IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 02-M-0651 (MJW)

MARK SHOOK and
DENNIS JONES, on behalf of themselves and all others similarly situated,

Plaintiffs, and

JAMES VAUGHAN and
SHIRLEN MOSBY,

Intervenor Plaintiffs,

v.

THE BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF EL PASO and TERRY MAKETA, in his official capacity as Sheriff of El Paso County,

Defendants.

SUPPLEMENTAL CLASS ACTION COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF

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1. Plaintiffs, on behalf of themselves and all others similarly situated, file this Supplemental Complaint pursuant to Fed. R. Civ. P. 15(d). This Supplemental Complaint sets forth events that have transpired since the filing of the original Complaint in this action (hereinafter "Complaint") on April 2, 2002. Plaintiffs file this Supplemental Complaint based upon limited information, as they have not yet been permitted to conduct depositions, expert inspections, document discovery, or any other discovery under the Federal Rules of Civil Procedure.

2. Conditions in the El Paso County Jail continue to pose a substantial risk of serious harm or death to persons with serious mental health needs, and defendants

continue to act with deliberate indifference to this risk. In addition to this risk of harm, numerous prisoners with serious mental health needs have suffered actual harm, and in some cases death, as a result of defendants' deliberately indifferent acts and omissions since the filing of the original Complaint.

3. Since the filing of the Complaint, at least three separate reports by outside investigators have documented the inadequate state of mental health care in the Jail. In October 2002, a citizens' panel appointed by the Sheriff of El Paso County (hereinafter "Citizens' Panel Report") noted numerous deficiencies in the Jail's mental health and suicide prevention measures.

4. On May 26, 2003, a consultant funded by the National Institute of Corrections, a division of the United States Department of Justice, issued a report "for the purpose of specifically reviewing the status of the mental health and suicide prevention programming in operation in the El Paso County Jails" (hereinafter "NIC Report"). The findings of this report make clear that conditions for mentally ill and suicidal prisoners at the Jail continue to present a grave risk of serious injury or death.

5. Most recently, a June 25, 2004 report by the National Commission on Correctional Health Care (NCCHC) (hereinafter "NCCHC Report") noted that the Jail is out of compliance with several "essential" and "important" NCCHC standards, and states that "the facility does need to correct deficiencies noted on a priority basis."

6. Despite these repeated warnings, defendants have failed to take meaningful corrective action. For example, defendants have failed take effective steps to ensure that the mental health services for which they have contracted with a private corporation are actually provided. As a result of defendants' deliberate indifference,

mental health services at the El Paso County Jail remain so systemically inadequate as to violate the Eighth and Fourteenth Amendments to the United States Constitution.

Overcrowding, increasing mental health needs, and inadequate housing facilities for the mentally ill (see Complaint, ¶¶ 20-23)

7. The Jail's population has more than doubled in the last ten years, and defendants project continued growth. On November 19, 2004, the Jail population reached 1,312, setting a new record. As currently stated on the El Paso County Sheriff's Office website, "This high inmate population has forced us to house inmates in the dayrooms of many of the wards because of the lack of cell bed space availability. This jeopardizes safety/security and increases disciplinary problems." The Sheriff's website describes overcrowding as "severe" and adds that "[d]ue to the County's growing population [and] the increasing jail population, we experienced an increase in inmate violence, suicide, and litigation." The Citizens' Panel Report similarly found that the Jail is "critically overcrowded" and that this overcrowding adversely affects the ability of Jail staff to identify and monitor prisoners who are mentally ill and/or suicidal. The NIC Report similarly noted that female prisoners who are suicidal or have "acute mental health needs" are housed with recently admitted prisoners, in a pod that is "overcrowded, with extra double bunks situated in the day room areas."

8. As the Jail's population increases, so too does the number of prisoners with serious mental health needs. In a recent deposition, the Sheriff's Detention Bureau Chief stated that approximately 20% of the prisoners in the Jail are mentally ill. Thus, at any given time, there are approximately 260 mentally ill prisoners in the Jail. According to the Sheriff's Office 2003 Annual Report, 22,625 persons were processed into the Jail in 2003; using the 20% figure, over 4,500 of those persons were mentally ill.

Harm to class members

9. The systemic deficiencies in mental health services identified in the original Complaint and in this Supplemental Complaint continue to pose a substantial risk of serious harm to Jail prisoners with serious mental health needs. In some cases, these deficiencies have led to serious harm or death.

