IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Case No. _____

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

Plaintiffs,

vs.

THE BOARD OF COUNTY COMMISSIONERS OF THE COUNTY OF EL PASO and JOHN WESLEY ANDERSON, in his official capacity as Sheriff of El Paso County,

Defendants.

CLASS ACTION COMPLAINT
FOR INJUNCTIVE AND DECLARATORY RELIEF

Plaintiffs, who are prisoners in the El Paso County Jail ("Jail") with serious mental health needs, and who are subject to the actions and omissions of defendants that are described in this Complaint, allege as follows:

BACKGROUND

1. Pre-trial detainee Michael Lewis died while strapped face-down to a restraint board in the Jail on May 7, 1998, his second time on the board for that day. The restraint was imposed by sheriff deputies, not medical or mental health personnel. For at least five days, he had been hallucinating and psychotic, the probable result of the Jail medical provider's decision to change his medications, a decision made without consulting with the therapist who had prescribed his former medications. Two days after security staff noted his decompensation, the Jail's counselor placed him on the waiting list to see the Jail's psychiatrist, who visited the Jail

only one morning every other week. Mr. Lewis did not live long enough to see the psychiatrist; he died while struggling against his restraints.

2. Since that death in May 1998, eight additional prisoners have died in the Jail, four of them in 2001. In almost every case, the deceased prisoner was suicidal, seriously mentally ill, or displaying symptoms of psychosis from overdose or withdrawal from street drugs or alcohol.

3. Shortly after the latest death, a suicide in November 2001, the American Civil Liberties Union wrote to defendant El Paso County Board of County Commissioners ("Board") to ask it to investigate the alarming pattern of prisoner deaths and consider whether the Jail was staffed with a sufficient number of competent medical, mental health, and security personnel who were adequately trained to recognize and respond appropriately to the needs of the Jail's population.

4. The Board declined to investigate.

INTRODUCTION

5. This class action for injunctive and declaratory relief is brought pursuant to 42 U.S.C. § 1983 to preserve the rights of the plaintiffs and the plaintiff class under the Eighth and Fourteenth Amendments to the United States Constitution.

6. The named plaintiffs and the plaintiff class are all subject to the actions, omissions and deliberate indifference of the defendants described herein. The named plaintiffs and the plaintiff class suffer from serious mental health problems, and the deliberate indifference of the defendants to these problems exposes each of them to conditions that constitute cruel and unusual punishment in violation of the Eighth Amendment and deprivation of liberty in violation of the Fourteenth Amendment. As a result of the defendants' actions and omissions, the named

plaintiffs and the plaintiff class face continued and further degradation of their mental health and daily exposure to a serious risk of injury or death.

7. This case is about the long-lasting and continuing failure and refusal of the Board and defendant Anderson to acknowledge or provide sufficient resources for the serious mental health needs of their prisoners during the time they are imprisoned in the Jail, and their failure to enter a contract with a medical services provider which (a) adequately provides for the prisoners' serious mental health needs, and (b) is rigorously enforced by defendants. The needs of mentally ill prisoners include diagnosis of their condition, timely provision of proper treatment and medication by competent staff, safe and appropriate housing, and protection from inhumane and punitive actions taken out of ignorance of or indifference to their mental state.

JURISDICTION AND VENUE

8. This Court has subject matter jurisdiction of this action pursuant to 28 U.S.C. § 1331 because this action arises under the Constitution and laws of the United States, and pursuant to 28 U.S.C. § 1343(a)(3) because this action seeks to redress the deprivation, under color of state law, of plaintiffs' constitutional rights. Venue is proper under 28 U.S.C. § 1391(b) because all defendants reside in this district, and because the events and omissions giving rise to plaintiffs' claims occurred in this district.

THE PARTIES

9. Plaintiff Mark Shook has been continuously confined in the Jail since the fall of 2001 and is mentally ill. See also paragraph 58.

10. Plaintiff James Robillard has been continuously confined in the Jail since the summer of 2000 and is mentally ill. See also paragraphs 59-62.

11. Plaintiff Dennis Jones has been continuously confined in the Jail since September, 2001 and is mentally ill. See also paragraph 63.

12. Defendant Board is a statutory governmental entity within the state of Colorado. It is a "person" within the meaning of 42 U.S.C. § 1983. The Board is responsible for the operation of the Jail and the El Paso County Sheriff's Department, and determines, through the annual award of contracts, the amount and nature of the mental health services provided to the prisoners in the Jail.

13. Defendant John Wesley Anderson ("Anderson") is the Sheriff of El Paso County, and pursuant to C.R.S. 30-10-511 has charge and custody of the Jail. He has final policy making authority for all matters relating to management of the Jail, including the provision for the mental health needs of the prisoners. He is sued in his official capacity.

