815 beds and a rated capacity of 627 [prisoners](#).² The adjacent Medium Security Facility has 285 beds and a rated capacity of 160 prisoners.

The Jail has a long history of overcrowding, with multiple court orders intended to set population caps. The Sheriff's Department has added to the Main Jail in an effort to keep up with overcrowding. According to the Santa Barbara County Grand Jury, "[t]he central part of the Main Jail opened in 1971 with additions in 1988, 1992, and 1999, with a current bed capacity of 618. In 2006 an adjacent honor farm was reconfigured as a medium security facility to provide an additional 161 [beds](#)."³ Recently, two conference rooms in the basement of the Main Jail were converted to dorms with 120 [beds](#).⁴

In response to chronic jail overcrowding, Sheriff Bill Brown convened a Blue Ribbon Commission of experts and local leaders,

¹ Under DRC's authorizing statute, 42 U.S.C. § 10802(5), "[t]he term 'neglect' means a negligent act or omission by any individual responsible for providing services in a facility rendering care or treatment which caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan for an individual with mental illness, the failure to provide adequate nutrition, clothing, or health care to an individual with mental illness, or the failure to provide a safe environment for an individual with mental illness, including the failure to maintain adequate numbers of appropriately trained staff." ["Return to Main Document"](#)

² California Board of State and Community Corrections ("BSCC"), Biennial Inspection Report of the Santa Barbara Jail, January 8, 2015, Attachment # 11. ["Return to Main Document"](#)

³ Report of the Santa Barbara County Grand Jury, 2010-2011, page 1, available from <http://www.sbcgj.org/2010/JailOvercrowding.pdf>. ["Return to Main Document"](#)

⁴ Report of the Santa Barbara Grand Jury Report, 2014-2015, page 2, available from http://www.sbcgj.org/2015/Detention_Facilities_020615.pdf. ["Return to Main Document"](#)

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which issued a report and recommendations in [2008](#).⁵ The Commission recommended that the County build a new 300 bed jail facility and develop a program of community corrections as an alternative to housing prisoners in the jail.

Today, the Department has funding and approval for an even larger, 600 bed correctional facility in Santa Maria, to be completed in 2018. The new facility will be a two-tier modular design with a “state of the art” medical clinic. After the new North Jail opens, the Department still plans to operate parts of the Main Jail but with a reduced census of 600 prisoners. The Department will close the medium security facility adjacent to the Main Jail.

One important recommendation of the Blue Ribbon Commission was to reduce the jail population by developing more pre-trial alternatives. Blue Ribbon Report, pps. 21-23. At that time, pre-trial detainees made up 70% of the jail population. Blue Ribbon Report, p. 15. Since then, pre-trial detainees have not decreased and to the contrary, have increased to make up 73% of the jail [population](#).⁶ This is significantly above the average in other counties, which is [62%](#).⁷ Some counties have been successful in affirmatively reducing their pre-trial population. For example, Sonoma County worked with consultants to reduce pre-trial detainees to 50% of the jail population by implementing a robust array of alternatives to detention, such as day reporting and electronic monitoring.

Like other jails, Santa Barbara must now house prisoners who are sentenced to the Jail for years at a time, following the implementation of AB 109 in [2011](#).⁸ The 2015 Grand Jury reported that “[p]rior to AB 109, the average length of stay in the Jail was 20 days. It has now increased to over one year due to the incarceration of serious long-term

⁵ Final Report and Recommendations of the Blue Ribbon Commission on Jail Overcrowding, page 14, available from <http://www.sbsheriff.org/BRCReport>. [“Return to Main Document”](#)

⁶ BSCC Jail Profile Study, Attachment # 10, page 6. [“Return to Main Document”](#)

⁷ BSCC Jail Profile Study, Attachment # 10, page 6. [“Return to Main Document”](#)

⁸ Public Policy Institute of California, “California’s County Jails,” available from http://www.ppic.org/main/publication_show.asp?i=1061. [“Return to Main Document”](#)

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offenders.⁹ The increasing length of stay makes adequacy of jail conditions even more pressing than in years past.

Corizon Health Care has provided physical health care services in the Jail for many years. Until recently, mental health services were provided by County Behavioral Health. In 2009, the Sheriff's Department terminated the contract with County Behavioral Health and contracted with Corizon to provide mental health care in the Jail.

FINDINGS RE: ABUSE AND/OR NEGLECT OF PRISONERS WITH DISABILITIES

Based on our monitoring visit on April 2, 2015, interviews with prisoners, their families and attorneys and on our review of public documents and prisoner medical records,¹⁰ we found the following evidence of abuse and neglect in Santa Barbara County Jail.

1. Excessive Use of Isolation and Solitary Confinement

Isolation and solitary confinement in correctional facilities are generally considered to be situations in which prisoners are held in their cells, alone or with a cellmate, for 22 to 24 hours per day.¹¹ In most jails, prisoners are held in isolation because they are classified as maximum security, are in administrative segregation or protective custody, or subject to short-term discipline. In contrast, prisoners in general population in most correctional facilities typically are housed in

⁹ Grand Jury Report, 2014-2015, footnote 4, page 2. [“Return to Main Document”](#)

¹⁰ The findings in this report are based in part on a review of the medical records for five prisoners, which we obtained these reports through signed releases from prisoners whom we interviewed and from their family members and attorneys; the records were not obtained through use of our access authority under 42 U.S.C. §10805(a)(1) and 29 U.S.C. § 794(f)(3). We have provided a copy of these records to the Sheriff's Department along with this report. [“Return to Main Document”](#)

¹¹ For support for this accepted definition of isolation, see, e.g., U.S. Department of Justice, Investigation of State Correctional Institution at Cresson, May 13, 2013, Attachment #7, p. 5, available at http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf (“terms ‘isolation’ or ‘solitary confinement’ mean the state of being confined to one’s cell for approximately 22 hours per day or more, alone or with other prisoners, that limits contact with others. ... An isolation unit means a unit where either all or most of those housed in the unit are subjected to isolation.”); *Wilkinson v. Austin*, 545 U.S. 209, 214, 224 (2005) (describing solitary confinement as limiting human contact for 23 hours per day); *Tillery v. Owens*, 907 F.2d 418, 422 (3d Cir. 1990) (21 to 22 hours per day). [“Return to Main Document”](#)

dormitories, or are locked in their cells only during sleeping hours, and are in dayrooms, activities or recreation areas during waking hours.