Lack of adequate protection from self-harm and suicide (see Complaint, ¶¶ 47-51)

10. The 2002 Citizens' Panel Report, the 2003 NIC Report, and the 2004 NCCHC Report all pointed out major deficiencies in the Jail's system for identifying prisoners who are at risk of suicide, and preventing them from harming or killing themselves. The NIC report described it as "an inefficient communication system that runs the danger of allowing someone to fall between the cracks." Although both NCCHC standards and the Jail's own policy require that all prisoners receive a comprehensive mental health evaluation, including assessment for suicide risk, within 14 days of admission, the NIC Report found that "not all inmates receive the comprehensive mental health screening to assess suicide risk." More than a year later, the NCCHC Report found that incoming prisoners are still not receiving a mental health assessment within 14 days. The NIC Report found that medical staff received no advanced mental health and suicide risk training, and that training for deputies in suicide issues has actually been reduced. Finally, the NIC Report found that the Jail's common use of the antidepressant Elavil is "worrisome," given "its potential to be used to effect suicide." (See ¶ 21, *infra*, describing two prisoners attempting suicide using Elavil).

11. Significantly, the May 2003 NIC Report refers to only two suicides at the Jail since January 2001, although it is undisputed that at least four pretrial detainees died

by hanging in the Jail between March 2001 and February 2003. Nevertheless, the Report concludes that even these two suicides "may point to a need for better inmate management in the CJC."

12. Since the filing of the Complaint, the Jail's inadequate suicide prevention procedures have led to the suicides of two additional pretrial detainees, Douglas Spencer Parrish and Marca Anne Wilson, as well as numerous serious suicide attempts. Indeed, the Jail's "Annual Report for Mental Health, 2003" states that there were 22 suicidal gestures and attempts in 2003, up from 16 in 2002.

Douglas Spencer Parrish

13. Douglas Spencer Parrish was booked into the Jail on June 5, 2002. Six days later, on June 11, another prisoner found Parrish hanging by a sheet from an air vent in his cell. He died the following day. Parrish had hung a towel over his cell door, blocking the view into his cell, for 30 to 45 minutes before he was found hanging. According to one of the Jail's commanders, it was impermissible for Jail staff to allow Parrish to cover the window in the cell door.

14. An April 2, 2002 note by a mental health worker, made during Parrish's previous incarceration in the Jail, reports that he was "[complaining of] depression" and had "ineffective coping skills while incarcerated." In addition, the autopsy report refers to a suicide attempt by Parrish a week before his June 5 arrest, which resulted in admission to a psychiatric hospital. There is no indication that either of these warnings resulted in any precautions being taken when Parrish was admitted to the Jail on June 5.

Marca Anne Wilson

15. During Marca Anne Wilson's incarceration in the Jail in September 2002, deputies had repeatedly characterized her as "suicidal," and noted that she had "tied something around her neck and made several statements that she wanted to kill herself." She was repeatedly placed in restraints for her own protection. On one occasion was observed to be "severely scratch[ing] her wrists with her nails;" on another, she was "periodically striking her head against the window of the cell door." Nevertheless, when she was readmitted to the Jail the following month, on October 14, 2002, she was classified as having no suicide potential.

16. Wilson's condition continued to deteriorate. Jail incident reports on December 29, 30, and 31, 2002, and January 1 and 2, 2003, note bizarre, delusional behavior, sometimes accompanied by strange drawings and incoherent writings. On January 4, she was tearful and complained to mental health staff of paranoia and increased anxiety. On February 10, 2003, a mental health worker cleared her to be housed in a cell alone. Seven days later, she hanged herself with a sheet tied to the upper bunk. She died the following day.

Prisoner No. 5

17. Twenty-year-old Prisoner No. 5 was arrested and admitted to the Jail in the early morning hours of May 25, 2003. On his Initial Classification Assessment Form, completed that same day, he indicated that he had attempted suicide 7 ½ years ago, had contemplated suicide 6 years ago, and had been a patient in a mental institution or psychiatric hospital 6 years ago, for 8-9 months. Similarly, his "Medical Screening Sheet," dated May 25, 2003, stated that had tried to hurt or kill himself in the past; had

past mental health hospitalization; and was currently taking antidepressant medications. His "Health Evaluation," dated May 25, 2003, indicated past psychiatric history and suicidal history. Prisoner No. 5's "Inmate Alert Status Report," dated June 1, 2003, noted that he had attempted suicide twice. Nevertheless, next to the item "suicide potential," the form indicates a letter "N," meaning "no."