14. With regard to all actions and omissions alleged herein, the defendants have acted and continue to act under color of state law.

FACTS RELATING TO THE CLASS AND THE CLASS ACTION

15. Plaintiffs bring this action pursuant to Fed. R. Civ. P. 23(a) and 23(b)(2) on behalf of themselves and all individuals who are members of a class defined as "all persons with serious mental health needs who are now, or in the future will be, confined in the El Paso County Jail."

16. The members of the class are so numerous, and the class so fluid, that joinder of all members is impracticable. The total population of the Jail exceeds 1,000, with approximately 20% having serious mental health needs. New prisoners and class members enter the Jail, and others are transferred or released, every day.

17. There are numerous questions of law and fact common to the class, including the scope and interpretation of the Eighth and Fourteenth Amendments in the Jail setting; the lawfulness of the policies, practices and omissions of the defendants in the provision of mental health services; and the effect of the defendants' deliberate indifference. All class members are equally subject to the conditions of confinement and the systemic deficiencies described in this Complaint, including the lack of sufficient staff with adequate training; lack of inpatient care; lack of adequate housing; lack of adequate protection from self-harm and suicide; lack of an adequate system for medication; and the use of restraints and excessive force. The named plaintiffs have each been affected by these constitutionally deficient conditions of confinement and face a substantial risk of being adversely affected by them in the future. The claims of the class representatives are typical of those of the class and the class representatives will fairly and adequately protect the interests of the class. The attorneys representing plaintiffs are experienced in handling class action cases involving claims that jail and prison conditions violate prisoners' constitutional rights.

18. The defendants have, individually and collectively, acted and refused to act on grounds generally applicable to the class, and final injunctive and declaratory relief with respect to the class as a whole is appropriate.

STATEMENT OF FACTS COMMON TO ALL PLAINTIFFS AND THE PLAINTIFF CLASS

The El Paso County Jail Facilities

19. The Jail houses recent arrestees, persons awaiting trial, and persons convicted and sentenced to terms of two years or less. The Jail houses both male and female prisoners and houses both adults and juveniles who have been charged as adults. The Jail comprises two

buildings, both located in Colorado Springs: the Criminal Justice Center ("CJC"), and the Metro Detention Center ("Metro").

20. The Jail's prisoner population regularly exceeds 1,000, and has been as high as 1,139. Both CJC and Metro are badly overcrowded; CJC was designed to house 588 prisoners and Metro was designed for 260 prisoners. A 1998 report by the American Correctional Association ("ACA") described CJC as "extremely overcrowded." On July 30, 2001, the ACA again notified defendant Anderson that the Jail is in violation of ACA capacity standards. Although CJC was originally designed to house prisoners in cells arranged around a dayroom area, as a result of overcrowding, many prisoners are forced to sleep in bunk beds set up in the dayroom area. Other prisoners are forced to sleep in "sled beds," which are coffin-like plastic forms placed directly on the floor.

21. Facilities for the mentally ill are virtually nonexistent. The "mental health unit" in CJC is merely a cellblock, identical to others, that has been given this designation. Like the other cellblocks in CJC, the mental health cellblock is seriously overcrowded, with mentally ill prisoners sleeping on sled beds on the floor. The dangerous physical structure and poor management of the mental health cellblock pose serious risks to the prisoners of self-harm and suicide. At Metro, there are no separate facilities whatever for the mentally ill.

22. There are no separate facilities anywhere in the Jail for mentally ill women. All female prisoners are confined together regardless of their mental health needs. This practice heightens the risk of victimization and aggravates the suffering of mentally ill women.

23. In connection with litigation over the death of Michael Lewis, the medical director of the Jail stated under oath that between ten and twenty percent of the Jail's prisoners

are prescribed psychotropic medications. While she was employed as the Jail's "mental health professional," Ruby Fink stated under oath that she sees 200 to 300 prisoners per month, and that she believes 25% of these prisoners are "acutely psychotic." At any given time, approximately 20% of the prisoners in the Jail have serious mental health needs.

24. Prisoners exhibiting signs of mental illness are frequently placed in "special detention calls." These tiny cells have no windows, no bed, no toilet, and no sink. Although Jail policies and corrections standards require deputies to check on the prisoner's welfare every 15 minutes, mentally ill prisoners are sometimes left in these cells unobserved by staff. In 1998, an ACA report "highly recommended that these rooms not be used as they do not meet accreditation standards." Nevertheless, defendants continue to use these cells to confine mentally ill prisoners. There is no therapeutic value in such confinement. Indeed, confinement of mentally disturbed prisoners in such conditions can exacerbate the seriousness of their illness.

