Attachment 5

PHILIP C. SNELL, ESQ. (Bar No. 88090) RAGGHIANTI FREITAS LLP 1101 Fifth Avenue, Suite 100 San Rafael, California 94901 Telephone: (415) 453-9433 3 Facsimile: (415) 453-8269 RECEIVED Attorneys for Plaintiff 5 JANA MILLER 6 7 SUPERIOR COURT OF THE STATE OF CALIFORNIA 8 COUNTY OF MENDOCINO 9 —o0o— 10 UNLIMITED CIVIL CASE 11 12 JANA MILLER individually and as Successor in) Case No.: SC UK CVPT 1362425 Interest to DAVID K. MILLER, deceased, 13 SECOND AMENDED COMPLAINT Plaintiff. FOR DAMAGES: SURVIVAL ACTION 14 (CCP §§ 377.20, 377.30) and WRONGFUL DEATH ACTION (CCP § VS. 15 377.60) COUNTY OF MENDOCINO, LEILA LAMUN; 16 and DOES 1 through 30, inclusive, 17 Defendants. 18 19 Plaintiff JANA MILLER alleges: 20 FIRST CAUSE OF ACTION **SURVIVAL ACTION (CCP §§ 377.20, 377.30)** 21 Plaintiff JANA MILLER was the Conservator of DAVID K. MILLER, and 22 1. brought the original Complaint in this case on behalf of DAVID K. MILLER in her capacity as 23 Conservator of DAVID K. MILLER. JANA MILLER is the mother of DAVID K. MILLER 24 and, having filed a Declaration of Successor in Interest in this action pursuant to Code of Civil 25

SECOND AMENDED COMPLAINT FOR DAMAGES

Procedure § 377.32, is the Successor in Interest to the pending action of DAVID K. MILLER, and brings this action pursuant to Code of Civil Procedure §§ 377.20 and 377.30.

- 2. On September 30, 2013, DAVID K. MILLER died as a result of the injuries caused by the negligence and omissions of defendants as herein alleged. DAVID K. MILLER, died intestate and left no surviving spouse, domestic partner or issue. Plaintiff, JANA MILLER, is a person entitled to the property of DAVID K. MILLER by intestate succession, and has filed a Declaration of Successor in Interest to Decedent, DAVID K. MILLER in this pending action, pursuant to CCP §377.32.
- 3. Prior to his death, DAVID K. MILLER obtained leave of court pursuant to an order granting him relief from the provisions of Government Code § 945.4, and thereby satisfied all conditions precedent to his state law claims, and filed the original Complaint for Damages in this case against the Defendants identified herein on August 29, 2013.
- 4. Plaintiff JANA MILLER, as Successor in Interest to the claims of DAVID K. MILLER, brings this First Amended Complaint to state, *inter alia*, a survivor action to the claims of DAVID K. MILLER as alleged in the original Complaint for Damages filed in this case, and re-alleges herein the claims that survive the original Complaint for Damages.
- 5. Plaintiff is ignorant of the true names and capacities of defendants sued herein under DOES 1 through 30, inclusive, and therefore sues these defendants by such fictitious names. Plaintiff will amend this complaint to allege their true name and capacities when ascertained. Plaintiff is informed and believes, and thereon alleges that each of the fictitiously named defendants is negligently responsible in some manner for the occurrences herein alleged, and that plaintiff's injuries as herein alleged were proximately caused by the negligence of these defendants. Any reference in this complaint to "Defendant," "Defendants," or to an individually named Defendant also refers to Defendants DOES 1 through 30.

6. At all times herein mentioned, Defendants LEILA LAMUN and DOES 1 through 5, and each of them, were nurses licensed to practice nursing and medicine under the laws of the State of California and were engaged in the practice of nursing and medicine in Mendocino County, California, and were acting in the course and scope of their duties as employees of Defendant COUNTY OF MENDOCINO.

- 7. At all times mentioned herein, Defendants DOES 6 through 15, were physicians licensed to practice medicine under the laws of the State of California and were engaged in the practice of medicine in Mendocino County, California.
- 8. At all times mentioned herein, Defendants DOES 16 through 20 were business entities organized under the laws of the State of California and licensed to do business in Mendocino County.
- 9. At all times Does 21 through 30 were employees of the COUNTY OF MENDOCINO employed as deputy sheriffs in charge of the inmates at the Mendocino County jail in Ukiah.
- 10. At all times mentioned in this First Amended Complaint, each of the Defendants was the agent and employee of each of the other Defendants and, in doing the things hereinafter alleged, were acting in the and scope of their agency and employment with the permission and consent of each of the Defendants.
- 11. JANA MILLER was the Conservator of DAVID K. MILLER, duly authorized by the Superior Court of California in and for the County of Marin as of August 29, 2012, and on August 29, 2013 filed the Complaint for Damages in this case on behalf of DAVID K. MILLER who at all times herein until his death on September 30, 2013 was incompetent as a result of mental illness preceding the matters alleged herein and also as a result of brain injuries proximately caused by the actions and omissions of the defendants as set forth in this First Amended Complaint.

- 12. Defendant COUNTY OF MENDOCINO is a public entity duly organized and existing under the laws of the State of California. Defendant COUNTY OF MENDOCINO is authorized by law to establish certain departments responsible for enforcing the laws and protecting the welfare of the people of COUNTY OF MENDOCINO. At all times mentioned Defendant COUNTY OF MENDOCINO was responsible for overseeing the operation, management and supervision of the Mendocino County Health and Human Services Agency and its Mental Health Branch and the Mendocino County jail and the employees of MENDOCINO COUNTY and of the Health and Human Services Agency who provided mental health services at the MENDOCINO COUNTY jail. Defendant COUNTY OF MENDOCINO is liable under Government Code Section 815.2 (a) for the negligent acts and omissions and breaches of duties of these aforementioned employees as described herein. COUNTY OF MENDOCINO is liable under Government Code Section 815.6 for failure of its employees to discharge mandatory duties to provide appropriate medical care for DAVID K. MILLER required by Government Code Section 845.6 as described herein. Defendant COUNTY OF MENDOCINO is liable for breach of duties of its jail employees to assist and protect DAVID K. MILLER while keeping him in custody and when releasing him from jail as described herein.
- 13. On March 14, 2012, at Mendocino County Mental Health Services in Fort Bragg, DAVID K. MILLER was found by to be bipolar with schizoaffective disorder or bipolar with psychotic features, his thought processes were delusional and bizarre, and he had run out of antipsychotic medication, Zyprexa. On March 26, 2012 he was arrested for trespassing on motel premises in Fort Bragg and was noted by the arresting officers to be irrational, and spoke in mumbles. The arrest report also states that DAVID K. MILLER had told the motel proprietor that his friend was staying in room 104 of the motel and was going to sign the room over to him so he could stay there; although the proprietor said that there was no one staying in

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room 104. DAVID K. MILLER was transported from Fort Bragg to the jail in Ukiah where a deputy requested the Mendocino County Health and Human Services Agency Mental Health Branch to see him due to his "bizarre behavior." He was seen in the jail by Defendants nurse LILA LAMUN and DOES 1 through 20 on March 28, 2012 who noted that he had direct, unblinking eye contact, and that he had to be directed to dress in layers because he was cold or to make his bed with sheets and a blanket that were in his bag. Defendants LAMUN and DOES 1 through 20 determined that DAVID K. MILLER was to be seen by a physician at the next physician's visit.

- 14. Pursuant to their special relationship of physician/patient, DAVID K. MILLER's vulnerability and dependence on them for health treatment, LEILA LAMUN and Defendant DOES 1 through 20 owed affirmative duties of reasonable care to examine, diagnose, treat, care for and assist DAVID K. MILLER, and to comply with the Policies and Procedures for mental health care providers at the Mendocino County jail in Ukiah.
- Defendants in the Mendocino County jail in Ukiah, Mendocino County, DAVID K. MILLER was mentally ill, incompetent, in obvious need of mental health care, gravely disabled and unable to care for himself, and a was a danger to himself. From and during the time DAVID K. MILLER was in Defendants' custody, Defendants LAMUN and DOES 1 through 20 were required by Policy and Procedures established by the Health and Human Services Agency Mental Health Branch of COUNTY OF MENDOCINO to provide medical services for mentally ill inmates including, but not limited to: psychiatric evaluation; an individual treatment plan to meet the treatment needs of the inmate during the inmate's incarceration; transferring inmates needing psychiatric care beyond the on-site capabilities to an off-site facility as deemed necessary; maintenance of progress notes reflecting data demonstrating the presence of the inmate's diagnosis and related current level of functioning impairments and/or

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probability of related deterioration in level of functioning; providing interventions designed to significantly diminish the inmate's impairment or prevent significant deterioration in functioning; continuity of care for the inmate from admission to discharge while in the facility, including referral to community care when indicated; evaluating the inmate's need for aftercare services enabling the inmate to achieve an optimal level of function prior to the time of discharge, ascertaining the inmate's prescription medications, physician/psychiatrists, treating facilities; and diagnosis if possible of any inmate on psychotropic medication by a psychiatrist or physician within 7 days.

16. When undertaking to provide treatment of DAVID K. MILLER, Defendants LAMUN and DOES 1 through 20 failed to reasonably and properly provide those services required by the Policies and Procedures of the COUNTY OF MENDOCINO by failing to properly evaluate DAVID K. MILLER, failing to develop an individual treatment plan to meet DAVID K. MILLER's treatment needs during his incarceration, failing to evaluate him concerning his need for placement in an off-site facility and transfer him to a facility for psychiatric care beyond the jail's capabilities, failing to diagnose him, failing to provide intervention to significantly diminish his mental impairment or prevent significant deterioration in his functioning, failing to provide continuity of care for him from admission to discharge while in the jail, failing to exercise discretion whether to confine him for mental health care, failing to evaluate his need for aftercare services prior to the time of his discharge and failing to ascertain his prescription medications, physican/psychiatrists and treating facilities. addition, said Defendants failed to exercise the proper degree of knowledge and skill that is ordinarily possessed and exercised by nurses and physicians in similar circumstances by failing to properly examine, diagnose, treat, and care for DAVID K. MILLER, failing to alert the jail employees to hold him in custody to ensure that he received the evaluation by a physician after said Defendants had determined that he needed to be seen by a physician, by their deliberate

indifference to the probability that he would be released at risk of harm in a deteriorated mental condition if he were not provided treatment prior to his release or confined to a facility, and by failing to take action to ensure that he would receive care that would diminish his mental impairment prior to his release.

- 17. As a legal result of negligent omissions, breaches of standards of care and failures to discharge duties by Defendants LAMUN and DOES 1 through 20 as set forth above, at the time DAVID K. MILLER was released from jail on March 29, 2012, he had mentally deteriorated, was gravely disabled, disoriented and unable to realize and avoid highway danger, such that on March 31, 2012 he walked on the roadway surface of U.S. Highway 101 in Willits, and was struck by a car, sustaining brain injuries and numerous fractures and internal injuries which caused his death on September 30, 2013.
- Defendants in the Mendocino County jail in Ukiah, Mendocino County, DAVID K. MILLER was mentally ill, incompetent, in obvious need of mental health care, gravely disabled and unable to care for himself, and a was a danger to himself. At all times herein Defendants, and each of them, knew or should have known that DAVID K. MILLER was in need of immediate mental health care. Pursuant to their special relationship of jailer/inmate, DAVID K. MILLER's vulnerability and dependence on Defendants for protection and Defendants' control over DAVID K. MILLER'S welfare, Defendants COUNTY OF MENDOCINO by its jail employees owed affirmative duties of reasonable care for DAVID K. MILLER'S health and to protect DAVID K. MILLER while in custody and upon his release. Pursuant to Cal. Gov. Code § 845.6 Defendant COUNTY OF MENDOCINO through its jail employees had a duty to monitor, check and respond to persons under their custody, supervision and control, particularly DAVID K. MILLER and summon needed mental health care for him.

- 19. From and during the time DAVID K. MILLER was in the custody of Defendants COUNTY OF MENDOCINO and DOES 20 through 30, said Defendants negligently, in breach their duties to act with reasonable care toward David Miller, and in breach of duties under Government Code § 845.6, failed to reasonably discharge the duty to summon medical care for DAVID K. MILLER, failed to hold him in custody for mental evaluation by a physician after Defendants LAMUN and DOES 1 through 20 had determined that he needed to be seen by a physician and failed to exercise discretion whether to confine DAVID K. MILLER for mental illness.
- 20. On or about March 29, 2012, Defendants COUNTY OF MENDOCINO through its jailer employees, DOES 26 through 30, negligently implemented a court order to release DAVID K. MILLER, in breach of their duties owed to DAVID K. MILLER, by releasing him into a situation of foreseeable peril made dangerous by his mental condition, with deliberate indifference to his medical needs, before he was seen by the physician who was scheduled to see him in the jail, without summoning medical care, without notifying the court of his severe mental illness, without notifying relatives of his mental condition at the time of his release, and by failing to assist him with means of transportation or wherewithal to get home, shelter or assistance when releasing him 57 miles from Fort Bragg.
- 21. As a legal result of each Defendant's negligent omissions, breaches of standards of care and failures to discharge their duties as set forth herein, DAVID K. MILLER mentally deteriorated and was incapable of taking care of himself, such that on March 31, 2012, he walked on the roadway surface of U.S. Highway 101 in Willits, disoriented and oblivious to danger, and was struck by a car, sustaining brain injuries and numerous fractures and internal injuries which caused his death on September 30, 2013.
- 22. As a further legal result of the negligence of defendants, and each of them, DAVID K. MILLER incurred medical, hospital, and related expenses prior to his death.

23. On March 19, 2013, DAVID K. MILLER duly served Defendant LEILA LAMUN with a Notice to Bring Action on Professional Negligence regarding the matter herein alleged, in compliance with Code of Civil Procedure Section 364.

Wherefore Plaintiff prays for judgment as hereinafter set forth.

SECOND CAUSE OF ACTION WRONGFUL DEATH

- 24. Plaintiff JANA MILLER, individually, refers to and by this reference incorporates herein the allegations stated in paragraphs 1 through 18 and 20 above.
- 25. Decedent DAVID K. MILLER did not have any children or spouse or domestic partner during his life, and JANA MILLER, his mother, brings this wrongful death action as the person entitled to the property of DAVID K. MILLER by intestate succession, pursuant to Code of Civil Procedure § 377.60(a).
- 26. Plaintiff, JANA MILLER, is informed and believes that the only other person who could be a plaintiff in this wrongful death cause of action is THOMAS MILLER, the father of DAVID K. MILLER, however, THOMAS MILLER has expressly declined to join in this Wrongful Death Cause of Action and in the First Cause of Action herein, the Survival Action.
- 27. By reason of the Defendants' conduct as alleged herein, plaintiff JANA MILLER has lost the love, comfort, companionship, care, society, services, benefits, and support of the decedent, her son, DAVID K. MILLER.
- 28. By reason of the Defendants' conduct as alleged herein, plaintiff, JANA MILLER has been compelled to incur expenses for funeral and burial of the decedent, her son, DAVID K. MILLER.

WHEREFORE, plaintiff prays for judgment as follows:

Damages for survival action:

1. For medical, hospital and related expenses according to proof;

1	2. For costs of suit herein incurred;				
2	3. For such other and further relief as the Court may deem proper.				
3	Damages for wrongful death action:				
4	1. For general damages according to proof.				
5	2. For funeral and burial expenses.				
6	3. For costs of suit herein incurred.				
7	4. For such other and further relief as the Court may deem proper.				
8	Dated: May 5, 2014 RAGGHIANTI FREITAS, LLP				
9	(2/1-1/1				
10	By PHIZIP C. SNELL				
11	Attorney for Plaintiffs				
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PROOF OF SERVICE

5/04/2019

UNITED STATES DISTRICT COURT 25 2015

NORTHERN DISTRICT OF CAREFORN DISTRICT COURT

EUREKA DIVISION

EUREKA DIVISION

KENNETH WAYNE ELLER

٧.

Plantiff

No. C 15-1905 NJV (PR)

Amendment of complaint

MENDOCINO COUNTY SHERIFFS OFFICE,

Defendants.

Plantiff alleges that M.C.S.O. medical staff
(Claire Teske- program manager), refuses to provide
him with painkillers prescribed to him by his primary
doctor (Dr. Jensen- Willits Ca.), showing deliberate
indifference to his cronic pain he is suffering, due
to a broken jaw and broken teeth that he has recently
suffered. Theese meds were given to him during his previous incarceration at the jail by medical staff and
there is no reason he should not be recieving them now.
Plantiff moves the court to add this as an amendment to
his origonal complaint as well as adding Claire Teske as
a defendant. Due to his belief that this denial of his
meds is a result of a policy that M.C.S.O has adopted
he asks that the sheriffs office remain a defendant

Kenneth Wayne Elle

Inmate Name (print) KENN95th W	ELLER	U.S. POSTAGE >> PITNEY BOWES
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JOHN L. BURRIS ESQ., SBN 69888 BENJAMIN NISENBAUM, ESQ., SBN 222173 JAMES COOK, ESQ., SBN 300212 LAW OFFICES OF JOHN L. BURRIS

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Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

VICTORIA LEE DALBEC; JASON JAY HAVRANEK; JOELLE BURGESS; KARA MARZAN,

Plaintiffs,

vs.

COUNTY OF MENDOCINO, a municipal corporation; KAITLYN OLSON, individually and in her capacity as a Corrections Deputy for the COUNTY OF MENDOCINO; CALIFORNIA FORENSIC MEDICAL GROUP INC., and DOES 1-50, inclusive,

Defendants.

CASE NO.: 3:16-cv-02414 WHO

FIRST-AMENDED COMPLAINT FOR DAMAGES (42 U.S.C §§ 1983, 1988; and pendent tort

claims)

JURY TRIAL DEMANDED

INTRODUCTION

1. This is an action for damages brought pursuant to Title 42 U.S.C §§ 1983 and 1988, the First, Fourth, and Fourteenth Amendments to the United States Constitution, and under California state law. This action is against the COUNTY OF MENDOCINO, Mendocino County Sheriff's

Corrections Deputy KAITLYN OLSON, CALIFORNIA FORENSIC MEDICAL GROUP INC., and DOES 1-50.

JURISDICTION

2. This action arises under Title 42 of the United States Code, Section 1983. Jurisdiction is conferred upon this Court by Title 42 of the United States Code, Section 1331 and 1343 and 42 U.S.C. Section 12188(a). This Court also has supplemental jurisdiction over Plaintiffs' state law causes of action under 28 U.S.C. Section 1367.

PARTIES

- 3. Decedent, GLORIA BURGESS, was an individual residing in the State of California.

 Decedent was unmarried at the time of her death and died intestate.
- 4. Plaintiff VICTORIA LEE DALBEC ("DALBEC") is the daughter of Decedent GLORIA BURGESS and is a resident of the State of California. Plaintiff DALBEC brings these claims individually and as a co-successor in interest for Decedent GLORIA BURGESS.
- 5. Plaintiff JASON JAY HAVRANEK ("HAVRANEK") is the son of Decedent GLORIA BURGESS and is a resident of the State of California. Plaintiff HAVRANEK brings these claims individually and as a co-successor in interest for Decedent GLORIA BURGESS.
- 6. Plaintiff JOELLE BURGESS ("BURGESS") is the daughter of Decedent GLORIA BURGESS and is a resident of the State of California. Plaintiff BURGESS brings these claims individually and as a co-successor in interest for Decedent GLORIA BURGESS.
- 7. Plaintiff KARA MARZAN ("MARZAN") is the daughter of Decedent GLORIA BURGESS and is a resident of the State of California. Plaintiff MARZAN brings these claims individually and as a co-successor in interest for Decedent GLORIA BURGESS.
- 8. CALIFORNIA FORENSIC MEDICAL GROUP, INC. ("CFMG") was at all times herein mentioned a corporation licensed to do business in California. Defendant CFMG provided medical and nursing care to prisoners and detainees in Mendocino County jails, pursuant to contract with the COUNTY. CFMG and its employees and agents are responsible for making and enforcing policies, procedures, and training relating to the medical care of prisoners and detainees in Defendant COUNTY jails, including providing reasonable medical care to prisoners and detainees.

- 9. COUNTY OF MENDOCINO ("COUNTY") is a political subdivision of the State of California. The Mendocino County Sheriff's Office is an administrative subdivision of the COUNTY; accordingly, all Sheriff's Office employees are employees of the COUNTY.
- 10. At all times herein mentioned, Defendant, KAITLYN OLSON (hereinafter "OLSON"), at all times mentioned herein, was a Corrections Deputy for the Mendocino County Sheriff's Office, and is sued in her individual capacity only, based on actions she took as a Corrections Deputy of the Mendocino County Sheriff's Office.
- 11. Plaintiffs are ignorant of the true names and capacities of Defendants DOES 1 through 50, inclusive, and therefore sues these defendants by such fictitious names. Plaintiffs are informed and believe and thereon allege that each defendant so named is responsible in some manner for the injuries and damages sustained by Plaintiffs as set forth herein. Plaintiffs will amend their complaint to state the names and capacities of DOES 1-50, inclusive, when they have been ascertained.

ADMINISTRATIVE PREREQUISITES

12. Plaintiffs are required to comply with an administrative tort claim requirement under California law. Plaintiffs have exhausted all administrative remedies pursuant to California Government Code Section 910. Plaintiffs filed an administrative claim with the COUNTY OF MENDOCINO on October 10, 2015. The claim was rejected by the COUNTY OF MENDOCINO on November 3, 2015.

FACTUAL ALLEGATIONS

13. Decedent GLORIA BURGESS was in custody as in inmate at Mendocino County Jail, a jail located in the County of Mendocino and operated by the Mendocino County Sheriff's Office, a municipal agency of COUNTY, when she died in the medical isolation unit on April 10, 2015, of medical complications related to renal failure caused and/or excacerbated by untreated and/or negligent-treatment of her life-threatening medical condition. At the time of Decedent's death, Defendant COUNTY had been aware that Decedent required medical treatment. Decedent GLORIA BURGESS was placed in medical isolation specifically because of her medical history of chronic renal failure. Even still, Defendants failed to treat Decedent after they were on notice that Decedent required immediate and continous medical care.

14. In spite of knowledge about Decedent's life threathening medical condition,
Defendant COUNTY unreasonably failed to monitor Decedent. The Defendant Deputies failed to
conduct call checks according to their protocol. The checks for the medical isolation unit were
supposed to be conducted every fifteen minutes. Without regard for Decedent BURGESS' life
threathening medical condition, her last cell check took place forty minutes before Defendant Deputy
OLSON found her dead. In addition COUNTY failed to reasonably ensure that CFMG provided
reasonable medical services and care to Decedent.

- 15. While COUNTY contracted for medical care to be provided to its inmates by CFMG, neither COUNTY, CFMG provided the required medical services and care of which they were subjectively aware. Said Defendants were deliberately indifferent to Decedent's known medical needs, and acted with subjective recklessness in disregarding Decedent's known medical needs, even under the awareness that Decedent could die as a consequence of her medical condition. Defendant deputies failed to provide Decedent GLORIA BURGESS the appropriate access to the medicines required for her life threathening medical condition. Defendant COUNTY and CFMG staff, of CFMG's failed to reasonably provide the necessary medical services and care, and unreasonably failed to provide reasonable medical services and care to Decedent by means other than through CFMG and unreasonably failed to compel CFMG to provide Decedent reasonable medical services and care, proximately causing Decedent's death.
- 16. Plaintiffs allege that COUNTY was aware and on notice substantially prior to the subject-incident that CFMG, and/or its alter ego companies with whom Defendant COUNTY also contracted for the provision of medical services and care to jail inmates, had a signficant history of negligence, malpractice, and deliberate indifference in providing and/or failing to provide medical services and care to jail inmates, including jail inmates in Mendocino County Jail, resulting in serious harm or death to inmates requring medical services and care. In spite of such notice, COUNTY continued to contract with CFMG to provide medical services and care to inmates in COUNTY jails without providing reasonable oversight of CFMG to reasonably ensure that CFMG were providing reasonable medical services and care to COUNTY jail inmates, proximately causing Decedent's death.

- 17. Decedent died of "renal failure" according to COUNTY coroner's office, from the known, but untreated or unreasonably treated, medical condition that Decedent had been desperately trying to have reasonably treated by Defendant COUNTY and CFMG. Had the medical condition been reasonably treated, Decedent would have lived.
- 18. Decedent's death was the result of all Defendants' deliberately indifferent failure to summon and/or provide medical treatment for Decedent's serious medical needs.
- 19. Alternatively or concurrently, Decedent's death was the proximate result of Defendant COUNTY'S failure to implement and enforce generally accepted, lawful policies and procedures at the jail, and allowing and/or ratifying the deliberate indifference to the serious medical needs of inmates. These substantial failures reflect Defendant COUNTY'S policies implicitly ratifying and/or authorizing the deliberate indifference to serious medical needs and the failure to reasonably train, instruct, monitor, supervise, investigate, and discipline deputy sheriffs employed by Defendant COUNTY.
- 20. Alternatively, or concurrently, Decedent's death was the proximate result of Defendant CFMG's failure to reasonably train their medical staff in the proper and reasonable care of inmates with life threatening but treatable medical conditions, failure to implement and enforce generally accepted, lawful policies and procedures at the jail, and deliberate indifference to the serious medical needs of inmates. These substantial failures reflect Defendant CFMG's policies implicitly ratifying and/or authorizing the deliberate indifference to serious medical needs by its medical staff and the failure to reasonably train, instruct, monitor, supervise, investigate, and discipline medical employed by Defendant CFMG in the handling individuals with serious medical conditions.
- 21. At all material times, and alternatively, the actions and omissions of each Defendant were conscience-shocking, reckless, deliberately indifferent to Decedent's and Plaintiffs' rights, grossly negligent, negligent, and objectively unreasonable.

