DONALD SPECTER (SBN 83925)
SARA NORMAN (SBN 189536)
CORENE KENDRICK (SBN 226642)
PRISON LAW OFFICE
1917 Fifth Street
Berkeley, California 94710
Telephone: (510) 280-2621
Fax: (510) 280-2704
dspecter@prisonlaw.com
snorman@prisonlaw.com
ckendrick@prisonlaw.com

Attorneys for Plaintiffs, *on behalf of themselves and others similarly situated*

UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

GABRIEL YOUNG, EDDIE WILLIAMS, AND GALE YOUNG,

on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

COUNTY OF CONTRA COSTA,

Defendant.

Case No.

CLASS ACTION

CLASS ACTION COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

NATURE OF THE ACTION

1. Contra Costa County violates the constitutional rights of the approximately 800 people incarcerated in its jails, the vast majority of whom are pre-trial detainees. Jail medical and mental health care is so deficient that it creates a risk of harm to the people it aims to serve. People with disabilities are locked in housing units that do not offer programming and services equivalent to those available to non-disabled people in the jail.

2. For years, County officials have been aware of constitutionally inadequate care and conditions that place the people incarcerated in their jails at significant risk of harm. In 2015, the Contra Costa County Office of the Sheriff published a Jail Needs Assessment documenting the "extremely troubling" overcrowding at the its main jail, the Martinez Detention Facility ("MDF"). Yet the County did not take adequate measures to mitigate the risk of harm faced by people entirely dependent on the County for basic medical and mental health care, or to prevent discrimination on the basis of disability.

3. Defendant County of Contra Costa operates three jail facilities – MDF, West County Detention Facility ("WCDF"), and Marsh Creek Detention Facility ("MCDF"). As of September 24, 2020, the population of incarcerated people was 785 people. The County is responsible for ensuring that the basic human needs of people in its custody are met and that they are not placed at risk of serious harm, including by providing appropriate funding, oversight, and corrective action to ensure adequate jail conditions.

4. In March 2017, the parties entered into a Structured Negotiations Agreement ("SNA") as an alternative to imminent litigation. The parties agreed to work toward a settlement to address the conditions of confinement in Defendant's jails. The parties further agreed that Defendant would retain neutral experts to advise it about health care and custodial practices in the jails, and make efforts to implement the experts' recommendations. The experts issued written findings identifying serious risks of psychological and physical harm to people in the jails, and called for significant and immediate changes to address the deficiencies.

5. Defendant retained correctional expert Dr. Roberta Stellman to evaluate the County's provision of mental health care to jail detainees, and she completed her report in March 2017. She detailed inadequate staffing; deficiencies in the County's mental health intake system; inadequate documentation and data collection; insufficient confidentiality for both the sick call process and actual treatment; problems with continuity of care; an absence of policies addressing critical mental health care issues, including segregation of individuals with serious mental illness, and criteria for psychiatry referrals; inappropriate delegation of some aspects of psychiatric care management to mental health staff, inadequate medication management and oversight, and delayed provision of care. Dr. Stellman also noted the complete absence of group therapy at MDF or West County Detention Facility ("WCDF"). She reported that custody had too great a role, and mental health staff too little a role, in the use of restraints on individuals in mental health crisis. And she also found inadequate discharge planning, which set people up for re-arrest and cycling back into the jail.

6. Dr. Stellman reported that the County's jails lack "treatment units designed to increase life skills and socialization" for detainees with serious mental illness, who were instead placed in isolation. She noted that detainees were receiving less than 10 hours of out of cell time per week and minimal or no therapeutic programming.

7. Defendant retained correctional expert Dr. Esmaeil Porsa to evaluate the County's provision of medical care to jail detainees, which he completed in August 2018. He reported delays in initial health assessments, up to 28 days, preventing appropriate chronic disease management. He found the jail's medication administration process to have opportunities for human error that put patients at risk. Dr. Porsa identified other problems including inadequate health care staffing; an absence of clear policies for certain key issues; inadequate record keeping; ineffective mortality reviews; incomplete follow-up after outside specialty care; and failure to properly screen and treat communicable diseases. He described the jail's drug and alcohol detoxification procedures as "extremely dangerous to the health and wellbeing" of detainees. He found that nurses were conducting

sick call encounters in non-clinical settings like common areas and visiting rooms. Dr. Porsa also found unreasonable delays in dental care.

