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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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Motion for Pro Hac Vice Admission Forthcoming

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NATURE OF ACTION

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

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

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

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

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

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

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

JURISDICTION

7. 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., Section 504 of

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

8. 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; 42 U.S.C. § 1983 and 12117(a); and California Government Code § 11135.

VENUE

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

PARTIES

Plaintiffs

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

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

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

12. Plaintiff SHAREEN WINKLE is a prisoner at the Santa Barbara County Jail. Plaintiff WINKLE has been diagnosed with mental illness, including bipolar disorder. Defendants have repeatedly placed Plaintiff WINKLE in solitary confinement for long periods based on such infractions as not being prepared for linen exchange on laundry day and not properly wearing her shirt. Plaintiff WINKLE's mental health deteriorated significantly in solitary confinement, where she suffered multiple serious panic attacks. Defendants further held Plaintiff WINKLE in a safety cell for a period of more than four (4) consecutive days, during which time she was forced to sleep on the floor and use a grate on the floor as a toilet. Defendants have failed to provide Plaintiff WINKLE adequate mental health treatment. In addition, Defendants have failed to accommodate Plaintiff WINKLE, who Defendants are aware has a seizure disorder, by placing her in an isolation cell that contains a single bunk that is elevated several feet above the ground, a situation that placed her at risk of a serious fall from the bunk in the event she has a seizure. Plaintiff WINKLE is a person with a disability as defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m).

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

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

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

Defendants

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

16. Defendant SANTA BARBARA COUNTY SHERIFF'S OFFICE is a

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

FACTUAL ALLEGATIONS

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

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

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

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

19. The Main Jail has many linear hallways with dead-end corridors and little or no natural light. The facility is old and difficult to maintain, and is significantly dilapidated. Prisoners and staff are exposed to dust, mold, and other unsanitary conditions. "Exercise areas" consist of small cell-like areas with cement 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

Brown himself has called the Main Jail "disgraceful, embarrassing and unacceptable for Santa Barbara County."

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

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

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

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

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

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

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

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

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

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

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

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

C. The County's Planned Construction of the Northern Branch Jail Will Not Address Deficiencies at the Existing Facilities.

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

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

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

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

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

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

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

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

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

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

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

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

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

II. DEFENDANTS FAIL TO PROVIDE ADEQUATE HEALTH CARE TO PRISONERS.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

C. Defendants Violate Prisoners' Patient Confidentiality Rights.

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

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

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

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

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

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

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

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

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

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

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

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

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

F. Defendants' Medical Care Delivery System Is Inadequate.

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

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

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

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

the observation cell, and died soon thereafter.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4. Defendants' System of Chronic Disease Management is Inadequate.

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

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

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

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

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

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

5. Defendants Fail to Provide Adequate Medication Administration and Management.

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

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

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

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

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

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

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

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

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

G. Defendants' Mental Health Care Delivery System Is Inadequate.

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

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

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

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

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

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

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

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

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

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

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

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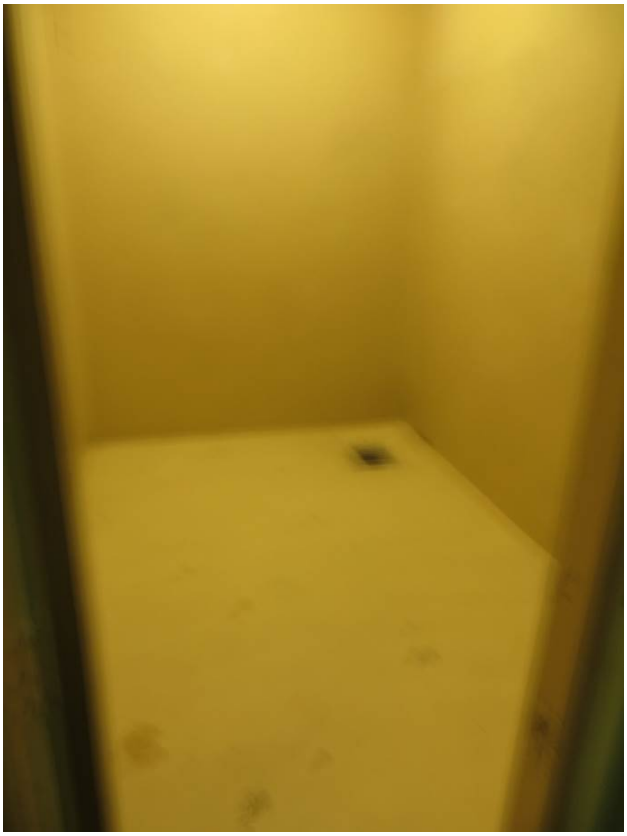


