

1 DONALD SPECTER (SBN 83925)
2 KELLY KNAPP (SBN 252013)
3 PRISON LAW OFFICE
4 1917 Fifth Street
5 Berkeley, California 94710
6 Telephone: (510) 280-2621
7 Fax: (510) 280-2704
8 dspecter@prisonlaw.com
9 kknapp@prisonlaw.com
10
11
12

13 Attorneys for Plaintiffs, *on behalf of*
14 *themselves and others similarly situated*
15
16

17 UNITED STATES DISTRICT COURT
18 FOR THE CENTRAL DISTRICT OF CALIFORNIA
19
20 EASTERN DIVISION - RIVERSIDE
21
22

23 GEORGE TOPETE AND ZACHERY
24 SHOVEY,
25 on behalf of themselves and all others
26 similarly situated,
27 Plaintiffs,
28 v.
COUNTY OF SAN BERNARDINO,
Defendant.

Case No. 5:16-CV-355

PROPOSED CLASS ACTION

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

NATURE OF THE ACTION

1
2 1. San Bernardino County is violating the constitutional rights of the
3 nearly 6,000 people it incarcerates in its jails. Jail medical, mental health, and
4 dental care is so deficient that it is harming the people it aims to serve. Jail staff
5 uses excessive force against people they are charged with protecting, and fails to
6 take even the most basic steps to prevent violence. Jail staff discriminates against
7 people with disabilities by locking them in housing units that don't have accessible
8 toilets and showers, and by locking people with mental health problems in tiny cells
9 for 22 to 24 hours a day, which only worsens their psychiatric conditions.

10 2. County officials have known for years that the conditions in the jails
11 are so deplorable that people housed there are at significant risk of harm. Yet the
12 County has failed to take reasonable measures to mitigate the risk of harm faced by
13 people entirely dependent on the County for basic health care, disability
14 discrimination, safety, and security.

15 3. Plaintiffs George Topete and Zachery Shovey, and the class they
16 represent, seek a declaration that San Bernardino County's ongoing practices violate
17 their constitutional and statutory rights, and seek injunctive relief compelling
18 Defendant to provide constitutionally adequate health care, to protect people from
19 violence, to provide equal access to programs, services, and activities, and to cease
20 the unnecessary and excessive use of force.

JURISDICTION

21
22 4. The claims alleged herein arise pursuant to 42 U.S.C. § 1983 and the
23 Eighth and Fourteenth Amendments to the United States Constitution, the
24 Americans with Disabilities Act (ADA), 42 U.S.C. §12101 et seq., and Section 504
25 of the Rehabilitation Act, 29 U.S.C. § 794.

26 5. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §§ 1331,
27 1343, and 1367. Plaintiffs seek declaratory and injunctive relief under 28 U.S.C. §§
28 1343, 2201, and 2202; and 42 U.S.C. § 1983.

1 **VENUE**

2 6. Venue is proper in the Central District of California under 28 U.S.C. §
3 1391(b) because a substantial part of the events or omissions giving rise to the
4 claims brought by Plaintiffs and the class have occurred in this District and
5 Defendant is located in this District.

6 **PARTIES**

7 **Plaintiffs**

8 7. George Topete is a convicted prisoner and pretrial detainee who
9 transferred from state prison to the West Valley Detention Center on October 14,
10 2011, to face new charges. He has difficulty walking and using stairs due to a
11 physical disability. Mr. Topete requires the use of a cane, but Defendant has
12 periodically refused to provide him with one for months at a time. In June 2015,
13 Defendant provided Mr. Topete with a wheelchair, but does not house him in a
14 wheelchair accessible unit or cell. As a result, he has fallen and is at risk of falling
15 when trying to access the visiting area, his cell, and the toilet. Defendant also denies
16 Mr. Topete adequate access to a C-PAP machine that he requires to treat his sleep
17 apnea.

18 8. Zachary Shovey is a pretrial detainee in the West Valley Detention
19 Center who was arrested on July 8, 2014. He has an extensive psychiatric history
20 that includes multiple suicide attempts, psychiatric medications, and a nine-month
21 stay in a state psychiatric hospital. Defendant failed to provide him mental health
22 treatment and psychiatric medications for one year after his arrest despite symptoms
23 including hallucinations, delusions, anxiety, and insomnia. Defendant has also
24 failed to provide him with timely medical treatment for his seizure disorder.

25 **Defendant**

26 9. Defendant County of San Bernardino operates four jail facilities – West
27 Valley Detention Center, Central Detention Center, High Desert Detention Center,
28 and the Glen Helen Rehabilitation Center -- that incarcerate approximately 6,000

1 people. Defendant also operates several detention facilities that incarcerate people
 2 for 96 hours or less. The County is responsible for ensuring that the basic human
 3 needs of individuals in its custody are met, and for ensuring that individuals are not
 4 at risk of serious harm, including by providing appropriate funding, oversight, and
 5 corrective action to ensure adequate conditions.