8. Defendant retained correctional expert Lindsay Hayes to evaluate the County's suicide prevention procedures, which he reviewed in August 2019 during a tour of MDF, and detailed in a November 2019 report. Mr. Hayes noted that although the County planned at that time to implement ten new suicide prevention cells, the two observation cells and three safety cells then available were insufficient and used inappropriately. He found the County's intake screening procedures defective, and that suicidal detainees are not being observed for long enough. He also was concerned about the lack of any programming opportunity or out of cell time for people on suicide watch, and the dehumanizing impact of the conditions in watch units. Mr. Hayes found that the suicide rate within the Contra Costa County Jail system was significantly higher than that of county jails of varying size throughout the United States.

9. Plaintiffs Gabriel Young, Eddie Williams, and Gale Young, and the putative class they seek to represent, seek a declaration that Contra Costa County's ongoing practices violate their constitutional and statutory rights, and seek injunctive relief compelling Defendant to provide constitutionally adequate medical and mental health care to all persons in their jails, and accommodations to people with disabilities.

JURISDICTION

10. The claims alleged herein arise pursuant to 42 U.S.C. § 1983 and the Eighth and Fourteenth Amendments to the United States Constitution, the Americans with Disabilities Act (ADA), 42 U.S.C. §12101 *et seq*., and Section 504 of the Rehabilitation Act, 29 U.S.C. § 794.

11. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §§ 1331, 1343, and 1367. Plaintiffs seek declaratory and injunctive relief under 28 U.S.C. §§ 1343, 2201, and 2202; and 42 U.S.C. § 1983.

VENUE

12. Venue is proper in the Northern District of California under 28 U.S.C. § 1391(b) because all events or omissions giving rise to the claims brought by Plaintiffs and the putative class occurred in this District, and Defendant is located in this District.

PARTIES

Plaintiffs

13. Plaintiff GABRIEL YOUNG is a 36-year-old pre-trial detainee with serious mental health needs who has been housed at both MDF and WCDF. Mr. YOUNG has schizophrenia and bipolar disorder. He reports that on numerous occasions, he has sought urgent medical or mental health care by pressing the "emergency medical" button inside his cell, but correctional staff at the jail refused to allow him to be seen by medical personnel. On several occasions when Mr. YOUNG had been experiencing mental health symptoms, he pressed the emergency medical button in his cell so that he could urgently meet with a clinician. Instead, deputies told him to stop pressing the button, and they refused to escort him to receive mental health care. Similarly, Mr. YOUNG has experienced nausea, vomiting, and diarrhea while at the jail. When he was symptomatic, he pressed the emergency medical button for medical attention, and deputies once again told him that he should not press the button and a doctor will not see him. Mr. YOUNG reports that he is not able to receive medical or mental health care when he urgently requires it. Defendant has failed to provide him with adequate medical and mental health care. Plaintiff YOUNG is a person with a disability as defined in 42 U.S.C. § 12102 and 29 U.S.C. § 705(9)(B).

14. Plaintiff EDDIE WILLIAMS is a 73-year-old pre-trial detainee with serious medical needs and physical disabilities who has been incarcerated at MDF since September 2019. Mr. WILLIAMS uses a wheelchair due to an above-the-knee amputation of much of his right leg and a large unhealed ulcer on the heel of his left foot. Mr. WILLIAMS has insulin-dependent diabetes, and must take insulin three times a day prior to meals. He also is diagnosed with Chronic Obstructive Pulmonary Disease (COPD),