18. On the afternoon of May 25, Prisoner No. 5 wrote a kite to the medical staff stating "I am having thoughts about suicide. I need to speak to someone soon." He was moved to the "mental health" ward and placed in a suicide gown. On May 31, 2003, he approached mental health staff and asked for sheets. The mental health counselor concluded that Prisoner No. 5 "presents as depressed but not an immanent [sic] danger to self." The following day, another mental health counselor spoke with Prisoner No. 5, who said that he wanted to be evaluated at the state hospital. The counselor noted that Prisoner No. 5 "continue[s] to have a high level of depression," but concluded that he "continues to present as depressed but not a risk to self."

19. On June 9, 2003, Prisoner No. 5 wrote the following request to mental health staff: "I am having a real hard time and my problems are only getting worse. I need to speak with Mrs. Chris as soon as possible. I need help soon and it starting to seem like once again I am not getting the help I need." On June 11, 2003, Prisoner No. 5 was seen by a mental health counselor, who noted that he "continues to [complain of] depression & wanting 'help.'" The counselor further noted that Prisoner No. 5 "presents [with] flat/depressed affect, monotone, quiet speech, almost [no] eye contact." The counselor concluded that Prisoner No. 5 "appears as depressed," but "may also be manipulating for [secondary] gain."

20. Despite these clear and repeated warnings of Prisoner No. 5's worsening depression and suicide potential, on June 24, 2003, he was able to attempt suicide in the Jail by hanging himself with a sheet tied to a power box in the "mental health" ward. By the time he was cut down by Jail staff, Prisoner No. 5 was unconscious, blue in color, and not breathing, and his pupils were non-reactive. Prisoner No. 5 was hospitalized; as of the following day, his condition remained critical.

Prisoner No. 6

21. Prisoner No. 6 has a long history of serious mental illness and suicidality. He had been identified as a suicide risk during previous stays in the Jail. On April 10, 2003, he begged mental health staff to prescribe Seroquel, an anti-psychotic medication that had successfully controlled his symptoms in the past: "this seroquel is the best stuff I used to take it helped me to cope with life." On April 14, 2003, mental health refused; "we do not have Seroquel on our formulary. If you can provide Seroquel that is a possibility." Seven days later, Prisoner No. 6 attempted suicide by stealing a bottle of Elavil from a medication cart and taking several of the pills. He was taken by ambulance to the hospital, where he was placed on a ventilator. Another prisoner also attempted suicide on the same day with pills from the same bottle of Elavil and was also hospitalized. Despite these two suicide attempts using Elavil, and despite the May 2003 warning in the NIC Report that the Jail's use of Elavil is "worrisome," given "its potential to be used to effect suicide," Elavil remains on the Jail's formulary to this day.

Prisoner No. 7

22. Prisoner No. 7 arrived at the Jail on November 18, 2004. She had just spent three days on the psychiatric ward of St. Francis Hospital after a suicide attempt on

November 15. At the hospital, she saw the psychiatrist every day, who put her on Seroquel. She was released to the Jail with a prescription for Seroquel morning and night and additional doses "as needed." She immediately wrote to the mental health staff asking for her psychiatric medications. Instead of providing Seroquel, however, the medical staff changed the medications, without a face-to-face consultation or any warning about possible side effects of the new drugs. She complained to mental health workers on several subsequent days. Eventually the Jail staff permitted the prisoner's family to pick up the previously-written prescription form from the prisoner's property, fill it at a community drugstore and bring the medications to the Jail. Ten days after arriving at the Jail, after she reported hearing voices, Prisoner No. 7 finally began receiving some, but not all, of the medications originally prescribed by the hospital psychiatrist.

23. In the following week, Prisoner No. 7 sent repeated written requests to the mental health staff reporting that she needed a higher dose or the more frequent administration of the medication that the hospital psychiatrist had authorized. The written requests became increasingly desperate, reporting deep anxiety, depression, and continued auditory hallucinations. On December 7, she wrote "I have requested and requested to see mental health regarding my medications and still nothing has happened. Please can we up my dosage. If not I may have a nervous brake [sic] down." After several such requests had gone unanswered, Prisoner No. 7, despite being on a "suicide watch," managed to ascend a stairway and jump off the top tier to the concrete floor below. Four weeks after arriving at the Jail and more than a week after this suicide

attempt, the Jail's psychiatrist met with her for the first time. The psychiatrist authorized the increased dosage of the medications.