6 **FACTUAL ALLEGATIONS**

7 **I. SAN BERNARDINO COUNTY FAILS TO PROVIDE ADEQUATE HEALTH CARE.**

8 10. Defendant subjects all people confined in the jails, including Plaintiffs,
 9 to a substantial risk of injury or death by failing to provide adequate medical, mental
 10 health, and dental care. Individuals in the jails are entirely dependent on Defendant
 11 for their basic health care needs. Defendant has a policy and practice of
 12 inadequately screening for serious health care conditions and disabilities, delaying
 13 access to clinicians and medications, understaffing health care professionals,
 14 delaying access to specialty care, and failing to provide the full array of services
 15 necessary to meet minimum standards of care. Defendant is deliberately indifferent
 16 to the risk of harm caused by these serious health care deficiencies.

17 **A. Mental Health Care Is Inadequate.**

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

21 12. There are not enough psychiatrists and therapists to meet the demands
 22 of the current jail population. As a result, Defendant cannot implement the essential
 23 components of an adequate mental health delivery system.

24 13. Upon arrival, untrained correctional officers, and not health care
 25 professionals, screen people for health care symptoms, including for mental illness
 26 and suicidality. If the screening correctional officer manages to identify an
 27 individual as mentally ill, he or she is referred to mental health staff for an
 28

1 evaluation. However, this evaluation is often delayed, incomplete, and inadequate.
2 The focus of the clinical evaluation is centered on any history of psychiatric
3 medications, and the other necessary components of an adequate assessment (e.g.,
4 current symptoms, substance abuse, social history, and suicide history) are given
5 short-shrift.

6 14. Defendant does not have a functioning system to ensure timely access
7 to mental health care. Once housed, the primary method for people to request health
8 care is to give a Health Service Request form (“HSR”) to a correctional officer.
9 This practice deters people from asking for help because custody staff may review
10 their personal information, and many HSRs are lost or destroyed before reaching
11 health care staff.

12 15. For those individuals who manage to transmit a request for help to
13 mental health staff, the treatment options are extremely limited. There is no therapy.
14 Instead, Defendant provides a brief, non-confidential, cell-front visit by a clinician,
15 flanked by at least one correctional officer, typically several weeks after the
16 individual first requested help, to assess if there are acute mental health symptoms.
17 There is no effort to explore or treat the underlying mental health condition. There
18 is no effort to provide people with practical skills to help them cope with their
19 symptoms or living conditions, including being locked in their cells for 23 or more
20 hours a day, as is common practice. Indeed, in August 2015, a jail therapist
21 documented that Mr. Shovey was depressed and sleeping poorly, but the only
22 treatment plan was to provide him with a list of outpatient clinics. The brief cell-
23 front visits often do not even address the symptoms described in the HSR that
24 prompted the visit. For example, even though a transgender woman had turned in at
25 least two HSRs describing gender dysphoria in October 2015, the clinician who
26 evaluated her in November 2015 did not discuss gender dysphoria symptoms with
27 her.

28 16. Moreover, because these visits occur at cell-front within earshot of

1 other prisoners and custody staff, people are reasonably hesitant to divulge personal
2 information that may result in stigmatization and abuse. Mr. Shovey, for example,
3 does not feel comfortable and has not disclosed all of his mental health symptoms to
4 jail clinicians because officers are present and other people can hear their
5 interactions. Mr. Shovey has no history of violence or violent charges, and does not
6 pose any security threat that requires custody officers to stand next to his clinicians,
7 especially when they are speaking to him through a cell door. For individuals in
8 administrative segregation, jail clinicians stoop over and speak to patients through
9 the food tray slot in the cell door even when there is no security risk involved in
10 opening the cell door and moving the patient to an appropriate clinical space.

11 17. Defendant has a policy and practice of denying or delaying access to
12 psychiatrists. Therapists generally operate as gatekeepers, and, based on
13 assessments they are not qualified to make, deny access to psychiatrists. Defendant
14 denied Mr. Shovey access to a psychiatrist for over a year after his arrest, despite
15 serious mental health symptoms, because a therapist decided medications were not
16 warranted since he had not been receiving them in the months before he was
17 arrested. Individuals who are referred to a psychiatrist must often wait several
18 weeks to be seen. Once a jail clinician finally referred Mr. Shovey to a psychiatrist
19 because of symptoms including paranoia and mania, he had to wait five weeks and
20 file two grievance before a psychiatrist evaluated him. People who are suffering
21 from severe symptoms must wait weeks or months before receiving psychiatric
22 medications.