congestive heart failure, venous thrombosis, Crohn's disease, and has a pacemaker and is on blood thinners due to a history of heart attacks. Mr. WILLIAMS suffers from incontinence, but reports that he does not always have an adequate supply of toileting supplies, including pull-up continence briefs. He has to repeatedly ask correctional officers and nursing staff to provide him with pull-ups. Before coming to the jail, Mr. WILLIAMS was a patient at the Veterans' Administration hospital, but the jail has not permitted him to have the VA send him a prosthetic leg that the VA fit him for prior to incarceration. When Mr. WILLIAMS first arrived at MDF, he was incarcerated in M module, where people with mental illness and physical disabilities normally are housed together. In October 2019, he was moved to F module because the M module was under construction and renovation, and while living in the F module he had more out-of-cell time and opportunities for group activities. On January 11, 2020, he was moved back to M module. Mr. WILLIAMS reports that he does not receive equivalent out of cell time he would otherwise receive in F module, and is housed in M module for no other reason but his physical disabilities and his insulin-dependent diabetes diagnosis. Mr. WILLIAMS is a person with a disability as defined in 42 U.S.C. § 12102 and 29 U.S.C. § 705(9)(B).

15. Plaintiff GALE YOUNG is a 38-year-old pre-trial detainee who has been incarcerated in MDF since March 2019. Mr. YOUNG uses a cane to assist in walking, because of a injury he suffered several years ago that destroyed his Achilles tendon, and required surgical reconstruction of his Achilles tendon. He experiences a great deal of pain and difficulty in walking without assistance, and in going up and down stairs. Prior to his incarceration, Mr. YOUNG used an orthopedic boot, knee scooter, and cane to assist him in getting around, and was undergoing physical therapy. However, he was not permitted to bring these mobility devices into the jail. He alleges that it took him almost three months to be issued a cane. Mr. YOUNG also was not provided a cell assignment on a ground floor, or a lower bunk, for three months. He also submitted multiple requests for referral to a physical therapist, but was not seen until September 20, 2019. The physical

therapist ordered eight weekly sessions at a minimum, but he has only gone to physical therapy one additional time.

Defendant

16. Defendant COUNTY OF CONTRA COSTA operates three jail facilities that incarcerate Plaintiffs and the putative class.

FACTUAL ALLEGATIONS

I. CONTRA COSTA COUNTY DOES NOT PROVIDE CONSTITUTIONALLY ADEQUATE HEALTH CARE TO PEOPLE IN ITS JAILS.

17. Defendant subjects all people confined in the jails, including Plaintiffs, to a substantial risk of serious injury by failing to provide adequate medical, mental health, and dental care (referred to collectively as "health care"). People detained in the jails are entirely dependent on Defendant to meet their basic health care needs. Defendant has a policy and practice of inadequately screening for serious health care conditions, delaying access to clinicians and medications, understaffing health care professionals, delaying access to specialty care, and failing to provide the full array of services necessary to meet minimum standards of care. Defendant also has a system for requesting health care that does not leave a paper trail for accountability and monitoring purposes. Defendant is deliberately indifferent to the risk of harm caused by these serious health care deficiencies.

18. Defendant has a number of systemic issues that impact its ability to provide mental health, medical, and dental treatment. The biggest problem is inadequate numbers of health care staff for the size of the jail population and its health care needs. The County's medical expert found that it also lacks clear, thorough policies regulating key aspects of health care, including a robust system to request health care, detoxification and withdrawal, medication administration, infection control, specialty care, and quality management and performance measurement. Many policies lack specific timeframes for actions to be taken.

19. While Defendant has an electronic health record-keeping system that it shares with the county-operated hospitals, obtaining information from the non-correctional

health care system regarding patient care and medication administration is challenging and time-consuming. Providers cannot find essential information about their patients.

20. Once incarcerated in the jail, the primary method for people to request health care is to give a health service request form to a correctional officer. Detainees can also request health services over a phone in the common area of the housing units (a process known colloquially as using the "triage phone"), but these calls are not confidential. The lack of confidentiality in requesting care deters people from asking for help, because custody staff may review their personal information in a written request, or staff or other detainees may overhear verbal requests on the triage phone. Since many requests for health care are made verbally, there is no written record of the request that people can rely upon to show that they requested treatment, or for quality assurance and tracking. For example, Plaintiffs WILLIAMS and GALE YOUNG report submitting requests to be seen via the "triage phone" on multiple occasions, but not being called out to see a nurse or doctor. As a result, the Plaintiffs do not have any sort of written record to memorialize their past requests for health care for purposes of filing grievances or escalating their requests to a more urgent status. In addition, Defendant does not have a policy that identifies time frames to designate requests as emergent, urgent, or routine.