Photo: Inside a "Safety Cell": View of cell with grate in floor for person to use as a toilet

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

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

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

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

3. Defendants Fail to Provide Adequate Facilities to Provide Mental Health Care.

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

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

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

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

4. Defendants' Mental Health Treatment Program Involves Little More than Responding to Emergencies.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

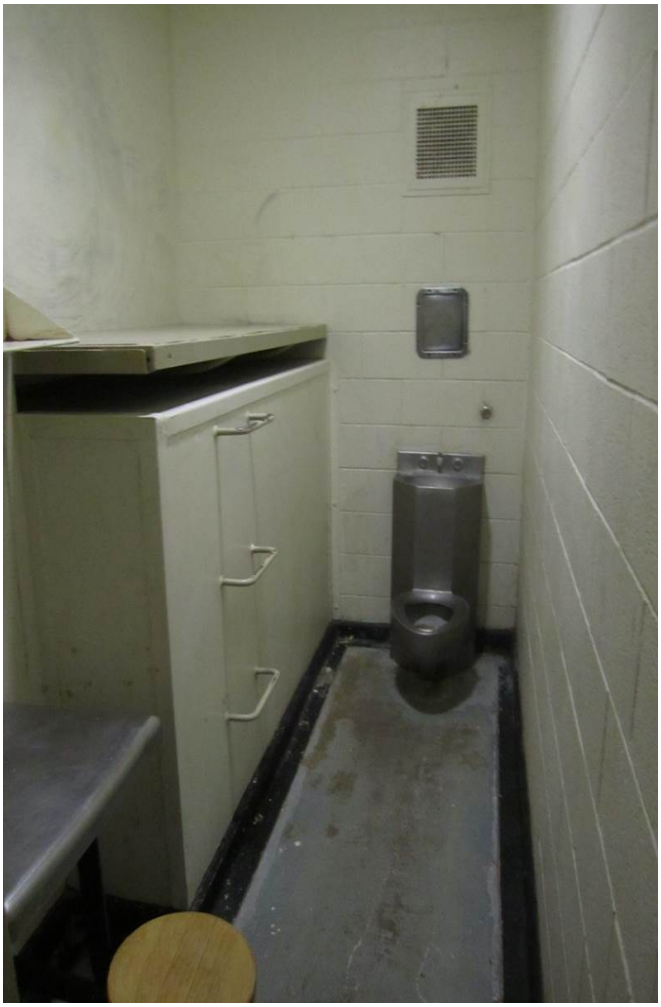
128. Plaintiff WINKLE also developed an infection in a women's housing unit. She notified Defendants of a painful and swollen area on her neck, and expressed concern that she had developed an infection through contact with another prisoner in her unit. Medical staff failed to provide treatment for several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

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

III. DEFENDANTS ROUTINELY OVERUSE AND IMPROPERLY USE SOLITARY CONFINEMENT

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

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



Photos: At Left: View inside an Isolation Cell

At Right: Dark corridor containing 6 windowless Isolation Cells

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

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

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

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

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

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Photo: The small concrete "Yard" where prisoners in solitary confinement receive 3 hours or less of out-of-cell time per week

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

CLASS ACTION ALLEGATIONS

Prisoner Class

180. Plaintiffs 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 men and women who are now or will in the future be incarcerated in the Santa Barbara County Jail system (the "Prisoner Class"). All Prisoner Class members are subject to an unreasonable risk of harm due to: Defendants' policies and practices of denying prisoners minimally adequate medical and mental health care; Defendants' misuse and overuse of solitary confinement; and Defendants' failure to maintain safe and adequate conditions of confinement.

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

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

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

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

184. This action is maintainable as a class action pursuant to Fed. R. Civ. P. 23(b)(1) since there are several thousand 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 the Defendants.

185. This action is maintainable as a class action pursuant to Fed. R. Civ. P. 23(b)(2) since Defendants have 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.