Even a short stay in conditions of extreme isolation is likely to worsen prisoners' mental health symptoms, causing them "to lapse in and out of a mindless state" or "semi-fatuous condition" at a heightened risk for suicide. See *Davis v. Ayala*, 576 U.S. ____, No. 13-1428, 2015 WL 2473373, at *20 (U.S. June 18, 2015) (Kennedy, J., concurring). Consequently, correctional facilities should place prisoners in isolation only when security conditions permit no [alternative](#).¹² Prisoners with mental health problems are especially harmed by prolonged isolation (defined as a duration of more than three to four [weeks](#)).¹³ Many state correctional systems, including those in California, Illinois, Massachusetts, Ohio and Pennsylvania, have adopted policies to ensure that prisoners with mental illness are excluded from isolation and solitary [confinement](#).¹⁴

We found widespread overuse of prolonged isolation and segregation in the Santa Barbara Jail. Many prisoners were locked in small cells for 22 to 24 hours per day and are not permitted to have radios or televisions. The primary exception is low to medium security prisoners, who are housed in dormitories.

Many parts of the Main Jail are old and built with a linear design, which limits access to dayrooms. However, increased out-of-cell time is possible even in this environment, especially since the jail census is

¹² Metzner J.L., Fellner J., "Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics," *J Am Acad Psychiatry Law* 38:104–8, 2010, Attachment #2. ["Return to Main Document"](#)

¹³ American Psychiatric Association, Position statement on segregation of prisoners with mental illness (2012), Attachment #4, available from <http://www.psychiatry.org/File%20Library/Learn/Archives/Position-2012-Prisoners-Segregation.pdf>. Accord, Society for Correctional Physicians, "Restricted Housing of Mentally Ill Inmates, Position Statement," July 9, 2013, Attachment #5, available from <http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates> ("prolonged segregation of inmates with serious mental illness, with rare exceptions, violates basic tenets of mental health treatment.") ["Return to Main Document"](#)

¹⁴ Metzner J.L., Dvoskin J.A., "An Overview of Correctional Psychiatry," *Psychiatr Clin North Am* 29:761–72 (2006), Attachment #1. See also, U.S. Department of Justice, "Investigation of the Pennsylvania Department of Corrections' Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities," February 24, 2014, Attachment #8, http://www.justice.gov/crt/about/spl/documents/pdoc_finding_2-24-14.pdf. ["Return to Main Document"](#)

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lower than in past years. Nevertheless, custody staff did not describe any particular efforts or initiatives to increase out-of-cell time.

Extended Placement in Isolation in Safety Cells

We found that prisoners are held in safety cells in the Santa Barbara Jail for many days at a time, on a repeated basis, with no access to mental health treatment. Safety cells are small, windowless rooms, with rubberized walls, a pit toilet in the floor, and no furniture, bedding or source of water. Prisoners are not permitted normal clothing and are typically given only a blanket or “suicide smock.” They are not provided with regular access to showers, telephones, outdoor recreation, visitation or indeed, any out-of-cell time whatsoever.

California Code of Regulations, title 15, Section 1055, states that safety cells “shall be used to hold only those inmates who display behavior which results in the destruction of property or reveals an intent to cause physical harm to self or others. ... In no case shall the safety cell be used for punishment or as a substitute for treatment.” Section 1055 also requires documented monitoring, twice every 30 minutes. Typically, in most jails, prisoners remain in safety cells for a few hours at a time.

Courts have ruled that safety cells may be used as a “temporary measure” to control violent or suicidal prisoners “until they ‘cooled down’ sufficiently to be released from those cells.” *Anderson v. County of Kern*, 45 F.3d 1310, 1314 (9th Cir. 1995). In the *Anderson* case, the federal court of appeal ruled that because “the inmates were confined to the safety cell only for short periods of time,” their constitutional rights were not violated. *Id.* In the *Anderson* case, one prisoner was held in the safety cell for 90 minutes, another was held there for 3 hours and a third was held overnight. 45 F.3d at 1313. The *Anderson* court contrasted this temporary use of safety cells in the Kern County Jail with other cases in which extended placement in safety cells for 48 hours or more resulted in significant constitutional violations.

In the Santa Barbara Jail, custody staff were quite clear that placement in safety cells was not temporary, and stated unequivocally that prisoners could be in a safety cell “for days.”

Medical records and prisoner interviews confirmed that prisoners with mental illness and behavioral problems are housed in safety cells for three days at a time on a repeated [basis](#).¹⁵ For example, medical records from Prisoner C., show that over an 8 week period from February 7, 2015 to April 6, 2015, he was placed in a safety cell three times, each time for a duration of three to four days. Prisoners D. and E. were also subjected to repeated safety cell placement. Placing prisoners with mental illness in safety cells for days at a time without mental health treatment constitutes abuse and/or neglect, is inconsistent with minimum standards of care and violates constitutional guarantees.

Even in the small sample of medical records to which we had access, we noted that prisoners were kept in safety cells long after their behavior ceased to pose any risk to themselves or others. Corizon's suicide watch forms confirm that on multiple occasions, Prisoner C. denied any suicidal intent after a few hours in a safety cell, but remained there for up to three additional days. An even more troubling example is Prisoner D. On two separate occasions, he was placed in a safety cell and after several days, was seen by a mental health counselor who concluded he was stable and could be released. Both times, the mental health counselor left him in the safety cell to be released "at classification's discretion," or "custody discretion." This practice subjects prisoners to needless emotional distress and physical discomfort, and cannot be justified. As noted above, prisoners in a safety cell have no bed, toilet or regular clothing, and no source of water in their cell, which is small, absolutely barren and completely isolated.