Prisoner No. 8

24. Prisoner No. 8 was booked into the Jail on April 7, 2003. The previous day, he had attempted suicide by hanging. According to Jail documents, his Medical/Mental Health Questionnaire "indicated strong history of suicide." Upon intake, the Jail classified him as a suicide risk, but this alert was inexplicably canceled five days later. An incident on April 21, in which Prisoner No. 8 swallowed medication given to him by another prisoner, did not result in renewal of the suicide alert. On May 1, 2003, Prisoner No. 8, though housed in the "mental health" ward, was able to hang himself with a sheet tied to a pipe approximately 20 feet above the floor. One prisoner reported that Prisoner No. 8 had been talking about killing himself for over a week, and that the prisoner had informed Jail staff of this. Numerous witnesses reported that when Prisoner No. 8 began tying the noose around his neck, the deputy on duty was not in the ward. Prisoner No. 8 was cut down and taken to the hospital by ambulance. A memorandum dated May 2, 2003, states that Prisoner No. 8's "mental and physical state is still in question as of this date."

25. Immediately upon Prisoner No. 8's return from the hospital, he was stripped naked and placed in a barren medical holding cell with only a blanket to cover himself. There is no indication that mental health staff participated in or approved this decision. The harsh and degrading environment of the holding cell caused Prisoner No. 8 to become suicidal again.

Prisoner No. 9

26. On March 2, 2003, Prisoner No. 9 fashioned a rope from a sheet and hanged himself in a shower stall at the Metro Detention Facility. Another prisoner found Prisoner No. 9 hanging and alerted staff. Prisoner No. 9 was cut down; he was foaming at the mouth and unresponsive at the time. He was sent by ambulance to the hospital. The physician at the hospital ultimately released Prisoner No. 9 with instructions that he be housed in a "suicide unit." A subsequent investigation found that the deputy had failed to check the unit every 30 minutes as required by policy.

Failure to provide appropriate medication for prisoners with serious mental health needs (see Complaint, ¶¶ 36-41)

27. Defendants fail to provide adequate medication for prisoners whose serious mental health needs require it. One aspect of this failure is defendants' policy and practice of removing serious mentally ill prisoners from medications on which they have been successfully stabilized, and substituting cheaper and less effective medications, often resulting in catastrophic psychiatric deterioration. The medications available to mentally ill prisoners are limited to those on the Jail's formulary, which the NIC Report describes as "largely antiquated." The NIC Report also describes the Jail's practice of discontinuing psychotropic medications for incoming prisoners as "somewhat disturbing."

28. In addition, defendants arbitrarily provide that certain mental health disorders, such as sleep disorders and anxiety disorders, will not be treated at all. A document titled "Medical Services Summary Information" informs Jail prisoners that "Mental health services are not comprehensive; medication(s) to stabilize *may* be provided. … [S]leep disorders and anxiety services are not available" (emphasis added).

29. Defendants also initiate, change, or discontinue psychotropic medications without a face-to-face interview with the patient by qualified mental health staff, and fail to provide adequate monitoring of the clinical effectiveness and side effects of psychotropic medications once prescribed.

Prisoner No. 10

30. Prisoner No. 10 was first diagnosed as manic depressive when she was 14 years old. She states that she shows signs of schizophrenia durng what she describes as her break-down periods, and she reports that her condition has been getting worse in recent years. Shortly before arriving at the El Paso County Jail in mid-April, 2003, she received in-patient psychiatric care, and her psychiatrist told her she would need to take medication the rest of her life.

31. At the Jail, she immediately began asking to resume the psychiatric medications she had successfully taken in the past. Over the next two months, she sent numerous and repeated written requests, without success. In response to one of those requests, nearly two months after she arrived at the Jail, a mental health assistant wrote back and said "please be patient." On June 26, prisoner No. 10 wrote again saying she still has not received any type of mental health medication. In response, the jail's Mental Health Coordinator wrote:

> "Correctional Healthcare is unable to provide Paxil for you. Paxil is not on our formulary. On 4.30.03 the doctor noted that you had problems taking Prozac. The goal is to find a substitute. The next best medication is Prozac. Are you willing to try Prozac again?"

Prisoner No. 4

32. Prisoner No. 4 is a severely mentally ill young woman with a long history of psychiatric hospitalization as a result of her serious mental health problems. One of her previous incarcerations in the Jail is described in the Complaint at ¶¶ 52-57.