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

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

Disabilities Subclass

188. The named Plaintiffs further 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 qualified individuals with disabilities, as that term is defined in 42 U.S.C. § 12102, 29 U.S.C. § 705(9)(B), and California Government Code § 12926(j) and (m), who are now, or will be in the future incarcerated in the Jail

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

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

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

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

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

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

CLAIMS FOR RELIEF

First Cause of Action

(Eighth Amendment; 42 U.S.C. § 1983)

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

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

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

Second Cause of Action

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

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

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

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

200. In violation of the Fourteenth Amendment, Defendants knew of and disregarded a substantial risk of serious harm.

201. In addition, Defendants violate the Fourteenth Amendment rights of prisoners who are awaiting trial or are civil detainees, and thus are not convicted of a crime, on the basis that Defendants made an intentional decision with respect to (1) Plaintiffs and members of the Prisoner Class's health care and (2) the conditions under which Plaintiffs and members of the Prisoner Class are confined that put them at substantial risk of suffering serious harm. Defendants failed to take reasonable available measures to abate that risk, even though a reasonable actor in the circumstances would have appreciated the high degree of risk involved – making the consequences of Defendants' conduct obvious.

Third Cause of Action

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

202. Plaintiffs re-allege and incorporate by reference herein all allegations previously made in paragraphs 1-201.

203. The ADA prohibits public entities, including Defendants, from denying "a qualified individual with a disability … the benefits of the services, programs, or activities of [the] public entity" because of the individual's disability. 42 U.S.C. § 12132.

204. Defendants are legally responsible for all violations of the ADA committed by its contractor in the course of performing its duties under its contractual agreement with the Sheriff's Office to provide medical and mental health care to prisoners in the Jail. *See* 28 C.F.R. § 35.130(b)(1).

205. Plaintiffs MURRAY, FRANCO, WINKLE, TRACY, and BROWN and members of the Disabilities Subclass are qualified individuals with disabilities

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

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

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

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

a. failing to "ensure that qualified inmates or detainees with disabilities shall not, because a facility is inaccessible to or unusable by individuals with disabilities, 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 public entity," 28 C.F.R. § 35.152(b)(1);

b. 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);

c. failing to "implement reasonable policies, including physical modifications to additional cells in accordance with the 2010 [accessibility] 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," 28 C.F.R. § 35.152(b)(3);

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

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

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

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

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

i. 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); and

j. 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).

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

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Fourth Cause of Action

(Rehabilitation Act, 29 U.S.C. § 794)

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

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

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

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

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

Fifth Cause of Action

(California Government Code § 11135)

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

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

217. Plaintiffs MURRAY, FRANCO, WINKLE, TRACY, and BROWN and members of the Disabilities Subclass are persons with disabilities as defined by California Government Code § 11135.

218. Defendants deny Plaintiffs full access to the benefits of the Jail's programs and activities which receive financial assistance from the State of California and unlawfully subject Plaintiffs MURRAY, FRANCO, WINKLE, TRACY, and BROWN and members of the Disabilities Subclass to discrimination within the meaning of California Government Code § 11135(a) on the basis of their disabilities.

219. Through their counsel and through grievances submitted to the Jail, Plaintiffs MURRAY, FRANCO, WINKLE, TRACY, and BROWN and members of the Disabilities Subclass demanded that Defendants stop their unlawful discriminatory conduct described above, but Defendants refused and still refuse to refrain from that conduct.

PRAYER FOR RELIEF

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

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

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

B. Adjudge and declare that the conditions, acts, omissions,

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

C. Enjoin Defendants, 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 Defendants, agents, officials, employees, and all persons acting in concert with them under color of state law or otherwise, to immediately provide adequate medical and mental health 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 adequate therapy, inpatient treatment, and suicide prevention;

E. Order Defendants, agents, officials, employees, and all persons acting in concert with them 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 other accommodations, housing people with disabilities in the least restrictive and most integrated settings appropriate to their needs, and providing an effective grievance system to contest disability discrimination;

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

G. Retain jurisdiction of this case until Defendants have fully

complied with the orders of this Court and there is a reasonable assurance that Defendants 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: December 6, 2017

Respectfully submitted,

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All other signatories listed above, and on whose behalf this filing is submitted, concur in the filing's content and have authorized the filing

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APPENDIX A

Disability Rights California

California's protection & advocacy system
Toll-Free (800) 776-5746

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

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,

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[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"

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

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[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"

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

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[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

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[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"

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 <u>not</u> 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"

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

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[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"

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

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[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"

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"

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"

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"

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"

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. <u>Denial of Rights under the Americans with Disabilities Act</u>

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

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

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[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"

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.

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[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"

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

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).
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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

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.
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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