23 18. If and when Defendant provides psychiatry services, the treatment is
24 often haphazard and inconsistent. Many people are denied medications entirely
25 until and unless they either threaten or attempt suicide. Defendant does not always
26 provide a comprehensive psychiatry evaluation before prescribing or changing
27 powerful psychiatric medications, and fails to adequately monitor people prescribed
28 such medications for side effects, drug interactions, and effectiveness.

1 19. Defendant's suicide prevention practices are dangerous and ineffective.
2 If and when Defendant identifies an individual at risk of suicide, correctional
3 officers force the individual to strip naked and lock him or her in a "safety cell,"
4 which is nothing more than a small jail cell with rubber coated walls, no furniture,
5 and a hole in the floor to use as a toilet. The individual is left in this cell for many
6 hours, sometimes days, without any meaningful treatment until Defendant receives
7 some assurance that the individual is no longer suicidal. However, Defendant then
8 abruptly releases such individuals back to their housing units without close
9 monitoring of their symptoms and a without a timely follow-up appointment with a
10 clinician. People quickly cycle in and out of safety cells because they remain
11 untreated.

12 20. Defendant worsens people's psychiatric conditions by locking them in
13 small cells for 22 hours or more a day, also known as "solitary confinement."¹ As a
14 result, they suffer from acute anxiety, depression, withdrawal, psychosis, agitation,
15 and an increased risk of suicide or violence. Defendant does not assess people with
16 mental illness before placing them in solitary confinement to ensure their symptoms
17 are not exacerbated or if they can be safely and adequately managed in such
18 conditions. Defendant also fails to monitor them or provide mental health services
19 once they are locked in solitary confinement despite the well-known risks inherent
20 in locking people in their cells for prolonged periods of time.

21
22 ¹ See U.S. Department of Justice, Investigation of State Correctional Institution at
23 Cresson, May 13, 2013, p. 5, available at
24 http://www.justice.gov/crt/about/spl/documents/cresson_findings_5-31-13.pdf
25 ("terms 'isolation' or 'solitary confinement' mean the state of being confined to
26 one's cell for approximately 22 hours per day or more, alone or with other prisoners,
27 that limits contact with other."); *Wilkinson v. Austin*, 545 U.S. 209, 214, 224, 125
28 S.Ct. 2384, 2389, 2394 (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).

1 **B. Medical Care is Inadequate.**

2 21. As described above, Defendant has a policy and practice of failing to
3 adequately complete the most important encounter in a medical care delivery system
4 – the intake screening. An adequate intake screening is integral because it identifies
5 medications, infectious diseases, and health care conditions that must be addressed
6 to prevent injury and death. Defendant assigns correctional officers to conduct the
7 majority of the intake screenings. These correctional officers are not qualified to
8 recognize and respond to the signs and symptoms of serious medical conditions such
9 as substance withdrawal or infectious diseases. They are not qualified to identify,
10 nor does Defendant verify, prescribed medications for individuals entering the jail,
11 especially for those who are in extreme distress or under the influence of substances.
12 They are not qualified, and the intake screening does not require them, to take vital
13 signs (e.g., blood pressure and temperature). Defendant also fails to conduct an
14 intake screening for individuals who are transferred from other facilities to West
15 Valley Detention Center for medical treatment, and instead sends them straight to
16 housing units without any contact with medical staff. Consequently, many people
17 are later hospitalized for conditions that could have been prevented if appropriately
18 identified and addressed at the intake screening.

19 22. Defendant does not conform to the professional standard of care in the
20 prevention and control of infectious diseases. It fails to adequately screen for
21 tuberculosis, a highly contagious and deadly disease with a high prevalence rate
22 among people in Defendant's custody. Defendant fails to provide adequate soap
23 and sanitizers to staff and prisoners. Defendant also does not adequately sanitize
24 shavers and hair clippers that are shared by dozens of individuals. Defendant's
25 policies and practices create an unreasonable risk of the spread of infectious
26 diseases.

27 23. Defendant does not adequately assess, manage, or treat individuals
28 suffering from substance withdrawal complications, and its policies and practices

1 regarding withdrawal do not conform to the professional standards of care.

2 24. Defendant does not consistently respond in a timely manner, it if
3 responds at all, to individuals who submit HSRs regarding serious medical
4 conditions. For example, Mr. Shovey submitted HSRs on February 22 and March 1,
5 2015, reporting recent seizures and that his seizure meds may need to be adjusted.
6 Medical staff did not respond to either HSR. Indeed, Defendant did not evaluate
7 him until April 3, 2015, when custody staff made an emergency call to nursing staff
8 because Mr. Shovey was having a seizure. Many of these types of emergencies,
9 including those that require hospitalizations, could be avoided if Defendant had a
10 policy and practice of timely responding to HSRs.