DAMAGES

22. Plaintiffs were physically, mentally, and emotionally injured and damaged as a proximate result of Decedent Burgess' wrongful death, including, but not limited to, the loss of

Decedent's familial relationships, comfort, protection, companionship, love, affection, solace, and moral support. In addition to these damages, Plaintiffs are entitled to recover for the reasonable value of funeral and burial expenses.

- 23. As a further direct and proximate result of the negligence and deliberate indifference of defendants, and each of them, Plaintiffs have been deprived of Decedent Burgess' financial support.
- 24. Each individual Defendant acted recklessly or with callous indifference to Decedent Burgess' life threatening medical condition and to Plaintiffs' constitutional rights. Plaintiffs, as decedent's successors in interest, are therefore entitled to an award of punitive damages against said individual Defendants.
- 25. Plaintiffs found it necessary to engage the services of private counsel to vindicate their rights, and the rights of decedent, under the law. Plaintiffs are therefore entitled to recover all attorneys' fees incurred in relation to this action pursuant to Title 42 United States Code section 1988.

FIRST CAUSE OF ACTION (42 U.S.C. § 1983)

(PLAINTIFFS DALBEC, HAVRANEK, BURGESS, and MARZAN Against DEFENDANTS CFMG, OLSON and DOES 1-50)

- 26. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 25 of this Complaint.
- 27. By the actions and omissions described above, Defendants violated 42 U.S.C. § 1983, depriving Plaintiffs of the following clearly established and well-settled constitutional rights protected by the Fourteenth Amendments to the United States Constitution:
 - a. The right to be free from deliberate indifference to Decedent's serious medical needs while in custody as secured by the Fourteenth Amendment; and
 - b. The right to be free from wrongful government interference with familial relationships and Plaintiffs' right to companionship, society, and support of each other, as secured by the First, Fourth, and Fourteenth Amendments, and as secured by California Code of Civil Procedure §§ 377.20 et seq. and 377.60 t seq.

- 28. Defendants subjected Plaintiffs to their wrongful conduct, depriving Plaintiffs of rights described herein with reckless disregard for whether the rights and safety of Plaintiffs (individually and on behalf of Decedent Gloria Burgess) and others would be violated by their acts and/or omissions.
- 29. As a direct and proximate result of Defendants' acts and/or omissions as set forth above, Plaintiffs sustained injuries and damages as set forth herein.
- 30. The conduct of Defendants entitles Plaintiffs to punitive damages and penalties allowable under 42 U.S.C. § 1983 and California Code of Civil Procedure §§ 377.20 et seq., and other state and federal law.

WHEREFORE, Plaintiffs pray for relief as hereinafter set forth.

SECOND CAUSE OF ACTION

(Monell - 42 U.S.C. § 1983)

(PLAINTIFFS DALBEC, HAVRANEK, BURGESS, and MARZAN Against DEFENDANTS CFMG, COUNTY, and DOES 26-50)

- 31. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 30 of this Complaint.
- 32. The unconstitutional actions and/or omissions of Defendants DOES 26-50, as well as other officers employed by or acting on behalf of the Defendants COUNTY and/or CFMG, on information and belief, were pursuant to the following customs, policies, practices, and/or procedures of the COUNTY and/or CFMG, stated in the alternative, which were directed, encouraged, allowed, and/or ratified by policymaking officers for the COUNTY and its Sheriff's Office, and/or CFMG:
 - a. To fail to institute, require, and enforce proper and adequate training, supervision, policies, and procedures concerning handling treatable life threatening conditions;
 - b. To deny inmates at the COUNTY's jail access to appropriate, competent, and necessary care for serious medical needs;
 - c. To fail to institute, require, and enforce proper and adequate training, supervision, policies, and procedures concerning handling persons with serious medical conditions at the County Jail;

- d. To cover up violations of constitutional rights by any or all of the following:
- i. By failing to properly investigate and/or evaluate complaints or incidents of the handling persons with life threatening medical conditions;
- ii. By ignoring and/or failing to properly and adequately investigate and/or investigate and discipline unconstitutional or unlawful law enforcement activity; and
- iii. By allowing, tolerating, and/or encouraging law enforcement officers to: fail to file complete and accurate reports; file false reports; make false statements; intimidate, bias and/or "coach" witnesses to give false information and/or to attempt to bolster officers' stories; and/or obstruct or interfere with investigations of unconstitutional or unlawful law enforcement conduct by withholding and/or concealing material information;
- e. To allow, tolerate, and/or encourage a "code of silence" among law enforcement officers and sheriff's department personnel, whereby an officer or member of the sheriff's department does not provide adverse information against a fellow officer or member of the department; and
- f. To use or tolerate inadequate, deficient, and improper procedures for handling, investigating, and reviewing complaints of officer misconduct, including claims made under California Government Code §§ 910 et seq.
- 33. Defendants CFMG, COUNTY, and DOES 26-50 failed to properly hire, train, instruct, monitor, supervise, evaluate, investigate, and discipline Defendants DOES 1-25, and other COUNTY, Sheriff's Office, and CFMG personnel, with deliberate indifference to Plaintiffs' constitutional rights, which were thereby violated as described above.
- 34. The unconstitutional actions and/or omissions of Defendants OLSON and DOES 1-25 and other Sheriff's Office personnel, as described above, were approved, tolerated, and/or ratified by policymaking officers for the COUNTY and its Sheriff's Office, including by Defendant CFMG. Plaintiffs are informed and believe and thereon allege that the details of this incident have been revealed to the authorized policymakers within the COUNTY, the Mendocino County Sheriff's Office, and CFMG, and that such policymakers have direct knowledge of the fact that the death of GLORIA BURGESS was not justified, but rather represented an unconstitutional display of deliberate indifference to serious medical needs. Notwithstanding this knowledge, the authorized

policymakers within the COUNTY, its Sheriff's Office, and CFMG have approved of DOES 1-25's conduct and decisions in this matter, and have made a deliberate choice to endorse such conduct and decisions, and the basis for them, that resulted in the death of GLORIA BURGESS. By so doing, the authorized policymakers within the COUNTY and its Sheriff's Office have shown affirmative agreement with the individual Defendants' actions and have ratified the unconstitutional acts of the individual Defendants.

- 35. The aforementioned customs, policies, practices, and procedures; the failures to properly and adequately hire, train, instruct, monitor, supervise, evaluate, investigate, and discipline; and the unconstitutional orders, approvals, ratification, and toleration of wrongful conduct of Defendants DOES 1-25 were a moving force and/or a proximate cause of the deprivations of Plaintiffs' clearly established and well-settled constitutional rights in violation of 42 U.S.C. § 1983.
- 36. Defendants subjected Plaintiffs to their wrongful conduct, depriving Plaintiffs of rights described herein, knowingly, maliciously, and with conscious and reckless disregard for whether the rights and safety of Plaintiffs and others would be violated by their acts and/or omissions.
- 37. As a direct and proximate result of the unconstitutional actions, omissions, customs, policies, practices, and procedures of Defendants COUNTY, and DOES 1-25 as described above, Plaintiffs sustained serious and permanent injuries and are entitled to damages, penalties, costs, and attorneys fees as set forth above in this Complaint.

THIRD CAUSE OF ACTION

(Negligence)

(PLAINTIFFS DALBEC, HAVRANEK, BURGESS, and MARZAN Against DEFENDANTS CFMG, OLSON and DOES 1-50)

- 38. Plaintiffs re-allege and incorporate by reference herein paragraphs 1 through 37 of this Complaint.
- 39. The present action is brought pursuant to section 820 and 815.2 of the California Government Code. Pursuant to section 820 of the California Government Code, as public employees, DOES 1-50 are liable for injuries caused by their acts or omissions to the same extent as a private person.

- 40. At all times, each Defendant owed Plaintiffs the duty to act with due care in the execution and enforcement of any right, law, or legal obligation.
 - 41. At all times, each Defendant owed Plaintiffs the duty to act with reasonable care.
- 42. These general duties of reasonable care and due care owed to Plaintiffs by all Defendants include but are not limited to the following specific obligations:
 - a. To provide, or cause to be provided, prompt and appropriate medical care for Decedent;
 - b. To refrain from unreasonably creating danger or increasing Decedent's risk of harm;
 - c. To refrain from abusing their authority granted them by law;
 - d. To refrain from violating Plaintiffs' rights as guaranteed by the United States and California Constitutions, as set forth above, and as otherwise protected by law.
- 43. Additionally, these general duties of reasonable care and due care owed to Plaintiffs by Defendants CFMG and DOES 1-50 include but are not limited to the following specific obligations:
 - a. To properly and reasonably hire, supervise, train, retain, investigate, monitor, evaluate, and discipline each person (i) who was responsible for providing medical care for Decedent, (ii) who was responsible for the safe and appropriate jail custody of Decedent, (iii) who denied Decedent medical attention or access to medical care and treatment;
 - b. To properly and adequately hire, investigate, train, supervise, monitor, evaluate, and discipline their employees and/or agents to ensure that those employees/agents act at all times in the public interest and in conformance with the law;
 - c. To institute and enforce proper procedures and training for prevention and treatment of life threatening medical conditions, to coordinate inmate assessment, placement, and care with the jail physicians and nursing staff, and jail corrections staff;
 - d. To make, enforce, and at all times act in conformance with policies and customs that are lawful and protective of individual rights, including Plaintiffs';
 - e. To refrain from making, enforcing, and/or tolerating the wrongful policies and customs set forth above.

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44. Defendants, through their acts and omissions, breached each and every one of the aforementioned duties owed to Plaintiffs, by failing to treat Decedent's medical condition.

As a direct and proximate result of Defendants' negligence, decedent and therefore 45. plaintiff sustained injuries and damages, and against Defendants CFMG, OLSON, and DOES 1-50 are entitled to relief as set forth in this Complaint, and punitive damages against all individual Defendants.

WHEREFORE, Plaintiffs pray for relief as hereinafter set forth.

FOURTH CAUSE OF ACTION

(Violation of California Government Code § 845.6) (PLAINTIFFS DALBEC, HAVRANEK, BURGESS, and MARZAN Against **DEFENDANTS CFMG, COUNTY, OLSON and DOES 1-50)**

- 46. Plaintiffs re-allege and incorporate by reference herein paragraphs 1 through 45 of this Complaint.
- 47. Defendant OLSON and DOES 1-50 knew or had reason to know that Decedent was in need of immediate and higher level medical care, treatment, observation and monitoring. Defendants failed to monitor Decedent GLORIA BURGESS according to protocol. Each such individual defendant, employed by and acting within the course and scope of his/her employment with Defendant COUNTY, knowing and/or having reason to know this, failed to take reasonable action to summon care and treatment for the Decedent in violation of California Government Code § 845.6.
- 48. As legal cause of the aforementioned acts of all Defendants, Plaintiffs were injured as set forth above, and their losses entitle them to all damages allowable under California law. Plaintiffs sustained serious and permanent injuries and are entitled to damages, penalties, costs, and attorney fees under California law.

JURY DEMAND

49. Plaintiffs hereby demands a jury trial in this action.

PRAYER

WHEREFORE, Plaintiffs pray for relief, as follows:

1. For general damages according to proof;

- 2. For punitive damages and exemplary damages in amounts to be determined according to proof as to defendants DOES 1 through 50 and/or each of them;
- 3. For reasonable attorney's fees pursuant to 42 U.S.C. §1988;
- 4. For cost of suit herein incurred; and
- Declaratory and injunctive relief, including but not limited to the following: 5.
 - i. An order requiring Defendants to institute and enforce appropriate and lawful policies and procedures for handling persons with serious medical needs.
 - ii. An order prohibiting Defendants and their sheriff's from engaging in the "code of silence as may be supported by the evidence in this case.
 - iii. An order requiring Defendants to train all medical professionals concerning generally accepted and proper tactics and procedures for the care and treatment of persons with serious medical needs.
- For such other and further relief as the Court deems just and proper. 6.

LAW OFFICES OF JOHN L. BURRIS

Dated: August 09, 2016 /s/ Benjamin Nisenbaum Benjamin Nisenbaum Esq.

Attorney for Plaintiffs

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1	COMPLAINT BY A PRISONER	UNDER THE C	IVIL RIGHTS ACT, 42 U.S.C. 1983	
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16)		
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18	Note: You must exhaust available administrative	e remedies before your c	laim can go forward. The court will dismiss any	
19	unexhausted claims.		·	
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21	B. Is there a grievance procedure	in this institution?	YES ⊠ NO □	
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23	procedure? YES	NO □		
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15	Indifference towards the Situration which was extremely mong.			
16	II. Parties.			
17	A. Write your name and present address. Do the same for additional plaintiffs, if any.			
18	Michael Roy France @ 951 law Everp Road (Jail) Ukiah CA, 95482.			
19	*Secondary Address? Michael Ray France, 40 Jan Cole wilson			
20	104 North school Street, object, CA 95482			
21	B. For each defendant, provide full name, official position and place of employment.			
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	PRISONER COMPLAINT (rev. 8/2015) Page 2 of 3			

III. Statement of Claim. 1 2 State briefly the facts of your case. Be sure to describe how each defendant is involved and to include dates, when possible. Do not give any legal arguments or cite any cases or statutes. If you have more than one claim, each claim should be set forth in a separate numbered paragraph. 4 Betwee at Shirtchange 5 6 7 8 9 10 11 DEFIND MUSELF, when my safety was threretened than 12 13 14 was Huromy 15 continued IV. Relief. 16 Your complaint must include a request for specific relief. State briefly exactly what you want the court to do for you. Do not make legal arguments and do not cite any cases or 17 statutes. 18 19 20 21 those who are responsible for this 22 23 24 I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT. 25 Executed on: Signature of Plaintiff Date PRISONER COMPLAINT (rev. 8/2015) Page 3 of 9 4 5

III. STATEMENT OF CLAIM continued From my Force, so I could not cover up. where upon I was Repeatedly Runched Kneed and kicked In the Face over 20x times. All of this was seen and heard by two witnesses and captured on different aneros. Deputy. S. Siderakis and Deputy. J. words gave ne two plack eyes, Brody Nose, Serious Facial Inpries, swelling Countusiers. And my they ankle was Intentionally twisted and Footweet to the Point it was Black and Swolley Bringes of Novayal Spice a Mouth later (New), It is still bruised and Smoller, Causing Severe pain. I was Refused Adequate neclical treatment, where told we they were ordered by OFFRETS to Do Withing For Me. another OFFRET. Cenne and took Photos OF My extensive Injuries, After my Bloody Shis was touded out. No Actual Desciplinary was given out to these Deputys when they should have been Fired At the least Administration has Shewn a lack of deliberate Indifferance and gross wegligence and by Doing & has encouraged Sich Violen'T treatment of Junicles and even condoned and covered up Such conduct. Captain pearce and LT. Bednar continue to Abuse there authority here and keep Tunnedes Safe and Secure From ViderT, Officers with leave knew Before hand About each officers propensify for violence Numerous Alternations but sid nothing but condarge and this behavior . They knew About Bruth Depatys Records, and Sackstic enjoyment in Attacking Inmates. The Two eye witnesses gave sidio testimony to go along with the DVR evidence, Testimony was taken by Set. Studen in his Internal AFFATTES threstigation both nitnesses are toggested In the facility and advantation and R More than willing to festily . as well as payself . I was Tortured and humiltated and covsed physical, constional psychological Pain of world suggestude

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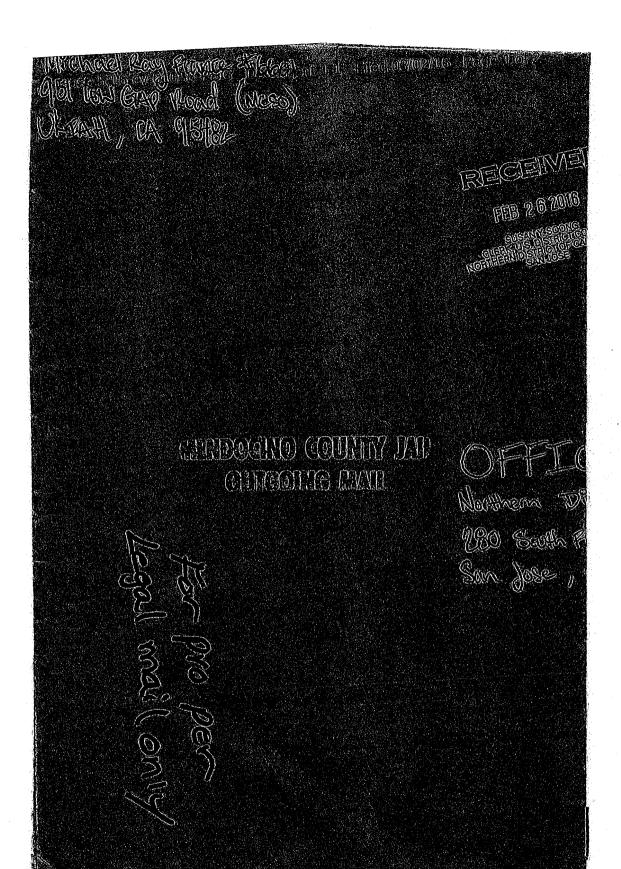
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	page 5 of 5

JS 44 (Rev. 12/12) cand rev (1/15/13)

CIVIL COVER SHEET

The JS 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. (SEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

I. (a) PLAINTIFFS Michael Pay France Outhering Western Marketing Bourg Western			Lt. Bednar Depoy J. WOIDA		
			captain pearce Deputy & Siderakis		
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(c) Attorneys (Firm Name,	Address, and Telephone Number)		Attorneys (If Known)		
981 law Gogs	road SURI				
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IV. NATURE OF SUIT	[(Place an "X" in One Box Only)				
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394-NJV Document 56 Filed 02/17 Page 1 of 13 CV 15 1794 N.\.../. Case: RECEIVED 1 Melodie Hughes FEB 172018 P.O. Box 207 9usan Y. Boong Clerk, U.S. District Court Northern District of California Willits, California 95490 3 707-651-2773 4 madmadmel61@vahoo.com 5 б 7 UNITED STATES DISTRICT COURT NORTHERN DISTRICT OF CALIFORNIA 8 9 10 11 IVIN DAVID SLATER, deceased, CASE: CV 15 1794 N.J.V. 12 By and through Melodie Hughes, . his mother: and SECOND AMENDED COMPLAINT 13 **MELODIE HUGHES** 1. Failure to Provide Medical Care in violation 14 Plaintiff of Eighth and Fourteenth Amendments 15 (42 U.S.C. 1983); 2. Deprivation of Substantive Due Process VS 16 in violation of First and Fourteenth **COUNTY OF MENDOCINO:** Amendments (42 U.S.C. 8 1983); 17 SHERIFF THOMAS ALLMAN, in his 3. Failure to Furnish Medical Care 18 individual capacity; (42 U.S.C. 8 1983); CALIFORNIA FORSENSIC MEDICAL 4. Negligent Supervision, Training, 19 GROUP; and Hiring, and Retention; DR. TAYLOR FITHIAN; 5. Negligence: 20 **JOEY DeMARCO #1176** 6. Wrongful Death. 21 **DEPUTY CHERA #2675** and DOES 1-100 22 Defendants **DEMAND FOR JURY TRIAL** 23 24 25 26 27 28

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INTRODUCTION

- 1. On March 22, 2014, Ivin Slater was arrested at approximately 9:49 p.m. for possession of heroin and a violation of probation. Bail was not allowed due to this violation.
- 2. During Ivin's stay at the Mendocino County Jail he was suffering from heroin withdrawal. The arresting deputies were very much aware of this and promised myself, Melodie Hughes, "They would get him the help he needed."
- 3. Throughout this lawsuit, Plaintiff seeks to hold Defendants accountable for refusing to provide adequate medical care, which led to Ivin Slater's untold suffering, unnecessary harm, and a painful suffering of lingering death.

JURISDICTION

- 4. This Complaint seeks damages for the violation of Civil Rights, privileges, and immunities guaranteed by the First, Eighth, and Fourteenth Amendments of the United States Constitution, pursuant to 42 U.S.C. 1983 and 1988, as well as for violations of California State Law.
 - 5. Plaintiffs invoke the pendent jurisdiction of this Court.
 - 6. This Court has jurisdiction over this lawsuit pursuant to 28 U.S.C. 1331 and 1343.
- 7. This Court has supplemental jurisdiction over the state law claims asserted herein pursuant to 28 U.S.C. 1367, because the claims form part of the same case or controversy arising under the United States Constitution and federal law.

VENUE

- 8. Plaintiffs' claims, alleged herein, arose in the County of Mendocino, California pursuant to 28 U.S.C. 1391(b)(2).
- 9. Rule 3 of the Federal Rules of Civil Procedure and Local Rule 3-2(e), authorizes assignment to this division because a substantial part of the events or omissions giving rise to Plaintiffs' claims occurred in the counties served by this division.

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PARTIES

- 10. Plaintiff, Melodie Hughes, brings claims on behalf of Ivin David Slater, deceased, her son. Ivin Slater was born in Mendocino County on October 22, 1987, was living in Mendocino County, and died in Mendocino County. This matter is based on violations of Ivin Slater's rights under the United States Constitution and California State Law.
- 11. Plaintiff, Melodie Hughes, is the mother of Ivin Slater, and resides in Mendocino County. She is suing individually for civil rights violations under the First and Fourteenth Amendments and California State Law.
- 12. Defendant, County of Mendocino, is a public entity, dully organized and existing under the laws of the State of California. Under its authority, Defendant County of Mendocino operates and manages Mendocino County Jail and is and was at all relevant times mentioned herein responsible for the actions and/or interactions and the policies, procedures, and practices/customs of the Mendocino County Sheriff's Office and Mendocino County Jail, and its entity's respective employees and/or agents. Mendocino County Sheriff's Office operates Mendocino County Jail, and is and was responsible for ensuring the provision of medical services to all Mendocino County Jail inmates. Mendocino County Sheriff's Office also operates the office at the Coroner.
- 13. Defendant Thomas Allman is, and was at all relevant times mentioned herein, the Sheriff-Coroner of the County of Mendocino, the highest position in the Mendocino County Sheriff's Office. As Sheriff-Coroner, Defendant Thomas Allman was responsible for the hiring, screening, training, retention, supervision, discipline, counseling, and control of all Mendocino County Sheriff' Office custodial employees and/or agents. Defendant Allman is and was charged by law with the administration of the Mendocino County Jail, and is responsible for safety and security of inmates housed at the jail. Defendant Allman also is and was responsible for the promulgation of the policies, procedures, and allowance of the practices/customs pursuant to which the acts of the Mendocino County Sheriff's Office alleged herein were committed. Defendant Thomas Allman is also charged with oversight of the Coroner's Division of the Mendocino County Sheriff's Office. Defendant Allman is being sued in his individual capacity. At all times referenced herein and relevant hereto, Thomas Allman was acting within the course and scope of his employment with the County of Mendocino.
- 14. Defendant California Forensic Medical Group (CFMG) is a California corporation, headquarters based in Monterey, California. CFMG is a private for-profit correctional health care provider that services approximately sixty-five (65) correctional facilities in twenty-seven (27)

 California counties. The County of Mendocino contracts with CFMG to provide medical and dental services for the Mendocino County Jail. At all times relevant herein, CFMG was responsible for the health services provided to Ivin Slater during his detention in the Mendocino County Jail, and was acting within the course and scope of its employment with the County of Mendocino.

15. Defendant Taylor Fithian is, and was at all relevant times mentioned herein, the co-founder, President, and Medical Director for the Defendant California Forensic Medical Group. Defendant Fithian is a Board-certified psychiatrist and oversees the delivery of medical, mental health and dental care in all CFMG served facilities, including standards of medical care and utilization review. Defendant Fithian is and was responsible for the promulgation of the policies and procedures and the allowance of the practices/customs pursuant to which the acts of California Forensic Medical Group alleged herein were committed. Defendant Fithian is being sued in his individual capacity. At all times relevant hereto and referenced herein, Defendant Fithian was acting in the course and scope of his employment with California Forensic Medical Group.

16.Deputy Joey DeMarco #1176 is being sued in his individual capacity. Deputy DeMarco is and was a deputy in the Mendocino County Sheriffs Office. Defendant DeMarco was the arresting officer on March 22, 2014. At this time he had a lengthy conversation with Melodie Hughes, Plaintiff. He looked her square in the eye and "Promised to get Ivin the help he needed." Ivin needed heroin detox, but DeMarco failed to follow through and make good his promise. He merely dropped Ivin Slater off at the Mendocino County Jail and never gave it another thought.

17. Deputy Chera #2675 is being sued in his individual capacity. Defendant Chera was the Intake Officer on duty the night of March 22, 2014. Chera failed to complete medical screening and call for a nurse. No mention of heroin detox.

EXHAUSTION OF PRE-LAW SUIT PROCEDURES FOR STATE LAW CLAIMS

18. Plaintiff filed governmental Tort Claims with Defendant County of Mendocino on behalf of Melodie June Hughes on September 10, 2014. By correspondence dated October 23, 2014, the County of Mendocino rejected the governmental Tort Claims.

(Exhibit #1)

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FACTUAL ALLEGATIONS

- 19. County of Mendocino, Mendocino County Sheriff's Office, and California Forensic Medical Group, have been on notice that their provisions of medical care to inmates at the Mendocino County Jail is inadequate and results in needless harm and suffering since at least 2001.

 (Exhibit #2)
- 20. California Forensic Medical Group, Taylor Fithian, and the counties they provide correctional facility medical services to have numerous lawsuits for:
 - a. Failure to provide Necessary medical treatments to inmates upon their arrival at the jail.
 - b. Failure to provide care in emergency situations.
 - c. Failure to diagnose and refer to outside specialists when necessary.
 - d. Failure to maintain adequate, accurate, and complete medical records.
- 21. Deputy Joey DeMarco ID#1176 and Verdot arrested Ivin Slater on March 22, 2014, for possession of heroin and a probation violation no-bail warrant. (Exhibit #3)
- 22 Deputies DeMarco and Verdot were very much aware of Ivin's heroin habit and his need for medical care and detox treatment. They assured us "he would get the help he needed."
- 23. Deputy DeMarco does not indicate need for heroin detox on Pre-booking record. Paperwork is also incomplete.