The Jail's monitoring of safety cell placements was also deficient. To comply with the requirement for documented monitoring twice every thirty minutes, custody staff clip a sheet to the door of the cell and log their observations as they occur. The safety cells have a solid door with a small Plexiglas window that is normally covered, so staff must open the window to observe the prisoner inside. During our inspection of the Main Jail, we observed one such "monitoring." As we passed Safety Cell #1, we noted that it was occupied. From the log, we saw that a prisoner had been placed there the night before. Staff observations

¹⁵ According to Jail policy and practices, mental health staff evaluate prisoners in safety cells twice each day. In the records we reviewed, we did not see notes that confirmed that this practice was being carried out. ["Return to Main Document"](#)

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were terse, with notes such as “breathing,” and “awake.” As we watched, a custody officer stepped up to the clip board, made a notation and stepped away without opening the window to the cell to observe the prisoner. The supervisor escorting us had to remind the officer to look in on the prisoner, which would not have occurred had we not been present.

Corizon mental health staff are only on-site during normal business hours; if incidents that require placement in a safety cell occur after hours or on weekends, custody staff stated that they do not contact Corizon mental health staff before safety call placement unless there is an emergency. This policy prevents mental health staff from providing necessary treatment and advice to inmates placed because of psychiatric reasons. Further, Custody staff stated their policy was that they waited until Corizon mental health staff assessed prisoners to determine when they get out of a safety cell placement, which will lead to extended stays in safety cells for prisoners who are calm and can return to their regular housing, simply because Corizon is not on site. In addition, even when Corizon staff does assess, prisoners are held longer than necessary, as noted above with Prisoner D., who was to be released at the discretion of classification, not mental health.

In interviews, other prisoners described the absence of any mental health treatment following their release from a safety cell placement for suicidality. One prisoner explained that he had been in the Jail for two months, had been on Effexor and Risperdal in the community and in prison, and had submitted requests to Corizon for mental health medications (his most recent request was almost a month earlier) and had been placed in a safety cell four to five times in the past month. Despite this history, at the time of our inspection, he told us that he still had not seen a mental health practitioner nor had he received a response to his medication request.

It is important to note that even a short stay in a safety cell can be extremely counter-therapeutic. One expert states unequivocally: “No one should be housed in segregation while they are acutely psychotic, suicidal or otherwise in the midst of a psychiatric [crisis.](#)”¹⁶ Yet this is precisely what the Santa Barbara Jail does with prisoners who are

¹⁶ Metzner and Dvoskin, footnote 16, page 2. [“Return to Main Document”](#)

suicidal and in crisis. According to another noted expert, “placing suicidal prisoners in barren observation cells ... ‘is counter-therapeutic in that no therapeutic relationship is formed and the prisoner learns it’s better to keep suicidal thoughts and plans to him or herself. In jails and prisons isolation ‘safety cells’ are used instead of doing what is essential in the treatment of anyone seriously contemplating suicide: talk to them. Thorough evaluation, continuity of contact with mental health clinicians, establishment of a trusting therapeutic relationship — these are the things that prevent suicides and assure the effectiveness of treatment — not fifteen minute checks on a prisoner in an observation/safety [cell.](#)”¹⁷

Leaving Prisoners on Psychiatric Holds under WIC § 5150 in Safety Cells without Mental Health Treatment.

One of the worst practices we observed from the medical records was the Jail’s failure to provide treatment for prisoners who have been placed on a psychiatric hold under Welf. & Inst. Code § 5150, and instead keeping them in a safety cell for the entire 72-hour duration of the hold. Attorneys who represent defendants reported that this happens repeatedly to their clients.

Under Section 5150, an individual may be detained for assessment, evaluation, crisis intervention and treatment if they are found to be a danger to self, danger to others or gravely disabled. In other jails, prisoners are typically transferred from the jail to an inpatient psychiatric hospital for treatment when they meet 5150 criteria. In Santa Barbara, the only LPS designated facility in the county is the county-owned psychiatric health facility, and Jail staff report difficulties locating an available bed there. However, if no beds are available, the alternatives are to transfer the prisoner to an LPS designated facility in another county, such as Vista Del Mar or Hillmont in Ventura County. If no beds are available there, the Department must provide intensive mental health treatment in the Jail itself.

When a prisoner is awaiting transfer to an inpatient facility, or when a bed cannot be located, Corizon does not appear to provide mental health treatment to prisoners who are placed on a §5150 hold. For

¹⁷ Human Rights Watch, *Ill-Equipped: U.S. Prisons and Offenders with Mental Illness* (2003), p. 183, quoting Dr. Terry Kupers, available <https://www.hrw.org/reports/2003/usa1003/usa1003.pdf> [“Return to Main Document”](#)

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example, Prisoner C. was placed on a § 5150 hold while in a safety cell; apart from a daily status check, Corizon staff provided no mental health treatment. After three days, the 5150 hold expired and he remained in the safety cell, still without any mental health intervention. This practice violates state statute and subjects prisoners to abuse and neglect.

Placing Prisoners with Mental Illness in Isolation

Because of the damaging impact of isolation on prisoners with mental illness, the recommended practice is that these prisoners be excluded from [isolation](#).¹⁸ Santa Barbara does not follow this guideline, and prisoners with mental illness are routinely placed in prolonged isolation, even apart from the excessive use of safety cells noted above.

In the Main Jail, prisoners in single cells are effectively held in isolation if they are designated as maximum classification, administrative segregation, or protective custody. Conditions in segregation cells are characterized by inadequate exercise and extreme social isolation. Prisoners are offered three hours of outdoor recreation as required by Title 15 of the state regulations, usually as 1.5 hours twice per week, and a few minutes of shower time every other day. This leaves prisoners locked in their cells for 24 hours per day for five days per week, and 22.5 hours per day on the days when they have outdoor recreation. This amounts to solitary confinement for a large portion of the Jail population.