33. Prisoner No. 4 arrived at the Jail from the Colorado Mental Health Institute at Pueblo (CMHIP), the state psychiatric hospital, on August 28, 2003. Her discharge summary from CMHIP stated that she was "stabilized sufficiently" to be discharged to the Jail. Among the medications on which she had been stabilized at CMHIP was Zyprexa, an antipsychotic medication; a supply of this medication accompanied her to the Jail. However, a September 1, 2003 note in her Jail medical file states that her supply of Zyprexa had run out. Rather than continue this medication, the following day Jail medical staff wrote an order to substitute Navane, a less expensive medication. Prisoner No. 4 refused to take Navane, and her condition deteriorated. On November 1, 2003, she was observed talking to herself. On November 12, 2003, she said she was hearing voices telling her that she would be dead by the end of the week. On November 28, 2003, she was placed in restraints (see ¶ 57, *infra*). A December 18, 2003 observation log notes that she was talking about hallucinations and voodoo.

Prisoner No. 11

34. Prisoner No. 11 suffers from bipolar disorder and has an extensive history of psychiatric hospitalization. During his incarceration in the Colorado Department of Corrections in 2003, this condition was successfully treated with Neurontin, a mood stabilizer. When Prisoner No. 11 entered the Jail on January 30, 2004, he told mental health staff of his successful treatment with Neurontin, and added that he suffers negative

side effects with lithium. Nevertheless, Jail staff told him that Neurontin was not available because it is too expensive, and wrote an order to substitute lithium for Neurontin. Prisoner No. 11 repeatedly told staff that the lithium was causing negative side effects, and ultimately refused to take it. His mental health and his behavior deteriorated. On March 10, 2004, he was involved in an altercation with another prisoner; Jail staff pepper-sprayed him. On May 24, 2004, he was involved in another altercation; staff threatened to shock him with a taser. On May 26, 2004, he wrote to staff, "I need some medication for the voices I'm starting to hear and something for my mood swings. I know they are trying to get me." On June 3, 2004, he wrote a note stating that "the Mason's and Illuminati's are part of a conspiracy to kill me. I seen my lawyer signing the judge to kill me. I have a chip they implanted in my brain to make me a criminal[.]"

Prisoner No. 12

35. Prisoner No. 12 has a history of psychiatric hospitalization and being prescribed powerful anti-psychotic medications. On March 31, 2004, Prisoner No. 12 wrote to mental health to request medication; "I am going crazy in this cell and I feel like I am about to snap." Four days later, he again asked for treatment for his anxiety; "I feel very anxious and agitated and worried and impatient." Mental health staff responded that "CHM [the Jail's contract medical provider] does not provide medication solely for the purpose of anxiety."

Inappropriate use of "special detention cells" to confine persons with serious mental health needs (see Complaint, ¶¶ 24-25, 46, 50-57)

36. Defendants continue to confine prisoners who are suicidal or suffer from serious mental illness in "special detention cells." The conditions in these cells – which

have no bed, no toilet, and no sink – violate minimal standards of decency. Moreover, the isolated, harsh, and degrading conditions in these cells pose a grave risk of exacerbating suicidality and other serious mental illness.

Prisoner No. 13

37. Prisoner No. 13 has a long history of psychiatric hospitalizations and diagnoses dating at least to the early 1990s. He has been diagnosed as bipolar with schizoaffective disorder and also as paranoid schizophrenic. He has been continuously incarcerated in the El Paso County Jail as a pretrial detainee since September 2003, except for several months in the state psychiatric hospital in Pueblo between March and June, 2003.

38. When prisoners are placed in "special detention" cells, deputies are supposed to record certain information on a "special detention documentation" form. One section requires deputies to document the fact that they notified the mental health staff and the time the staff was notified. Prisoner No. 13 has been confined in a "special detention" cell eight times. In only two of the eight cases do the forms indicate that deputies notified mental health staff while the prisoner was confined in the special detention cell. None of the incident reports indicates that mental health staff were consulted about the need to place the prisoner in a special detention cell, nor about the decision to return the prisoner to the regular ward.

Prisoner No. 14

39. Prisoner No. 14 was admitted to the Jail on or about January 16, 2004. He has a history of multiple suicide attempts and psychiatric hospitalization. He has been diagnosed by Jail mental health personnel as suffering from major depression and post-

traumatic stress disorder. A January 16, 2004 entry in Prisoner No. 14's mental health file indicates that he has current suicidal ideation with a plan; a note the following day states that he "presents to be depressed and at risk of self-harm." The Jail's "Basic Classification Report" on Prisoner No. 14 identifies him has having "suicide potential."