21. Defendant has a policy and practice of failing to adequately review, document, or correct deficiencies in care. As noted above, Defendant fails to properly document verbal requests for care. The jail does not differentiate between different types of medical encounters. This inhibits the County's ability to conduct performance audits. Defendant's expert found that its reviews of in-custody deaths lack a robust root cause analysis, a timeframe for completing any resulting action plans, or any built-in accountability. Defendant's failure to implement an effective death review and quality assurance program leads to a substantial risk of future harm of preventable injury and death to the people in its jails.

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A. Mental Health Care Is Inadequate.

22. Defendant's mental health care delivery system is deficient in staffing, screening, therapeutic treatment, suicide prevention, medication management, timely evaluations, recordkeeping, and confidentiality.

23. There are not enough psychiatrists and therapists to meet the demands of the current jail population. As a result, Defendant cannot implement the essential components of an adequate mental health delivery system. Between January 2015 and October 2019, ten (10) people died by suicide in Defendant's jail system, which given the size of the jail system is a significantly higher suicide rate than that found on average in jails across the United States. .

24. After arrest and upon arrival to the jail, nurses ask jail detainees initial mental health screening questions at a desk in the center of the jail's intake area, where people are within earshot of other arrestees, arresting/transporting law enforcement officers, as well as custody, health care, and other miscellaneous jail staff. After some initial screening questions, detainees identified with a possible mental health diagnosis or symptoms of mental distress are asked a second round series of more in-depth questions to determine whether the person is referred for a full mental health assessment. The County completed construction of two secure and confidential intake booths at MDF to use in some cases during the second stage of mental health intake. But Defendant has yet to implement a system in which *all* mental health intake for *all* detainees occurs with sufficient privacy. This compromises the accuracy of the information shared with staff, and puts people at risk of harm.

25. Intake nursing staff do not and cannot always review the information about detainees that may be in the County's community/public health department's records. In addition, pre-booking forms that arresting or transporting officers complete do not ask if the officer observed odd thought patterns or behavior by the arrestee. This incomplete information means that people with significant mental health problems may not be properly identified during jail intake.

26. As described above, requests for health care are made either via a written slip turned into custody officers, or via the triage phones. Once people manage to transmit a request for help to mental health staff, treatment options are limited. Usually a clinician provides a brief, non-confidential visit, either cell-front or in a common area, to assess if there are acute mental health symptoms. Because many mental health visits occur at cell-front or in open areas within earshot of other prisoners and custody staff, patients understandably are hesitant to divulge personal information that may result in stigmatization and abuse. This compromises the accuracy of the information shared with jail health staff, and puts people at risk of having serious mental health issues go undetected and untreated. Plaintiff GABRIEL YOUNG's healthcare records indicate that many of his mental health appointments occur cell-front, with the clinician in the open common area where other incarcerated people and custody staff are often within earshot.

27. Mental Health Clinical Specialists (MHCSs) operate as gatekeepers, and, based on assessments they are not qualified to make, deny access to psychiatrists. Defendant lacks an adequate system for referrals to psychiatry, without consistent criteria and with an overemphasis on whether the person has a history of psychiatric medication. If there are no suicide concerns or immediate need for referral to psychiatry, there is no scheduled follow-up or treatment.

28. Individuals who are referred to a psychiatrist must often wait several weeks to be seen. If the person is referred to and followed by a psychiatrist, their services—other than prescribing psychotropic medication—consist of monthly brief cell-front visits. Clinicians do not have dedicated caseloads, and there is minimal continuity of care.