(Exhibit #6)

(Exhibit #4 and #5)

24. Deputy Chera ID#2675 completed the Medical Booking Screening paperwork. There are two (2) copies, one unsigned and one signed by a nurse. No referral indicated, no mention of heroin detox.

(Exhibit #7 and #8)

25. Ivin Slater was not evaluated for a full twenty-four (24) hours. He was then allegedly put on California Forensic Medical Group Withdrawal Protocol.

(Exhibit #9 and #10)

26. According to an inmate statement, Ivin Slater became extremely sick in the first 24 hours. He was vomiting and had diarrhea. He was unable to take care of himself, laying in his own excrement. Ivin was unable to get up to get meals. This is documented from statement of cell-mate Mike England. (Exhibit #11)

mother. The last two (2) hours of Ivin's life he did not use heroin.

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39. Melodie Hughes has suffered great mental strain and anxiety over this horrible ordeal. Ivin left her five (5) days earlier in the custody of the Mendocino County Sheriff's Department. They promised Melodie Hughes that Ivin would get the help he needed and wanted. Ms. Hughes was actually relieved. Five days later he returned, looking like he aged 30 years. Melodie Hughes had no idea what was wrong, and was in shock at his condition. Melodie Hughes planned to feed him and then take him to the hospital, but time ran out.

(Exhibit #5)

Case:

40. Autopsy results claim death due to heroin intoxication, but overlooks the fact that Ivin had several tears in his gastric bag and the area is autolyzed.. Ivin's peritoneal cavity contained air and 600 ml fluid with food particles floating in it. This is evidence that he may have died from a perforated stomach.

(Exhibit #22)

- 41. Defendant DeMarco started this horrible chain of events when he promised Plaintiff Hughes, looked her straight in the eye, that he would make sure Ivin Slater got the medical care he needed to get off heroin. He lied. What kind of person does that? DeMarco did nothing, said nothing. He is guilty of deprayed indifference and worse.
- 42. This charade was continued by officers at the jail and medical staff of California Forensic Medical Group. Not by one or two negligent acts; instead it went on for 4 (four) day. All the while Plaintiff Slater is getting progressively worse. How do people, claiming to be doing their job, not see how horribly sick Slater was? The inmates saw it.
- 43. The County of Mendocino and Sheriff Allman ignored numerous warnings of negligent medical care at the jail. There has been numerous other deaths at the jail because of this.
- 44. The practices and policies of California Forensic Medical Group to provide the least amount of medical care possible is well known throughout the state. Staff is encouraged to turn a blind eye to anything that might cost them money. What they do is unconscionable, negligent and downright criminal.

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<u>CLAIMS FOR RELIEF</u> FIRST CLAIM FOR RELIEF

Deliberate Indifference to Serious Medical Needs and Failure to Protect from Harm in Violation of the Eighth and Fourteenth Amendments to the United States Constitution (Survival Action - 42 U.S.C.§ 1983).

(Against All Defendants)

- 45. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 44 as though fully set forth therein.
 - 46. Defendants failed to provide Ivin Slater with necessary and appropriate medical care.
- 47. Defendants DOE 1-100, medical staff and officers on duty failed to respond to Ivin Slater's increasing distress, failed to request or summon a more qualified doctor to attend to Ivin.
- 48. Defendants Mendocino County and Sheriff Thomas Allman failed to heed Grand Jury reports of inadequate medical care policies, continuing to employ California Forensic Medical Group as its medical provider for the jail.
- 49. Defendants Mendocino County, Sheriff Thomas Allman, and California Forensic Medical Group failed to ensure appropriate policies, procedures and practices were in place to guide all employees for medical emergencies, and failed to provide adequate training.
- 50. Mendocino County, Sheriff Allman, the county sheriff's office and all jail employees had a duty to protect Mr. Slater from harm, and failed to do so.
- 51. Defendants Taylor Fithian and California Forensic Medical Group, a for-profit company with numerous lawsuits for inadequate care; continue to practice inadequate policies and procedures in identifying inmates in need of medical care and providing appropriate medical treatment.
- 52. Defendants have consistently failed to meet their constitutional obligation to provide adequate medical care in their jail despite notice of significant and dangerous problems, evidences "Deliberate Indifference" in the provision of medical care.
- 53. Defendants' acts and/or omissions as alleged herein constitute Deliberate Indifference to Ivin Slater's serious medical needs, health and safety.
- 54. As a direct and proximate result of Defendant's conduct, Ivin Slater suffered physical pain, emotional distress, a slow painful lingering death, and loss of life.

 55. The aforementioned acts and/or omission of Defendants Thomas Allman, in an individual capacity, the officers and medical staff on duty, California Forensic Medical Group, and Taylor Fithian were willful, wanton, malicious and oppressive, thereby justifies an award to Plaintiffs of exemplary and punitive damages to punish the wrongful conduct alleged herein and to deter such conduct in the future.

SECOND CLAIM FOR RELIEF

Deprivation of Substantive Due Process Rights in Violation of First and Fourteenth Amendments of the United States Constitution – Loss of Parent/Child Relationship (42 U.S.C. § 1983)

(Against all Defendants)

- 56. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 55 as fully set forth therein.
- 57. The aforementioned acts/or omissions of Defendants Doe 1-100, on duty nurses and jail personnel, in being deliberately indifferent to Ivin Slater's serious medical needs, health and safety, and their failure to act on or take appropriate measures violates Ivin Slater's constitutional rights and in turn led to his lingering death; deprived Plaintiff Melodie Hughes of their liberty interest in the parent/child relationship in violation of their due process rights as defined by the First and Fourteenth Amendments of the United States Constitution.
- 58. The aforementioned acts or omissions of Defendants Thomas Allman, California Forensic Medical Group, and Taylor Fithian in being deliberately indifferent to the medical needs of Ivin Slater and his health and safety, violating Ivin Slater's constitutional rights, and their failure to train and supervise employees and/or to take other appropriate measures to prevent the acts or omissions that led to the wrongful death of Ivin Slater; deprived Plaintiff Melodie Hughes of their liberty interest in the parent-child relationship in violation of their substantive due process rights as defined by the First and Fourteenth Amendments of the United States Constitution.
- 59. The continuing decision of Defendant County of Mendocino to employ California Forensic Medical Group and Taylor Fithian to administer and provide medical care for Mendocino County Jail inmates; despite warnings by several Grand Jury reports, mounting complaints and several other deaths of inmates due to inadequate and non-existent medical services; the County acted with deliberate indifference to the medical needs of Ivin Slater and all other inmates thus leading to the untimely death of Ivin Slater, violating his constitutional rights, and deprived Plaintiff Melodie Hughes of their liberty

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FOURTH CLAIM FOR RELIEF

Negligent Supervision, Training, Hiring and Retention

(Survival Action - California State Law)

(Against Defendants Sheriff Allman, California Forensic Medical Group,

Taylor Fithian, and any officer in a supervisory position)

- 68. Plaintiffs re-allege and incorporate by reference paragraphs 1 67 as though fully set forth herein.
- 69. Defendants had a duty to hire, supervise, train and retain employees and/or agents so that employees and/or agents would refrain from the conduct and/or omissions alleged herein.
- 70. Defendants breached this duty causing the conduct alleged herein. Such breach constitutes negligence under California Stat Law, including California Government Code 815.2(a).
- 71. As a direct and proximate result of Defendants failure, Plaintiffs, Ivin Slater and Melodie Hughes, suffered injuries and damages alleged herein.

FIFTH CLAIM FOR RELIEF

Negligence

(Survival Actions - California State Law)

(Against All Defendants)

- 72. Plaintiffs re-allege and incorporate by reference paragraphs 1 thru 71, as though fully set forth herein.
- 73. Defendants, (Does 1-100) nurses and officers failed to comply with a minimum professional standard in the provision of medical care to Ivin Slater. They failed to assess him in a timely manor, failed to re-evaluate his progress, failed to provide and administer meds and suppositories, or even food and drink. They could not even complete paperwork and records. They never thought about bringing in a doctor or calling for an ambulance.
- 74. Defendants Thomas Allman, California Forensic Medical Group, Taylor Fithian and any supervisors failed to adopt even a minimum standard of policies, procedures and training for all staff.

 There in lies the problem: THERE IS NO MEDICAL CARE AT THE MENDOCINO COUNTY JAIL!
- 75. Together, these Defendants acted negligently and improperly breached their respective duties, and as a direct and proximate result, Plaintiffs suffered injuries and damages as alleged herein.

Document 56 Filed 02/17

Page 12 of 13

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PRAYER FOR RELIEF

Wherefore, Plaintiff prays for the following relief:

- 1. Issue an injunction ordering the County of Mendocino to cease and desist their use of California Forensic Medical Group's "alleged medical services";
- 2. Issue an injunction ordering County of Mendocino to find and put in place medical services for the Mendocino County Jail, preferably from local sources that will better address inmates' needs;
- 3. Issue an injunction ordering County of Mendocino to research and develop a safe place that inmates and the greater public can use for Heroin Detox; to address the growing population of young adults in Mendocino County that are being ravaged by heroin addiction;
- 4. For compensatory general and special damages against each Defendant, jointly and severally, in an amount to be proven at trial;
 - 5. For damages related to loss of family relations as to Plaintiff Melodie Hughes, \$2,000,000.00;
- 6. General damages, including damages for physical and emotional pain, emotional distress, hardship, suffering, shock, worry, anxiety, sleeplessness, illness, trauma and suffering the loss of the services, society, care and protection of the decedent, as well as the loss of economic security; in the amount of \$3,000,000.00.
 - 7. Prejudgment interest;
- 8. For punitive and exemplary damages against each individual named Defendant in an amount appropriate to punish Defendant(s) and deter others from engaging in similar misconduct;
 - 9. For costs of suit and reasonable attorney fees and costs pursuant to
- 42 U.S.C. 1988, and as otherwise authorized by statute or law;
 - 10. For restitution as the Court deems just and proper;
- 11. For such other relief, including injunctive and/or declaratory relief, as the Court may deem proper.

Plaintiff demands trial by jury in this action.

Dated: 1-14-2014

Respectfully Submitted,

Melodie Hughes

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SECOND AMENDED COMPLAINT FOR DAMAGES

	Case 3:15-cv-03780-HSG Document 7 Filed 12/23/15 Page 1 of 10		
	amended Complaint		
1	COMPLAINT BY A PRISONER UNDER THE CIVIL RIGHTS ACT, 42 U.S.C. § 1983		
2	Name: Kramer Terry. L		
3	(Last) (Middle Initial)		
4	Prisoner Number: 54266		
5	Institutional Address: 951, Kow Man Road FILED		
6	11kinh Ca 195482		
7	NEC. 53 \$018		
8	SUSAN Y. SOONG CLERK, U.S. DISTRICT COURT NORTHERN DISTRICT GOURT UNITED STATES DISTRICT COURT NORTHERN DISTRICT OF CALLED BURNING.		
9	NORTHERN DISTRICT OF CALIFORNIA		
10	Terry Lea Kramoctalith		
11	(Enter your full name.)		
12	Vs. $\left\{\begin{array}{c} \text{Case No.} \ 15 - 3780 \ \text{HSG}(PR) \\ \text{(Provided by the clerk upon filling)} \end{array}\right\}$		
13	COMPLAINT UNDER THE		
14	CIVIL RIGHTS ACT, 42 U.S.C. § 1983		
15	(Enter the full name(s) of the defendant(s) in this action.)		
16			
17	I. Exhaustion of Administrative Remedies.		
18			
19	A. Place of present confinement Mendocino Courty Jail		
20	1		
21	B. Is there a grievance procedure in this institution? YES NO		
22	C. If so, did you present the facts in your complaint for review through the grievance		
23	procedure? YES X NO		
24	D. If your answer is YES, list the appeal number and the date and result of the appeal at each		
25	level of review. If you did not pursue any available level of appeal, explain why.		
26	1. Informal appeal:		
27			
28			
	PRISONER COMPLAINT (rev. 8/2015)		
1	Page 1 of 3		

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1		2. First formal level:			
2					
3					
4		3. Second formal level:			
5	1167				
6					
7		4. Third formal level:			
8					
9					
o	E. Is the	e last level to which you appealed the highest level of appeal available to you?			
1	E. 15 the	1			
- 1					
2	F. If yo	u did not present your claim for review through the grievance procedure, explain why.			
3					
4					
5					
6	II. Par	ties.			
7		e your name and present address. Do the same for additional plaintiffs, if any.			
8	Icra	Lec Krampr			
9	35/	Leo Kramer Low Gap Road UKiah CA 95482			
0		/			
1	B. For e	each defendant, provide full name, official position and place of employment.			
2	Medy	IN MD Mendocino County Jail			
3	RH John's RN Mendocino County Jail				
4	Tom allman Sheriff Mendocino County Jail				
5	T Peace Captain Mendocino County Jail				
6	California Forensic Medical Ecoup Contractor				
7	Mendocino County Jail				
8.	Clair Tecke RN Meddeeine County Jail				
0.		The state of the s			
	PRISONER Page 2 of 3	COMPLAINT (rev. 8/2015)			

1	III. Statement of Claim.		
2	State briefly the facts of your case. Be sure to describe how each defendant is involved and to include dates, when possible. Do not give any legal arguments or cite any cases or statutes. If you have more than one claim, each claim should be set forth in a separate		
3	numbered paragraph.		
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15	<i>f</i> .		
16	IV. Relief.		
17	Your complaint must include a request for specific relief. State briefly exactly what you want the court to do for you. Do not make legal arguments and do not cite any cases or statutes.		
18	Luant to by compensated for my poin and		
19	suffering to the amount of 1.3 million.		
20	I Changes nord to he made so we wil		
21	not forced to perfor wedge inhugunes conditioning		
22	- thouse at the Mando the Country fail		
23			
24	I DECLARE UNDER PENALTY OF PERJURY THAT THE FOREGOING IS TRUE AND CORRECT.		
25	Executed on: 11-17-2015 IPAN KAMMA Date Signature of Plaintiff		
	PRISONER COMPLAINT (rev. 8/2015) Page 3 of 3		

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have been found when there is an finitent ional denies of medical care, or when a prison official's conduct indicates deliberate indifference to the medical needs of prisoners.

Case 3:15-cv-03780-HSG Document 7 Filed 12/23/15 Page 7 of 10

Case 3:15-cv-03780-HSG Document 7 Filed 12/23/15 Page 8 of 10

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Jampill 130 F. 3d 432, 438 (9 Cir 1997)

See I Montell v. Dept of Social Services,
436 U.S. 658, 690 (1978)

California Forensic Medical Moup

who Contracts with the State to,

provide a service acts under the Color

of State law as they were an affirmative

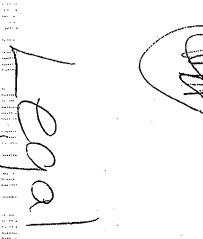
l'obligation to provide medical Care to

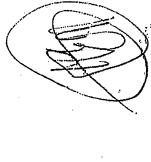
mismers see West 487 U.S. at 55-56

(1988) CMF6 is therefore obligated to prove case that is protected by the eighth

anendment of the Constitution.

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1	Stephen A. Mason, Esq. (SBN:36454) LAW OFFICES OF STEPHEN A. MASON				
2	432 D Street				
3	3 Telephone: (530) 760-4070	Davis, CA 95616 Telephone: (530) 760-4070			
4	Facsimile: (530) 760-4071 E-mail: steve@stevemasonlaw.com				
5		Attorneys for Plaintiff			
6	JULIAN MURPHY, a minor, by and through Steven Murphy, the duly appointed Guardian of the person and estate of Julian Murphy				
7					
8	UNITED STATES DIS	UNITED STATES DISTRICT COURT			
9	NORTHERN DISTRICT	NORTHERN DISTRICT OF CALIFORNIA			
10					
11	= 11	No.: 1:15-cv-04624-NJV			
12	through Steven Murphy, the duly appointed Guardian of the person and	OND AMENDED COMPLAINT FOR			
13	3 estate of Julian Murphy, CIV	IL RIGHTS VIOLATIONS PURSUANT			
14		12 U.S.C. §1983; WRONGFUL DEATH; STATE LAW CLAIMS MAND FOR JURY TRIAL]			
15	5 VS.	MAND FOR JORT TRIAL			
16					
17	COUNTY OF MENDOCINO; CALIFORNIA FORENSIC MEDICAL GROUP; TAYLOR				
18	FITHIAN, M.D.; and DOES 1 through				
19	100, all in their individual and official capacities.				
20	$\mathbf{p} \parallel$				
21	Defendants.				
22	INTRODUCTION				
23	This is an action resulting from the wrongf	ul death of Shane Allen Murphy, a 36 year			
24	old inmate of Mendocino County Adult Detention Facility in Ukiah, California, with a medica				
25	history of mental health conditions. Mr. Murphy died in custody on October 8, 2014				
26	Blaintiff, JULIAN MURPHY, is the minor child of de	Plaintiff, JULIAN MURPHY, is the minor child of decedent, Shane Allen Murphy.			
27	///				
28	3 / / /				
- 1	11				

Plaintiff is suing for violations of civil rights pursuant to 42 U.S.C. section 1983 for wrongful death pursuant to California Code of Civil Procedure section 377.60 et seq., associated survival actions pursuant to California Code of Civil Procedure section 377.20 et seq. and associated causes of action under the California Government Code.

JURISDICTION AND VENUE

- 1. This case is brought pursuant to 42 U.S.C. §1983. Jurisdiction is based on 28 U.S.C. §§ 1331. With respect to those claims brought pursuant to California law, plaintiff has complied with the administrative claim requirements. The court has supplemental jurisdiction over plaintiff's state claims pursuant to 28 U.S.C. §1367.
- 2. The claims alleged herein arose in the City of Fort Bragg and County of Mendocino, State of California. Therefore, venue is proper in the Northern District of California pursuant to 28 U.S.C. § 1391(b)(2).

DEMAND FOR JURY TRIAL

3. Plaintiff demands a jury trial.

EXHAUSTION OF PRE-LAWSUIT PROCEDURES

4. Plaintiff JULIAN MURPHY, a minor, by and through Steven Murphy, the duly appointed Guardian of the person and estate of Julian Murphy, on behalf of himself, filed governmental tort claims with the City of Fort Bragg and Defendant COUNTY OF MENDOCINO as a pre-requisite to the state law claims alleged herein on April 6, 2015 and March 19, 2015, respectively. By correspondence dated April 21, 2015, defendant COUNTY OF MENDOCINO rejected plaintiff's governmental tort claims.

PARTIES

5. Plaintiff JULIAN MURPHY, a minor, is the son of Shane Allen Murphy. He is suing for the wrongful death of his father and his resulting loss and for the violation of Shane Allen Murphy's Fourteenth Amendment rights. JULIAN MURPHY, at all times mentioned is, a citizen of the United States of America. He resides in the County of Glenn during the events described herein.

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- organized and existing under the laws of the State of California, with the capacity to sue and be sued. Defendant COUNTY is responsible for the actions, omissions, policies, procedures, practices and customs of its various agents and agencies, and is sued in accord with the California Tort Claims Act, Government Code 910 et seq., for the acts and omissions of public employees DOES 1 through 100, and each of them. At all times relevant to the facts alleged herein, defendant COUNTY was responsible for assuring that the actions, omissions, policies, procedures, practices and customs of their employees and agents, DOES 1 through 100, complied with the laws of the State of California and the Constitution of the United States. Plaintiff is informed and believes that defendant COUNTY is responsible for administering the jail facilities and for making, overseeing, and implementing the policies, practices and customs challenged herein relating to the operation of Mendocino County Adult Detention Facility. The Mendocino County Adult Detention Facility is located at 951 Low Gap Road, Ukiah, California 95482.
- 7. Plaintiff is informed and believes and thereon alleges that Defendant CALIFORNIA FORENSIC MEDICAL GROUP is a California corporation, with a principal place of business in Monterey County, that has contracted with COUNTY OF MENDOCINO to provide medical services to the Mendocino County Adult Detention Facility since 1990.
- 8. Plaintiff is informed and believes and thereon alleges that Defendant TAYLOR FITHIAN, M.D., an individual, with a principal place of business in Monterey County, is the president and Chief of Behavioral Health Services for defendant CALIFORNIA FORENSIC MEDICAL GROUP.
- 9. Defendant DOES 1-50 were at all relevant times alleged herein, were employees of COUNTY OF MENDOCINO and/or CALIFORNIA FORENSIC MEDICAL GROUP in charge of assisting administration and operation of the Mendocino County Adult Detention Facility; making policies and/or ensuring constitutionally adequate policies were implemented and followed; commanding relevant watches; and supervising, training, and disciplining staff members.

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- 10. Defendant DOES 51-100 were at all relevant times alleged herein, COUNTY OF MENDOCINO and/or CALIFORNIA FORENSIC MEDICAL GROUP employees and others, including, but not limited to, staff of the jail, or medical personnel contracted or otherwise retained by the COUNTY OF MENDOCINO, who were involved in the wrongful death of Shane Allen Murphy, and any resultant investigation into his death.
- 11. The true names and identities of Defendants DOE 1 through DOE 100 are presently unknown to Plaintiff. Plaintiff alleges on information and belief that each of Defendants DOE 1 through DOE 100 were employed or contracted by the COUNTY OF MENDOCINO and/or CALIFORNIA FORENSIC MEDICAL GROUP at the time of the conduct alleged herein. Plaintiff alleges on information and believe that each of the Defendants DOE 1 through DOE 100 were responsible for the training, supervision and/or conduct of the FBPD, jail employees, and/or agents involved in the conduct alleged herein. Plaintiff alleges that each of Defendants DOE 1 through DOE 100 were responsible for and caused the acts and injuries alleged herein. Plaintiff alleges that each of the DOE defendants is legally responsible and liable for the incident, injuries and damages hereinafter set forth. Each defendant proximately caused injuries and damages because of their negligence, breach of duty, negligent supervision, management or control, violation of public policy, and arrest. Each defendant is liable for his or her personal conduct, vicarious or imputed negligence, fault or breach of duty, whether severally or jointly, or whether based upon agency, employment, ownership, entrustment, custody, care, control, or upon any other act or omission. Plaintiff will ask leave to amend this Complaint subject to further discovery.
- 12. Plaintiff will seek to amend this Complaint as soon as the true names and identities of Defendants DOE 1-100 have been ascertained.
- 13. In doing the acts alleged herein, Defendants, and each of them acted within the course and scope of their employment.
- 14. In doing acts and/or omissions alleged herein, Defendants, and each of them, acted under color of authority and/or under color of law.

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15. Due to the acts and/or omissions alleged herein, Defendants, and each of them, acted as the agent, servant, and employee and/or in concert with each of said other Defendants herein.

PRELIMINARY ALLEGATIONS

- 16. The COUNTY OF MENDOCINO is a public entity and is sued under Title 42 U.S.C. §1983 for violations of the Eighth and/or Fourteenth Amendments of the United States Constitution, California state law, the California Tort Claims Act, and the Government Code for the acts and omissions of the individual defendants and public employees, DOES 1-100, and each of them, who at the time they caused Plaintiff's and Shane Allen Murphy's injuries, damages, and death were duly appointed, qualified, and acting officers, employees, and/or agents of COUNTY and acting within the course and scope of their employment and or agency.
- 17. Plaintiff alleges that the conduct of each defendant deprived Shane Allen Murphy of his constitutional right to life, his constitutional right to medical and mental health care for his serious but treatable medical and mental health needs, and caused Shane Allen Murphy to suffer grievous harm, emotional and physical injuries prior to his death, and ultimately caused his death while he was in the custody of the defendants.
- 18. Each of the Defendants caused and is responsible for the unlawful conduct and resulting harm by, inter alia, personally participating in the conduct, or acting jointly and in concert with others who did so, by authorizing acquiescing, condoning, acting, omitting or failing to take action to prevent the unlawful conduct, respondent superior, by promulgating or failing to promulgate policies and procedures pursuant to which the unlawful conduct occurred, by failing and refusing to initiate and maintain adequate training, supervision and staffing with deliberate indifference to Shane Allen Murphy's rights, by failing to maintain proper and adequate policies, procedures and protocols, and by ratifying and condoning the unlawful conduct performed by agents and officers, deputies, medical providers and employees under their direction and control.

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GENERAL ALLEGATIONS

- 19. Shane Allen Murphy was 36 years old on October 8, 2014, the day of his death. He died while in custody at Mendocino County Adult Detention Facility in Ukiah, California.
- 20. He had been incarcerated at Mendocino County Adult Detention Facility in Ukiah, California since his arrest on October 6, 2014 for allegedly carrying a concealed weapon, while under the influence.
- 21. Prior to this death, Shane Allen Murphy had a medical history of mental health conditions, including, but not limited to, anxiety, panic attacks, and depression.
- 22. Shortly before his arrest, Shane Allen Murphy was under a doctor's care for mental health conditions and had been prescribed medications to treat the aforementioned mental health conditions.
- 23. At the time of his arrest, it was apparent and known to defendants, and officers of Fort Bragg Police Department, including, but not limited to, Officer McLaughlin and Officer Brandon Lee, that Shane Allen Murphy was suicidal and in need of mental health care.
- 24. Plaintiff is informed and believes that the arresting officers, Officer McLaughlin and Officer Brandon Lee knew the Shane Allen Murphy's possession of a firearm was for the purpose of Shane Allen Murphy taking his own life that morning based on his own statements and actions. As a result, the arresting officers knew or should have known that Shane Allen Murphy was suicidal at the time of his arrest and deliberately failed to obtain reasonable medical care for him.
- 25. Plaintiff is informed and believes that the arresting officers, Officer McLaughlin and Officer Brandon Lee transported Shane Allen Murphy to jail without obtaining necessary medical and mental health care.