25. The oppressive conditions in the special detention cells, including the lack of toilet facilities, can and do cause prisoners to pound on the cell door in an effort to get deputies to let them use a restroom or attend to other needs. Deputies often respond aggressively as though the prisoner is causing a disturbance, prompting the prisoner to respond with anger and frustration in turn. The resulting cycle of agitation and anger often escalates into a confrontation that can result in prisoners being forcibly restrained with shackles in the "fetal position," or strapped into the restraint chair, and/or medicated with drugs to "calm" the prisoner.

The Provision of Health Services

26. Health care services at the Jail, including mental health services, were, until recently, provided by Correctional Medical Services, Inc. ("CMS") pursuant to a contract with

the Board. Such services are now provided pursuant to a contract with Correctional Healthcare Management ("CHM").

27. The defendants have failed in the past to ensure that the medical contractor provides fully the services promised in the contract. The former medical services provider, CMS, failed in numerous material respects to provide the mental health services called for in its contract. For example, it (1) failed to conduct full mental health evaluations within the 14 days specified in the contract; (2) failed to provide a staff of licensed or certified mental health professionals; (3) failed to furnish the contractually-required clinical supervision; (4) failed to fulfill the medication monitoring standards set forth in the contract; (5) failed to have mental health staff on call and available 24 hours a day; and (6) failed to provide the necessary care and treatment for prisoners who need in-patient psychiatric care.

28. Defendants have failed to establish procedures to ensure that the new medical services provider, now CHM, complies fully with its contract, and provides all the services set forth therein.

29. The annual amount spent by the defendant Board for all health care at the Jail is approximately $2.3 million. Of this, only a small fraction is for the provision of mental health services.

30. Mental health staffing, which has not kept pace with the explosive growth in the Jail's population and the increasing percentage of that population with serious mental health needs, is inadequate to meet the serious mental health needs of the Jail's prisoners. The Jail's mental health staff are concentrated at CJC. Long delays frequently occur in the provision of essential care to mentally ill prisoners. The current contract for health services with CHM

provides for psychiatric services of only 2 hours per week, or approximately 36 seconds per mentally ill prisoner per week. It provides for a psychologist for only 16 hours a week, and much of this time is spent on administrative matters. There are no psychiatric nurses. The two additional mental health employees the defendants provide are inadequate in number, are unlicensed and lack sufficient background and training to provide for the serious mental health needs of the Jail's prisoners.

31. Some prisoners suffer from such acute mental health needs that transfer to an inpatient psychiatric facility is required for their safety and well being. Staff at the Jail fails to timely transfer these prisoners to an inpatient psychiatric setting where they could receive the treatment their condition requires. In the course of litigation over the death of Michael Lewis, the administrator of Correctional Medical Services stated under oath that the El Paso County Jail is "full of individuals that belong in the state hospital." According to this testimony, the state hospital does not accept all patients who need inpatient psychiatric care; it accepts only those who fit the more restrictive criterion of posing a danger to themselves or others. Even when prisoners in the Jail meet this more restrictive standard, at least half the time there is no bed available in the state hospital. When inpatient psychiatric care is needed but is not available at the state hospital, it is essential that the defendants provide it at some other location, but they do not do so. Defendants do not even take the minimal step of requiring that a prisoner who needs hospitalization be placed in the Jail's infirmary.

32. Security staff play a crucial role in mental health care in a jail setting. Because of their close and frequent contact with prisoners, they must be trained to recognize and understand the difference between willfully defiant behavior that violates jail rules, and behavior that is the

product of psychosis or mental illness. In the latter case, they must promptly call upon mental health staff for assistance and evaluation, but often they do not do so. They must also regularly monitor mentally ill prisoners and intervene to protect them from attempts at self-harm or suicide. In part because the Jail is chronically understaffed as well as overcrowded, the security staff at the Jail are not able to maintain adequate surveillance of mentally ill prisoners. Moreover, they are not sufficiently trained to perform their mental health-related duties in a competent manner.

33. On numerous occasions, security staff rather than mental health staff make decisions that only trained mental health professionals are qualified to make. For example, security staff often decide that a prisoner is suicidal and act on that decision by confining the prisoner in a special detention cell, sometimes with restraints. Without consulting with the Jail's mental health personnel, security staff often decide that the prisoner is no longer suicidal and can be released from the special detention cell. Security staff, rather than medical staff or the Jail's mental health personnel, often make the decision to place suicidal or mentally ill prisoners in restraints, including full body restraints such as the restraint chair. Security staff often respond to symptoms of mental illness with inappropriate use of force, rather than by summoning mental health staff to make appropriate mental health interventions.