29. Defendant's suicide prevention policies and practices are dangerous and ineffective. First, the initial, non-confidential contact during intake may cause the jail to fail to detect people who are suicidal and/or are at risk of engaging in acts of self-harm. Second, the jail does not monitor people who are suicidal for long enough, and clinicians make decisions about removing people from observation that are driven by the limited number of suicide watch cells. Third, the County places people who report suicidal

thoughts or who engage in acts of self-harm in overly restrictive and dehumanizing conditions, depriving them of clothes, reading material, medical devices such as eyeglasses and canes, access to medical and mental health programming, and the ability to go to court while on suicide watch. These overly harsh conditions – and the denial of access to the courts – also result in an unwillingness by people in the jail to report thoughts of self-harm or suicide to custody or mental health staff.

B. Medical Care is Inadequate.

30. Defendant has a policy and practice of failing to provide a timely initial health assessment. Correctional standards require either that all detainees receive a health assessment within 14 days, or that all individuals with clinically significant health findings identified at intake receive a full health assessment within two days. The County does not provide either by policy, in some cases delaying an assessment for someone with clinically significant findings for as long as 28 days, resulting in increased risk of harm.

31. For example, Plaintiff WILLIAMS reports that when he came in to MDF, he had a diabetic ulcer on his left heel. He reports that he was not provided orientation information about how to request medical care. During his intake, he reported and showed the ulcer to nursing staff, but in the weeks after he was incarcerated, the wound worsened and grew in size. He reports that he asked the nurses who came to his housing unit to administer insulin that his wound was worsening, but did not see a doctor about it until more than two weeks after he came to the jail. He was sent offsite to see a wound specialist, and the ulcer had grown in size compared to its size prior to incarceration.

32. Defendant does not adequately identify, assess, manage, or treat people suffering from substance withdrawal complications, and its policies and practices regarding withdrawal do not conform to the professional standards of care. Intake nurses are solely responsible for identifying people in withdrawal, as well as making decisions regarding complex detoxification protocol like frequency and dose of medication, which is dangerous to the health of detainees. The fact that screening for withdrawal occurs during the County's problematic intake process results in late or missed identification of

symptoms, which can be life-threatening. In addition, the County's practice of frequent dosing for drug and alcohol withdrawal without a close observation unit is unsafe.

33. Defendant does not have a functional system to ensure that people receiving outside specialty care, diagnostic tests, emergency care, and inpatient services are evaluated upon their return to the jail, that discharge instructions are obtained and followed, and that specialists' treatment recommendations are provided.

34. For example, Plaintiff GALE YOUNG reports that he had pins removed from his foot in an orthopedic surgery months before his incarceration in March 2019, and was told by the specialist to return for follow-up. He reports that he continues to experience difficult and pain walking, but has not been sent to see an orthopedist for follow-up, even after his outside providers sent copies of his medical records to jail health care staff. He also was undergoing regular physical therapy prior to his incarceration, but was not sent out to continue the physical therapy until late September 2019, and since then has had only one additional session of physical therapy.

35. Plaintiff WILLIAMS, as a U.S. Marines Corps veteran, received services from the Veterans' Administration Hospital prior to his arrest, including being fitted for a prosthetic leg so that he would not be forced to rely upon a wheelchair for mobility. He reports he has asked jail medical staff if he could be taken to the VA so he could have the final fitting for the prosthetic and bring it back to the jail, but that has not occurred.

36. Defendant's medication administration process is unsafe and puts patients at risk. Defendant's electronic medical record system does not allow for offline electronic medication administration. Nursing staff instead collect every patient's medication at the beginning of a shift, discard the printed electronic system information, and instead put the pills in an envelope and transcribe the patient identification and medication administration information by hand onto the envelope. These envelopes go through several hands, and may receive additional handwritten notations before reaching the patient. This introduces numerous opportunities for human error, but makes any errors very difficult to track.

Nursing staff also cannot contemporaneously verify important patient information such as allergies while administering medication.

37. Similar to mental health encounters, nurses conduct most sick call encounters in common areas or visiting rooms devoid of privacy and dignity. There is also inadequate privacy in intake, and in the telephone and paper sick call processes. The lack of privacy prevents the provision of adequate medical care.