The mental health housing unit, known as 100, consists of cells in which prisoners are held alone, although they were designed for double occupancy. Consequently, prisoners in the mental health unit are held in conditions as isolating as maximum security housing. We interviewed prisoners with severe mental illness in dorms who said that, as difficult as their current housing was, the mental health unit was far worse because of the isolation conditions. Custody staff told us that prisoners get out-of-cell time for 1.5 hours twice per week in which to use the

¹⁸ See, Metzner J.L., Dvoskin J.A., “An Overview of Correctional Psychiatry,” Attachment #1. A recent agreement between the Department of Justice and a county jail in Georgia provides that segregation “shall be presumed contraindicated” for inmates with serious mental illness. If an inmate has a “serious mental illness” or other acute mental health contraindications to segregation, that inmate “shall not remain in segregation absent extraordinary and exceptional circumstances.” MOA Between the U.S. Department of Justice and Columbus, Georgia Regarding the Muscogee County Jail, January 16, 2015, Attachment #9, available from http://www.justice.gov/crt/about/spl/documents/muscogee_moa_1-16-15.pdf. [“Return to Main Document”](#)

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outdoor yard and shower, which meets the state regulations but still constitutes extreme, prolonged isolation.

Accepted treatment standards require mental health staff to take affirmative steps to ameliorate the harsh impact of isolation and segregation on prisoners with serious mental illness, assuming that the physical constraints of the facility and/or the security status of the prisoner do not allow alternative housing. The minimum standard of care for a segregated mental health unit is the following: “For prisoners with a serious mental illness [in segregation], the specialized mental health program should offer at least 10 to 15 hours per week of out-of-cell structured therapeutic activities in addition to at least another 10 hours per week of unstructured exercise or [recreation](#).”¹⁹ A recent settlement agreement between the U.S. Department of Justice and a county jail in Georgia describes a program consistent with these minimum standards. There, the jail agreed that prisoners housed in its secure mental health unit “would be offered a minimum of:

- i. At least 10 hours of out-of-cell structured time each week, with every effort made to provide two scheduled out-of-cell sessions of structured individual or group therapeutic treatment and programming Monday through Friday and one session on Saturdays, with each session lasting approximately one hour, with appropriate duration to be determined by a qualified mental health professional and detailed in that inmates individual treatment plan, and
- ii. At least two hours of unstructured out of cell recreation with other inmates each day, including exercise, dining and other leisure activities that provide opportunities for socializing, for a

¹⁹ Metzner and Dvoskin, footnote 19, Attachment #1, page 3. See also, American Psychiatric Association (“APA”) Position Statement on Segregation of Prisoners with Mental Illness,” Attachment #4 (“If an inmate with serious mental illness is placed in segregation, out of cell structured therapeutic activities (i.e., mental health/psychiatric treatment) in appropriate programming space and adequate unstructured out of cell time should be permitted.”); Society of Correctional Physicians, “Position Statement: Restricted Housing of Mentally Ill Inmates,” Attachment #5, page 1 (if inmates with serious mental illness cannot be excluded from prolonged segregation, “the conditions of their confinement should be modified in a manner that allows for adequate out-of-cell structured therapeutic activities.”). [“Return to Main Document”](#)

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total of at least 14 hours of out of cell unstructured time each week.²⁰

The manner in which the mental health unit is operated and the services provided by Corizon in this unit fail to meet these minimum standards of care, deny prisoners with mental illness needed treatment, subject them to abuse and neglect and violate their constitutional rights.

We note that some prisoners with serious mental illness are offered even less out-of-cell time than that reportedly provided in the mental health unit and segregation cells. We reviewed records from Prisoner E., a mentally ill prisoner who was in the Jail for four months until he was finally transferred to the County psychiatric health facility. Prisoner E. was held on a misdemeanor charge and had been declared incompetent to stand trial based on his mental illness. Custody staff wrote to his family stating that he was out of his single cell for only two hours per week, rather than the three hours per week required by Title 15. This is extreme isolation, and had a damaging impact on this prisoner's already fragile mental health.

Corizon does appear to conduct regular rounds of prisoners in isolation, which is a positive and important practice. However, the rounds consist of brief cell-front contact, with words exchanged through the small gap on the side of the solid metal door front. This cell front contact is no substitute for actual counseling and therapeutic contact, which Corizon does not provide.

2. Inadequate Mental Health Care

Under the U.S. Constitution, there are "six basic, essentially common sense, components of a minimally adequate prison mental health care delivery system." *Coleman v. Brown*, 938 F. Supp.2d 955, 970 (E.D. Cal. 2013). The components are: screening, staffing, recordkeeping, medication, suicide prevention, and "a treatment program that involves more than segregation and close supervision of mentally ill inmates." *Id.* at 970 n. 24; *Balla v. Idaho State Board of Corrections*, 595 F. Supp. 1558, 1577 (D. Idaho 1984); *Ruiz v. Estelle*, 503 F. Supp. 1265, 1339 (S.D.Tex.1980). The Jail must address the negative effects of housing in harsh segregated environments (*Coleman*, 938 F. Supp.2d at

²⁰ Muscogee Jail Agreement, footnote 19, Attachment #9, page 13. ["Return to Main Document"](#)

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979–80), and provide “treat[ment] in an individualized manner” for mental disorders. *Id.* at 984. Treatment must have the goal of “stabilization and symptom management.” *Madrid v. Gomez*, 889 F. Supp. 1146, 1222 (N.D. Cal. 1995).

Absence of Group or Individual Out-of-Cell Therapeutic Activities

Outpatient mental health care in the Santa Barbara Jail appears consists solely of sporadic medication management and brief, cell-front interviews. Corizon staff do not conduct mental health groups or provide more extended therapeutic contacts apart from assessments and cell-front checks. For example, one prisoner we interviewed was housed in a dorm, reported a history of significant mental health treatment and said that he had been “suicidal” the previous night. He said that he wants medication but only if he can also speak to a mental health professional for ongoing therapy, which he had been told was not possible in the Jail.