40. On June 29, 2004, following an altercation, Prisoner No. 14 was placed in a "special detention cell" at the Metro Jail. Mental health staff were not contacted until more than five hours later. A memorandum from a lieutenant states that Prisoner No. 14 was placed in the special detention cell "naked as is [Jail] procedure." According to the lieutenant, "[t]he use of [the special detention cells] has been very restricted for years and only recently has there been an ideological change that incorporates the use of these detention cells for behavior modification and severe incident intervention." The cell had no toilet, but only a hole in the floor covered with a metal grate. Prisoner No. 14 was told by Jail staff that, when he defecated, he was to push his feces through the grate with his hands. When Prisoner No. 14's attorney came to meet with him on June 30, Jail staff refused to bring Prisoner No. 14 to the attorney visiting room; instead, the attorney was taken to see Prisoner No. 14 in the special detention cell. Prisoner No. 14 was naked, as he still had been given no clothing at this time.

41. A July 6, 2004 "behavior modification" plan for Prisoner No. 14 was created by custody staff, with no apparent participation by mental health staff. The plan provides for Prisoner No. 14 to be housed in a special detention cell, and states that "[a]ll of his remaining personal belongings will be confiscated." It further states that "[h]e will be stripped of his jumpsuit and given a suicide gown. He will not be allowed books, including a Bible. He will not be afforded a mattress or pillow." The plan further

provides that Prisoner No. 14 may be placed in a restraint chair, but contains no requirement that mental health staff be consulted or notified before this is done.

Prisoner No. 4

42. On the evening of April 1, 2003, Prisoner No. 4 began talking to a deputy about killing herself. The deputy contacted the medical unit and asked that Prisoner No. 4 be housed in a medical cell, but this request was refused. A short time later, Prisoner No. 4 was found curled in a fetal position on the floor next to the deputies' desk. In the early morning hours of April 2, Prisoner No. 4 again said she was going to kill herself. She was eventually placed in a special detention cell in handcuffs and leg irons. A deputy threatened to shock her with a taser. When she began screaming and banging her head against the window of the cell, a helmet was placed on her head and secured with tape. The "Special Detention Documentation" form indicates that mental health staff was not notified.

43. On several other occasions (April 11, 12, 20, 21, and 25, 2003; May 11, 2003; November 7, 2003), Prisoner No. 4 was placed in a special detention cell for nothing more than verbal disruption. On all of these occasions, the "Special Detention Documentation" form either indicates that mental health staff was not notified, or it is not completed.

Restraints and use of force against prisoners with serious mental health needs (see Complaint, ¶¶ 25, 33-35, 46)

44. Jail staff continue to use pepper spray against prisoners with mental illness (see ¶ 34, *supra).* Moreover, in March 2003, the Jail security staff began carrying and using electroshock weapons, known as "tasers." These weapons deliver a painful and incapacitating electric shock. Their use by law enforcement and correctional staff has

been implicated in scores of deaths throughout the United States in the last four years. The use of these weapons on mentally ill persons can cause substantial harm, including the exacerbation of their mental illness. The use of such weapons on persons who are taking psychotropic medications is particularly dangerous and can result in physical injury or death.

45. Despite these serious risks, the Jail's written policy on use of tasers contains no warnings about their use on persons with mental illness or persons who are taking psychotropic medications. Indeed, faced with a policy that imposes few meaningful restrictions on their use, Jail staff sometimes use these dangerous weapons in situations in which there is no need to use force at all.

46. Placing a prisoner in full-body restraints, such as a restraint chair, poses a serious risk of injury or death, and thus must be used only as a last result resort when necessary to prevent imminent harm to the prisoner or to others. Moreover, such restraints may be continued only as long as they remain necessary to prevent imminent harm. Defendants sometimes place mentally ill prisoners in restraints, including the restraint chair, in circumstances in which there is no risk of harm. Rather, the restraint chair is sometimes used as summary punishment for verbal disruption. In addition, defendants fail to consult with, or even notify, mental health staff when mentally ill prisoners are placed in the restraint chair. Finally, defendants leave mentally ill prisoners in the restraint chair long after any conceivable risk of harm has passed.