38. The clinical areas at MDF lack detainee waiting rooms, and there is no assigned custody staff for medical escort purposes, causing inefficiency in the delivery of medical care.

C. Dental Care is Inadequate.

39. Defendant has a policy and practice of delaying access to dental care. The efficiency of dental care is impacted by the lack of waiting space and assigned medical escorts custody staff. Patients are sometimes required to wait as long as seven days for an urgent dental referral, and 70 days for a non-urgent referral. Defendant subjects detainees to undue pain and suffering and potential health risks and complications from these delays.

II. CONTRA COSTA COUNTY DISCRIMINATES AGAINST PEOPLE WITH DISABILITIES

38. Defendant does not house people with physical disabilities in locations where they can access programs and services, and Defendant has a policy and practice of failing to ensure that people with disabilities have equal access to programs, services, and activities in the jails. For example, when Mr. WILLIAMS first arrived at MDF, he was incarcerated in M module, where people with mental illness and physical disabilities normally are housed together. In October 2019, he was moved to F module because the M module was under construction and renovation, and while living in the F module he had more out-of-cell time and opportunities for group activities. On January 11, 2020, he was moved back to M module, as he was told by custody and nursing staff that all people who take insulin, are seriously mentally ill, or use wheelchairs, would be housed in this unit together. Mr. WILLIAMS does not receive equivalent out of cell time he would otherwise receive in F module, and is housed in M module for no other reason but his physical

disabilities and his insulin-dependent diabetes diagnosis. Plaintiff WILLIAMS is a person with a disability as defined in 42 U.S.C. § 12102 and 29 U.S.C. § 705(9)(B).

39. Defendant does not provide timely or adequate access to medical supplies or durable medical equipment for people with physical disabilities. For example, Plaintiff Mr. WILLIAMS suffers from incontinence, but reports that he does not always have an adequate supply of toileting supplies, including pull-up incontinence briefs. He has to repeatedly ask correctional officers and nursing staff to provide him with pull-ups. As noted above, before coming to the jail, Mr. WILLIAMS has not been able to have the VA send him a prosthetic leg that the VA fit him for prior to incarceration. Nor have health care staff authorized him to be sent to the VA to retrieve the prosthesis. As a result, he has to use a wheelchair and is not afforded the greatest degree of independence to allow him equal access to programs, services, and activities. 28 CFR § 35.130; 42 U.S.C. § 12132.

40. Defendant does not have an effective complaint procedure for people to contest disability discrimination. The only mechanism Defendant provides to raise disability issues is the jail grievance form. But incarcerated people with disabilities must ask correctional officers for grievance forms who often refuse to provide them. Defendant requires correctional officers to review and sign any grievances before they are processed, but many officers attempt to dissuade prisoners from filing them, threaten retaliation for use of the grievance process, or refuse to sign or process the forms. Moreover, many people with disabilities are unaware of Defendant's obligation to ensure equal access to programs, services, and activities because Defendant has failed to provide notice of their disability related rights as required by federal law. Plaintiff WILLIAMS was not provided information about his rights under the ADA.

45. Defendant's policies and procedures regarding screening, housing, assistive devices and medical supplies, grievances, and the use of solitary confinement for people with disabilities is a direct violation of the ADA and Section 504 of the Rehabilitation Act.

III. CLASS ALLEGATIONS

40. Plaintiffs GABRIEL YOUNG, WILLIAMS, and GALE YOUNG bring this action on their own behalf and, pursuant to Rule 23(a), (b)(1), and (b)(2) of the Federal Rules of Civil Procedure, on behalf of all people who are or will in the future be incarcerated in the Contra Costa County Jail system. All class members are at risk of harm due to Defendant's following policies and practices: failure to provide minimally adequate medical, mental health, and dental care, including identification and monitoring of serious health conditions; sufficient staffing levels; timely access to appropriate clinicians, medications, and treatment plans; effective suicide prevention practices, the complete range of health care services necessary to maintain health; failure to provide equal access of people with disabilities to programs, services, and activities in the jails; the denial of health care appliances, assistive devices, durable medical equipment, and other reasonable accommodations; an inadequate disability grievance process; and the improper housing of people with disabilities in unnecessarily restrictive placements without equal access to programming and services, for no other reason than their disability.