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- 26. Plaintiff is informed and believes that the arresting officers took Shane Allen Murphy into custody and failed to inform personnel at the Mendocino County Adult Detention Facility of the circumstances of his arrest, pursuant to policies and procedures in place for arresting and transporting officers, to arrestees coming into the facility, which would have triggered suicide precautions and necessary mental health evaluations.
- 27. Plaintiff is informed and believes that Officer McLaughlin and Officer Brandon Lee knew at the time of the arrest that Shane Allen Murphy was a heightened suicide risk and failed to take reasonable measures at the time of his arrest to prevent harm from occurring.
- 28. Plaintiff is informed and believes that Defendant COUNTY OF MENDOCINO contracts with defendant CALIFORNIA FORENSIC MEDICAL GROUP to provide medical care to arrestees and inmates of the Mendocino County Adult Detention Facility.
- 29. Defendant COUNTY OF MENDOCINO, Defendant CALIFORNIA FORENSIC MEDICAL GROUP, and Defendant TAYLOR FITHIAN, M.D. all oversee health care at Mendocino County Adult Detention Center.
- 30. Plaintiff is informed and believes that DEFENDANT COUNTY OF MENDOCINO, DEFENDANT CALIFORNIA FORENSIC MEDICAL GROUP, and DEFENDANT TAYLOR FITHIAN, M.D., along with unknown jail personnel, failed in staffing a qualified medical and/or mental health professional at the jail to evaluate the mental health for incoming inmates.
- 31. Plaintiff is informed and believes that defendant COUNTY OF MENDOCINO, Defendant CALIFORNIA FORENSIC MEDICAL GROUP, and Defendant TAYLOR FITHIAN, M.D., along with unknown jail personnel have continued to allow uncredentialed staff, including licensed vocational nurses to perform intake medical assessments and/or mental health assessments on patients without any appropriate clinical supervision by a registered nurse, physician, or otherwise proper health care professional despite prior and subsequent similar incidents of jail suicide.
- 32. Plaintiff is informed and believes that jail personnel failed to conduct a medical assessment of Shane Allen Murphy when he was booked into the Mendocino County Adult

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Detention Facility and failed to follow proper protocols in assessing his medical and mental health status.

- 33. Plaintiff lacks personal knowledge about the circumstances surrounding the alleged suicide by hanging death of his father, Shane Allen Murphy.
- 34. On information and belief, Shane Allen Murphy was found by other inmates hanging by his neck in his holding cell.
- 35. On information and belief, Shane Allen Murphy was not provided with adequate medical and psychiatric care upon his arrest and later, while he was in jail.
- 36. Plaintiff alleges on information and belief that Defendants have allowed conditions at Mendocino County Adult Detention Facility to deteriorate causing an environment where health care is ignored and inmate safety is disregarded.
- 37. Plaintiff alleges on information and belief that Defendants, with deliberate indifference, gross negligence, and reckless disregard to the safety, security, and constitutional and statutory rights of plaintiff, maintained, enforced, tolerated, permitted, acquiesced in, and applied policies, practices, or customs and usages that caused the death of Shane Allen Murphy.
- 38. Plaintiff alleges on information and belief that defendants failed to train, supervise, and discipline officers, employees, and/or agents regarding the safety and protection of inmates with mental health conditions.
- 39. Plaintiff alleges on information and belief that defendants failed to comply with Mendocino County Sheriff's Office Corrections Division Policy and Procedures Manual, specifically related to mental health care, inmate classification, suicide prevention, and inmate walk through checks.
- 40. Plaintiff alleges on information and belief that defendants failed to comply with Mendocino County Adult Detention Facilities' policies and procedures pertaining to mental health care and Title 15 of the California Code of Regulations, Minimum Standards for Local Detention Facilities, Art. 10.

- 41. Plaintiff alleges on information and belief that defendants failed to place Shane Allen Murphy on suicide watch in an appropriate safety cell to allow observation with a camera.
- 42. Plaintiff alleges on information and belief that defendants have been on deliberately indifferent to the deteriorating conditions at the jail due to an increasing number of jail suicides and other mental health related injuries and fatalities within the past 5 years.
- 43. Plaintiff alleges on information and belief that defendants improperly classified Shane Allen Murphy under the Mendocino County Sheriff's Office Corrections Division Policy and Procedures Manual while he was a pre-trial arrestee in conscious disregard for his safety.
- 44. Plaintiff alleges on information and believe that defendants were trained or should have been trained under the Mendocino County Sheriff's Office Corrections Division Policy and Procedures Manual on risk factors of suicide.
- 45. Shane Allen Murphy should have been classified as a "high risk inmate" due to his arrest on alcohol related charges and exhibiting other warning signs of suicidal tendencies.
- 46. Plaintiff is informed and believes that the County jail staff had actual knowledge of Shane Allen Murphy's immediate and serious medical needs and did not provide him with care.
- 47. Plaintiff is informed and believes that defendant Mendocino County's employees and/or agents at the jail failed to inquire of City of Fort Bragg's arresting and/or transporting officers if there were indications of suicide as required under Mendocino County Sheriff's Office Corrections Division Policy and Procedures Manual.
- 48. Plaintiff is informed and believes that defendant Mendocino County's employees and/or agents at the jail failed to implement and enforce generally accepted, lawful policies and procedures of the jail, and allowing or ratifying deliberate indifference to the serious medical / psychiatric needs of inmates or arrestees. These substantial failures reflect Defendant County's policies implicitly or directly ratifying and/or authorizing the

deliberate indifference to serious medical needs and the failure to reasonably train, instruct, monitor, supervise, investigate, and discipline County employees and/or agents as to inmates' and arrestees' medical needs.

- 49. Shane Allen Murphy's death was the direct result of the Defendants failure to investigate, properly staff the facility, supervise and discipline its employees, officers, and officials notwithstanding the fact that they were on notice of Murphy's mental health condition.
- 50. Plaintiff JULIAN MURPHY was physically, mentally, emotionally, and financially injured and damaged as, a proximate result of Shane Allen Murphy's wrongful death, including, but not limited to, the loss of decedent's familial relationships, comfort, protection, companionship, love, affection, solace, and moral support. In addition to these damages, Plaintiff is entitled to recover for the reasonable value of funeral and burial expenses.
- 51. All of the individual defendants were acting under color of authority as employees and/or agents of the COUNTY.
- 52. Their actions were the proximate cause of the damages, specifically, Shane Allen Murphy suffered damages, including but not limited to, wrongful death, and his son, plaintiff, JULIAN MURPHY, lost the support of his father.
- 53. The Defendants' deliberate indifference to the serious medical needs of Shane Allen Murphy resulted in his suffering and untimely wrongful death.
- 54. As a result, plaintiff JULIAN MURPHY has lost the lifelong love and companionship of his father. Plaintiff also suffered special and general damages, according to proof at trial.
- 55. Plaintiff is Shane Allen Murphy's successor-in-interest under Code of Civil Procedure section 377.20 et seq.
- 56. Plaintiff Julian Murphy, a minor, by and through Steven Murphy, the duly appointed guardian of the person and estate of Julian Murphy, individually and as successor-in-interest of the estate of Shane Allen Murphy, Deceased has filed the required declaration under Code of Civil Procedure section 377.32. See attached as Exhibit A to this Complaint.

CAUSES OF ACTION

FIRST CAUSE OF ACTION

42 U.S.C. Section 1983

Violation of 8th and/or 14th Amendment to the Constitution Failure to Provide Medical Care (Against CALIFORNIA FORENSIC MEDICAL GROUP, TAYLOR FITHIAN, M.D. and DOES 1 through 100)

- 57. Plaintiff re-alleges and incorporates by reference Paragraphs 1 through 56 as though fully set forth herein.
- 58. Defendants failed to provide Shane Allen Murphy with appropriate medical care during and after his arrest and detention. Defendants violated Shane Allen Murphy's constitutionally protected rights by engaging in various acts, including but not limited to:
 - a) Failing to provide Shane Allen Murphy adequate, timely treatment for his mental health condition;
 - b) Failing to medically clear Shane Allen Murphy prior to placement in the Mendocino County Adult Detention Facility;
 - c) Failure to restrain Shane Allen Murphy for his safety and protection against harming himself;
 - d) Failure to monitor and/or place Shane Allen Murphy on suicide watch while detained in the Mendocino County Adult Detention Facility;
 - e) Failure to evaluate or assess Shane Allen Murphy for mental health conditions or suicidal ideation;
 - f) Failure to maintain life-saving equipment in working order;
 - g) Failure to summon emergency medical services or medical care under Government Code section 845.6;
 - h) Failure to supervise while in custody;
 - i) Failure to determine Shane Allen Murphy's medication needs during arrest, intake, and/ or detention.

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- 59. Plaintiff JULIAN MURPHY claims damages as a result, according to proof at trial.
- 60. As a result of these individual Defendants' conduct and deliberate indifference to the serious medical, mental, and physical health conditions and constitutional rights of Shane Allen Murphy, JULIAN MURPHY suffered loss of society, comfort, companionship, solace, love, affection, and services of his father, incurred funeral and burial expenses, and continues to suffer these damages.
- 61. By virtue of 42 U.S.C. Section 1988, Plaintiff is entitled to and demand an award of reasonable attorneys' fees and costs according to proof.
- 62. Each individual Defendant acted recklessly or with callous indifference to Shane Allen Murphy's mental and physical condition and constitutional rights, and should be assessed punitive damages.

WHEREFORE, Plaintiff prays for relief as set forth below.

SECOND CAUSE OF ACTION 42 U.S.C. Section 1983

Violation of the Fourteenth Amendment to the Constitution
Failure to Adequately Staff and Supervise
Mendocino County Adult Detention Facility
(Against CALIFORNIA FORENSIC MEDICAL GROUP, TAYLOR FITHIAN, M.D. and DOES 1 through 100)

- 63. Plaintiff re-alleges and incorporates by reference Paragraphs 1 through 62 as fully set forth herein.
- 64. Plaintiff is informed and believes that Defendants maintained a policy, custom or practice of understaffing the Mendocino County Adult Detention Facility with supervisory custody personnel.
- 65. Plaintiff is informed and believes that Defendants' policy, custom or practices of under staffing the jail facility with supervisory custody personnel was the moving force behind the violation of Shane Allen Murphy's constitutional rights.

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66. Defendants knew or should have known that the policy, custom or practice of under staffing the jail facility with properly trained supervisors would cause grievous injury to Shane Allen Murphy in violation of his constitutional rights.

67. As a proximate result of the conduct of Defendants, plaintiff JULIAN MURPHY suffered personal injury and emotional distress and incurred general damages for the deprivation of Shane Allen Murphy's constitutional rights.

WHEREFORE, Plaintiff prays for relief as set forth below.

THIRD CAUSE OF ACTION 42 U.S.C. Section 1983

Violation of the Fourteenth Amendment to the Constitution Failure to Adequately Train Jail Staff (Against COUNTY OF MENDOCINO and DOES 1 THROUGH 100) (Monell Claim)

- 68. Plaintiff re-alleges and incorporates by reference Paragraphs 1 through 69 as though full set forth herein.
- 69. Plaintiff is informed and believes that Defendants maintained a policy, custom or practice of under staffing the jail facility with sufficiently trained custody personnel.
- 70. Plaintiff is informed and believes that defendants' policy, custom, or practices or under staffing the jail facility with sufficiently trained custody personnel was the moving force behind the violation of Shane Allen Murphy's constitutional rights.
- 71. Plaintiff is informed and believes, and on that basis alleges, that Defendants failed to properly train custody personnel, including but not limited to members of the Mendocino County Adult Detention Facility on the proper procedures for inmate safety, use of restraints, summoning medical care, emergency medical situations, mental health intake, mental health evaluation, medication administration, suicide prevention, suicide watch, as well as the care and treatment of those inmates, such as Shane Allen Murphy, with known mental health conditions and provision of medical care.

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72. Defendants knew or should have known that the policy, custom, or practice of failing to adequately train jail staff would cause grievous injury to Shane Allen Murphy in violation of his constitutional rights.

73. As a proximate result of the conduct of defendants, JULIAN MURPHY suffered personal injury and emotional distress and incurred general damages for the deprivation of Shane Allen Murphy's constitutional rights.

WHEREFORE, Plaintiff prays for relief as set forth below.

FOURTH CAUSE OF ACTION

42 U.S.C. Section 1983

Violation of 14th Amendment to the Constitution
Policy Denying Medical Care
(Against CALIFORNIA FORENSIC MEDICAL GROUP, TAYLOR FITHIAN, M.D. and
DOES 1 through 100)

- 74. Plaintiff re-alleges and incorporates by reference Paragraphs 1 through 73 as though fully set forth herein.
- 75. Plaintiff is informed and believes that Defendants maintained a policy, custom or practice of under staffing the jail facility with properly trained and supervised medical staff.
- 76. Plaintiff is informed and believes that defendants maintained a policy, custom, or practice of denying prisoners access to medical care.
- 77. Plaintiff is informed and believes that defendants maintained a policy, custom, or practice of failing to ensure that lifesaving equipment was available, maintained, and in good working order.
- 78. Plaintiff is informed and believes that defendants' policies, customs, and /or practices of understaffing and failing to properly supervise medical staff, failing to provide access to care, and failing to maintain life-saving equipment was the moving force behind the violation of Shane Allen Murphy's constitutional rights.

- 79. Defendants knew or should have known that these policies, customs, or practices would cause grievous injury to Shane Allen Murphy in violation of his constitutional rights.
- 80. As a proximate result of the conduct of defendants, JULIAN MURPHY suffered personal injury and emotional distress and incurred general damages for the deprivation of Shane Allen Murphy's constitutional rights.

WHEREFORE, Plaintiff prays for relief as set forth below.

FIFTH CAUSE OF ACTION

(42 U.S.C. Section 1983 – Violation of Decedent's Right to Personal Safety and Security)

(Against CALIFORNIA FORENSIC MEDICAL GROUP, TAYLOR FITHIAN, M.D. and DOES 1 through 100)

- 81. Plaintiff re-alleges and incorporates by reference Paragraphs 1 through 80 as though fully set forth herein.
- 82. The Fourteenth Amendment to the United States Constitution provides that persons held in custody in jails have the right to enjoy personal safety and security and that defendants had a corresponding duty to take reasonable precautions to ensure decedent Shane Allen Murphy's physical safety and security while he was in custody.
- 83. Defendants, and each of them, breached their duty, thereby proximately causing him injury and death in violation of Decedent's Fourteenth Amendment Rights.

WHEREFORE, Plaintiff prays for relief as set forth below.

SIXTH CAUSE OF ACTION

(42 U.S.C. Section 1983 – Violation of Plaintiff's Rights to Enjoy Continued Family Relations)

(Against CALIFORNIA FORENSIC MEDICAL GROUP, TAYLOR FITHIAN, M.D. and DOES 1 through 100)

- 84. Plaintiff re-alleges and incorporates by reference Paragraphs 1 through 83 as though fully set forth herein.
- 85. The Fourteenth Amendment to the United States Constitution protects the rights of children and parents to enjoy continued family relations with each other.

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86. By proximately causing the death of Decedent, Defendants, and each of them, violated the rights of Plaintiff to enjoy the continued companionship and society of Decedent and the right of the minor plaintiff to enjoy the financial support, guidance and protection of his father.

WHEREFORE, Plaintiff prays for relief as set forth below.

SEVENTH CAUSE OF ACTION

Wrongful Death

(California Code of Civil Procedure Sections 377.60)
(Against All Defendants herein and DOES 1 through 100)

- 87. Plaintiff re-alleges and incorporates by reference Paragraphs 1 through 86 as though fully set forth herein.
- 88. At all times mentioned, all Defendants and DOES 1- 100 inclusive, were subject to a duty of care to avoid causing unnecessary physical harm and death to persons in their custody. The wrongful conduct of Defendants, as set forth herein, did not comply with the standard of care to be exercised by reasonable persons, proximately causing JULIAN MURPHY to suffer injuries and damages as set forth herein.
- 89. Pursuant to Government Code Section 815.2(a), Defendants COUNTY and CITY, CALIFORNIA FORESENIC MEDICAL GROUP and TAYLOR FITHIAN, M.D. are vicariously liable to plaintiff for injuries and damages suffered as alleged herein, incurred as a proximate result of the aforementioned wrongful conduct of its officers, employees and/or agents.
- 90. As a direct consequence of Defendants' acts, Plaintiff has been damaged and harmed.
- 91. As a proximate result of the acts, customs, policies, patterns and practices of Defendants alleged herein, JULIAN MURPHY suffered personal injury and wrongful death of his father, Shane Allen Murphy. Plaintiff JULIAN MURPHY has suffered emotional distress and incurred both special and general damages for the deprivation of his constitutional rights.

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WHEREFORE, Plaintiff prays for relief as set forth below.

EIGHTH CAUSE OF ACTION

Negligent Training, Supervision and Discipline (Against CALIFORNIA FORENSIC MEDICAL GROUP, TAYLOR FITHIAN, M.D. and DOES 1 through 100)

- 92. Plaintiff re-alleges and incorporates by reference Paragraphs 1 through 91 as though fully set forth herein.
- 93. Defendants had a mandatory duty of care to properly and adequately train, retrain, supervise, and discipline its staff at Mendocino County Adult Detention Facility so as to avoid unreasonable risk of harm to its citizens. Defendants failed to take necessary, proper, or adequate measures in order to prevent the violation of Plaintiff's rights and prevent his injury.
- 94. Defendants owed a special duty of care under the law to Shane Allen Murphy, and his son, plaintiff, Julian Murphy.
- 95. Defendants breached a duty of care to plaintiff by failing to train, retrain, supervise, and discipline its officers, staff, agents, contractors, and medical personnel within Mendocino County Adult Detention Facility.
- 96. As a proximate result of the failure to train, retain, supervise, and discipline its officers, staff, agents, contractors, and medical personnel within Mendocino County Adult Detention Facility, Plaintiff has been damaged and harmed, according to proof at trial.

WHEREFORE, Plaintiff prays for relief as set forth below.

NINTH CAUSE OF ACTION

California Government Code Sections 844.6 and 845.6 (Against CALIFORNIA FORENSIC MEDICAL GROUP, TAYLOR FITHIAN, M.D. and DOES 1 through 100)

97. Plaintiff re-alleges and incorporates by this reference Paragraphs 1 through 96 as though fully set forth herein.

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98. Pursuant to California Government Code section 845.6, these Defendants had a duty to monitor, check, and respond to the persons under their custody, supervision, and control.

- 99. Defendants knew or had reason to know that Shane Allen Murphy was in need of immediate medical care, and on-going follow up medical care, and failed to take reasonable action to summon such medical care.
- 100. As a result of Defendants breach of said duty to take reasonable action to summon such medical care to Shane Allen Murphy, Plaintiff suffered damages as set forth herein.

TENTH CAUSE OF ACTION

Survival Action (California Code of Civil Procedure Sections 377.20)

(Against All Defendants herein and DOES 1 through 100)

- 101. Plaintiff re-alleges and incorporates by reference Paragraphs 1 through 100 as though fully set forth herein.
- 102. At all times mentioned, all Defendants and DOES 1- 100 inclusive, were subject to a duty of care to avoid causing unnecessary physical harm and death to persons in their custody. The wrongful conduct of Defendants, as set forth herein, did not comply with the standard of care to be exercised by reasonable persons, proximately causing Shane Allen Murphy to suffer injuries and damages as set forth herein.
- 103. Defendants owed Shane Allen Murphy a duty of care to provide him immediate medical and mental health care. Defendants CFMG and Dr. Taylor Fithian and their employees breached this duty, causing the conduct alleged herein. Such breach constituted negligent hiring, supervision, training and retention under the laws of the State of California.

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104. The conduct of Defendant CFMG, Dr. Fithian, and their employees alleged herein, including but not limited to the facts that Defendants knew or had reason to know that Shane Allen Murphy was in need of immediate medical and mental health care. Defendants CFMG and Dr. Fithian had a duty to hire, supervise, train, and retrain employees and/or agents so that employees and/or agents refrain from the conduct and/or omissions alleged herein.

- 105. Defendant County had a duty to supervise and train or retrain CFMG, Dr. Fithian, or CFMG employees to prevent the conduct and/or omissions alleged herein.
- 106. Defendant County had knowledge of the conduct and/or omissions alleged herein and continued to maintain their contract or relationship with CFMG and Dr. Fithian, to the detriment of Shane Allen Murphy.
- 107. Defendants failed to timely and appropriately respond to Shane Allen Murphy's expressions of suicidal ideation.
- 108. Pursuant to Government Code Section 815.2(a), Defendants COUNTY, CALIFORNIA FORESENIC MEDICAL GROUP and TAYLOR FITHIAN, M.D. and DOES 1-100 are vicariously liable to Shane Allen Murphy for injuries and damages suffered as alleged herein, incurred as a proximate result of the aforementioned wrongful conduct of its officers, employees and/or agents. At all times mentioned, defendants were in the course and scope of their employment.
- 109. As a direct consequence of Defendants' acts and breach of duty, Shane Allen Murphy and Julian Murphy suffered injury and damages cause great pain and leading to his death, as alleged herein.
- 110. As a proximate result of the acts, customs, policies, patterns and practices of Defendants alleged herein, Shane Allen Murphy suffered personal injury and wrongful death. As a result, Plaintiff has incurred both special and general damages for the deprivation of Shane Allen Murphy's constitutional rights, according to proof at trial.

WHEREFORE, Plaintiff prays for relief as set forth below.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff JULIAN MURPHY prays for relief as follows:

- 1. For General Damages in the sum of \$25,000,000 (Twenty Five Million Dollars);
- For Special Damages according to proof;
- 3. For punitive damages against the appropriate defendants;
- 4. For funeral and burial expenses according to proof;
- 5. For damages for future lost earnings and lost earning capacity according to proof;
 - For other losses in an amount according to proof;
 - 7. For costs of suit;
- 8. For attorneys' fees and costs pursuant to 42 U.S.C. §1988, and as otherwise authorized by statute or law;
- 9. For declaratory relief as the court deems appropriate including revision of the defendants' policies related to the handling and restraining of prisoners with mental health conditions, suicide prevention, and ensuring that medical and custody staffing levels are maintained at constitutional standards, and ensuring that sufficient and effective supervision and oversight over jail operations are in place;
 - 10. For such other relief as the Court deems proper.

DATED: July 19, 2016.

Law Offices of Stephen A. Mason

By /s/
Stephen A. Mason
Attorney for Plaintiff JULIAN MURPHY, a minor, by and through Steven Murphy, the duly appointed Guardian of the person and estate of Julian Murphy

JURY DEMAND

Plaintiff hereby demands a jury trial in this action.

DATED: July 19, 2016.

Law Offices of Stephen A. Mason

Stephen A. Mason
Attorney for Plaintiff
JULIAN MURPHY, a minor, by and through Steven
Murphy, the duly appointed Guardian of the person
and estate of Julian Murphy

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7
                           UNITED STATES DISTRICT COURT
8
                         NORTHERN DISTRICT OF CALIFORNIA
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    JAMES NEUROTH, Individually and as
    Successor in Interest of Decedent STEVEN
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                                                  Case No. 1:15-CV-03226-NJV
    KELLOGG NEUROTH,
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                Plaintiff,
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                                                  THIRD AMENDED COMPLAINT
          vs.
                                                  FOR DAMAGES AND DEMAND
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    MENDOCINO COUNTY, a public entity;
                                                  FOR JURY TRIAL
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    MENDOCINO COUNTY SHERIFF-
    CORONER THOMAS D. ALLMAN,
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   individually; CORRECTIONS CAPTAIN TIM
   PEARCE; SERGEANT LORI KNAPP;
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    DEPUTY FRANK MASTERSON; DEPUTY
    CRAIG BERNARDI; DEPUTY MICHAEL
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    GRANT; DEPUTY JEANETTE HOLUM;
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   DEPUTY ROBERT PAGE; DEPUTY
    CHRISTINE DE LOS SANTOS; CITY OF
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    WILLITS, a public entity; WILLITS POLICE
    OFFICER KEVIN LEEF; CALIFORNIA
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    FORENSIC MEDICAL GROUP,
    INCORPORATED, a California corporation;
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    TAYLOR FITHIAN, M.D.; JENNIFER L.
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    CAUDILLO, L.V.N., and COUNTY
    DEPUTIES DOES 9-20, and DOES 23-35,
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    individually, jointly, and severally,
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               Defendants.
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Case No. 1:15-CV-03226-NJV - THIRD AMENDED COMPLAINT AND JURY DEMAND

Plaintiff, by and through his attorneys, HADDAD & SHERWIN LLP, for his Third Amended Complaint against Defendants, states as follows:

JURISDICTION

1. This is a civil rights wrongful death/survival action arising under 42 U.S.C. §§ 1983 and 1988, and the Fourth and Fourteenth Amendments to the United States Constitution, and the laws and Constitution of the State of California. Jurisdiction is conferred upon this Court by 28 U.S.C. §§ 1331 and 1343. Plaintiff further invokes the supplemental jurisdiction of this Court pursuant to 28 U.S.C. § 1367, to hear and decide claims arising under state law. The amount in controversy herein, excluding interest and costs, exceeds the minimum jurisdictional limit of this Court.

INTRADISTRICT ASSIGNMENT

2. A substantial part of the events and/or omissions complained of herein occurred in the County of Mendocino, California, and this action is properly assigned to the Oakland or San Francisco Division of the United States District Court for the Northern District of California.

PARTIES AND PROCEDURE

- 3. Plaintiff JAMES NEUROTH is the brother of Decedent STEVEN NEUROTH and a resident of the State of California. Plaintiff JAMES NEUROTH brings these claims individually and as successor in interest for Decedent STEVEN NEUROTH pursuant to California Code of Civil Procedure §§ 377.10 et seq. Decedent STEVEN NEUROTH had no children, and his parents are deceased, making his brother, Plaintiff JAMES NEUROTH, entitled to intestate succession as his next of kin.
- 4. Plaintiff brings these claims pursuant to California Code of Civil Procedure §§ 377.20 et seq. and 377.60 et seq., which provide for survival and wrongful death actions. Plaintiff also brings his claims individually and on behalf of Decedent STEVEN NEUROTH on the basis of 42 U.S.C. §§ 1983 and 1988, the United States Constitution, federal and state civil rights law, and California law.