The absence of any group or individual therapy, or other structured out-of-cell therapeutic activities violates minimum standards of care for prisoners with serious mental illness. For example, the National Commission on Correctional Health Care has adopted a standard that “[r]egardless of facility size or type, basic on-site outpatient [mental health] services include, at a minimum, individual counseling, group counseling and psychosocial/psychoeducational programs.” *Standards for Health Services in Jails* (2014), Standard J-G-04, Attachment #3.

As discussed in the previous section, the Jail has a designated mental health unit for prisoners with serious mental illness. Custody keeps these prisoners in their cells for between 23 and 24 hours per day. As we noted above, Corizon staff do not provide the recommended out-of-cell structured therapeutic activities necessary to compensate for the impact of these isolation conditions on prisoners with mental illness.

We observed some positive practices. As noted above, Corizon mental health staff conduct regular isolation rounds. The Jail will provide 7 days of follow-up medications at release, and sometimes as much as 30 days. The Sheriff’s Department has a full time discharge planner.

Inadequate Screening, Poor Medication Continuity

Prisoners we interviewed had many complaints about their inability to continue the medications they had been on in the community. More than a dozen people reported that they had gone for weeks and months without the mental health medications they had been taking in the

community, despite disclosing this need during their initial screening and in later requests. By report, the lack of medication continuity extended to medications for physical health care conditions, and the medical records we reviewed confirmed these reports.

For example, Prisoner A. was taking medication for PTSD, anxiety and seizures before he was arrested. After booking, he was denied access to his anti-seizure medication, Dilantin. After four days, he had a grand mal seizure. The next day, staff started him back on Dilantin but did not address his need for medication for anxiety and PTSD. He had to wait more than two months after booking before he was seen by a Corizon psychiatrist who finally prescribed medication for his PTSD.

Some of the problems with medication continuity can be attributed to poor initial screening. For example, when Prisoner B. was booked into the Jail, he brought a bag with all his VA-issued medications, including medication for anxiety and PTSD. He was screened a week after booking by a therapist who listed all the medications prescribed by his VA doctors in the community, but failed to order any bridge medications for his physical or mental health needs or to refer him to a psychiatrist for further evaluation. He had to wait an additional two months before he was seen by a Corizon psychiatrist, who still did not prescribe the only medication that the VA had found effective in treating his PTSD.

Poor screening may also explain why Corizon reports that so few prisoners have serious mental illness in the Santa Barbara Jail. Corizon mental health staff told us that 13-16% of the jail population is identified with mental illness, and that 90 people are on psychotropic medications, which is roughly 11% of the prisoner population. Eight years earlier, the Blue Ribbon Commission had reported a mental illness rate of 29%, noting that this “understates the true picture, since it only counts those who agree to treatment and take jail-issued [medication.](#)”²¹ The difference between the reported rates of mental illness in 2007 and 2015 could be attributable to a change in mental health providers in the jail. When the Blue Ribbon Commission issued its report, mental health services were provided by County Behavioral Health. Corizon Health Care, which is a for-profit provider, took over the contract to provide mental health

²¹ Blue Ribbon Commission Report, footnote 7, page 18. [“Return to Main Document”](#)

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services in the Jail in 2009. Corizon's report that 11% of prisoners are on mental health medication is half the rate reported by the Blue Ribbon Commission, and well below the expected prevalence rate based on reports of national [experts](#).²² We are concerned that Corizon could be overlooking or under-treating prisoners with mental illness through inadequate screening or other practices discussed in this report.

Untimely Response to Requests for Mental Health Medication and Services

In brief interviews in one dormitory, five prisoners complained that they had submitted multiple requests over several months to be seen by mental health staff, with no response. Other prisoners whom we interviewed at greater length and whose records we obtained had the same complaint. Significantly, none of the records we reviewed included copies of prisoners' requests for medical and mental health care, so we could not verify their reports, but the consistency of the complaints suggests a problem.

We asked Corizon mental health staff about delays in responding to requests. Their reply was that they closely monitor requests, that urgent requests are answered immediately and that it may be two to three weeks to get a response to non-urgent requests. However, we are concerned that Corizon's reporting system may not be capturing all the sick call slips and psych line requests submitted by prisoners, especially because these requests are apparently not logged in the medical records. We plan to conduct further investigation to determine the extent of delays in responding to requests for mental health care.

We observed problems with medication management. From the records, we noted instances in which prisoners were placed on or discontinued from significant psychotropic medications with little monitoring. For example, Prisoner C. had been at a state hospital for six months, where he was restored to competence on a regime that included seven psychotropic medications, including several long-acting injectable anti-psychotic medications. A month after his return, the Jail psychiatrist abruptly discontinued all but two of these seven medications

²² Metzner, "Overview of Correction Psychiatry," Attachment #1 (prevalence rate of 20% for serious mental illness); Metzner and Fellner, Attachment # 2 (same, plus an additional 15 to 20% require mental health intervention, including medication). ["Return to Main Document"](#)

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without tapering or transition; two days later, Prisoner C. attempted suicide. In another example, Prisoner D. was diagnosed with psychosis, but was prescribed Wellbutrin, an anti-depressant that can cause agitation. Two months later, after a cell extraction and assault on a deputy, a different Corizon psychiatrist terminated the order for Wellbutrin with a note that “this medication can worsen these [assaultive] behaviors.”

We noted a high number of suicide attempts in the medical records we reviewed. Custody staff informed us that the Jail had only one completed suicide in the last four years, but there have been 35 to 40 attempts. Corizon’s suicide prevention program appears to consist primarily of extended safety cell placement, which, as noted above, is not a substitute for mental health treatment and can also deter prisoners from reporting suicidal ideation.