11 25. Defendant does not have a functioning system to ensure that people
12 receive timely access to specialty care and that specialists' treatment
13 recommendations are provided. Defendant provides many specialty services on site
14 at the West Valley Detention Center, but then fails to arrange transportation to those
15 services for individuals housed at the other jail facilities. Those individuals wait
16 months or are never rescheduled for the specialty services because Defendant does
17 not have a tracking system to identify missed appointments. In addition, the jail
18 providers responsible for the overall care of the individuals needing specialty
19 services fail to monitor them once referred, and thus do nothing when a specialty
20 appointment is missed or when a specialist recommends treatment that must be
21 ordered by the jail provider. Similarly, Defendant does not have an effective system
22 to timely receive diagnostic test results that are necessary for adequate treatment of
23 serious medical conditions.

24 26. Defendant has a policy and practice of failing to adequately review,
25 document, or correct any deficiencies in care. For individuals who die in custody,
26 Defendant's practice is to gather records for at least eight to 12 months regarding the
27 death, and then confer with its attorneys. There are no documented findings or
28 conclusions from the records. There are no psychological autopsies of suicides.

1 Defendant does not interview or meet with custody and health care staff who may
2 have been involved in a death. There is no documented plan for corrective action.
3 For individuals who do not die in custody, there is no assessment or evaluation of
4 the overall quality of care, identification of problems or shortcomings in the delivery
5 of care, corrective action to overcome these deficiencies, or follow-up monitoring to
6 ensure corrective steps are effective. Defendant's failure to implement an effective
7 death review and quality assurance program results in a substantial risk of harm of
8 preventable injury and death.

9 **C. Dental Care is Inadequate.**

10 27. Defendant has a policy and practice of denying the full range of dental
11 services that is necessary to maintain dental health. It does not, for example,
12 provide root canals, dentures, or dental floss, even for those people who will be
13 incarcerated for several years. For those patients who require root canals, Defendant
14 offers to extract teeth at no cost or refers the patient to a private dentist who charges
15 the patient for hundreds or thousands of dollars for root canals and other treatment
16 alternatives to save the teeth. This practice forces many indigent people to extract
17 teeth that might otherwise be saved. Many people who do not have access to money
18 in jail refuse extraction and wait in pain and discomfort with the hope that they can
19 pay for the appropriate treatment alternative once released. Those individuals, who
20 may be incarcerated for long periods of time, are at risk of infection and further
21 complications as a result of Defendant's policies and practices. Defendant also fails
22 to timely respond to HSRs describing serious dental symptoms.

23 **D. Health Care Records are Inadequate.**

24 28. Defendant has a policy and practice of failing to maintain accurate,
25 complete, and organized medical, mental health, and dental records. Defendant uses
26 paper, instead of electronic, records that are not in chronological order or organized
27 in such a way that providers can find essential information about their patients.
28

1 Some of the providers' handwriting is illegible, and many psychiatry records are
2 unintelligible. Defendant loses, misfiles, or inappropriately destroys essential
3 records, including HSRs. The records are not always available during health care
4 appointments, especially when individuals are transferred to different jail facilities.
5 As a result of Defendant's failure to maintain adequate records, individuals suffer
6 from a substantial risk of misdiagnosis, dangerous mistakes, and unnecessary delays
7 in care.

8 29. Defendant also has a policy and practice of denying people copies of
9 their own jail health care records in violation of 45 C.F.R. § 164.524.

10 **II. SAN BERNARDINO COUNTY HAS A POLICY AND PRACTICE OF USING**
11 **EXCESSIVE FORCE**

12 30. Defendant has a policy and practice of using excessive force in the jails
13 that subjects people to serious injury or the risk of serious injury. Correctional
14 officers tase, fire non-lethal weapons at close range, punch, push, stomp, slam, or
15 restrain individuals when it is not necessary to ensure safety and security. These
16 assaults result in broken bones, dislocated joints, swelling, bruising, and
17 hemorrhaging.

18 31. Defendant has a pattern of using force as a first resort in reaction to any
19 behavior that might possibly be interpreted as aggressive. Force is used on people
20 who are deemed, correctly or not, to have disrupted jail operations, disobeyed jail
21 rules, complained about conditions, or disrespected jail staff. In many instances, the
22 use of force is completely unnecessary to control behavior or maintain order in the
23 jails. In some instances, the use of force may be necessary *initially*, but after the
24 need for force has passed, the individual is subjected to retaliatory assault.