- 5. Defendant COUNTY OF MENDOCINO ("COUNTY") is a public entity, duly organized and existing under the laws of the State of California. Under its authority, the COUNTY operates the Mendocino County Sheriff's Office (MCSO).
- 6. Defendant SHERIFF-CORONER THOMAS D. ALLMAN ("ALLMAN"), at all times mentioned herein, was employed by Defendant COUNTY as Sheriff-Coroner for the COUNTY, and he was acting within the course and scope of that employment. In that capacity, Defendant ALLMAN was a policy making official for the COUNTY OF MENDOCINO. Further, Defendant ALLMAN was ultimately responsible for the provision of medical care to inmates at the jails, including assessing inmates for possible mental health needs, and all CFMG policies, procedures, and training related thereto. He is being sued individually.
- 7. Defendant CORRECTIONS CAPTAIN TIM PEARCE ("PEARCE"), at all times mentioned herein, was employed by Defendant COUNTY as Captain and Commander of the Corrections Division, including the jail, for the COUNTY, and he was acting within the course and scope of that employment. In that capacity, Defendant PEARCE was a policy making official for the COUNTY OF MENDOCINO. Further, Defendant PEARCE was responsible for the general management and control of the Corrections Division, with primary authority and responsibility for the operations, staff assignments, program development, personnel supervision and training, maintenance and auxiliary inmate services at the jail, subordinate only to the Sheriff and/or Undersheriff.
- 8. Defendant SERGEANT LORI KNAPP ("KNAPP"), at all times mentioned herein, was employed by Defendant COUNTY as a sergeant and supervisor at the jail, and was acting within the course and scope of that employment.
- 9. Defendant DEPUTY FRANK MASTERSON ("MASTERSON"), at all times mentioned herein, was employed by Defendant COUNTY as a corrections deputy at the jail, and was acting within the course and scope of that employment.
- 10. Defendant DEPUTY CRAIG BERNARDI ("BERNARDI"), at all times mentioned herein, was employed by Defendant COUNTY as a corrections deputy at the jail, and was acting within the course and scope of that employment.

- 11. Defendant DEPUTY MICHAEL GRANT ("GRANT"), at all times mentioned herein, was employed by Defendant COUNTY as a corrections deputy at the jail, and was acting within the course and scope of that employment.
- 12. Defendant DEPUTY JEANETTE HOLUM ("HOLUM"), at all times mentioned herein, was employed by Defendant COUNTY as a corrections deputy at the jail, and was acting within the course and scope of that employment.
- 13. Defendant DEPUTY ROBERT PAGE ("PAGE"), at all times mentioned herein, was employed by Defendant COUNTY as a corrections deputy at the jail, and was acting within the course and scope of that employment.
- 14. Defendant DEPUTY CHRISTINE DE LOS SANTOS ("DE LOS SANTOS"), at all times mentioned herein, was employed by Defendant COUNTY as a corrections deputy at the jail, and was acting within the course and scope of that employment.
- 15. Defendant CITY OF WILLITS is a public entity, duly organized and existing under the laws of the State of California. Under its authority, the CITY operates the Willits Police Department.
- 16. Defendant WILLITS POLICE OFFICER KEVIN LEEF ("LEEF"), at all times mentioned herein, was employed by Defendant CITY OF WILLITS as a police officer, and was acting within the course and scope of that employment. Defendants MENDOCINO COUNTY, CITY OF WILLITS, and OFFICER KEVIN LEEF intentionally concealed the extent and nature of LEEF'S involvement in STEVEN NEUROTH'S death, and LEEF'S abusive and torturous mistreatment of STEVEN NEUROTH while he was in psychiatric crisis. Plaintiff only discovered LEEF'S misconduct and the extent of LEEF'S involvement after the COUNTY produced disclosures in this matter on or about March 31, 2016.
- 17. Defendant COUNTY DEPUTIES DOES 9–20 were each at all times herein mentioned deputy sheriffs employed by Defendant COUNTY, and each was acting within the course and scope of that employment.
- 18. In engaging in the conduct described herein, Defendant COUNTY DEPUTIES DOES 9–20 acted under the color of law and in the course and scope of their employment with the COUNTY.

- 19. Defendant CALIFORNIA FORENSIC MEDICAL GROUP, INC. ("CFMG"), was at all times herein mentioned, a California corporation licensed to do business in California. Defendant CFMG provided medical and nursing care to prisoners and detainees in Mendocino County jails, pursuant to contract with the COUNTY OF MENDOCINO. On information and belief, CFMG and its employee and agent Defendant TAYLOR FITHIAN, M.D., are responsible for making and enforcing policies, procedures, and training related to the medical care of prisoners and detainees in Defendant COUNTY OF MENDOCINO's jails, including assessing inmates for mental health needs.
- 20. Defendant TAYLOR FITHIAN, M.D. ("FITHIAN") was at all times herein mentioned a physician licensed to practice medicine in the State of California, an employee and/or agent of Defendant CFMG, working as the medical director of Defendant COUNTY's jails responsible for overseeing and providing medical care to prisoners and detainees, and he was acting within the course and scope of that employment. In that capacity, Defendant FITHIAN was a policy making official for CFMG. On information and belief, Defendant FITHIAN was ultimately responsible for CFMG's provision of medical care to inmates at the jails, including assessing inmates for possible mental health needs, and all CFMG policies, procedures, and training related thereto.
- 21. Defendant JENNIFER CAUDILLO, L.V.N. ("CAUDILLO") was at all times herein mentioned employed by Defendant CFMG as a licensed vocational nurse in Defendant COUNTY OF MENDOCINO's jails, and was acting within the course and scope of that employment. On information and belief, Defendant CAUDILLO performed the intake medical assessment on Decedent when he was booked into jail, and failed to follow appropriate protocols for assessing, monitoring, and treating Decedent STEVEN NEUROTH, including failing to summon medical care for Decedent STEVEN NEUROTH despite his exhibiting symptoms consistent with having a medical and/or mental-health emergency requiring immediate transfer to a hospital for inpatient emergency and psychiatric treatment.
- 22. Plaintiff is ignorant of the true names and capacities of Defendant DOES 9-20, 23-35 ("REMAINING DEFENDANT DOES") and therefore sues these Defendants by such fictitious names. Plaintiff is informed and believes and thereon alleges that each Defendant so named is Case No. 1:15-CV-03226-NJV THIRD AMENDED COMPLAINT AND JURY DEMAND

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responsible in some manner for the injuries and damages sustained by Plaintiff as set forth herein.

Plaintiff will amend his complaint to state the names and capacities of remaining DOE

DEFENDANTS when they have been ascertained.

- 23. Plaintiff is informed and believes and thereon alleges that each of the Defendants was at all material times an agent, servant, employee, partner, joint venturer, co-conspirator, and/or alter ego of the remaining Defendants, and in doing the things herein alleged, was acting within the course and scope of that relationship. Plaintiff is further informed and believes and thereon alleges that each of the Defendants herein gave consent, aid, and assistance to each of the remaining Defendants, and ratified and/or authorized the acts or omissions of each Defendant as alleged herein, except as may be hereinafter specifically alleged. At all material times, each Defendant was jointly engaged in tortious activity and an integral participant in the conduct described herein, resulting in the deprivation of Plaintiff's and Decendent's constitutional rights and other harm.
- 24. The acts and omissions of all DEFENDANTS as set forth herein, except for Defendants CITY OF WILLITS and OFFICER LEEF, were at all material times pursuant to the actual customs, policies, practices and procedures of the COUNTY, the Mendocino County Sheriff's Office and/or CFMG. The acts and omissions of Defendant WILLITS POLICE OFFICER KEVIN LEEF were at all material times pursuant to the actual customs, policies, practices and procedures of the CITY OF WILLITS and the Willits Police Department.
- 25. At all material times, each Defendant acted under color of the laws, statutes, ordinances, and regulations of the State of California and either Mendocino County or the City of Willits.
- 26. Plaintiff timely and properly filed a tort claim pursuant to California Government Code sections 910 et seq., and this action is timely filed within all applicable statutes of limitation.
- 27. This complaint may be pled in the alternative pursuant to Federal Rule of Civil Procedure 8(d).
- 28. This Third Amended Complaint is being filed pursuant to the District Court's "Amended Order on Motion to Dismiss," dated January 29, 2016, to reflect the rulings already made in that order (Doc. 39). Further, Plaintiff, and all named Defendants herein, have additional facts supporting Plaintiff's claims that Plaintiff is precluded from stating in this amended complaint

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due to Defendants' improper confidentiality designations over documents and audio and video recordings produced in this matter, and which presently are the subject of Plaintiff's motion challenging confidentiality designations (Doc. 55).

GENERAL ALLEGATIONS

- 29. Plaintiff realleges each and every paragraph in this complaint as if fully set forth here.
- 30. STEVEN NEUROTH was a mentally ill man, having been diagnosed with paranoid schizophrenia, schizo-affective disorder, and depression. When STEVEN NEUROTH died, he was fifty-five years old; he was about 5'9" tall, and he weighed about 156 lbs.
- 31. On or about June 10, 2014, at approximately 10:00 p.m., Willits Police Department Officer Andrade and Defendant Officer LEEF contacted STEVEN NEUROTH in public, who was in a psychiatric crisis, paranoid and delusional, and told the officers that an unknown person was after him, and that all the traffic in Willits was going to hurt him. Plaintiff is informed and believes and thereon alleges Defendant Officer LEEF believed that taking a person who is "5150" (in psychiatric crisis and either unable to care for himself or a danger to himself or others pursuant to Welfare and Institutions Code § 5150) to jail is always preferable to taking them to a hospital for emergency psychiatric care, and further he would rather take STEVEN NEUROTH to the MENDOCINO COUNTY jail than sit at a hospital with STEVEN NEUROTH. Plaintiff is informed and believes and thereon alleges that Defendant COUNTY's refusal to provide any psychiatric inpatient acute care anywhere within the COUNTY creates a disincentive for law enforcement officers within the COUNTY to take people suffering from psychiatric emergencies to a hospital for needed treatment, as the officers must transport the person several miles outside the county and wait with him or her until admission. Defendant COUNTY'S deliberate indifference and reckless disregard for the wellbeing of mentally ill patients within the COUNTY causes mentally ill persons in psychiatric crisis to be taken to MENDOCINO COUNTY jail, instead of to a hospital where they can receive emergency and necessary psychiatric treatment. Officer Andrade and Defendant LEEF discussed having a family member come to pick up STEVEN NEUROTH,

and STEVEN told them to call his brother, Plaintiff JAMES NEUROTH. Officers Andrade and 1 2 LEEF instead arrested STEVEN NEUROTH on suspicion that he was under the influence of a 3 controlled substance in violation of California Health & Safety Code § 11550(a). According to the officers' report(s), STEVEN NEUROTH was "extremely paranoid," "believed someone was out to 4 5 'kill him," and "was going through a psychosis state." Once STEVEN NEUROTH was in the 6 officers' patrol car, he told them that there were "snakes" on the patrol car's floor, and "started to scream." On information and belief, when Defendant LEEF was transporting STEVEN 8 NEUROTH, Defendant LEEF intentionally provoked, agitated, and terrorized STEVEN NEUROTH, including by repeatedly yelling, "snakes!" and causing STEVEN NEUROTH's mental 10 disturbance and paranoia to further escalate. Defendant Officer LEEF transported STEVEN 11 NEUROTH to the Mendocino County jail, where he was booked and held as a pretrial detainee. At 12 the time of booking, Decedent did not have any apparent physical injuries. On information and 13 belief, Defendant LEEF did not inform jail staff that STEVEN NEUROTH's paranoid, aggravated, 14 and disoriented mental condition was due in part to LEEF's intentional provocation and mental torture of STEVEN NEUROTH before bringing him to the jail. LEEF"s emotional abuse and 15 intentional provocation of STEVEN NEUROTH made it much more difficult for STEVEN 16 17 NEUROTH to understand or follow lawful directions.

32. On information and belief, Defendant LEEF knew or must have known that STEVEN NEUROTH was in need of emergency psychiatric care, known as a "5150 hold," because STEVEN NEUROTH was a danger to himself due to his mental disturbance and impairment. Because the COUNTY closed its psychiatric health facility in 1999 as described in more detail herein, and as Defendant SHERIFF ALLMAN has been quoted, "In Mendocino County, since there is no inpatient psychiatric facility where this 72-hour holding can occur, this assessment, called a 5150, often means a trip to the county jail," Defendant LEEF chose to transport and book STEVEN NEUROTH for a minor crime at the jail, rather than take STEVEN NEUROTH to a psychiatric facility in another county as required for his serious psychiatric needs.

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33. At about 11:40 p.m. on the day of STEVEN NEUROTH'S arrest, on information and belief, Defendant JENNIFER CAUDILLO, L.V.N., and possibly other named Defendants and/or remaining DOES, performed the jail's intake medical and mental health assessment on STEVEN NEUROTH. As a matter of California law, as a Licensed Vocational Nurse, Defendant CAUDILLO was not competent and was not permitted by her license to conduct an intake medical or mental health assessment on an inmate, including STEVEN NEUROTH. According to the Coroner's Investigator's Report, Defendant CAUDILLO took STEVEN NEUROTH's vital signs. Defendant CAUDILLO noted that STEVEN NEUROTH's heart beat was 129 beats per minute, which indicated that he was suffering from tachycardia, given that a healthy adult heart normally beats 60–100 times per minute. Defendant CAUDILLO further noted both that STEVEN NEUROTH's blood pressure was 151/92, whereas normal blood pressure is less than 120/80, and that his respiration rate was 18 breaths per minute, whereas the respiration rate for a normal adult is 12 breaths per minute. Defendant CAUDILLO noted that STEVEN NEUROTH was "very paranoid." Defendant CAUDILLO and any other Defendant involved in STEVEN NEUROTH's intake had actual knowledge that STEVEN NEUROTH was in extreme medical and psychiatric distress and in need of emergency medical/psychiatric care, and she/they decided not to provide or request such necessary care for STEVEN NEUROTH, and she/they decided not to secure, or request, such necessary treatment for STEVEN NEUROTH in a hospital.

- 34. On information and belief, Defendants CAUDILLO and the remaining DOE DEFENDANTS knew and/or must have known that STEVEN NEUROTH had serious medical and psychiatric needs requiring emergency treatment, care, and hospitalization, and that with deliberate indifference to such needs, Defendant CAUDILLO and/or remaining DOES caused STEVEN NEUROTH to be deprived of such necessary, life-saving medical and psychiatric care.
- 35. At approximately 11:30 p.m. on June 10, 2014, while jail and CFMG staff had actual knowledge that STEVEN NEUROTH was apparently psychotic, paranoid, and suffering from serious medical/psychiatric needs, Defendants were deliberately indifferent to those serious medical/psychiatric needs, and denied STEVEN NEUROTH necessary medical and/or psychiatric

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care, including necessary emergency care. Defendants were deliberately indifferent to STEVEN NEUROTH's safety and medical/psychiatric needs in their jail placement, assessment, and custody decisions. On information and belief, due to such deliberate indifference, STEVEN NEUROTH's medical/psychiatric condition deteriorated, and on information and belief, STEVEN NEUROTH became unable to care for himself or to understand and follow the commands and directives of jail personnel.

36. When STEVEN NEUROTH allegedly acted paranoid and was briefly uncooperative but not aggressive or threatening in any way, Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS used a high level of injurious force against STEVEN NEUROTH that was sufficient to cause his death. On information and belief, such injurious force was used against STEVEN NEUROTH in the Sobering Cell and then continued after he was carried out in handcuffs and leg restraint shackles and placed in Safety Cell No. 2. On information and belief, among other uses of force, Defendants MASTERSON and BERNARDI participated in slamming STEVEN NEUROTH to the floor of the Sobering Cell while he was still handcuffed. In the Sobering Cell, Defendants MASTERSON and BERNARDI, were quickly joined by Defendants LEEF, KNAPP, GRANT, and HOLUM, who integrally participated in the uses of force against STEVEN NEUROTH, including painful control holds, improper restraint impairing STEVEN NEUROTH'S ability to breathe, and other significant force. In the Sobering Cell and Safety Cell No. 2, Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS integrally participated in the use of very high levels of force against STEVEN NEUROTH over more than sixteen minutes, including multiple closed fist strikes, control holds, pain compliance holds including "figure 4" leg restraints and wrist locks, and very substantial compression to STEVEN NEUROTH's neck and back impairing his respiration. On information and belief, at one point while Defendants were applying great concerted force on STEVEN NEUROTH's legs and joints with a "figure 4" pain compliance hold, a female Defendant threatened to the effect, "Your leg is going to break if you move it." Defendant KNAPP also threatened STEVEN NEUROTH with her Taser. Most of this concerted force against

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STEVEN NEUROTH was done while he was already fully restrained in both handcuffs and leg shackles. Before and during the time that Defendants used and permitted the use of such extreme and unnecessary force, STEVEN NEUROTH was repeatedly pleading with Defendants not to hurt him or kill him with statements such as, "I'm not a bad guy," "Please don't hurt me, please don't hurt me, please don't hurt me," "God help me," "Please don't let me die," and "Please don't kill me, please don't kill me." Defendants killed STEVEN NEUROTH, who never posed an immediate threat to anyone to justify the high level of injurious force used and permitted against him in the jail.

Additionally, on information and belief, Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS subjected STEVEN NEUROTH to improper and excessive restraint, leading to restraint associated asphyxia (or positional asphyxia) and death. During this entire incident over sixteen minutes, after Defendants slammed STEVEN NEUROTH to the floor, Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS improperly restrained STEVEN NEUROTH in a prone, face down position, contrary to generally accepted law enforcement and corrections standards (see, Drummond v. City of Anaheim, 343 F.3d 1052, 1056-57 (9th Cir. 2003), cert. den. 542 U.S. 918 (2004)), in violation of Defendants' own training, and in violation of MCSO's written policies and procedures. Section 1058 of Title 15 of the California Code of Regulations provides that restraints should not be used as a substitute for treatment. On information and belief, for several minutes, with our without Defendant PAGE involved, Defendants KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, and DE LOS SANTOS used their combined weight to press STEVEN NEUROTH to the floor while he was laying prone, on his stomach. Defendants KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS continued to apply great pressure to STEVEN NEUROTH's back until he became silent, motionless and limp, then Defendants left STEVEN NEUROTH face down with his hands still resting on his own lower back, released from handcuffs. Defendants exited the cell to get their stories straight to prepare to write their reports. STEVEN NEUROTH never moved again from that prone position, his hands

Cell.

38. Plaintiff is informed and believes and thereon alleges that asphyxiation of individuals

still resting, limp, on his own back, in which Defendants left him prone on the floor of the Safety

- during restraint is well documented and generally accepted such that reasonable law enforcement agencies as a matter of routine train their peace officer personnel in avoiding asphyxiation of individuals during restraint. On information and belief, Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS, and possibly remaining DOE Defendants, violated such generally accepted standards and training, among other ways, by restraining and leaving STEVEN NEUROTH restrained in a prone position, lying face down, and/or otherwise impairing STEVEN NEUROTH's respiration by their use of pressure and improper restraints.
- 39. According to the official Mendocino County autopsy, injuries that DEFENDANTS caused to STEVEN NEUROTH in the jail included:
 - Blunt force injuries (contusions, abrasions, avulsions), widespread;
 - Fracture, essentially non-displaced, of the left fifth rib at the costochondral junction;
 - General visceral passive hyperemia (organ injuries);
 - Petechiae, epicardial, focal; and other serious physical injuries.

STEVEN NEUROTH did not have these injuries when he entered the Mendocino County Jail. Due to DEFENDANTS' deliberate indifference to his serious medical/psychiatric needs, and the excessive and unreasonable force used by LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS, STEVEN NEUROTH suffered severe injuries, and died on June 11, 2014, at approximately 12:46 a.m.

40. In addition to the foregoing evidence of the use of unjustified, injurious force on STEVEN NEUROTH, Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS, and possibly remaining DOE Defendants, also caused further trauma to STEVEN NEUROTH as noted in the autopsy performed by the COUNTY's

1	Office of the Sheriff-Coroner, Defendant THOMAS D. ALLMAN, on or about June 12, 2014, all					
2	evidence of their use of a very high degree of unnecessary force on STEVEN NEUROTH:					
3	Head and Front Torso					
4	o 1" x 0.75" contusion covering the right zygoma (cheekbone);					
5	o 2" irregular area of slight contusions on the right lateral clavicular line in the					
6	skin overlying the lateral pectoralis muscle;					
7	o 0.25" slight abrasion on the mid right rib cage;					
8	o 0.5" contusion overlying the right anterior superior iliac spine (pelvis);					
9	o 0.75" contusion in a contralateral position to the right anterior superior iliac					
10	spine;					
11	o 1.5" faint contusion on the abdominal wall;					
12	o 1.25" contusion lateral to the left mid clavicular line over the inferior most					
13	rib cage;					
14	o 0.5" rounded contusion slightly above and to the side of the 1.25" contusion					
15	described immediately above;					
16	o 0.75" rounded contusion slightly above and to the side of the 1.25" contusion					
17	described above;					
18	Back and Buttocks					
19	o 1.375" diagonally oriented linear abrasion near the right mid scapular line at					
20	the inferior extent of the rib cage;					
21	o 1.5" contusion near the right mid scapular line at the inferior extent of the rib					
22	cage;					
23	 0.5" contusion in the skin overlying the mid right scapula; 					
24	o 0.25" contusion in the skin of the inferior lateral aspect of the right buttock;					
25	Right Upper Extremity					
26	o 1.75" contusion in the proximal portion of the distal third of the right arm;					
27	o 1" vertical linear abrasion in the proximal portion of the distal third of the					

1	right arm;
2	o 0.5" faint contusion in the ventrolateral mid portion of the right forearm;
3	o 1.75" contusion, bearing a 0.5" abrasion and a milder 0.75" abrasion on the
4	ventrolateral aspect of the right distal most forearm;
5	o 0.5" minimal abrasion just distal to the junction of approximately the middle
6	and distal thirds of the right forearm ventrolaterally;
7	o 2" x 0.75" contusion with a 0.5" horizontal mild abrasion and a 0.125"
8	punctate abrasion on the right hand, overlying the proximal second
9	metacarpal and extending to the wrist;
10	o 1" region of irregular punctate abrasions between the right second and third
11	metacarpals just proximal to the metacarpophalangeal joints;
12	o 0.75" contusion (lying adjacent to the previously described contusion) on the
13	dorsolateral aspect of the right forearm at the junction of the middle and
14	distal thirds;
15	o 0.5" abrasion near the head of the right radius dorsomedially
16	o 1.25" area containing three irregular abrasions near the head of the right
17	radius dorsomedially;
18	o 1" contusion with dorsally situated abrasions of up to 0.125" on the medial
19	aspect of the right wrist at the base of the thenar eminence;
20	o 0.5" abrasion of the dorsal/dorsomedial aspect in the proximal portion of the
21	proximal third of the right arm;
22	o 0.375" faint contusion on the medial aspect of the right elbow.
23	Left Upper Extremity
24	o 0.375" and 0.25" minimal abrasions on the medial aspect of the proximal
25	most portion of the left arm;
26	o 0.375" region of abrasions just proximal to the olecranon, on the distal most
27	portion of the dorsum of the left arm;
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- 2" irregular contusion with abrasion, one linear and 1.25" long, on the dorsal aspect of the proximal most left arm;
- 1" mild contusion on the anterior aspect of the left arm in the mid portion of the distal third;
- 2.25" contusion, with a slight abrasion, on the lateral aspect of the proximal portion of the distal third of the left forearm, curling about the radius.
- o 0.75" contiguous region of contusion, with mild abrasions, immediately distal to the 2.25" contusion described immediately above;
- 1" irregular contusion, slightly abraded, on the lateral aspect of the left wrist near the head of the radius;
- 0.2" by up to 0.75" contusion on the dorsum of the left wrist joint;
- 0.5" contusion, with slight abrasion, between the proximal-most portions of the proximal phalanges of the left third and fourth fingers.

Right Lower Extremity

- 0.625" irregular region of abrasion on the medial aspect of the right knee;
- 0.75" region of linear contusion in the distal portion of the distal third of the medial aspect of the right leg;
- 1.25" contusion, with mild avulsion of the epidermis not associated with bleeding, overlying the right medial malleolus;
- 0.5" irregular abrasion on the anterolateral aspect of the proximal most right leg;

Left Lower Extremity

- o 0.25" area of very minimal punctate abrasions and mild contusions beginning on the medial aspect of the left knee and extending distally for about 3".
- 1" slightly diagonal linear abrasion immediately dorsal to the region immediately described;
- 1.75" region of contusion, with a 0.5" abrasion with minimal avulsions, on

the anterior aspect of the left leg in the mid distal third;

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o 0.75" contusion on the superior aspect of the left hallux

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50 mm region of petechiae in the epicardium of the posterior aspect of the

- 41. Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS, and possibly remaining DOE Defendants, grossly violated the generally accepted training and standards for proper and safe restraint of a person, and for use of force, in their misconduct against STEVEN NEUROTH. Plaintiff also alleges that the extreme physical injuries to STEVEN NEUROTH—especially the injuries to Decedent's torso and neck are all evidence of an extremely high degree of force, of improper restraint, and of wanton and willful violations of STEVEN NEUROTH's and Plaintiff's Constitutional rights.
- 42. Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS, and possibly remaining DOE Defendants, on information and belief, were present and integral participants in their joint conduct to severely beat, punch, choke, improperly restrain, contort, threaten, and brutalize STEVEN NEUROTH. On information and belief, Defendants' uses of unnecessary and excessive force against STEVEN NEUROTH lasted over sixteen minutes before he died. Each Defendant deputy/officer used, or caused the use of, extreme and/or deadly force against STEVEN NEUROTH, causing severe injuries and deadly trauma to him, including but not limited to as described above. On information and belief, at the time Defendants used such force and restraints on STEVEN NEUROTH, as described herein, STEVEN NEUROTH never struck or kicked any deputy/officer, and did not pose an immediate threat to any person. Decedent STEVEN NEUROTH was severely mentally ill, suffering from psychosis, was weak and thin, and was vastly outnumbered by deputies. Further, STEVEN NEUROTH had been arrested for a non-serious, non-violent crime, and Defendants failed to use available less-forceful alternatives to the force and restraints used.