We also failed to find any evidence in the medical records of a functioning behavior management program. Corizon’s form for monitoring prisoners on suicide watch is comprehensive and includes box that can be checked if a behavior management plan is being developed. However, this box was blank in every form we examined, and no prisoner records included a behavior management plan. Apparently Corizon staff do not develop written behavior management plans even for individuals such as Prisoner C., who made a suicide attempt and reported auditory hallucinations commanding him to commit suicide, or for Prisoner E., who was described as the “most difficult” prisoner in the Jail and had also attempted suicide by hanging. A template for a behavior management plans used in the San Francisco Jail are included as Attachment #12 to this report.

3. Denial of Rights under the Americans with Disabilities Act

Title II of the Americans with Disabilities Act (“ADA”) provides that “no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity.” 42 U.S.C. § 12132. Jails and prisons are subject to the prohibitions and protections in Title II. *Pierce v. County of Orange*, 526 F.3d 1190, 1214 (9th Cir. 2008) (citing *Pa. Dep’t of Corr. v. Yeskey*, 524 U.S. 206, 209-10 (1998)). In correctional settings, the ADA requires that prisoners with disabilities be ensured equal access to jail programs, services and activities, including the ability to safely use personal hygiene services such as toilets and showers, to engage in

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activities such as ambulation and exercise, and participate in programs such as visitation, educational classes, religious services, and inmate worker programs on the same basis as non-disabled prisoners.

Accessible Cells and Housing.

In 2010, the Department of Justice issued a new regulation specifically addressing the “nondiscrimination and program access obligations” of a correctional facility. 28 C.F.R. § 35.152, effective March 15, [2011](#).²³ This regulation provides in part that “[p]ublic entities shall implement reasonable policies, including physical modifications to additional cells in accordance with the 2010 Standards, so as to ensure that each inmate with a disability is housed in a cell with the accessible elements necessary to afford the inmate access to safe, appropriate housing.” 42 C.F.R. § 35.152(b)(3). Justice Department commentary on this regulation makes clear that it concerns the *program access* obligations of a correctional facility, which do not depend on the date of construction, as opposed to requirements for architectural accessibility, which are tied to the date of construction or [modification](#).²⁴

The Department houses most prisoners with disabilities in the Main Jail in South Dorm 25. This dorm contains double bunks with lower and upper levels. The Jail assigns prisoners to a lower bunk in this dorm if they have mobility impairments or another condition such as epilepsy. There is apparently no formal policy to monitor and enforce lower bunk orders. We observed a number of people sleeping on the floor in this dorm, with deputies looking on. Prisoners we interviewed stated that others had already taken all the lower bunks, and that they had no choice but to sleep on the floor. For example, Prisoner A. was in South Dorm 25 because he has epilepsy. He reported that he slept on the floor because he could not get a lower bunk and was afraid that he would be injured if he fell off an upper bunk during a seizure. In fact, because the Jail failed to provide him with his epilepsy medication, he had a grand mal seizure in his first few days in the Jail. Prisoner A. stated that he

²³ U.S. Department of Justice, Notice re: Final Regulations implementing Title II of the ADA, 75 Fed. Reg. 56164, 56218-56223 (2010), Attachment #6, also available at http://www.ada.gov/regs2010/titleII_2010/titleII_2010_regulations.htm#a2010guidance. [“Return to Main Document”](#)

²⁴ DOJ Regulations, 75 Fed. Reg. at 56218-56223, Attachment #6. [“Return to Main Document”](#)

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had made multiple requests for a “boat,” which is a temporary plastic sleep surface that rests directly on the floor and on which prisoners can place a mattress. Floor sleeping was so common in this dorm that Prisoner A stated that those who get “boats” were the “lucky ones.”

During our inspection, custody staff ignored the floor sleepers and made no effort to enforce lower bunk orders, although it was obvious that these were being disregarded, or that the number of lower bunks was insufficient to meet the need. This is a blatant denial of one of the most basic accommodations for prisoners with – an accessible bed. The Jail apparently has no policy or practice to ensure that lower bunk orders are issued, honored and enforced.

Surprising, although prisoners with mobility impairments are concentrated in the South Dorm, the toilet and shower areas do not meet architectural standards for wheelchair use, and lack properly placed grab bars, shower heads, [etc.](#)²⁵ Medical records for Prisoner A, for example, note that he fell in the shower. During our inspection, we asked custody staff whether there was housing that complied with the ADA. Custody staff showed us a cell in a different area of the Jail that was supposedly ADA compliant. However, the toilet would be completely inaccessible to anyone in a wheelchair – the seat was far too low and there were no grab bars installed.

We also note that the Jail has carried out alterations to its facilities, such as the renovation of the honor farm in 2006 to add 161 medium security beds and the conversion of basement conference rooms to dormitories in 2013. The ADA applies to alterations to existing buildings after January 26, 1992, the effective date of the ADA. 28 C.F.R. § 35.151 (b). Consequently, these portions of the Jail must conform to the ADA’s architectural access standards, which are more comprehensive than the program access requirements discussed above. See, Uniform Federal Accessibility Standards on www.ada.gov.

²⁵ We are able to provide you with copies of DOJ publications on accessibility standards for correctional facilities, which can also be obtained online: ADA/Section 504 Design Guide: Accessible Cells in Correctional Facilities, available from <http://www.ada.gov/accessiblecells.htm> and the ADA standards for Accessible Design that specify the requirements for an accessible shower, §§ 603.1 to 610.4; acceptable reach ranges for fixtures, § 308, and accessible faucet and handle types, § 309.4. <http://www.ada.gov/regs2010/2010ADAStandards/2010ADAstandards.htm#sec805>. [“Return to Main Document”](#)

Denial of Accommodations

Prisoners complained to us about the Jail's failure to provide accommodations for their disabilities, in addition to the problem noted above regarding access to lower bunks. One prisoner with low vision reported that the Jail would not help him with reading and writing. Prisoner B., who uses a wheelchair, reported multiple falls because of untrained custody staff and accessibility barriers. When booked, the Jail took away his personal wheelchair and gave him another that had faulty brakes and was too large to pass through doorways. According to his records, he was injured in a fall off the transport bus in October 2014; was injured again in March 2015 when he attempted to transfer from his wheelchair to his bunk, and again in April 2015 when he fell in the shower, which did not have any grab bars. Prisoner B. reported that he has filed multiple grievances, to no effect.