25 32. These patterns of excessive force occur because Defendant does not
26 adequately train, supervise, and discipline correctional officers. These patterns also
27 occur because Defendant's written policies and procedures are inadequate. For
28 example, Defendant's policies do not require that officers first attempt to verbally

1 resolve or use only the minimum force necessary to stop or control a potentially
2 dangerous interaction. Officers are not required to document every use of force
3 incident, and not all use of force incidents are reviewed by supervisory staff.
4 Defendant's policies do not include any limitations on the use of force against
5 people who are unable to comply with commands due to severe mental illness, or
6 the use of restraints on people who are vulnerable to injuries, including pregnant
7 women. There is no system for people in custody to confidentially report excessive
8 use of force.

9 33. All people in the jail, including Plaintiffs, are at risk of harm due to
10 Defendant's policies and practices regarding the use of force.

11 **III. SAN BERNARDINO FAILS TO PROTECT PEOPLE FROM VIOLENCE**

12 34. People in Defendant's custody face a substantial risk of harm from
13 violence at the hands of other incarcerated people due to its policy and practice of
14 failing to adequately supervise and classify people in its custody. Vulnerable
15 individuals are regularly assaulted and victimized by other individuals in the
16 facilities or during transportation because Defendant has failed to take reasonable
17 measures to protect them. Defendant is deliberately indifferent to the danger of
18 assault faced by people in its custody.

19 35. Given the structural design of the housing units, there are not enough
20 correctional officers assigned to each unit to adequately supervise people. In West
21 Valley Detention Center, officers are stationed in an enclosed control booth that
22 overlooks several separate housing pods. Officers cannot see all areas of the
23 housing pods from the control booth, and there are substantial periods of time when
24 there are no officers in the pods. As a result, people are often assaulted in the
25 housing units when officers are not looking or present. In February 2015, Mr.
26 Topete was assaulted during a riot in his housing unit when there were no officers
27 present. Defendant knew the riot was going to happen because an individual wrote
28

1 a note to correctional officers about the planned riot, but nothing was done to
2 prevent it. During the riot, Mr. Topete tried to avoid the fighting by standing next to
3 the door where the officers would enter. While he stood there, he was punched in
4 the face, hit with a milk crate, and hit with a plastic bedframe before he finally used
5 his cane to keep attackers away from him. Correctional officers did not enter the
6 housing pod until several minutes later.

7 36. Defendant does not adequately classify and assign people to housing
8 locations where they will be safe from injury and violence. Individuals who are
9 incompatible are regularly housed together. For example, in September 2015, a
10 gang member was stabbed repeatedly in his cell by a rival gang member. Defendant
11 moved the victim to another housing unit for a few days, but then moved him back
12 to the same housing unit where he was again stabbed repeatedly. Defendant knew
13 that one or both of these assaults was going to occur because correctional officers
14 intercepted a note discussing the planned attack. In other instances, people who
15 notify staff that they are gang “drop-outs” are housed with the general population,
16 instead of in protective custody, where they are attacked by active gang members.
17 People who are obviously psychotic and unstable are also housed with the general
18 population where they assault or are assaulted by other individuals.

19 37. Even when Defendant properly classifies people, they face an
20 unreasonable risk of violence when they leave their housing units. Individuals with
21 different classifications are placed together in holding cells when they wait for court
22 hearings or other appointments and in vehicles when they are transported to other
23 locations such as the courthouse, hospital, or other jail facilities. What is more,
24 individuals with different classifications are chained together in these holding cells
25 and vehicle transports. A significant percentage of assaults occur outside of the
26 housing units.

27 38. When individuals notify staff members that they are at risk of assault,
28 Defendant fails to adequately respond and ameliorate the risk. Correctional officers

1 laugh at or ignore them, tell them that they have no choice but to “get along,” or in
 2 some instances even encourage them to fight when they notify them of a risk of
 3 violence. Correctional officers do not arrive on the scene of an attack until it is
 4 completed, if they are ever aware of an attack at all.

5 39. As a result of these policies and practices, there is a high rate of
 6 violence, and people are suffering from serious injuries. In fact, most people who
 7 are assaulted require medical attention, oftentimes at an off-site emergency room.
 8 Defendant has failed to take reasonable measures to mitigate this harm, and, as a
 9 result, a culture of violence between incarcerated individuals flourishes.

10 **IV. DEFENDANT DISCRIMINATES AGAINST PEOPLE WITH DISABILITIES**

11 40. Defendant has a policy and practice of failing to ensure that people
 12 with disabilities have equal access to programs, services, and activities in the jails.

13 41. At the time of intake, Defendant does not appropriately identify
 14 individuals’ disabilities and needed assistive devices. Defendant’s intake screening
 15 form does not include any questions about physical disabilities, and there is no place
 16 to document if an individual requires a cane, wheelchair, walker, or accessible
 17 housing.