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belief, were integral participants in brutalizing, beating, striking, choking, threatening, applying excessive control holds, and unreasonably restraining Decedent STEVEN NEUROTH, and under federal law and generally accepted law enforcement standards and training, each was responsible for the totality of force used in his/her presence. Further, each of these Defendant deputies/officers failed to intervene to stop, prevent, or report the use of excessive and unreasonable force and restraint by other deputies/officers, in violation of the law and generally accepted law enforcement standards and training.

44. The type and amount of force Defendants LEEF, KNAPP, MASTERSON,

PAGE, and DE LOS SANTOS, and possibly remaining DOE Defendants, on information and

Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM,

- 44. The type and amount of force Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS, and possibly remaining DOE Defendants, used against STEVEN NEUROTH as described herein, including multiple blows to STEVEN NEUROTH's body, improper control holds, crushing force applied to his back, neck, and head, and restriction of STEVEN NEUROTH's airways, neck, and back areas, amounted to the use of deadly force under the circumstances. The use of deadly force was not justified or lawful under the circumstances.
- 45. Alternatively, or concurrently, Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS', and possibly remaining DOE Defendants', own excessive, unreasonable, reckless, and provocative actions created a risk of harm to STEVEN NEUROTH, created the situation in which Defendants used extreme and otherwise unnecessary force, and caused an escalation of events leading to STEVEN NEUROTH's death.
- 46. Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS', and possibly remaining DOE Defendants' unreasonable restraint and use of excessive force against STEVEN NEUROTH was done at least in part because of STEVEN NEUROTH's untreated serious medical needs and/or psychiatric condition and disability.
- 47. Following Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS', and possibly remaining DOE Defendants' use of

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extreme and deadly force against STEVEN NEUROTH, he was transferred to Ukiah Valley Medical Center where he died, after cardiac arrest, at about 12:46 a.m. on June 11, 2014.

- 48. During and after their uses of excessive force and violation of STEVEN NEUROTH's rights, Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS, and possibly remaining DOE Defendants, violated their duty to intervene to stop such violations of STEVEN NEUROTH'S rights, and they engaged in a code of silence to cover up such violations of rights. The Ninth Circuit has explained that a law enforcement "code of silence" has been described as consisting of a single rule: "an officer does not provide adverse information against a fellow officer." Blair v. City of Pomona, 223 F.3d 1074, 1081 (9th Cir.2000) (taking judicial notice of the Report of the Independent Commission on the Los Angeles Police Department 168 (1991) (the Christopher Commission Report)). Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, and DE LOS SANTOS, and possibly remaining DOE Defendants, failed to report their own and other officers' uses of force both in their written reports and when interviewed in official investigations of this incident. Further, Defendants' official accounts of this incident, and the uses of force deployed or observed, fail to account for the severe and widespread physical injuries and trauma found on STEVEN NEUROTH's body.
- 49. On behalf of the MCSO, Defendants SERGEANT KNAPP and CORRECTIONS CAPTAIN PEARCE officially approved Defendant Deputy DE LOS SANTOS' refusal to be interviewed by investigators for the District Attorney and/or the MCSO concerning her involvement and observations in this incident, and Defendants KNAPP and PEARCE officially approved Defendant DE LOS SANTOS' intentional destruction of her own official written report concerning this incident that she wrote within hours of STEVEN NEUROTH's death. Defendants' failure to intervene and report misconduct in this incident, involving no less than seven deputies and a police officer, with the explicit approval of supervisors including SERGEANT KNAPP, and the jail commander, CORRECTIONS CAPTAIN PEARCE, is strong evidence of a widespread custom within the Mendocino County Jail of a code of silence.

 Decedent necessary medical care; failure to provide competent medical care and treatment; failure to provide him access and delivery to a hospital for the care and treatment for his life-threatening medical emergency; failure to provide any inpatient psychiatric treatment facility within the entire county; the manner in which they treated and incarcerated him, and their other acts and omissions under these circumstances, were contrary to generally accepted reasonable jail and medical procedures and standards, failed to comply with the appropriate standard of care, and contributed to the wrongful death of STEVEN NEUROTH.

- 51. Plaintiff is informed and believes and thereon alleges that Defendants COUNTY, ALLMAN, CFMG, and FITHIAN failed to have a qualified and competent medical and/or mental-health professional conduct intake and mental-health evaluations on inmate patients, with deliberate indifference to the inmate patients' serious medical and mental-health needs. Furthermore, Plaintiff is informed and believes and thereon alleges that Defendants COUNTY, ALLMAN, CFMG, and FITHIAN allowed, and continue to allow, un-credentialed staff, including Licensed Vocational Nurses, to perform intake medical assessments and/or mental health assessments on patients without any appropriate clinical supervision by a Registered Nurse, physician, or otherwise properly licensed and credentialed health care provider, in violation of California law and generally accepted national standards. Plaintiff is informed and believes and thereon alleges that COUNTY, ALLMAN, CFMG, and FITHIAN allowed, and continue to allow, un-credentialed staff to perform medical and mental-health assessments because it costs significantly less money than paying for properly licensed staff to do the work.
- 52. CFMG, a for-profit corporation, is the largest private provider of correctional healthcare in the State of California, stating on its website that it currently has contracts covering 27 counties with 65 facilities that have an average daily population of 16,000 inmates. Its contract alone with MENDOCINO COUNTY has brought it several million dollars in profits. CFMG holds itself out as offering a complete health care delivery system for MENDOCINO COUNTY inmates that complies with California law, while knowingly violating the law governing patient assessments

and allowing incompetent and uncredentialed people to do medical and mental health assessments on patients beyond their legal scope of practice.

- 53. CFMG holds itself and its officers, directors, and managing agents out as experts in the field of correctional healthcare. Yet, CFMG has been criticized for its inadequate health care provided to inmates throughout the State of California. A January 17, 2015, article in the *Sacramento Bee* entitled, "California for-Profit Company Faces Allegations of Inadequate Inmate Care," reported that CFMG's population-adjusted rate of deaths in custody is 50% higher than non-CFMG counties.
- 54. Plaintiff is informed and believes and thereon alleges that CFMG must pay for inpatient hospital treatment for Mendocino County jail inmates, creating a disincentive for CFMG to refer jail inmates such as STEVEN NEUROTH off-site for necessary, emergency inpatient hospitalization or psychiatric treatment.
- 55. Plaintiff is further informed and believes and thereon alleges that CFMG allows uncredentialed Licensed Vocational Nurses (LVN's) to perform the work of Registered Nurses (RN's) and higher level care providers, in order to save money, since CFMG pays LVN's significantly less than it pays RN's. CFMG only provides one Registered Nurse, Monday through Friday from 8:00 a.m. until 4:00 p.m., and one RN Manager Monday through Friday from 7:00 a.m. until 3:00 p.m., and the rest of the time may provide uncredentialed LVN's working outside their scope of practice, to care for the serious medical needs of patients in the Mendocino County Jail.
- 56. The California Nurse Practice Act, Cal. Bus. & Prof. Code § 2732 provides, "No person shall engage in the practice of nursing, as defined in Section 2725, without holding a license which is in an active status issued under this chapter except as otherwise provided in this act." The licensed referred to is that for a Registered Nurse. *Id*.
- 57. Cal. Bus. & Prof. Code § 2795 provides that it is unlawful for any person "to practice or to offer to practice nursing in this state unless the person holds a license in an active status." Cal. Bus. & Prof. Code § 2799 provides that violation of the provisions of the chapter is a misdemeanor.
 - Cal. Bus. & Prof. Code § 2725(b) defines the practice of nursing:

The practice of nursing within the meaning of this chapter means those functions, including basic health care, that help people cope with difficulties in daily living that are associated with their actual or potential health or illness problems or the

treatment thereof, and that require a substantial amount of scientific knowledge or technical skill, including all of the following:

- (1) Direct and indirect patient care services that ensure the safety, comfort, personal hygiene, and protection of patients, and the performance of disease prevention and restorative measures
- (2) Direct and indirect patient care services, including, but not limited to, the administration of medications and therapeutic agents, necessary to implement a treatment, disease prevention, or rehabilitative regimen ordered by and within the scope of licensure of a physician, dentist, podiatrist, or clinical psychologist, as defined by Section 1316.5 of the Health and Safety Code.
- (3) The performance of skin tests, immunization techniques, and the withdrawal of human blood from veins and arteries.
- (4) Observation of signs and symptoms of illness, reactions to treatment, general behavior, or general physical condition, and (A) determination of whether the signs, symptoms, reactions, behavior, or general appearance exhibit abnormal characteristics, and (B) implementation, based on observed abnormalities, of appropriate reporting, or referral, or standardized procedures, or changes in treatment regimen in accordance with standardized procedures, or the initiation of emergency procedures.

Cal. Bus. & Prof. Code § 2725(b)(emphasis added).

58. In contrast, 16 Cal. Code Regs. § 2518.5(a) sets forth the scope of a LVN's practice:

The licensed vocational nurse performs services requiring technical and manual skills which include the following:

(a) Uses and practices basic assessment (data collection), participates in planning, executes interventions in accordance with the care plan or treatment plan, and contributes to evaluation of individualized interventions related to the care plan or treatment plan.

16 CCR § 2518.5 (emphasis added).

- 59. The California Medical Board's IMQ Health Care Accreditation Standards state that even *Registered Nurses* who are involved in a jail's mental health program act under the supervision of a physician and "must have evidence of advanced post-graduate training in mental health." The IMQ Standards note: "Mental health programs that rely solely on psychiatric technicians, registered nurses without special university education qualifications or national certification, and non-licensed staff to provide on-site evaluation and counseling services do not meet this essential accreditation standard."
- 60. Yet, CFMG allows unsupervised LVN's to provide independent mental health assessments without any appropriate clinical supervision. CFMG's staffing pattern only provides

for one unsupervised psychiatric RN, licensed clinical social worker, or marriage and family therapist Monday through Friday from 8:00 a.m. to 4:00 p.m., and otherwise has no licensed mental health clinicians on site at the Mendocino County Jail. CFMG will only provide up to 8 hours per week, *in toto*, of remote "telepsychiatry" for all of the Mendocino County jail inmates' psychiatric needs combined, and only one medical director/physician for a total of 8 hours per week. Otherwise, uncredentialed, unsupervised, and unqualified health care workers are left alone to care for inmates in the jail. Defendant MENDOCINO COUNTY deliberately contracted for this unqualified and incompetent care of its jail inmates, with deliberate indifference on the part of the COUNTY, ALLMAN, CFMG and FITHIAN to the serious medical and mental health needs of inmates, including STEVEN NEUROTH.

- 61. Furthermore, Defendant COUNTY does not even have an inpatient psychiatric facility in which to house mentally ill, gravely disabled people in a psychiatric crisis, like STEVEN NEUROTH. Defendant COUNTY failed to accommodate STEVEN NEUROTH'S mental illness and disability, by deliberately indifferently failing to provide for appropriate inpatient psychiatric treatment for its residents, including STEVEN NEUROTH.
- 62. A January 29, 2016, article in the *Independent Coast Observer* ["ICO"] entitled, "Sheriff Spearheads Initiative to Fund Mental Health Center," noted that Defendant COUNTY closed its psychiatric health facility in 1999 and contracted with other counties such as Yolo County and Solano County for 72-hour inpatient psychiatric holds pursuant to Cal. Welf. & Inst. Code § 5150. However, Defendant ALLMAN acknowledged that being housed 100 miles from home and family is not beneficial to the patient. (ICO, 1/29/16, p. 12).
- 63. Moreover, law enforcement officers in MENDOCINO COUNTY must sit with the mentally ill patient in a hospital emergency room, sometimes for hours, to wait for the patient to be transported to Yolo or Solano County, which creates a disincentive for officers to choose to admit a patient pursuant to § 5150, and incentivizes arresting them for minor crimes related to their mental illness so they can be taken to jail instead.
- 64. In a December 4, 2015, article entitled "Jail No Place for Mentally III' Says Mendocino County Sheriff," the ICO noted, "According to Allman, because there's no in-patient mental health facility in Mendocino County, the county jail has become the de facto place to put Case No. 1:15-CV-03226-NJV THIRD AMENDED COMPLAINT AND JURY DEMAND

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26 27 people who are mentally ill and need to be dealt with in a crisis situation. ... In Mendocino County, since there is no inpatient psychiatric facility where this 72-hour holding can occur, this assessment, called a 5150, often means a trip to the county jail." (ICO, 12/4/15, pp. 1, 8).

- 65. According to the National Institute of Mental Health, 18% of all adults in the United States have had at least one mental illness in 2014, the year STEVEN NEUROTH was killed. (http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-usadults.shtml). According to the United States Department of Justice, Bureau of Justice Statistics' 2006 report entitled "Mental Health Problems of Prison and Jail Inmates," 64.2% of inmates in local jail populations have at least one mental health problem. (http://www.bjs.gov/content/pub/pdf/mhppji.pdf, p. 3, Table 2).
- 66. Defendant ALLMAN acknowledges that "We really, truly don't want mental health patients in our jail[.] Jail isn't the place for them in Mendocino County." (ICO, 12/4/15, p. 8). Defendant ALLMAN also acknowledges, "Without a shadow of a doubt, mental health is the number one public safety issue in Mendocino County." (ICO, 11/27/15, p. 1). Despite these facts, Defendant COUNTY fails to provide for the serious medical and mental health needs of its residents, causing the jailing of mentally ill, nonviolent people in psychiatric crisis -- like STEVEN NEUROTH – with deliberate indifference to their serious medical needs. Defendant COUNTY then contracts with CFMG for inadequate assessment and care for the mentally ill taken to its jails, including allowing un-credentialed Licensed Vocational Nurses to perform the work of Registered Nurses and Psychiatric Registered Nurses, in violation of California law and regulations.
- STEVEN NEUROTH's death was the proximate result of all Defendants' 67. deliberately indifferent failure to summon and/or provide care and treatment for STEVEN NEUROTH's serious medical/psychiatric needs, and the unreasonable seizure and restraint, use of excessive force, and Defendants' conduct without a legitimate law enforcement purpose.
- 68. Alternatively or concurrently, STEVEN NEUROTH's death was the proximate result of Defendant COUNTY's, ALLMAN's, and PEARCE's failure to reasonably train and require their Deputy Sheriffs to use only proper and reasonable force when necessary under the circumstances, failure to implement and enforce generally accepted, lawful policies and procedures at the jail, and allowing and/or ratifying excessive and unreasonable force and restraint, permitting Case No. 1:15-CV-03226-NJV - THIRD AMENDED COMPLAINT AND JURY DEMAND

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and fostering a code of silence at the jail, and deliberate indifference to the serious medical/psychiatric needs of inmates. These substantial failures reflect Defendant COUNTY's policies implicitly or directly ratifying and/or authorizing the deliberate indifference to serious medical needs and the use of excessive and unreasonable force and restraint by its deputy sheriffs, and the failure to reasonably train, instruct, monitor, supervise, investigate, and discipline deputy sheriffs employed by Defendants COUNTY, ALLMAN, and PEARCE in the use of force and inmates' medical needs.

- 69. Alternatively or concurrently, Decedent's death was the proximate result of Defendant CFMG and FITHIAN's failure to reasonably staff, train, supervise, and equip their medical and mental healthcare staff in the proper and reasonable care of mentally ill, and/or emotionally disturbed inmates; failure to implement and enforce generally accepted, lawful policies and procedures at the jail; and deliberate indifference to the serious medical/psychiatric needs of inmates. These substantial failures reflect Defendant CFMG's policies implicitly ratifying and/or authorizing the deliberate indifference to serious medical needs by its medical and mental healthcare staff and the failure to reasonably train, instruct, monitor, supervise, investigate, and discipline medical and mental healthcare staff employed by Defendant CFMG in the handling of mentally ill, and/or emotionally disturbed inmates.
- 70. At all material times, and alternatively, the actions and omissions of each Defendant were intentional, wanton, and/or willful, conscience-shocking, reckless, malicious, deliberately indifferent to Decedent's and Plaintiff's rights, done with actual malice, grossly negligent, negligent, and objectively unreasonable.
- 71. As a direct and proximate result of each Defendant's acts and/or omissions as set forth above, to the extent permitted and pled by the various legal claims set forth below, Plaintiff sustained the following injuries and damages, past and future, among others:
 - a. Wrongful death of STEVEN NEUROTH, pursuant to Cal. Code of Civ. Proc. § 377.60 et. seq.;

1 2		b.	Loss of support and familial relationships, including loss of love, companionship, comfort, affection, society, services, solace, and moral support, pursuant to Cal. Code of Civ. Proc. § 377.60 et. seq.;		
3		c.	STEVEN NEUROTH's Hospital and medical expenses, pursuant to Cal. Code of Civ. Proc. § 377.20 et. seq.;		
5		d.	STEVEN NEUROTH's Coroner's fees, funeral and burial expenses, pursu to Cal. Code of Civ. Proc. § 377.20 et. seq.;	ıant	
6		e.	Violation of STEVEN NEUROTH's constitutional rights, pursuant to Cal.		
7 8		f.	Code of Civ. Proc. § 377.20 et. seq. and federal civil rights law; STEVEN NEUROTH's loss of life, pursuant to federal civil rights law;		
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10		g.	STEVEN NEUROTH's conscious pain, suffering, and disfigurement, pursuant to federal civil rights law;		
11 12		h.	All damages and penalties recoverable under 42 U.S.C. §§ 1983 and 1988, and as otherwise allowed under California and United States statutes, code and common law.		
13			FIRST CAUSE OF ACTION		
14	(42 U.S.C. § 1983) – Survival Claim				
15	Į.		DANTS_LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLU <u>DE LOS SANTOS, CAUDILLO, AND REMAINING DOES</u>	IVI,	
16	72.	Plainti	ff realleges each and every paragraph in this complaint as if fully set forth		
17	here.				
18 19	73.	Plainti	ff brings the claims in this cause of action as survival claims permissible ur	nder	
20	federal and California law, including Cal. Code of Civ. Proc. Section 377.20 et. seq.				
21	74.	By the	actions and omissions described above, Defendants LEEF, KNAPP,		
22	MASTERSON	I, BERI	NARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, CAUDILLO, AN	D	
23	REMAINING	DOES	violated 42 U.S.C. § 1983, depriving Decedent STEVEN NEUROTH,		
24	through Plaint	iff here	in, of the following clearly established and well-settled constitutional rights	3	
25	protected by the	ne Four	th and Fourteenth Amendments to the United States Constitution:		
26		a.	Decedent's right to be free from excessive and unreasonable force and		
27			restraint in the course of seizure and as a pretrial detainee, as secured by the Fourth and/or Fourteenth Amendments; and	ne	
28	Case No. 1:15-CV-	.03226-N.1	IV – THIRD AMENDED COMPLAINT AND JURY DEMAND	24	

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- b. Decedent's right to be free from deliberate indifference to STEVEN NEUROTH's serious medical needs while in custody as a pretrial detainee as secured by the Fourth and/or Fourteenth Amendments.
- 75. Defendants subjected Decedent to their wrongful conduct, depriving Decedent of rights described herein, knowingly, maliciously, and with conscious and reckless disregard for whether the rights and safety of Decedent and others would be violated by their acts and/or omissions.
- 76. As a direct and proximate result of Defendants' acts and/or omissions as set forth above, Decedent, through Plaintiff herein, sustained injuries and damages as set forth above at ¶71.
- 77. The conduct of Defendants entitles Plaintiff to punitive damages and penalties allowable under 42 U.S.C. § 1983 and as provided by law. Plaintiff does not seek punitive damages against Defendant COUNTY.
- 78. Plaintiff is also entitled to reasonable costs and attorneys' fees under 42 U.S.C. § 1988, and other applicable United States and California codes and laws.

SECOND CAUSE OF ACTION (Monell - 42 U.S.C. § 1983) - Survival Claim AGAINST DEFENDANTS COUNTY AND CFMG

- 79. Plaintiff realleges each and every paragraph in this complaint as if fully set forth here.
- 80. Plaintiff brings the claims in this cause of action as survival claims permissible under federal and California law, including Cal. Code of Civ. Proc. Section 377.20 et. seq.
- 81. The unconstitutional actions and/or omissions of Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, CAUDILLO, AND REMAINING DOES, as well as other officers employed by or acting on behalf of the Defendants COUNTY and/or CFMG, on information and belief, were pursuant to the following customs, policies, practices, and/or procedures of Defendants COUNTY and/or CFMG, stated in the Case No. 1:15-CV-03226-NJV - THIRD AMENDED COMPLAINT AND JURY DEMAND

alternative, which were directed, encouraged, allowed, and/or ratified by policymaking officers for Defendant COUNTY and its Sheriff's Office, and/or Defendant CFMG:

- a. To deny inmates access to appropriate, competent, and necessary care for serious medical and psychiatric needs, including but not limited to failing to provide any inpatient psychiatric facilities within the entire County of Mendocino, and requiring mentally ill County residents in crisis to be taken to jail instead of providing for their serious psychiatric needs;
- b. To allow Licensed Vocational Nurses to perform intake medical and mental health assessments without clinical supervision by a Registered Nurse or physician, and otherwise to contract for inadequate and incompetent medical and mental health care for jail inmates;
- c. To allow, encourage, and require unlicensed, incompetent, inadequately trained and/or inadequately supervised staff to assess inmates' medical and psychiatric condition, needs, and treatment, including to decide whether or not to provide inmates with necessary emergency care and hospitalization;
- d. To use or tolerate the use of excessive and/or unjustified force, including deputies' failures to intervene in excessive force and violations of rights by other deputies, and improper prone restraint of inmates increasing the risk of injury and death by restraint associated asphyxia;
- e. To use or tolerate the use of unlawful deadly force;
- f. To engage in or tolerate unreasonable seizures and restraints;
- g. To fail to institute, require, and enforce proper and adequate training, supervision, policies, and procedures concerning seizures and the use of control holds and restraint techniques, including avoiding asphyxiation of subjects being restrained by deputy sheriffs and avoiding blows and uses of force to a subject's head and/or neck during altercations absent justification;
- h. To fail to use appropriate and generally accepted law enforcement procedures for handling mentally ill and/or emotionally disturbed persons;
- i. To fail to institute, require, and enforce proper and adequate training, supervision, policies, and procedures concerning handling mentally ill and/or emotionally disturbed persons;
- j. To fail to use appropriate and generally accepted jail procedures for handling and housing mentally ill and/or emotionally disturbed persons, including, but not limited to, the standards of the National Commission on Correctional Health Care Standards for Health Services in Jails, and Title 15 of the California Code of Regulations;

- k. To cover up violations of constitutional rights by any or all of the following:
 - i. By failing to properly investigate and/or evaluate complaints or incidents of excessive and unreasonable force, unlawful seizures, and/or handling of mentally ill and/or emotionally disturbed persons;
 - ii. By ignoring and/or failing to properly and adequately investigate and/or investigate and discipline unconstitutional or unlawful law enforcement activity; and
 - iii. By allowing, tolerating, and/or encouraging law enforcement officers to: fail to file complete and accurate reports; file false reports; make false statements; intimidate, bias and/or "coach" witnesses to give false information and/or to attempt to bolster officers' stories; and/or obstruct or interfere with investigations of unconstitutional or unlawful law enforcement conduct by withholding and/or concealing material information;
- I. To allow, tolerate, and/or encourage a "code of silence" among law enforcement officers and sheriff's office personnel, whereby an officer or member of the sheriff's office does not provide adverse information against a fellow officer or member of the MCSO;
- m. To use or tolerate inadequate, deficient, and improper procedures for handling, investigating, and reviewing complaints of officer misconduct, including claims made under California Government Code §§ 910 et seq.
- n. To fail to have and enforce necessary, appropriate, and lawful policies, procedures, and training programs to prevent or correct the unconstitutional conduct, customs, and procedures described in this Complaint and in subparagraphs (a) through (m) above, with deliberate indifference to the rights and safety of Decedent, of Plaintiff and the public, and in the face of an obvious need for such policies, procedures, and training programs.
- 82. Defendants COUNTY and CFMG, through their employees and agents, and through their policy-making supervisors, ALLMAN, PEARCE, FITHIAN, and remaining DOES, failed to properly hire, train, instruct, monitor, supervise, evaluate, investigate, and discipline Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, CAUDILLO, AND REMAINING DOES, and other COUNTY, Sheriff's Office, and CFMG

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personnel, with deliberate indifference to Plaintiff's, Decedent's, and others' constitutional rights, which were thereby violated as described above.

83. The unconstitutional actions and/or omissions of Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, CAUDILLO, AND REMAINING DOES, and other Sheriff's Office personnel, as described above, were approved, tolerated, and/or ratified by policymaking officers for the COUNTY and its Sheriff's Office, including Defendants ALLMAN and PEARCE, and by CFMG and FITHIAN. Plaintiff is informed and believes and thereon alleges that the details of this incident have been revealed to the authorized policymakers within the COUNTY, the Mendocino County Sheriff's Office, and CFMG, and that such policymakers have direct knowledge of the fact that the death of STEVEN NEUROTH was not justified, but represented unconstitutional uses of unreasonable, excessive and deadly force, and deliberate indifference to serious medical needs. Notwithstanding this knowledge, the authorized policymakers within the COUNTY, its Sheriff's Office, and CFMG have approved of the conduct and decisions of Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, CAUDILLO, AND REMAINING DOES in this matter, and have made a deliberate choice to endorse such conduct and decisions, and the basis for them, that resulted in the death of STEVEN NEUROTH. By so doing, the authorized policymakers within the COUNTY and its Sheriff's Office have shown affirmative agreement with the individual Defendants' actions and have ratified the unconstitutional acts of the individual Defendants. Furthermore, Plaintiff is informed and believes, and thereupon alleges, that DEFENDANTS ALLMAN, PEARCE, FITHIAN and other policy-making officers for the COUNTY and CFMG were and are aware of a pattern of misconduct and injury caused by COUNTY law enforcement officers and CFMG employees similar to the conduct of Defendants described herein, but failed to discipline culpable

law enforcement officers and employees and failed to institute new procedures and policy within the COUNTY and CFMG.