Prisoner No. 12

47. On March 24, 2004, security staff made the decision to place Prisoner No. 12 in the restraint chair. There is no allegation in Jail documents that Prisoner No. 12

posed any risk of harm to himself or to anyone else. The only justification for placing him in the restraint chair is that he was "yelling to other inmates and seemed to be encouraging them to become disruptive." There is no indication that mental health staff were consulted regarding the decision to place Prisoner No. 12 in the restraint chair, or notified after he was placed in the chair. The "Level Three Restraint Documentation" Form, on which deputies are to record periodic welfare checks on prisoners in the restraint chair, was not completed.

Prisoner No. 15

48. Prisoner No. 15, who turned 21 in the El Paso County Jail in December, 2004, first received in-patient psychiatric care when she was 10 years old. She was hospitalized in psychiatric units again in 1994 and 1998. In 2000, she was a patient at the Colorado Mental Health Institute at Pueblo. She has a past history of suicide attempts and a diagnosis of bipolar disorder with psychotic features.

49. Prisoner No. 15 spent several months in the Jail in 2003. On May 19, 2003, shortly after the Jail authorities switched her psychiatric medications, deputies wrote that the prisoner "became disruptive" in her cell and then resisted the deputies' efforts to place her in a special detention cell. The deputies' report shows that she was placed in handcuffs and leg irons and threatened with a taser. After arriving at the special detention cell, deputies decided, without consulting with the Jail's mental health staff, to strap her into the Jail's restraint chair to prevent her from harming herself. After she was strapped down, she was threatened with use of the taser again when she did not lift her head as ordered so that the deputies could take her photograph. Two hours later, deputies

decided, again without consulting the Jail's mental health staff, that it was safe to release her from the restraint chair and, later, from the special detention cell.

50. Prisoner No. 15 was 3 months pregnant when she began a 40-day sentence at the Jail on November 18, 2004. At intake, the nurse noted the prisoner's history of psychiatric hospitalizations and her diagnosis as bipolar. She also noted that the prisoner had stopped taking her medications because of her pregnancy. The intake nurse further noted that the prisoner appeared agitated and was biting herself, and she asked the mental health staff to follow up.

51. The next day, a mental health assistant interviewed the prisoner. The interview notes confirm that the prisoner is bipolar and has not been taking medications because of her pregnancy. The notes conclude that the prisoner requires no mental health services. The prisoner was encouraged to send written requests to mental health on an as-needed basis.

52. A month later, on December 18, 2004, Prisoner No. 15 experienced what she later described to the Jail's disciplinary committee as a "psychotic episode." The deputies responded first by handcuffing her and then using a knife to cut off the top of her Jail uniform. They pulled off her pants and underpants and put her in a suicide gown. Then they strapped her into the Jail's restraint chair. The Jail's incident report shows that deputies made the decision to put her in the restraint chair "for her safety," without consulting the medical or mental health staff. After an hour in the chair, she told a deputy that she had to urinate, but the deputy refused to let her use a toilet. The deputy told Prisoner No. 15, "you can piss all over yourself for all I care." After about two hours, deputies also made the decision, again without consulting medical or mental health

staff, that it was safe to release Prisoner No. 15 from the restraint chair and return her to the cellblock.

Prisoner No. 13

53. In October, 2003, Prisoner No. 13 was in 23-hour lockdown and on suicide watch. During his one hour out of the cell, the prisoner was allowed to review his mail but was told he could not take any of the letters back into his cell. After the hour out, the prisoner returned to his cell with one of the letters, which he insisted was private because it concerned medical matters. The prisoner declined to return it to the deputies, and they decided to take it back by force. They administered a 50,000 volt shock from a taser, forced the prisoner to the floor, handcuffed him, and took him to a special detention cell.

54. In January 2004, a member of the mental health staff ordered that Prisoner No. 13 be put on suicide alert and placed in a suicide gown. The prisoner refused to put on the suicide gown. Deputies then inflicted a 50,000-volt electric shock with a taser, despite their knowledge that the prisoner was taking psychiatric medications. They placed the prisoner face down on the floor, handcuffed him behind his back, and shackled his legs with leg irons. Deputies then took him to a special detention cell, removed his clothes, and placed him in a suicide gown. The prisoner tried to bang his head on the floor, and the deputies decided to strap the prisoner into a restraint chair. The mental health staff was not consulted about using the taser or using the restraint chair. After several hours, again without consulting any mental health staff, deputies decided to remove the prisoner from the restraint chair, and, after another hour, from the special detention cell.