18 42. Defendant does not timely provide appropriate assistive devices,
 19 including but not limited to wheelchairs, walkers, crutches, canes, braces, and
 20 hearing aids, to people who require them, if they ever provide them at all. For
 21 example, a jail physician ordered a four-wheeled walker for a woman with a
 22 mobility impairment in March 2015. She did not receive the walker until over three
 23 months later, and then only after Plaintiffs’ counsel repeatedly asked Defendant to
 24 provide it.

25 43. After intake, Defendant does not house people with physical disabilities
 26 in locations where they can safely programs and services. For example, Defendant
 27 does not house Mr. Topete, who uses a wheelchair, in an accessible housing unit.
 28

1 His wheelchair does not fit through his cell door, which means he must stand up,
2 fold his wheelchair, push it through the doorframe, and then unfold the wheelchair
3 again once inside. There are no grab bars next to the toilet inside his cell or the
4 shower. Defendant forces him to go up and down stairs, without any assistance, to
5 access the visiting room to visit his family. Once he reaches the top of these stairs,
6 Defendant does not provide him with his wheelchair that remains on the floor
7 below. Mr. Topete has fallen and it at risk of serious injury as a result of
8 Defendant's failure to accommodate him. Defendant does not have enough housing
9 units equipped with accessible features to meet the needs of its current jail
10 population.

11 44. Defendant violates the rights of people with psychiatric and/or
12 intellectual disabilities by housing them in solitary confinement. Solitary
13 confinement, or locking people in their cells for 22 hours a day or longer, can be
14 traumatic for everyone, but even more traumatic for people with psychiatric and/or
15 intellectual disabilities. Defendant has not modified its policies and procedures to
16 accommodate people with such disabilities so that they do not suffer harm from
17 solitary confinement. Defendant locks people with psychiatric and/or intellectual
18 disabilities in solitary confinement for nonconforming and erratic behaviors related
19 to their conditions, some of which could have been avoided if Defendant provided
20 adequate mental health care or accommodations. The harsh conditions and the lack
21 of mental health care or accommodations cause them to continue and escalate these
22 symptomatic behaviors. In response, Defendant locks them in solitary confinement
23 for longer periods of time. Defendant's policy and practice of locking people with
24 psychiatric and/or intellectual disabilities in solitary confinement, based on their
25 disabilities, inappropriately deprives them of access to programs, services, and
26 activities that are only available in less restrictive settings.

27 45. Defendant does not provide timely or adequate access to medical
28 supplies or equipment for people with physical disabilities. People who require

1 colostomy supplies are at risk of infections because Defendant does not consistently
2 deliver the appropriate supplies. Mr. Topete, in addition to a wheelchair, requires
3 the use of a C-PAP machine to sleep at night. Defendant currently houses him in a
4 cell that does not have an electrical outlet, and requires him to sleep in the dayroom
5 if he wants to plug in his C-PAP machine. Defendant also requires Mr. Topete to
6 drag a plastic bedframe and mattress to and from storage, without assistance, many
7 evenings and the following mornings. Once Mr. Topete manages to get his bed into
8 the dayroom, he has difficulty getting in and out of the bed because the frame sits
9 directly on the ground and it is difficult for him to bend and stoop. At least a few
10 times a month, Mr. Topete wakes up choking and gasping for air because
11 correctional officers have turned off the power in the dayroom and he cannot
12 breathe through his C-PAP machine without electricity.

13 46. Defendant does not have an effective complaint procedure for people to
14 contest disability discrimination. The only mechanism Defendant provides to raise
15 disability issues is the jail grievance form. However, individuals must ask
16 correctional officers for grievance forms who often refuse to provide them.
17 Defendant requires correctional officers to review and sign any grievances before
18 they are processed, but many officers attempt to dissuade prisoners from filing them,
19 threaten retaliation for use of the grievance process, or refuse to sign or process the
20 forms. Moreover, many people with disabilities are unaware of Defendant's
21 obligation to ensure equal access to programs, services, and activities because
22 Defendant has failed to provide notice of their disability related rights as required by
23 federal law.

24 47. Defendant's policies and procedures regarding screening, housing,
25 assistive devices and medical supplies, grievances, and the use of solitary
26 confinement for people with disabilities is a direct violation of the ADA and Section
27 504 of the Rehabilitation Act.
28

1 **V. CLASS ALLEGATIONS**

2 48. Plaintiffs George Topete and Zachery Shovey bring this action on their
3 own behalves and, pursuant to Rule 23(a), b(1), and (b)(2) of the Federal Rules of
4 Civil Procedure, on behalf of all people who are or will in the future be incarcerated
5 in the San Bernardino County Jail.