41. There are questions of law and fact common to the class including whether (a) Defendant by its policy and practice of denying minimally adequate mental health, medical, and dental care violates the Due Process Clause of the Fourteenth Amendment and the Cruel and Unusual Punishments Clause of the Eighth Amendment; (b) denying people with disabilities reasonable accommodations, assistive devices, medical supplies, and accessible housing violates the ADA and Section 504 of the Rehabilitation Act; and (c) failing to provide notice to people with disabilities about their rights under the ADA, and a meaningful way to request accommodations or to challenge disability discrimination, violates the ADA.

42. Since there are approximately at least 785 class members, separate actions by individuals would in all likelihood result in inconsistent and varying decisions, which in turn would result in conflicting and incompatible standards of conduct for Defendant.

43. Defendant has acted and failed to act on grounds that apply generally to the class, so that final injunctive or corresponding declaratory relief is appropriate respecting the class as a whole.

44. Plaintiffs' claims are typical of the claims of the class, since their claims arise from the same policies, practices, and courses of conduct and their claims are based on the same theories of law as the class's claims.

45. The named Plaintiffs, through counsel, will fairly and adequately protect the interests of the class. Plaintiffs do not have any interests antagonistic to the plaintiff class. Plaintiffs, as well as the Plaintiff class members, seek to enjoin the unlawful acts and omissions of Defendant. Further, Plaintiffs are represented by counsel experienced in civil rights litigation and complex class action litigation on behalf of incarcerated persons, and in disability law.

CLAIMS FOR RELIEF

First Cause of Action

(Fourteenth Amendment – Substantive Due Process, 42 U.S.C. § 1983)

46. Plaintiffs incorporate by reference each and every allegation contained in Paragraphs 1-45 as if set forth fully herein.

47. By the policies and practices described herein, Defendant subjects Plaintiffs and other pretrial detainee class members to a substantial risk of serious harm and injury from inadequate health care, and violates their rights under the substantive due process clause of the Fourteenth Amendment to the United States Constitution to be free from risk of harm while in custody. These policies and practices have been and continue to be implemented by Defendant and its agents, officials, employees, and all persons acting in concert under color of state law, in their official capacity, and are the proximate cause of the Plaintiffs' and the class's ongoing deprivation of rights secured under the Fourteenth Amendment.

48. Defendant has been and is aware of the deprivations complained of herein, and has condoned or been deliberately indifferent to such conduct.

49. In addition, Defendant violates the Fourteenth Amendment substantive due process rights of Plaintiffs and class members who are awaiting trial or are civil detainees, and thus are not convicted of a crime, on the basis that the conditions of confinement amount to punishment, thus placing Plaintiffs and the members of the class at substantial risk of suffering serious harm. Defendant failed to take reasonable available measures to abate that risk, even though a reasonable actor in similar circumstances would have appreciated the degree of risk involved.

Second Cause of Action

(Eighth Amendment – Cruel and Unusual Punishments, 42 U.S.C. § 1983)

50. Plaintiffs incorporate by reference each and every allegation contained in Paragraphs 1-45 as if set forth fully herein.

51. By the policies and practices described herein, Defendant subjects Plaintiffs and class members to a substantial risk of serious harm and injury from inadequate health care, and has violated their right to be free from cruel and unusual punishments under the Eighth Amendment to the United States Constitution. These policies and practices have been and continue to be implemented by Defendant and its agents, officials, employees, and all persons acting in concert under color of state law, in their official capacity, and are the proximate cause of the Plaintiffs' and the class's ongoing deprivation of rights secured under the Eighth Amendment.

52. Defendant has been and is aware of all of the deprivations complained of herein, and has condoned or been deliberately indifferent to such conduct.