Discrimination against Prisoners with Serious Mental Illness

The ADA regulations require public entities such as the Sheriff's Department to "administer programs, services and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities." 28 C.F.R. § 35.130(d); 28 C.F.R. § 152(b)(2) (requiring correctional facilities to house prisoners with disabilities in the most integrated setting appropriate). In a recent investigation, the Department of Justice found that a Pennsylvania prison violated these provisions by automatically placing prisoners with mental illness in segregation and isolation [conditions](#).²⁶ The prison was required to "ensure that qualified prisoners with serious mental illness ... have as equal an opportunity as other prisoners to participate in and benefit from its housing and classification services, programs and activities, and the benefits that flow from them, such as out-of-cell time, interaction with other prisoners and movement outside of confined [environments](#)."²⁷

The Department discriminates against prisoners with serious mental illness by housing them in isolation conditions in the mental health unit, regardless of their classification level, and by failing to

²⁶ US DOJ, Cresson Investigation, Attachment #7, page 32. See also, US DOJ Investigation of Pennsylvania DOC, Attachment #8, pages 17-22. ["Return to Main Document"](#)

²⁷ US DOJ, Cresson Investigation, Attachment #7, page 34. ["Return to Main Document"](#)

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provide them with support and accommodations to enable them to function in an integrated setting.

ADA Coordinator

The ADA regulations require the Jail to have an ADA coordinator. 42 C.F.R. § 35.106. The coordinator's role is "to ensure that individuals dealing with large agencies [such as the Sheriff's Department] are able to easily find a responsible person who is familiar with the requirements of the [ADA and the DOJ regulations] and can communicate those requirements to other individuals in the agency who may be unaware of their responsibilities." *Appendix A to Part 35*, 28 C.F.R. at page 568.

The Department does not appear to have an ADA coordinator for the Jail. When questioned, staff were unaware of such a position and could not identify any particular individual responsible for arranging accommodations. We conclude that the Jail is violating this requirement.

Notice of Rights and Complaint Procedure

The Jail also has an obligation to provide notice to prisoners of their rights under the ADA (28 C.F.R. § 35.106), and must have an ADA complaint procedure by which prisoners with disabilities may contest any disability-based discrimination or violation of the ADA. 28 C.F.R. § 35.107(b). The complaint procedure must provide for "*prompt and equitable* resolution of complaints alleging any action that would be prohibited by [the ADA regulations]." § 35.107(b) (emphasis added). The Jail's designated ADA coordinator is responsible for investigating complaints submitted through this process. § 35.107(a).

In interviews, prisoners with disabilities had complaints about their inability to obtain accommodations but were unfamiliar with any procedure for requesting accommodations for their disabilities, or appealing the denial of accommodations. This violates the notice requirement in 28 C.F.R. § 35.106. The Jail does not have an ADA complaint system, and the existing grievance system cannot substitute because it does not meet the ADA requirements listed above.

We did not have an opportunity to review the Jail's informing materials or substantive policies regarding prisoners with disabilities. However, the ADA regulations require the Sheriff's Department to conduct a self-evaluation of its services, policies and practices to determine whether they meet the requirements of the ADA. 28 C.F.R. § 35.105(a). Since the Jail has more than 50 employees, it was also

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required to complete a Transition Plan by July 1993, detailing the steps and timeline it will take to achieve compliance with the ADA. Although the deadline to complete a self-evaluation and transition plan is long past, this is a continuing obligation and public entities that missed this deadline are not exempt from compliance. Reviewing policies and procedures is one part of the self-evaluation required by §35.105(a).

4. Other Areas of Concern, Including Medical and Dental Care

a. Floor sleeping and Overcrowding

The Jail has had a problem with floor sleepers due to overcrowding. Custody staff informed us that they had no floor sleepers at the time of our inspections, and had not had floor sleepers for the past four months. However, we observed several prisoners who were sleeping on mattresses on the floor especially in the medical unit (South) and among the inmates in protective custody. Custody staff stated they had the most problems with overcrowding with this classification group.

Other problems were excessive crowding in the dormitories and multi-man cells, which exceed rated capacity according to the BSCC. Attachment #11, pages 3-4.

Prisoner B., who has a collapsed lung and asthma, complained about the mold and dust in the Jail, which aggravated his asthma breathing problems. We observed that the air quality and ventilation in the converted basement dormitories was especially poor and several prisoners housed there complained about breathing problems.

b. Jail Design and Prisoner Safety

We observed one housing area with 14 inmates in multi-man cells with bars on the front; these cells open onto a small day room area and bathroom. The central control booth for these cells is down a hallway, so deputies have no direct line of sight into the housing area. There are cameras and a call button in the hallway, but prisoners cannot access these. We were told that deputies walk the hallways, but in between these patrols, prisoners have no means to report man down, and deputies cannot observe prisoners. Prisoners are at risk of attack, injury or rape from others in this setting, which is contrary to the requirements of the Prison Rape Elimination Act (PREA). The converted basement dorms also raise PREA concerns, since they are large and essentially unmonitored, with no line of sight from custody.

c. Medical Care for Chronic Conditions and Disabilities

In interviews, prisoners complained about poor care for asthma, diabetes and other chronic conditions.

INITIAL RECOMMENDATIONS

1. Isolation (defined as being locked down in a cell for at least 22 hours per day).

- a. Increase out-of-cell time and ameliorate isolation conditions in administrative segregation, protective custody, maximum security and mental health housing.
- b. Ensure that prisoners in single cells in the Main Jail are provided with a minimum of 4 hours per day of out-of-cell time.
- c. Develop procedures to exclude prisoners with serious mental illness from isolation and segregation absent extraordinary or exceptional circumstances.
- d. Develop new protocols for the outpatient mental health housing unit, so that prisoners are offered structured and unstructured out-of-cell time consistent with minimum standards outlined in this report.
- e. Ensure that Custody and Corizon mental health staff develop and implement behavior management plans for inmates with serious mental illness who engage in dangerous or disruptive behaviors with the goal of preventing their placements, or shortening the amount of time spent, in isolation conditions.