- 84. The aforementioned customs, policies, practices, and procedures; the failures to properly and adequately hire, train, instruct, monitor, supervise, evaluate, investigate, and discipline; and the unconstitutional orders, approvals, ratification, and toleration of wrongful conduct of Defendants COUNTY and CFMG were a moving force and/or a proximate cause of the deprivations of Decedent's clearly established and well-settled constitutional rights in violation of 42 U.S.C. § 1983, as more fully set forth above at ¶ 74.
- 85. Defendants subjected Decedent to their wrongful conduct, depriving Decedent of rights described herein, knowingly, maliciously, and with conscious and reckless disregard for whether the rights and safety of Decedent, Plaintiff and others would be violated by their acts and/or omissions.
- 86. As a direct and proximate result of the unconstitutional actions, omissions, customs, policies, practices, and procedures of Defendants COUNTY and CFMG, as described above, Decedent and Plaintiff sustained serious and permanent injuries and Plaintiff is entitled to damages, penalties, costs, and attorneys' fees against Defendants COUNTY and CFMG as set forth above in ¶¶ 75-78, including punitive damages against Defendant CFMG.

THIRD CAUSE OF ACTION (Supervisory Liability - 42 U.S.C. § 1983) – Survival Claim AGAINST DEFENDANTS ALLMAN, PEARCE, FITHIAN, AND REMAINING DOES

- 87. Plaintiff realleges each and every paragraph in this complaint as if fully set forth here.
- 88. Plaintiff brings the claims in this cause of action as survival claims permissible under federal and California law, including Cal. Code of Civ. Proc. Section 377.20 et. seq.

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monitor, supervise, evaluate, investigate, and discipline the other Defendants in this matter, as well as all employees and agents of the Mendocino County Sheriff's Office and/or CFMG.

90. Defendants COUNTY, ALLMAN, PEARCE, CFMG, FITHIAN, and REMAINING DOES failed to properly hire, train, instruct, monitor, supervise, evaluate, investigate, and discipline

REMAINING DOES, had the duty and responsibility to constitutionally hire, train, instruct,

At all material times, Defendants ALLMAN, PEARCE, FITHIAN, and

- DOES failed to properly hire, train, instruct, monitor, supervise, evaluate, investigate, and discipline Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, CAUDILLO, AND REMAINING DOES, and other COUNTY, Sheriff's Office, and CFMG personnel, with deliberate indifference to Plaintiff's, Decedent's, and others' constitutional rights, which were thereby violated as described above.
- 91. The unconstitutional customs, policies, practices, and/or procedures of Defendants COUNTY and/or CFMG, stated in the Second Cause of Action herein, were directed, encouraged, allowed, and/or ratified by policymaking officers for Defendant COUNTY and its Sheriff's Office, and/or Defendant CFMG, including Defendants ALLMAN, PEARCE, FITHIAN, and REMAINING DOES, with deliberate indifference to Plaintiff's, Decedent's, and others' constitutional rights, which were thereby violated as described above.
- 92. The unconstitutional actions and/or omissions of Defendants Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, CAUDILLO, AND REMAINING DOES, and other Sheriff's Office personnel, as described above, were approved, tolerated, and/or ratified by policymaking officers for the COUNTY and its Sheriff's Office, including Defendants ALLMAN and PEARCE, and by CFMG and FITHIAN. Plaintiff is informed and believes and thereon alleges that the details of this incident have been revealed to Defendants ALLMAN, PEARCE, and FITHIAN, and that such Defendant-policymakers have direct knowledge of the fact that the death of STEVEN NEUROTH was not justified, but

represented an unconstitutional use of unreasonable, excessive and deadly force, and deliberate

indifference to serious medical needs. Notwithstanding this knowledge, on information and belief,

Defendants ALLMAN, PEARCE, and FITHIAN have approved of the conduct and decisions of

Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS

SANTOS, CAUDILLO, AND REMAINING DOES in this matter, and have made a deliberate

choice to endorse such conduct and decisions, and the basis for them, that resulted in the death of

STEVEN NEUROTH. By so doing, Defendants ALLMAN, PEARCE, and FITHIAN have shown

affirmative agreement with the individual Defendants' actions and have ratified the unconstitutional

acts of the individual Defendants. Furthermore, Plaintiff is informed and believes, and thereupon

alleges, that Defendants ALLMAN, PEARCE, FITHIAN and other policy-making officers for the

silence, caused by COUNTY law enforcement officers and CFMG employees similar to the conduct

The aforementioned customs, policies, practices, and procedures; the failures to

COUNTY and CFMG were and are aware of a pattern of misconduct and injury, and a code of

of Defendants described herein, but failed to discipline culpable law enforcement officers and

employees and failed to institute new procedures and policy within the COUNTY and CFMG.

properly and adequately hire, train, instruct, monitor, supervise, evaluate, investigate, and

discipline; and the unconstitutional orders, approvals, ratification, and toleration of wrongful

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conduct of Defendants COUNTY, ALLMAN, PEARCE, FITHIAN, CFMG, and REMAINING 21 DOES were a moving force and/or a proximate cause of the deprivations of Decedent's clearly established and well-settled constitutional rights in violation of 42 U.S.C. § 1983, as more fully set forth above at \P 74. 24 94.

Defendants subjected Decedent to their wrongful conduct, depriving Decedent of rights described herein, knowingly, maliciously, and with conscious and reckless disregard for

whether the rights and safety of Decedent, Plaintiff and others would be violated by their acts and/or omissions.

95. As a direct and proximate result of the unconstitutional actions, omissions, customs, policies, practices, and procedures of Defendants ALLMAN, PEARCE, FITHIAN, and REMAINING DOES as described above, Plaintiff sustained serious and permanent injuries and is entitled to damages, penalties, costs, and attorneys' fees as set forth above in ¶¶ 75-78, and punitive damages against Defendants ALLMAN, PEARCE, FITHIAN, and REMAINING DOES in their individual capacities.

FOURTH CAUSE OF ACTION (Violation of Civil Code § 52.1) – Survival Claim AGAINST DEFENDANTS_LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, CAUDILLO, AND REMAINING DOES, ALLMAN, PEARCE, FITHIAN, AND CFMG

- 96. Plaintiff realleges each and every paragraph in this complaint as if fully set forth here.
- 97. Plaintiff brings the claims in this cause of action as survival claims permissible under California law, including Cal. Code of Civ. Proc. Section 377.20 et. seq.
- 98. By their acts, omissions, customs, and policies, DEFENDANTS LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, CAUDILLO, and REMAINING DOES, ALLMAN, PEARCE, FITHIAN, and CFMG, each Defendant acting in concert/conspiracy, as described above, and by threat, intimidation, and/or coercion, interfered with, attempted to interfere with, and violated STEVEN NEUROTH'S rights under California Civil Code § 52.1 and under the United States Constitution and California Constitution as follows:
 - a. The right to be free from excessive and unreasonable force and restraint in the course of a seizure as secured by the Fourth and/or Fourteenth Amendments to the United States Constitution and by the California Constitution, Article 1, §§ 7 and 13;

- b. The right to be free from deliberate indifference to STEVEN NEUROTH's serious medical needs while in custody as a pretrial detainee as secured by the Fourth and/or Fourteenth Amendments to the United States Constitution and by California Constitution, Article 1, §§ 7 and 13;
- c. The right to enjoy and defend life and liberty; acquire, possess, and protect property; and pursue and obtain safety, happiness, and privacy, as secured by the California Constitution, Article 1, § 1;
- d. The right to protection from bodily restraint, harm, or personal insult, as secured by California Civil Code § 43; and
- e. The right to medical care as required by California Government Code § 845.6.
- 99. Separate from, and above and beyond, Defendants' attempted interference, interference with, and violation of STEVEN NEUROTH'S rights as described above, Defendants violated Decedent's rights by the following conduct constituting threats, intimidation, or coercion:
 - a. With deliberate indifference to STEVEN NEUROTH's serious medical needs, suffering, and risk of grave harm including death, depriving STEVEN NEUROTH of necessary, life-saving care for his medical and/or psychiatric needs;
 - b. Threatening STEVEN NEUROTH with violence in the absence of any threat presented by Mr. NEUROTH, or any justification whatsoever;
 - c. Using deliberately reckless and provocative tactics on STEVEN NEUROTH in violation of generally accepted law enforcement training and standards, and in violation of STEVEN NEUROTH's rights;
 - d. Threatening violence against STEVEN NEUROTH, with the apparent ability to carry out such threats, in violation of Civ. Code § 52.1(j);
 - e. Causing STEVEN NEUROTH to be subjected to multiple blows, strikes, painful joint control holds, choking, crushing, and other injurious force without justification;
 - f. Restraining STEVEN NEUROTH in a manner well-known to impair and obstruct his ability to breathe;
 - g. Causing STEVEN NEUROTH to be subjected to violence, and threat of violence, because of his disability(ies) and medical/psychiatric condition;
 - h. Violating STEVEN NEUROTH's rights to be free from excessive force and deliberate indifference to his serious medical needs; and

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i. Instituting and maintaining the unconstitutional customs, policies, and practices described herein, when it was obvious that in doing so, individuals such as STEVEN NEUROTH would be subjected to violence, threat, intimidation, and coercion, as Decedent was here.

As a direct and proximate result of Defendants' violation of California Civil Code § 52.1 and of Decedent's rights under the United States and California Constitutions, Plaintiff (as successor in interest for Decedent) sustained injuries and damages, and against each and every Defendant is entitled to relief as set forth above at ¶¶ 75-78, and punitive damages against all individual Defendants, including all damages allowed by California Civil Code §§ 52 and 52.1 and California law, not limited to costs attorneys' fees, and civil penalties.

FIFTH CAUSE OF ACTION

(Negligence) - Survival and Wrongful Death Claims AGAINST DEFENDANTS LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, AND REMAINING DOES

- 101. Plaintiff realleges each and every paragraph in this complaint as if fully set forth here.
- 102. Plaintiff brings the claims in this cause of action as survival claims permissible under California law, including Cal. Code of Civ. Proc. Section 377.20 et. seq., and as wrongful death claims permissible under California law, including Cal. Code of Civ. Proc. Section 377.60 et. seq.
- 103. At all times, Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, and REMAINING DOES owed Plaintiff and Decedent the duty to act with due care in the execution and enforcement of any right, law, or legal obligation.
- At all times, these Defendants owed Plaintiff and Decedent the duty to act with reasonable care.
- 105. These general duties of reasonable care and due care owed to Plaintiff and Decedent by these Defendants include but are not limited to the following specific obligations:

- 109. Plaintiff brings the claims in this cause of action as survival claims permissible under California law, including Cal. Code of Civ. Proc. Section 377.20 et. seq., and as wrongful death claims permissible under California law, including Cal. Code of Civ. Proc. Section 377.60 et. seq.
- 110. Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, and REMAINING DOES, placed STEVEN NEUROTH in immediate fear of death and severe bodily harm, and killed him by beating, battering, choking, and crushing him without just provocation or cause, constituting assault and battery.
- 111. Defendants' conduct was neither privileged nor justified under statute or common law.
- 112. As a direct and proximate result of these Defendants' assault and battery of STEVEN NEUROTH, Plaintiff and Decedent sustained injuries and damages and are entitled to relief as asset forth above at ¶¶ 75-78, including punitive damages against Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, and REMAINING DOES, in their individual capacities.

SEVENTH CAUSE OF ACTION

(Violation of California Government Code § 845.6) – Survival and Wrongful Death Claims AGAINST DEFENDANTS LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM, PAGE, DE LOS SANTOS, AND REMAINING DOES, and COUNTY

- 113. Plaintiff realleges each and every paragraph in this complaint as if fully set forth here.
- 114. Plaintiff brings the claims in this cause of action as survival claims permissible under California law, including Cal. Code of Civ. Proc. Section 377.20 et. seq., and as wrongful death claims permissible under California law, including Cal. Code of Civ. Proc. Section 377.60 et. seq.
- 115. Defendants LEEF, KNAPP, MASTERSON, BERNARDI, GRANT, HOLUM,
 PAGE, DE LOS SANTOS, and REMAINING DOES knew or had reason to know that STEVEN
 NEUROTH was in need of immediate medical care and treatment, including being transferred for
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emergency inpatient hospitalization, and each failed to take reasonable action to summon immediate medical care and treatment. Each such individual defendant, employed by and acting within the course and scope of his/her employment with Defendant COUNTY, knowing and/or having reason to know of STEVEN NEUROTH's need for immediate medical care and treatment, failed to take reasonable action to summon such care and treatment in violation of California Government Code § 845.6.

- 116. Defendant COUNTY is vicariously liable for the violations of state law and conduct of its officers, deputies, employees, and agents, including individual named defendants, under California Government Code sections 815.2 and 845.6.
- 117. As legal cause of the aforementioned acts of these DEFENDANTS, Plaintiff and Decedent were injured as set forth above, and their losses entitle Plaintiff to all damages allowable under California law. Plaintiff (individually and as Successor in Interest for Decedent) sustained serious and permanent injuries and is entitled to damages, penalties, costs, and attorney fees under California law as set forth in ¶¶ 75-78, above, and punitive damages against these Defendants in their individual capacities.

EIGHTH CAUSE OF ACTION (Intentional Infliction of Emotional Distress) – Survival Claim <u>AGAINST DEFENDANTS LEEF and CITY OF WILLITS</u>

- 118. Plaintiff realleges each and every paragraph in this complaint as if fully set forth here.
- 119. Plaintiff brings the claims in this cause of action as survival claims permissible under California law, including Cal. Code of Civ. Proc. Section 377.20 et. seq.,
- 120. Before STEVEN NEUROTH was booked into the jail, Defendant LEEF intentionally caused STEVEN NEUROTH to suffer severe emotional distress by Defendant LEEF's outrageous conduct, including but not limited to abusing his authority, taking advantage of Case No. 1:15-CV-03226-NJV THIRD AMENDED COMPLAINT AND JURY DEMAND

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STEVEN NEUROTH's mental and psychological disabilities, impairments, and vulnerabilities, such as repeatedly yelling "Snakes!" while STEVEN NEUROTH was handcuffed and locked in his police car and under the paranoid belief that there were deadly snakes in the car. In this conduct, Defendant LEEF found pleasure in tormenting and terrorizing STEVEN NEUROTH, apparently enjoying STEVEN NEUROTH's screams of fright and panic that Defendant LEEF deliberately caused, over and over again. On information and belief, while Defendant LEEF was yelling, "snakes!" to deliberately terrorize STEVEN NEUROTH, Defendant LEEF laughed and bragged to another member of his police department to the effect: "I yelled and he freaked out. Yelled.

Because he was starting to get a little kicky back there. So what I like to do is say snakes very loud and he jumps and it freaks him. It's pretty funny." Defendant LEEF did so while STEVEN NEUROTH was in his custody and care, after Defendant LEEF already had determined that STEVEN NEUROTH was in a psychotic state and unable to care for himself. Further, by this intentional, extreme, and outrageous conduct, Defendant LEEF caused STEVEN NEUROTH to further decompensate, becoming more paranoid, more fearful, more disoriented, and more at risk of being subjected to unnecessary force in the jail.

- 121. Despite Plaintiff's lawful pre-suit requests for such information to both the CITY OF WILLITS and MENDOCINO COUNTY, Defendants concealed the information in the preceding paragraph from Plaintiff until March 31, 2016, when such information was first provided in Defendant COUNTY's initial disclosures in this matter.
- 122. Defendant CITY OF WILLITS is vicariously liable for Defendant LEEF's torturous and tortious conduct pursuant to California Government Code § 815.2.
- 123. As legal cause of the aforementioned acts of Defendants LEEF and CITY OF WILLITS, Decedent suffered severe emotional distress, and as Decedent's Successor in Interest,

Plaintiff is entitled to all damages allowable under California law as set forth in ¶¶ 75-78, above, and punitive damages against Defendant LEEF in his individual capacity.

RELIEF REQUESTED 1 WHEREFORE, Plaintiff respectfully requests the following relief against each and every 2 3 Defendant herein, jointly and severally: 4 Compensatory and exemplary damages in an amount according to proof and a. which is fair, just, and reasonable; 5 b. Punitive damages under 42 U.S.C. § 1983 and California law in an amount 6 according to proof and which is fair, just, and reasonable; 7 All other damages, penalties, costs, interest, and attorneys' fees as allowed by 8 42 U.S.C. §§ 1983 and 1988; California Code of Civil Procedure §§ 377.20 et seq., 377.60 et seq., and 1021.5; California Civil Code §§ 52 et seq., 52.1; 9 and as otherwise may be allowed by California and/or federal law; 10 d. Such further relief, according to proof, that this Court deems appropriate and 11 lawful. 12 **JURY DEMAND** 13 Plaintiff hereby demands a jury trial in this action. 14 15 16 Dated: June 8, 2016 HADDAD & SHERWIN LLP 17 18 /s/ Michael J. Haddad MICHAEL J. HADDAD 19 Attorneys for Plaintiff 20 21 22 23 24 25 26 27

Case 1:17-c 0911-NJV Document 1 Filed 02/22 Page 1 of 17 CONTRACTOR DOMESTICS . Man of the motors. 1 **DAVID L. FIOL (SBN: 203546)** NATHANIEL M. LEEDS (SBN: 246138) 55.7 FEB 24 PM 2 C8 2 BRENT, FIOL & PRATT, LLP 1000 Fourth St., Ste. 750 EMECALIVE COMOR 3 San Rafael, CA 94901 Telephone: (415) 839-8370 The second secon 4 Facsimile: (415) 373-4420 UNDER THE PROBLEM Attorneys for Plaintiffs MARGARET WARD. 5 in her personal capacity, and as executor of the estate of Earl Ward, Deceased; KEVIN WARD; 6 and INA WARD, surviving heir of JEFF WARD. Deceased 7 8 UNITED STATES DISTRICT COURT 9 NORTHERN DISTRICT OF CALIFORNIA 10 MARGARET WARD, in her personal Case No. 3:17-cy-00911 11 capacity, and as executor of the estate of Earl Ward, Deceased, KEVIN WARD and INA PLAINTIFFS' COMPLAINT FOR: 12 WARD, surviving heir of JEFF WARD, Deceased. 1) VIOLATION OF 42 USC § 13 1983: FOURTEENTH Plaintiffs. AMENDMENT 14 2) VIOLATION OF 42 USC § 1983: SUPERVISOR 15 LIABILITY THE COUNTY OF MENDOCINO, a 3) ELDER ABUSE 16 municipal corporation, SHERIFF THOMAS 4) WRONGFUL DEATH BASED D. ALLMAN, individually and in his official ON MEDICAL NEGLIGENCE 17 capacity as Sheriff of THE COUNTY OF MENDOCINO, LORRIE KNAPP, MICHAEL AND 18 GRANT, CALÍFORNIA FORENSIC MEDICÁL GROUP, INC, DR. MICHAEL **DEMAND FOR JURY TRIAL** 19 MEDVIN, DR. MARVIN TROTTER and DOES 1 THROUGH 50, INCLUSIVE 20 21 Defendants. 22 23 24 Plaintiffs MARGARET WARD, KEVIN WARD and INA WARD (collectively "Plaintiffs") 25 allege generally against Defendants THE COUNTY OF MENDOCINO, SHERIFF THOMAS D. ALLMAN, individually and in his official capacity as Sheriff of THE COUNTY OF MENDOCINO, 26 27 CALIFORNIA FORENSIC MEDICAL GROUP, INC, ("CFMG") DR. MICHAEL MEDVIN, DR. 28 MARVIN TROTTER and DOES 1-50 (collectively "Defendants") as follows:

PLAINTIFFS' COMPLAINT; DEMAND FOR JURY TRIAL

INTRODUCTION

- 1. On the evening of March 20, 2016, Earl Ward, a 77 year-old retired police officer, high school basketball coach and Navy veteran, was taken into custody by the Mendocino County Sheriff's Department. Mr. Ward was suffering from dementia which made him prone to confusion and uncontrollable rages. On the night of his arrest Mr. Ward's wife of 46 years, MARGARET WARD, had called officers to assist her with her husband. After officers arrested Mr. Ward he was transferred to the Mendocino County Jail in Ukiah where he remained in custody until April 16, 2016. During his time in custody Mr. Ward's medical needs were recklessly neglected, he showed a marked decline in mental health, fell repeatedly and was allowed to become severely malnourished and dehydrated. On April 16th Mr. Ward was found lying on the floor of his jail cell in pain, highly disoriented and suffering from several spine fractures, multiple broken ribs, internal bleeding, a partially collapsed lung, dehydration and acute kidney failure. The orthopedic injuries Mr. Ward suffered in the Mendocino County Jail required surgery, which led to complications and ultimately to Mr. Ward's death on May 30, 2016.
- 2. This was not the first incident in the Mendocino County Jail in which a mentally ill man was mistreated and died. For example, on or about June 11, 2014 a schizophrenic man, Steven Kellogg Neuroth, died in the same facility after being improperly cared for and restrained.

PARTIES AND JURISDICTION

- 3. Mr. Ward died on May 30, 2016 and was survived by his wife, Plaintiff MARGARET WARD, and two sons: Plaintiff KEVIN WARD, a Jeff Ward, who post-deceased Mr. Ward.
- 4. Plaintiff INA WARD is Jeff Ward's surviving wife and heir and brings survival claims on behalf of Jeff Ward's Estate.
- 5. There are no known heirs or potential heirs to Mr. Ward's estate who have not either joined as plaintiffs in this action or waived their claims.
- 6. Mr. Ward was born on November 18, 1938. At all times relevant to this complaint Mr. Ward was an "elder" within the meaning of California Welfare and Institutions Code section 15610.27.

7. MARGARET WARD was married to Mr. Ward for 46 years and lived with him at the time of Mr. Ward's death and has been named as the executor of Mr. Ward's estate by the Mendocino County Superior Court on September 29, 2016 (Case No. CVPB 16-26682). Accordingly, MARGARET WARD has and is asserting standing to bring the claims described herein as follows:

- a. MARGARET WARD has standing to bring a survival actions under both state and federal law as Mr. Ward's successor in interest pursuant to California Code of Civil Procedure section 377 et seq. and brings this survival action on behalf of Mr. Ward's estate.
- b. As executor of Mr. Ward's estate MARGARET WARD is Mr. Ward's personal representative within the meaning California Code of Civil Procedure section 377.60, and therefore has standing to and does pursue a California a state wrongful death cause of action on behalf of all persons who have such claims.
- c. In losing her husband, Mr. Ward, MARGARET WARD has standing to assert her own individual Federal claims under 42 U.S.C. §§ 1983 and 1988 for the loss of a liberty interest under the Fourteenth Amendment of the United States Constitution.
- 8. KEVIN WARD is the surviving son of Mr. Ward and in losing his father has standing and does assert his personal claims under 42 U.S.C. §§ 1983 and 1988 for the loss of a liberty interest under the Fourteenth Amendment of the United States Constitution.
- 9. INA WARD is the surviving spouse of Mr. Ward's son, Jeff Ward. Jeff Ward survived Mr. Ward, but died prior to the initiation of this action. In life Jeff Ward had a personal claim under 42 U.S.C. §§ 1983 and 1988 for the loss of a liberty interest under the Fourteenth Amendment of the United States Constitution which survives. INA WARD has standing to bring a survival actions under both state and federal law as Jeff Ward's successor in interest pursuant to California Code of Civil Procedure section 377 et seq. and brings this survival action on behalf of Jeff Ward's estate.
- 10. Defendant THE COUNTY OF MENDOCINO is a public entity established by the laws of the Constitution of the State of California, and owns, operates, manages, directs, and controls the Mendocino County Jail and the Mendocino County Sheriff's department, also a public entity, which employs the other defendants in this action. THE COUNTY OF MENDOCINO is within the Northern

 District of California. Plaintiffs submitted a California Government Code 910 et seq. claim to THE COUNTY OF MENDOCINO on September 19, 2016, which was rejected on October 4, 2016.

- 11. Defendant SHERIFF THOMAS D. ALLMAN was employed by Defendant THE COUNTY OF MENDOCINO as Sheriff for THE COUNTY OF MENDOCINO. He is being sued in his individual and official capacity as Sheriff for THE COUNTY OF MENDOCINO.
- 12. Defendants LORRIE KNAPP and MICHAEL GRANT are, and at all times relevant for this complaint, were, uniformed Sheriff's deputies employed by THE COUNTY OF MENDOCINO to work in the Mendocino County Jail, in Ukiah, California, under the supervision of SHERIFF THOMAS D. ALLMAN. They are being sued in their individual and official capacities, and as agents and employees of SHERIFF THOMAS D. ALLMAN and THE COUNTY OF MENDOCINO.
- 13. CFMG is a California Corporation based in Monterrey County, California that offers and manages medical services in jails and prisons throughout California including within the Northern District of California. The conduct of CFMG alleged herein occurred in the Mendocino County Jail in Ukiah, California.
- 14. DR. MICHAEL MEDVIN is a doctor licensed to provide medical care in California with a principal place of business in Santa Rosa, California, which is within the geographic jurisdiction of the Northern District of California.
- 15. DR. MARVIN TROTTER is a doctor licensed to provide medical care in California with a principal place of business in Ukiah, California, which is within the geographic jurisdiction of the Northern District of California.
- 16. The true names and capacities, whether individual, corporate, partnership, joint venture, or otherwise of Defendants DOES 1 through 50 inclusive, are unknown to Plaintiffs who therefore sues Defendants by such fictitious names; and leave of court will be asked to amend this complaint to show their true names and capacities when the same have become ascertained.
- 17. Each of the Defendants named here as a DOE is legally responsible in some manner for the events and happenings referred to here, and proximately and legally caused injury and damage to plaintiffs as alleged here. Plaintiffs pray leave to amend this complaint when their true names have been ascertained.