6 49. All class members are at risk of harm due to the following policies and
7 practices:

8 (a) Using force that subjects people to serious injury or the risk of
9 serious injury even when it is unnecessary to control behavior or maintain order in
10 the jails;

11 (b) Denying minimally adequate health care including identification
12 and monitoring of serious conditions, sufficient staffing levels, timely access to
13 appropriate clinicians, medications, and treatment plans, effective suicide prevention
14 practices, and the complete range of health care services necessary to maintain
15 health;

16 (c) Failing to adequately supervise and classify individuals to ensure
17 that they do not face an unreasonable risk of injury and violence from other
18 incarcerated individuals;

19 People with disabilities also face the additional risk of disability discrimination due
20 to Defendant's inadequate policies and practices regarding solitary confinement,
21 assistive devices and medical supplies, accessible housing, and grievances.

22 50. There are questions of law and fact common to the class including
23 whether Defendant by its policy and practice of (1) denying minimally adequate
24 mental health, medical, and dental care violates the Due Process Clause of the
25 Fourteenth Amendment and the Cruel and Unusual Punishment Clause of the Eighth
26 Amendment; (2) using excessive force violates the Due Process Clause of the
27 Fourteenth Amendment and the Cruel and Unusual Punishment Clause of the Eighth
28

Amendment; (3) denying adequate supervision and classification to protect people from violence violates the Due Process Clause of the Fourteenth Amendment and the Cruel and Unusual Punishment Clause of the Eighth Amendment; (4) denying assistive devices, medical supplies, and accessible housing to people with physical disabilities violates the ADA and Section 504 of the Rehabilitation Act; and (4) locking people with psychiatric disabilities and/or intellectual disabilities in solitary confinement based on their disabilities violates the ADA and Section 504 of the Rehabilitation Act.

51. Since there are thousands of 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.

52. 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.

53. 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.

54. 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 prisoners' rights litigation and complex class action litigation.

CLAIMS FOR RELIEF

First Cause of Action

(Fourteenth Amendment - Cruel and Unusual Conditions, 42 U.S.C. § 1983)

55. Plaintiffs incorporate by reference each and every allegation contained

1 in the

2 preceding paragraphs as if set forth fully herein.

3 56. By the policies and practices described herein, Defendant subjects
4 Plaintiffs and the class to a substantial risk of serious harm and injury from
5 inadequate health care, violence between prisoners, and excessive force, and has
6 violated their right to basic human dignity and to be free from cruel and unusual
7 conditions under the Fourteenth Amendment to the United States Constitution.
8 These policies and practices have been and continue to be implemented by
9 Defendant and its agents, officials, employees, and all persons acting in concert
10 under color of state law, in their official capacity, and are the proximate cause of the
11 Plaintiffs' and the class's ongoing deprivation of rights secured under the Fourteenth
12 Amendment.

13 57. Defendant has been and is aware of all of the deprivations complained
14 of herein, and has condoned or been deliberately indifferent to such conduct. It
15 should be obvious to Defendant and to any reasonable person that the conditions
16 imposed on class members for many months or years cause tremendous mental
17 anguish, suffering, and pain to such individuals. Moreover, Defendant has
18 repeatedly been made aware, through administrative grievances and written
19 complaints, that class members are currently experiencing, or are at risk of,
20 significant and lasting injury.

21 **Second Cause of Action**
22 **(Eighth Amendment – Cruel and Unusual Punishment, 42 U.S.C. § 1983)**

23 58. Plaintiffs incorporate by reference each and every allegation contained
24 in Paragraphs 1 - 54 as if set forth fully herein.

25 59. By the policies and practices described herein, Defendant subjects
26 Plaintiffs and the class to a substantial risk of serious harm and injury from
27 inadequate health care, violence between prisoners, and excessive force, and has
28 violated their right to be free from cruel and unusual punishment under the Eighth

1 Amendment to the United States Constitution. These policies and practices have
 2 been and continue to be implemented by Defendant and its agents, officials,
 3 employees, and all persons acting in concert under color of state law, in their official
 4 capacity, and are the proximate cause of the Plaintiffs' and the class's ongoing
 5 deprivation of rights secured under the Eighth Amendment.

6 60. Defendant has been and is aware of all of the deprivations complained
 7 of herein, and has condoned or been deliberately indifferent to such conduct. It
 8 should be obvious to Defendant and to any reasonable person that the conditions
 9 imposed on class members for many months or years cause tremendous mental
 10 anguish, suffering, and pain to such individuals. Moreover, Defendant has
 11 repeatedly been made aware, through administrative grievances and written
 12 complaints, that class members are currently experiencing, or are at risk of,
 13 significant and lasting injury.