2. Safety Cells

- a. Inmates placed in safety cells as a result of behaviors related to mental health symptoms should not be housed there for longer than 12 hours at a time. If the facility administrator, in cooperation with licensed mental health staff, determines that there is no less restrictive housing appropriate after 12 hours, the inmate should be taken to a facility for 72-hour treatment and evaluation pursuant to Section 5150 of the Welfare and Institutions Code and Section 4011.6 of the Penal Code.
- b. Inmates who are released from mental health related safety cell placements, or who return from treatment and evaluation pursuant to Section 5150 of the Welfare and Institutions Code and Section 4011.6 of the Penal Code, should be evaluated

by a mental health clinician in a confidential, out-of-cell setting, the next working day and then again within three to seven days depending on their clinical status.

3. Mental Health Treatment

- a. Establish a screening protocol at booking that (i) identifies all prisoners who are on mental health medication or otherwise in need of mental health treatment, and (ii) ensures that these prisoners are assessed and either provided with bridge medications, or if a determination is made not to provide requested medications, documenting the basis for the denial of medication and informing the prisoner in writing of how to file a grievance regarding this denial.
- b. Respond to prisoner requests in a timely manner. Qualified mental health staff should triage health needs request forms that seek mental health treatment the same day they are collected by the health care staff. The forms should be date-stamped at the time they are triaged, and noted in the prisoner's medical record. When qualified mental health staff determines clinician follow-up is necessary for diagnosis and treatment of an inmate's condition, the inmate should be referred to a clinician for a face-to-face evaluation that takes place immediately for emergent concerns, within 24 hours for urgent concerns, and within 14 calendar days for non-emergent or non-urgent concerns. Corizon should and report on monitor times to respond to requests
- c. For prisoners housed in the mental health housing unit, provide individual and/or group treatment, structured recreation, and rehabilitation services (e.g., psycho-education, supervised Activities of Daily Living and cell cleaning). They should receive ten to fifteen hours of out-of-cell-unstructured time each week (solo progressing to group) and ten to fifteen hours of out-of-cell structured activities with staff.

4. ADA

- a. Modify existing cells to offer wheelchair-accessible cells in different classification and housing areas, including medium and minimum security dormitory housing. This requirement applies to all areas in the Main Jail as needed to achieve program access, and to the basement dormitories in the Main Jail and the Medium Security facility adjacent to the Main Jail.
- b. Develop policies and procedures to assign and enforce orders for lower bunks and other disability-related accommodations, and monitor compliance with these orders on a regular basis.
- c. Ensure that prisoners with physical, sensory and mental health disabilities have access to the full range of Jail programs and activities and are not categorically assigned to more restricted housing than other prisoners.
- d. Appoint an ADA coordinator, establish an effective ADA complaint system, conduct a self-evaluation and develop a Transition Plan to achieve ADA compliance.
- e. Develop informational materials for prisoners with disabilities about how to request accommodations and file ADA grievances and complaints.

ATTACHMENTS

1. Metzner J.L., Dvoskin J.A., “An Overview of Correctional Psychiatry,” *Psychiatr Clin North Am* 29:761–72 (2006).
2. Metzner J.L., Fellner J., “Solitary Confinement and Mental Illness in U.S. Prisons: A Challenge for Medical Ethics,” *J Am Acad Psychiatry Law* 38:104–8, 2010.
3. National Commission on Correctional Health Care, *Standards for Health Services in Jails* (2014), Standards J-E-09 and J-G-04.
4. American Psychiatric Association, *Position statement on segregation of prisoners with mental illness* (2012), <http://www.psychiatry.org/File%20Library/Learn/Archives/Position-2012-Prisoners-Segregation.pdf>
5. Society for Correctional Physicians, “Restricted Housing of Mentally Ill Inmates, Position Statement,” July 9, 2013, available from <http://societyofcorrectionalphysicians.org/resources/position-statements/restricted-housing-of-mentally-ill-inmates>.
6. U.S. Department of Justice, Notice re: Final Regulations implementing Title II of the ADA, 75 Fed. Reg. 56164, 56218-56223 (2010), also available from http://www.ada.gov/regs2010/titleII_2010/titleII_2010_regulations.htm#a2010guidance.
7. U.S. Department of Justice, Investigation of State Correctional Institution at Cresson, May 13, 2013 at 5, available at http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf
8. U.S. Department of Justice, “Investigation of the Pennsylvania Department of Corrections’ Use of Solitary Confinement on Prisoners with Serious Mental Illness and/or Intellectual Disabilities,” February 24, 2014, http://www.justice.gov/crt/about/spl/documents/pdoc_finding_2-24-14.pdf
9. Memorandum of Agreement Between the United States Department of Justice and the Consolidated Government of Columbus, Georgia Regarding the Muscogee County Jail, January 16, 2015, available from http://www.justice.gov/crt/about/spl/documents/muscogee_moa_1-16-15.pdf

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10. [California Board of State and Community Corrections \(“BSCC”\) Jail Profile Study, First Quarter of 2015, available from http://www.bscc.ca.gov/downloads/2015_1st_Qtr_JPS_Full_Report.pdf.](http://www.bscc.ca.gov/downloads/2015_1st_Qtr_JPS_Full_Report.pdf)
11. [BSCC Biennial Inspection report of the Santa Barbara Jail, January 8, 2015.](#)
12. [Jail Psychiatric Services, San Francisco Jail, Template for Behavior Management Plan.](#)

(Attachments are available upon request, please contact: Richard Diaz, richard.diaz@disabilityrightsca.org or call 213-213-8000)

[Read Santa Barbara County Sheriff’s Office response to DRC final report on inspection of Santa Barbara County Jail](#)

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