Third Cause of Action

(Americans with Disabilities Act, 42 U.S.C. § 12132 and 28 C.F.R. § 35.152(b)(1))

53. Plaintiffs incorporate by reference each and every allegation contained in Paragraphs 1-45 as if set forth fully herein.

54. Defendant is a public entity as defined under 42 U.S.C. § 12131(1)(A).

55. Defendant violates the ADA by failing to ensure that people with disabilities have access to, are permitted to participate in, and are not denied the benefits of, programs, services, and activities. 42 U.S.C. § 12132; 28 C.F.R. § 35.152(b)(1).

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

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

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

59. Defendant violates the ADA by failing to notify people about their rights under the ADA while detained in its jails. 28 C.F.R. § 35.106.

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

61. As a result of Defendant's policies and practices regarding people with disabilities in its jails, Plaintiffs and class members with disabilities do not have equal access to jail activities, programs, and services for which they are otherwise qualified.

Fourth Cause of Action

(Section 504 of the Rehabilitation Act)

62. Plaintiffs incorporate by reference each and every allegation contained in Paragraphs 1-45 as if set forth fully herein.

63. Defendant receives federal funding within the meaning of the Rehabilitation Act.

64. Defendant violates Section 504 of the Rehabilitation Act by discriminating against people with disabilities solely on the basis of their disabilities and by failing to reasonably accommodate people with disabilities in its facilities, programs, activities, and services. 29 U.S.C. § 794.

65. As a result of Defendant's discriminating against and failing to provide a grievance procedure and reasonable accommodations to people with disabilities, Plaintiffs and class members with disabilities do not have equal access to jail activities, programs, and services for which they are otherwise qualified.

PRAYER FOR RELIEF

66. Plaintiffs and the class they seek to represent have no adequate remedy at law to redress the wrongs suffered as set forth in this complaint. Plaintiffs have suffered and will continue to suffer irreparable injury as a result of the unlawful acts, omissions, policies, and practices of the Defendant as alleged herein, unless they are granted the relief requested. The need for relief is critical because the rights at issue are paramount under the Constitution of the United States, the ADA, and Section 504 of the Rehabilitation Act.

67. WHEREFORE, Plaintiffs on behalf of themselves and the class and subclass they represent, request that this Court grant the following relief:

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

b. Adjudge and declare that the conditions, acts, omissions, policies, and practices of Defendant and its agents, officials, and employees are in violation of the rights of Plaintiffs and the Class they represent under the Fourteenth and Eighth Amendments to the U.S. Constitution, the ADA, and Section 504 of the Rehabilitation Act;

c. Enjoin Defendant, its agents, officials, employees, and all persons acting in concert under color of state law or otherwise, from continuing the unlawful acts, conditions, and practices described in this Complaint;

d. Order Defendant, its agents, officials, employees, and all persons acting in concert under color of state law or otherwise, to provide adequate mental health, medical, and dental care, including but not limited to sufficient intake screening, sufficient staffing, timely access to appropriate clinicians, timely prescription and distribution of appropriate medications and supplies, timely access to specialty care, and timely access to competent therapy, inpatient treatment, and suicide prevention;

e. Order Defendant, its agents, officials, employees, and all persons acting in concert under color of state law or otherwise, to provide equal access to programs, services, and activities for people with disabilities, including but not limited to housing people with physical disabilities in accessible housing appropriate to their needs, timely delivery of and appropriate access to assistive devices and medical supplies, providing an effective grievance system to contest disability discrimination, and notifying people with disabilities their rights under the ADA and Section 504 of the Rehabilitation Act.;

f. Award Plaintiffs, pursuant to 29 U.S.C. § 794, 42 U.S.C. § 1988, and 42 U.S.C. §§ 12205, 12133, and other applicable law, the costs of this suit and reasonable attorneys' fees and litigation expenses;

g. Retain jurisdiction of this case until Defendant has fully complied with the orders of this Court, and there is a reasonable assurance that Defendant will continue to comply in the future absent continuing jurisdiction;

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

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

Dated: September 30, 2020

Respectfully submitted,

/s/ Corene T. Kendrick
Corene T. Kendrick

Attorney for Plaintiffs