14 **Third Cause of Action**
 15 **(Americans with Disabilities Act)**

16 61. Plaintiffs incorporate by reference each and every allegation contained
 17 in Paragraphs 1 - 54 as if set forth fully herein.

18 62. Plaintiffs Topete and Shovey and other class members with physical,
 19 psychiatric, or intellectual disabilities are qualified individuals with disabilities as
 20 defined in the ADA. They have an impairment that substantially limits one or more
 21 major life activities, they have a record of such impairment, or they are regarded as
 22 having such an impairment. All people with disabilities in the jails meet the
 23 essential eligibility requirements for the receipt of services or the participation in
 24 programs or activities provided by Defendant. 42 U.S.C. § 12102(2); 42 U.S.C. §
 25 12131(2).

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

27 64. Defendant violates the ADA by failing to ensure that people with
 28 disabilities have access to, are permitted to participate in, and are not denied the

1 benefits of, programs, services, and activities. 42 U.S.C. § 12132; 28 C.F.R. §
2 35.152(b)(1).

3 65. Defendant violates the ADA by failing to make “reasonable
4 modifications in policies, practices, or procedures when the modifications are
5 necessary to avoid discrimination on the basis of disability” 28 C.F.R. Section
6 35.130(b)(7).

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

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

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

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

19 70. As a result of Defendant’s policies and practices regarding people with
20 disabilities in its jails, Plaintiffs Topete and Shovey and other class members with
21 disabilities do not have equal access to jail activities, programs, and services for
22 which they are otherwise qualified.

23 **Fourth Cause of Action**
24 **(Section 504 of the Rehabilitation Act)**

25 71. Plaintiffs incorporate by reference each and every allegation contained
26 in Paragraphs 1 - 54 as if set forth fully herein.

27 72. Plaintiffs Topete and Shovey and other class members with disabilities
28 are qualified individuals with disabilities as defined in Section 504 of the

1 Rehabilitation Act, 29 U.S.C. § 794.

2 73. Defendant receives federal funding within the meaning of the
3 Rehabilitation Act.

4 74. Defendant violates Section 504 of the Rehabilitation Act by
5 discriminating against people with disabilities solely on the basis of their
6 disabilities. 29 U.S.C. § 794.

7 75. Defendant violates Section 504 of the Rehabilitation Act by failing to
8 reasonably accommodate people with disabilities in its facilities, programs,
9 activities, and services.

10 76. Defendant's policy and practice of discriminating against people with
11 psychiatric and/or intellectual disabilities in the use of solitary confinement is not
12 reasonably related to legitimate penological interests because (1) it worsens their
13 psychiatric conditions; (2) there are no alternative means for them to access
14 programs, services, and activities; (3) there are alternative means to safely and cost-
15 effectively house them in the jails; and (4) it is an exaggerated response as they do
16 not require restrictive housing on the basis of their disabilities.

17 **PRAYER FOR RELIEF**

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

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

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

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

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

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

16 F. Order Defendant, its agents, officials, employees, and all persons acting in
17 concert under color of state law or otherwise, to develop and implement, as soon as
18 practical, a plan to eliminate the excessive use of force. Defendant's plan at a
19 minimum must address deficiencies in use of force policies and procedures, training,
20 supervision, investigations, and disciplinary practices;

21 G. Order Defendant, its agents, officials, employees, and all persons acting in
22 concert under color of state law or otherwise, to develop and implement, as soon as
23 practical, a plan to reduce the risk of injury and violence between individuals in its
24 custody. Defendant's plan at a minimum must address deficiencies in classification
25 policies and procedures, staffing levels, and policies and practices related to the
26 transportation of people in its custody;

1 G. Order Defendant, its agents, officials, employees, and all persons acting in
2 concert under color of state law or otherwise, to provide equal access to programs,
3 services, and activities for people with disabilities, including but not limited to
4 housing people with physical disabilities in accessible housing appropriate to their
5 needs, timely delivery of and appropriate access to assistive devices and medical
6 supplies, housing people with psychiatric and/or intellectual disabilities in the least
7 restrictive and most integrated settings appropriate to their needs, providing an
8 effective grievance system to contest disability discrimination, and notifying people
9 with disabilities their rights under the ADA and Section 504 of the Rehabilitation
10 Act.;

11 I. Award Plaintiffs, pursuant to 29 U.S.C. § 794, 42 U.S.C. §§ 1988, 12205,
12 and 12133, the costs of this suit and reasonable attorneys' fees and litigation
13 expenses;

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

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

18 Dated: February 29, 2016

PRISON LAW OFFICE

19 By: /s/ Kelly Knapp

20 DONALD SPECTER
21 KELLY KNAPP
22 Attorneys for Plaintiffs
23
24
25
26
27
28