- 18. At all times mentioned herein, the defendants, DOES 1 through 25, inclusive, and each of them, were the agents, servants and employees of the other Defendants, and at all times herein mentioned, were acting within the course and scope of their agency and employment with said principal and/or employer.
- 19. At all times mentioned herein, the defendants DOES 26 through 50, inclusive, and each of them, were the co-joint-venturers, masters and employers of the remaining Defendants, and each of them, who, at all times herein mentioned, were acting within the course and scope of their agency, employment and/or joint venture.
- 20. Plaintiffs are informed and believe that at all times here mentioned, certain of the Defendants DOES are the successors in interest to each of the remaining Defendants and on that basis, are liable for any act, or omission of said Defendants alleged here.
- 21. At all times mentioned here, Defendants, and each of them, were the agents and employees of the remaining Defendants and were at all times acting within the course and scope of said agency and employment.
- 22. The acts and omissions of all Defendants (excluding DR. MICHAEL MEDVIN, and DR. MARVIN TROTTER) as set forth herein were at all material times pursuant to the actual customs, policies, practice and procedures of the Mendocino County Sheriff's Department, and/or THE COUNTY OF MENDOCINO.
- 23. Jurisdiction and venue are proper in Northern District of California for the following reasons:
 - a. Federal jurisdiction over the claims stated under 42 U.S.C. § 1983 is proper in this Court under 28 U.S.C. § 1331, which invests federal district courts with original jurisdiction over all claims arising under federal law;
 - b. Federal jurisdiction in this Court exists over the state law claims stated herein because they arise out the same transaction, occurrence, or series of transactions or occurrences as the claims under 42 U.S.C. § 1983.

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alleged herein occurred in Ukiah, California, which is within the confines of this district.

COMMON LIABILITY ALLEGATIONS

24. This case arises out of the improper incarceration, care and medical treatment of Earl

c. Venue is proper in the Northern District of California under 28 U.S.C. § 1391(b)(1)&(2)

because all known defendants reside within the district, and events and omissions

- Ward that began on or about March 20, 2016 when Mr. Ward was held as a pretrial detainee in the Mendocino County Jail, in Ukiah, California.

 25. On March 21, 2016 Mr. Ward became agitated, was observed by Defendants hitting the
- 25. On March 21, 2016 Mr. Ward became agitated, was observed by Defendants hitting the window within his cell and stating that he wanted to die; Defendants' employees observed that Mr. Ward was confused and kept on pushing on the door of his cell; he was placed in a safety cell.
- 26. On March 22, 2016 MARGARET WARD talked with an unidentified employee of defendant, CFMG, sued herein under a fictitious name and explained that over the weeks prior to his arrest Mr. Ward had become confused, delusional and paranoid.
- 27. Mr. Ward continued to exhibit confusion, delusions and paranoia within the jail; Defendants observed the following on March 22nd:
 - a. At 5:30 a.m. Mr. Ward was seen standing at his door, smiling, and trying to push out.
 - b. At 8:15 a.m. Mr. Ward was observed staring at the wall, holding a drinking cup on his head.
 - c. At 9:30 a.m. a member of the jail staff observed that Mr. Ward appeared confused, although he spoke clearly, he had what was described as a "disorganized thought process."
- 28. On March 24, 2016 a social worker from the United States Department of Veteran's Affairs ("VA") medical services observed that Mr. Ward was unable to articulate why he had been arrested. This state of confusion was readily apparent to Defendants.
 - 29. On March 28, 2016 Defendants noted that Mr. Ward refused to take his medications.
- 30. On March 28, 2016 a social worker from the VA medical services talked to Mr. Ward and Mr. Ward expressed his erroneous belief that he was in Chicago.

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- 31. On April 2, 2016 defendant MICHAEL GRANT observed Mr. Ward standing on his bunk trying to push his window open.
- 32. Also on April 2, 2016, defendant LORRIE KNAPP observed Mr. Ward standing on his bunk, and then fall backwards, possibly hitting his head.
- 33. On April 2, 2016, neither defendant GRANT nor defendant KNAPP made any efforts to intervene prior to Mr. Ward's fall; their failure to do so constituted deliberate indifference to Mr. Ward's medical needs.
- 34. On April 3, 2016 at 3:40 a.m. Mr. Ward was observed to have a bruise on his head with dry blood and was taken to the Ukiah Valley Medical Center ("UVMC") where UVMC staff noted that Mr. Ward remained asleep through is exam but "[p]atient will wake up but is not oriented to person, place or time. According to deputies, this is the first time he has slept at all that they are aware of since his incarceration [on March 20, 2016]."
- 35. On April 3, 2016, blood tests performed at UVMC showed that Mr. Ward had an elevated Blood Urea Nitrogen, a sign of dehydration and renal failure. This information was communicated to and noted in jail medical records by unidentified employees of CFMG.
- 36. On April 3, 2016 DR. MARVIN TROTTER discharged Mr. Ward back to the Mendocino County Jail despite observing that "Patient does have dementia, recently residing in the jail, likely had an acute episode of delirium, probably due to lack of sleep, as it is reported he had not slept for a week and a half prior to presenting to the emergency room. He was on his bunk when he dozed off and fell."
- 37. Defendants did not undertake adequate fall-risk protection efforts after Mr. Ward's falls on April 2nd and 3rd. Failure to provide fall-risk protection after a known fall is below the standard of care of a reasonable medical professional and, in light of the knowledge of Mr. Ward's propensity to fall, constituted deliberate indifference to Mr. Ward's medical needs.
- 38. By placing Mr. Ward in an unsupervised cell after April 3rd and depriving him of appropriate medical care, Defendants increased the danger that Mr. Ward would suffer further injury beyond what he would have been exposed to either a) under appropriate medical supervision or b) had he not been retained in custody.

- 39. On April 6, 2016 an unidentified Licensed Vocational Nurse ("LVN") believed to be an employee of CFMG, and sued herein under a fictitious name, noted in the jail medical records that the LVN observed that Mr. Ward was showing increased agitation, confusion and delusion, and was continually trying to climb out of a fixed window and presented an increased fall risk.
- 40. Defendant DR. MICHEAL MEDVIN was consulted by the LVN, but Defendants did not undertake adequate efforts to address Mr. Ward's declining mental health or increased risk that he would continue to injure himself.
- 41. Defendants did not undertake adequate fall-risk protection efforts after observing Mr. Ward's attempts to climb within this cell on April 6th. Failure to provide fall-risk protection to a mentally-ill elderly patient who was known to be climbing within his cell was below the standard of care of a reasonable medical professional and, in light of the knowledge of Mr. Ward's propensity to fall and declining mental health, constituted deliberate indifference to Mr. Ward's medical needs.
- 42. By placing Mr. Ward in an unsupervised cell after observing his cognitive incapacity an inability to care for himself or avoid injury and the depriving him of appropriate medical care,

 Defendants increased the danger that Mr. Ward would suffer further injury beyond what he would have been exposed to had he been provided appropriate medical supervision within the jail or diverted to a proper custodial setting within a healthcare facility.
- 43. On April 16, 2016 Mr. Ward was found lying on the floor of his jail cell in pain and highly disoriented and was taken for a further medical evaluation which revealed that Mr. Ward had multiple transverse vertebral fractures, multiple broken ribs, internal bleeding, a partially collapsed lung, dehydration and acute kidney failure.
- 44. The orthopedic injuries Mr. Ward suffered in the Mendocino County Jail required surgery, which lead to complications and ultimately to Mr. Ward's death on May 30, 2016.
- 45. As a proximate result of Defendants' misconduct Mr. Ward and Plaintiffs suffered injury including but not limited to the following:
 - a. Mr. Ward suffered considerable emotional distress, pain and discomfort as a result of his neglect between March 20, 2015 and his death;

- b. Mr. Ward incurred significant expenses to pay for the surgical, medical, rehabilitative and palliative care that were necessitated by the injuries he suffered on or about April 16, 2016;
- c. Mr. Ward lost his life;
- d. Plaintiffs and/or Mr. Ward's estate incurred burial and funeral expenses;
- e. Plaintiffs were deprived of Mr. Ward's services (including household services), advice, training, love, companionship, comfort, affection, support, society solace, moral support and Mr. Ward's contribution to Plaintiffs' household and well-being; these losses constitute the loss of a liberty interest under the Fourteenth Amendment.

COUNT ONE

42 USC § 1983

FOURTEENTH AMENDMENT - PERSONAL CAPACITY -

AGAINST LORRIE KNAPP, MICHAEL GRANT, SHERIFF THOMAS D. ALLMAN, CFMG, DR. MICHAEL MEDVIN, DR. MARVIN TROTTER, AND DOES 1-50

Plaintiffs as individuals and on behalf of the estates of Mr. Ward and Jeffrey Ward for a first cause of action, allege against LORRIE KNAPP, MICHAEL GRANT, SHERIFF THOMAS D.

ALLMAN, CFMG, DR. MICHAEL MEDVIN, DR. MARVIN TROTTER, and DOES 1-50:

- 46. Plaintiffs incorporate by reference paragraph(s) 1 to 45 above, as though fully set forth here.
- 47. Defendants LORRIE KNAPP, MICHAEL GRANT, SHERIFF THOMAS D.

 ALLMAN, CFMG, DR. MICHAEL MEDVIN, DR. MARVIN TROTTER, and DOES 1-50 acting under the color of state law in their individual and personal capacities, deprived Mr. Ward of the rights, privileges and immunities secured by the Fourteenth Amendment to the United States Constitution, to not be deprived of life without due process of law, and to be free from cruel and unusual punishment, by subjecting him, or through their deliberate indifference allowing others to subject him to improper medical monitoring, and a delay and denial of access to medical care for a serious but treatable medical condition, leading to his death.

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48. Defendants LORRIE KNAPP, MICHAEL GRANT, SHERIFF THOMAS D. ALLMAN, CFMG, DR. MICHAEL MEDVIN, DR. MARVIN TROTTER, and DOES 1-50 knew or must have known that Mr. Ward's medical condition was serious but treatable and knew or must have known that he required careful monitoring, and that they further had a duty to provide Mr. Ward reasonable housing to allow for monitoring of his health, yet they deliberately failed to provide for any of those needs.

- 49. Defendants LORRIE KNAPP, MICHAEL GRANT, SHERIFF THOMAS D. ALLMAN, CFMG, DR. MICHAEL MEDVIN, DR. MARVIN TROTTER, and DOES 1-50 acting under the color of state law in their individual and personal capacities, denied Mr. Ward his Fourteenth Amendment right to not be deprived of his life without due process of law by purposefully or through their deliberate indifference denying and refusing proper housing, and/or provide necessary medical care and treatment, and/or by delaying and denying him access to medical care and treatment for a serious but treatable medical condition; and/or causing others to deny and/or delay medical care and treatment to Mr. Ward.
- 50. As a result of these defendants' deliberate indifference to Mr. Ward's need for medical care and treatment, and their disregard and ignoring of said conditions, Mr. Ward suffered damages, pain and suffering, anxiety, confusion, disorientation, loss of life and deprivation of his constitutional rights in an amount not yet ascertained but to be proven.
- . 51. By the actions and omissions described above, defendants LORRIE KNAPP. MICHAEL GRANT, SHERIFF THOMAS D. ALLMAN, CFMG, DR. MICHAEL MEDVIN, DR. MARVIN TROTTER, and DOES 1-50 violated 42 USC § 1983, deprived Mr. Ward and Plaintiffs of the following clearly-established and well-settled constitutional rights protected by the Fourteenth Amendment to U.S. Constitution:
 - a. Mr. Ward's right to be free from deliberate indifference to his serious medical needs while in custody as a pretrial detainee as secured by the Fourteenth Amendment:
 - b. The right of Mr. Ward and Plaintiffs to be free from wrongful government interference with familial relationships, and right to companionship, society and support, as secured by the Fourteenth Amendment.

- c. The right of Mr. Ward's heirs under the California Wrongful Death Statutes, Cal. Code of Civil Procedure § 377.60 et seq., to future support, love, care, comfort, affection, society, presence, companionship, protection, and, as to MARGARET WARD, deprived of consortium, and thus have suffered pecuniary loss.
- 52. Defendants subjected Mr. Ward and Plaintiffs to their wrongful conduct, depriving them of the rights described herein, knowingly, maliciously, and with conscious and reckless disregard for whether the rights and safety of Mr. Ward and his survivors would be violated by their acts and/or omissions.
- 53. As a direct and proximate result of Defendants' acts and/or omissions as set forth above, Mr. Ward, his wife and children sustained injuries and damages as set forth above.
- 54. The conduct of Defendants LORRIE KNAPP, MICHAEL GRANT, SHERIFF THOMAS D. ALLMAN, CFMG, DR. MICHAEL MEDVIN, DR. MARVIN TROTTER, and DOES 1-50 entitles Plaintiffs to punitive damages and penalties allowable under 42 USC § 1983, Cal. Code of Civil Procedure § 377.34 et seq., and other state and federal law.
- 55. Plaintiffs are also entitled to reasonable costs and attorney fees under 42 USC § 1988 and applicable federal and California codes and laws.

COUNT TWO

42 USC § 1983

FOURTEENTH AMENDMENT - SUPERVISORY LIABILITY AGAINST SHERIFF THOMAS D. ALLMAN AND DOES 1-50

Plaintiffs as individuals and on behalf of the estates of Mr. Ward and JEFFREY WARD for a second cause of action, allege against SHERIFF THOMAS D. ALLMAN and DOES 1-50:

56. Plaintiffs incorporate by reference paragraph(s) 1 to 55 above, as though fully set forth here.

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- 57. On or before March 20, 2016, Defendant SHERIFF THOMAS D. ALLMAN, and DOES 1-50 failed to properly train, assign, supervise, and guide their staff and medical personnel at the Mendocino County Jail and at the Mendocino County Sheriff's Department respectively, to take necessary measures to ensure the health and safety of arrested persons and to ensure that they are provided with all necessary monitoring and medical care.
- Defendants SHERIFF THOMAS D. ALLMAN, and DOES 1-50 have either participated in, or known of, or must have known of their subordinates' deliberate indifference in failing to take immediate measures to ensure that a person in custody be provided with all necessary monitoring and medical care to protect his or her health and safety, subsequently causing injuries or deaths. SHERIFF THOMAS D. ALLMAN's knowledge of the shortcomings of his subordinates was based in part, but not exclusively, on the wrongful death in the Mendocino County Jail of a schizophrenic man, Steven Kellogg Neuroth, who was improperly restrained on or about June 11, 2014 in a manner that led to Mr. Neuroth's death; that prior wrongful death of a mentally ill arrestee should have, and did apprise SHERIFF THOMAS D. ALLMAN of the fact that his subordinates did not have proper training in the treatment of mentally ill persons in custody.
- 59. Notwithstanding the death of Steven Kellogg Neuroth, defendant SHERIFF THOMAS

 D. ALLMAN took no steps to revise or adopt policies and procedures in order to apprise his
 subordinates of the proper manner for treating mentally ill persons in custody, and of circumstances in
 which mentally ill persons in custody should cannot be safely accommodated in the jail.
- 60. Furthermore, on or before March 20, 2016, defendant SHERIFF THOMAS D.

 ALLMAN and DOES 1-50 failed to properly supervise the medical services for arrestee-prisoners, in that Mendocino County Jail personnel were not trained to properly classify, house or monitor pretrial detainees suffering from health conditions, including mental health conditions, failed to provide appropriate care to pretrial detainees for serious but treatable medical conditions, and operated without adequate safeguards, audits, or reporting requirements reviewable by supervisors.

	61.	Additionally, as a policy making officials for THE COUNTY OF MENDOCINO,
defer	dants SI	HERIFF THOMAS D. ALLMAN, and DOES 1-50 were responsible for THE COUNTY
OF M	1ENDO	CINO's unconstitutional customs, policies, practices, and procedures, as well as failures t
prope	erly hire,	train, instruct, monitor, supervise, evaluate, investigate, manage, and discipline, as
descr	ibed abo	eve, and they ratified the misconduct and constitutional violations as described above.

- 62. Said acts and omissions, customs and practices by defendants SHERIFF THOMAS D. ALLMAN, and DOES 1-50 set in motion a series of acts by their subordinates that they knew or must have known would cause the subordinates to deprive Mr. Ward, the Plaintiffs and Mr. Ward's heirs of their rights as alleged above.
- 63. As a direct and proximate result of the actions, omissions, and practices of defendants SHERIFF THOMAS D. ALLMAN, and DOES 1-50, as described above, Mr. Ward, the Plaintiffs and Mr. Ward's heirs sustained serious and permanent injuries and are entitled to damages, penalties, costs and attorney fees as set forth above.

COUNT THREE

CAL. WEL & INST. §§ 15600 et seq.

ELDER ABUSE

AGAINST ALL Defendants

(EXCLUDING DR. MICHAEL MEDVIN AND DR. MICHAEL TROTTER)

Plaintiffs as individuals and on behalf of the estates of Mr. Ward and JEFFREY WARD for a third cause of action, allege against all Defendants (excluding DR. MICHAEL MEDVIN and DR. MICHAEL TROTTER):

- 64. Plaintiffs incorporate by reference paragraph(s) 1 to 63 above, as though fully set forth here.
- 65. Mr. Ward was at all times an "elder" within the meaning of California Welfare and Institutions Code section 15610.27 owing to the fact that he resided in the State of California, and was over 65 years of age.
- 66. Once Mr. Ward was taken into custody in the Mendocino County Jail in Ukiah,

 Defendants, each of them was a person "having care or custody of" Mr. Ward within the meaning of

California Welfare and Institutions Code section 15610.57(a) by virtue of his pretrial detention and housing within their facility.

- 67. By virtue of the foregoing, Defendants, and each of them, have committed "neglect" as defined in California Welfare and Institutions Code section 15610.57 by:
 - a. Their failure to provide Mr. Ward with medical care within the meaning of Section 15610.57(b)(2) by failing to provide appropriate mental health care including supervision;
 - b. Their failure to protect Mr. Ward from health and safety hazards within the meaning Section 15610.57(b)(3);
 - c. Their failure to prevent dehydration within the meaning of Section 15610.57(b)(4).
- 68. By virtue of the foregoing, and repeated sentinel events suffered by Mr. Ward between March 20, 2016 and April 16, 2016 at all times during Defendants' care and/or custody of the Mr. Ward, Defendants' failure to address Mr. Ward's decline and protect him from safety hazards was reckless and constituted deliberate indifference to Mr. Ward's medical and mental health needs.
- 69. By virtue of the foregoing, Plaintiffs are entitled to recover Mr. Ward's pre-death pain and suffering damages and attorney's fees under California Welfare and Institutions Code section 15657.

COUNT FOUR

MEDICAL NEGLIGENCE - WRONGFUL DEATH AGAINST ALL Defendants

(EXCLUDING SHERIFF THOMAS D. ALLMAN, LORRIE KNAPP and MICHAEL GRANT)

- Plaintiffs as individuals and on behalf of the estates of Mr. Ward and JEFFREY WARD for a fourth cause of action, allege against all Defendants (excluding SHERIFF THOMAS D. ALLMAN, LORRIE KNAPP and MICHAEL GRANT):
- 70. Plaintiffs incorporate by reference paragraph(s) 1 to 69 above, as though fully set forth here.
- 71. Defendants against whom this cause of action is alleged are private parties, public employees, and public agencies who were lawfully engaged in in the practice of one of the healing arts

them had assumed responsibility for the medical care and supervision of Mr. Ward.

and/or operated a custodial facility in which persons are entitled to medical treatment and each of

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72. By virtue of the foregoing, Defendants, and each of them, owed a duty of ordinary care to the Mr. Ward, to use that degree of care and skill that a reasonably prudent person and/or facility would use given the Defendants' respective role, function, knowledge, training, expertise and skill and to exercise prudent, reasonable judgment and care in the selection, employment and control of qualified, trained, experienced nurses, nurse practitioners, nursing personnel, orderlies, assistants, aides and employees under their supervision, control, direction, responsibility and authority while performing services and caring for persons within the custody of THE COUNTY OF MENDOCINO including, but not limited to, Mr. Ward.

- 73. The medical treatment and monitoring provided by Defendants, and each of them, and by Defendants' employees, and each of them, to Mr. Ward, negligently failed to conform to the standard of care both with respect to the care and treatment rendered to Mr. Ward, and with respect to providing Mr. Ward with information about the risks, hazards, or other harmful consequences, that might follow from the treatment and diagnosis Defendants, and each of them, planned for Mr. Ward.
- 74. At all times herein mentioned, Defendants negligently and carelessly failed to properly ensure the character, quality, ability and competence of individuals, including the remaining Defendants, and each of them, treating patients in said hospital, custodial facility and clinics, and as a proximate result thereof, Mr. Ward died.
- 75. Before, during, and after said times, Defendants and each of them, so negligently treated, and so negligently cared for Mr. Ward while he was under their care, and so negligently operated, managed, maintained, selected, designed, controlled and conducted their services, activities, personnel and equipment in connection with Mr. Ward's care and treatment that the same proximately caused Mr. Ward's death.
 - Defendants and each of them breached the aforesaid duty of care by: 76.
 - a. Failing to provide Mr. Ward with appropriate mental health care;
 - b. Failing to take adequate measures to prevent Mr. Ward from injuring himself, including, but not limited to, taking adequate fall-risk prevention precautions;

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DEMAND FOR JURY TRIAL

Plaintiffs demand a jury trial on each and all of the causes of action set forth in this Complaint.

Dated:

By: <u>/s/</u>

Nathaniel M. Leeds Attorneys for Plaintiffs

Nathaniel M. Leeds

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JS 44 (Rev 08/16)

The 1S 44 civil cover sheet and the information contained herein neither replace nor supplement the filing and service of pleadings or other papers as required by law, except as provided by local rules of court. This form, approved by the Judicial Conference of the United States in September 1974, is required for the use of the Clerk of Court for the purpose of initiating the civil docket sheet. ISEE INSTRUCTIONS ON NEXT PAGE OF THIS FORM.)

I. (a) PLAINTIFFS Margaret Ward, Kevin W	ard, and Ina Ward		The County of Mendocino, Thomas D. Allman, Lorrie Knapp, Michael Grant, California Forensic Medical Group, Michael Medvin, Marvin Tro						
(b) County of Residence of	of First Listed Plaintiff M NCKPT IN U.S. PLAINTIFF CA	lendocino ses)	······································	County of Residence of First Listed Defendant Mendocino (IN U.S. PLAINTIFF CASES ONLY) NOTE: IN LAND CONDEMNATION CASES, USE THE LOCATION OF THE TRACT OF LAND INVOLVED.					
(c) Attorneys (titral Name, Nathanial Leeds of Brent San Rafael, CA 94901 Telephone: 415-839-837) 0 Fourth Street, Str	ə. 750 ;	Attorneys (If Known) Unknown		·			
II. BASIS OF JURISDI	CTION (Plow on "X" DO	ne Box Onlyj	III. CI	TIZENSHIP OF P	RINCIPA	L PARTIES	Place an "X" in	One Bax fo	r Plainiff
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17 2 U.S. Government Defendant	Cl 4 Diversity (Indicate Citizenship of Parties in Iron III)		Citiz	en of Another State 9	2 (7) 2	Incorporated and P of Business In A		EI 5	O 5
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Case 1:17-c 0911-NJV Document 4 Filed 02/23 Page 1 of 1

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1	DAVID L. FIOL (SBN: 203546) NATHANIEL M. LEEDS (SBN: 246138)	•						
2	BRENT, FIOL & PRATT, LLP 1000 Fourth St., Ste. 750							
3	San Rafael, CA 94901							
4	Telephone: (415) 839-8370 Facsimile: (415) 373-4420							
5	Attorneys for Plaintiffs MARGARET WARD, in her personal capacity, and as executor of the							
6	estate of Earl Ward, Deceased; KEVIN WARD;							
7	and INA WARD, surviving heir of JEFF WARD, Deceased							
8	UNITED STATES DISTRICT COURT							
9	NORTHERN DISTRICT OF CALIFORNIA							
10								
11	MARGARET WARD, in her personal capacity, and as executor of the estate of Earl) Case No. 3:17-cv-00911- NJV						
12	Ward, Deceased, KEVIN WARD and INA WARD, surviving heir of JEFF WARD,	PLAINTIFFS' CERTIFICATION OF						
13	Deceased,) INTERESTED ENTITIES OR) PERSONS, PURSUANT TO LOCAL						
14	Plaintiffs,) RULE 3-15)						
15	v.	}						
16	THE COUNTY OF MENDOCINO, a))						
17	municipal corporation, SHERIFF THOMAS D. ALLMAN, individually and in his official))						
18	capacity as Sheriff of THE COUNTY OF MENDOCINO, LORRIE KNAPP, MICHAEL))						
19	GRANT, CALIFORNIA FORENSIC MEDICAL GROUP, INC, DR. MICHAEL). }						
İ	MEDVIN, DR. MARVIN TROTTER and DOES 1 THROUGH 50, INCLUSIVE							
20		{						
21	Defendants.	{						
22		}						
23								
24	Pursuant to Civil L.R. 3-15, the undersigned certifies that as of this date, other than the named parties,							
25	there is no such interest to report.							
26	Dated: 2/23/17	· ·						
27	F	3y:/s/ .						
28	Nathaniel M. Leeds							
ļ		Attorneys for Plaintiffs						
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	PLAINTIFFS' COMPLAINT; DEMAND FOR JURY TRIAL							