Inadequate mental health and custody staffing (see Complaint, ¶¶ 30, 32)

55. Defendants fail to provide adequate numbers of qualified staff to provide for the needs of prisoners with serious mental health needs. Mental health staffing at the Jail is inferior, in both numbers and qualifications of staff, to mental health staffing at other Colorado jails. As a result, prisoners who are in acute distress often remain untreated for hours or days. In addition, inadequate custody staffing results in prisoners with serious mental health needs not being supervised by deputies, with the result that they are able to harm themselves or attempt suicide (see ¶ 24, *supra*, describing a suicide attempt that occurred while the deputy on duty in the "mental health" ward was absent from the ward). Finally, the staff that do exist are inadequately trained in mental health issues. Some of the mental health counselors, who make such critical decisions as whether a prisoner is a suicide risk, are unlicensed and have only a bachelor's degree.

56. Both the Citizens' Panel Report and the NIC Report found inadequacies in mental health staffing. The Citizens' Panel Report called for the hiring of additional mental health staff, as well as increased mental health training for deputies and for the medical staff who evaluate incoming prisoners. The NIC Report noted reports by Jail staff that "during the recent suicide crises, … the [mental health] counselors did not respond by coming into the facility." The NIC Report also noted that mental health staff "are behind on reevaluating inmates who are under mental health watches," and "there appears to be no particular attention paid to the inmates placed in the mental health unit."

Prisoner No. 4

57. On November 28, 2003, Prisoner No. 4 was taken to a special detention cell and placed in restraints, and medical staff were called to check on the restraints. At

2:10 a.m., a note in the medical record notes "inmate getting more aggressive." The nurse on the scene tried to reach an on-call physician or physician assistant to authorize medication. Seven attempts to reach an on-call provider, over a period of several hours, were unsuccessful. In the meantime, Prisoner No. 4 was urinating and defecating on the floor of the toiletless special detention cell. A physician was not reached until approximately 4 ½ hours later.

Prisoner No. 12

58. Prisoner No. 12 was admitted to the Jail on or about December 11, 2002. Presumably because of his history of psychiatric hospitalization and being prescribed powerful anti-psychotic medications, mental health staff placed him on the list to see the psychiatrist on December 19, 2002. Over the next month, Prisoner No. 12 complained of depression and hearing voices, and begged to see the psychiatrist. The mental health staff told him to "be patient" and said that "it takes time to see the psychiatrist because he is here once per week & there are people on that list before you." As of January 16, 2003, Prisoner No. 12 still had not been seen by the psychiatrist.

Class action allegations

59. All class members are equally subject to defendants' policies and practices regarding the treatment of prisoners with serious mental health needs. The mental health care all class members receive is governed by a single contract. The treatment of all class members is governed by policies promulgated by a single decisionmaker: defendant Terry Maketa.

60. The policies and practices of defendants to which all class members are equally subject include, but are not limited to:

61. Defendants' policy of failing to provide sufficient numbers of mental health and custody staff, with adequate training, to provide for the serious mental health needs of class members.

62. Defendants' policy of failing to provide safe and appropriate housing for prisoners with serious mental health needs.

63. Defendants' policy of using "special detention cells" to house prisoners exhibiting signs of mental illness.

64. Defendants' policy of failing to provide inpatient psychiatric care for prisoners whose serious mental health needs require it.

65. Defendants' policy of inappropriately using restraints, pepper spray, and electroshock weapons ("tasers") against prisoners exhibiting signs of mental illness.

66. Defendants' policy of failing to maintain an adequate system to provide appropriate medication to prisoners whose serious mental health needs require it and to monitor the effects of that medication.

67. Defendants' policy of failing to provide adequate screening and precautions to prevent self-harm and suicide.

Prayer for relief

68. WHEREFOR, in addition to the relief sought in plaintiffs' original Complaint, plaintiffs respectfully request that the Court enjoin defendants to:

a. provide sufficient numbers of mental health and custody staff, with adequate training, to provide for the serious mental health needs of class members;

b. provide safe and appropriate housing for prisoners with serious mental health needs;

c. discontinue use of the "special detention cells" to house prisoners exhibiting signs of mental illness;

d. provide inpatient psychiatric care for prisoners whose serious mental health needs require it;

e. cease using restraints, pepper spray, and electroshock weapons ("tasers") against prisoners exhibiting signs of mental illness in circumstances that pose a substantial risk of serious harm to such prisoners;

f. implement an adequate system to provide appropriate medication to prisoners whose serious mental health needs require it and to monitor the effects of that medication; and

g. provide adequate screening and precautions to prevent self-harm and suicide.

Respectfully submitted January 24, 2005.

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