Restraints and Use of Force Against Prisoners With Mental Illness

34. The Jail's use-of-force policy permits officers to use pepper spray against prisoners "in the maintenance of order and discipline." Pepper spray is sprayed in the face, and causes excruciating pain, gagging, and temporary paralysis of the larynx. Its use in custodial settings has been associated with side effects including high blood pressure, nerve damage,

chemical burns, and death. The Jail's policy and training materials do not caution officers that pepper spray often fails to achieve the desired effect when the prisoner's unruly behavior is the result of mental illness or overdose or withdrawal from drugs or alcohol. Nor do the Jail's policy or training materials provide that officers should limit use of pepper spray to a single one-second burst. As a result, mentally ill prisoners are likely to be subjected to repeated doses of pepper spray, with the accompanying increased risk of serious health consequences and even death. The El Paso County Coroner identified pepper spray as a contributing cause of the death of Andrew Spillane, a pre-trial detainee who died in the Jail in May, 2000. See paragraph 46.

35. Mental health patients, particularly those taking psychotropic medications, and those who are psychotic and highly agitated, are at particular risk of death while in restraints. At the Jail, restraints, including so-called "fetal position" restraints and the fully-immobilizing restraint chair, are used inappropriately on prisoners exhibiting signs of mental illness. In 1998, the ACA recommended that the Jail consider all restraints to be medical restraints, which would require that health care staff, rather than security staff, determine that restraint is appropriate. The defendants rejected this suggestion, and security staff continue to make the decision to place mentally ill prisoners in restraints, often without any subsequent evaluation by medical or mental health personnel to determine whether the situation warrants psychiatric intervention or other medical management.

Improper Delivery of Medications

36. Many class members depend on medications to help them maintain mental stability and the minimum level of social functioning that is required for them to follow the rules and instructions of Jail staff. When they are deprived of their necessary medications, and faced

with the added stresses of incarceration, class members are at high risk of mental destabilization.

37. Monitoring of persons taking medications for their mental illness is critically important, both to ensure that the medication is having the desired therapeutic effect and to detect potentially serious side effects and toxicity. The Jail has insufficient staff and an inadequate system for effective monitoring of those who are taking medications, and class members have been and will in the future be harmed as a result.

38. Sudden or prolonged discontinuation of prescribed medications can have disastrous results. Before their arrest, many class members had medications prescribed by outside therapists to treat their mental illness, and these medications are taken away at arrest or booking into the Jail. However, the medication orders are not reinstated by the Jail's medical staff for long periods of time, sometimes for up to two weeks, putting class members who depend on their medications at high risk of mental destabilization.

39. Abrupt changes in medications can have seriously negative effects. The Jail's health care services provider maintains a formulary, a restrictive list of medications that are available for the Jail's physicians to prescribe. Many times, a specific medication that a class member was being treated with successfully outside the Jail is not available on the Jail's formulary. In that event, defendants force class members to accept an alternative medication that may not work as well for them. Frequently, the decision to switch prisoners to a new medication is made for monetary rather than medical reasons. When any change in medication is made, the Jail has an inadequate system for monitoring the therapeutic or toxic effects of the change.

40. Forced changes in medications are a particular problem for class members who have received psychiatric treatment at a state or local inpatient facility, and are then brought to the Jail. These class members are often stabilized on specific medications at the hospital, and then forced to switch to new medications at the Jail because the medications that hospital doctors used to stabilize them are not available on the Jail's formulary. The abrupt change in medication can lead to destabilization and injury.

41. The Jail's medication delivery system is inadequate, thus putting class members at risk that their prescribed medication will not be effective or will have increased toxicity. Medications that are supposed to be taken at 12-hour intervals are delivered to the cellblocks as early as 4:30 a.m. and as late as 9:00 p.m. Some medications should be taken three or four times a day, but are given twice daily for the convenience of staff. Some medications should be taken with food, and some should be taken on a empty stomach, but the schedule of the medication carts is independent of the food delivery schedule. Some medications that are designed with special pharmaceutical coatings, and must be swallowed whole in order to have the intended effect, are crushed before dispensing to prisoners.

Tragic Consequences of Inadequate Mental Health Care

42. Prisoners in general have greater mental health needs than the free-world population, and the needs of jail prisoners are especially great. Having recently been arrested, many jail prisoners are experiencing withdrawal from alcohol and other substances. Facing the trauma of sudden arrest and incarceration, and the stress and uncertainty of a trial and a potentially lengthy prison sentence, many jail prisoners experience serious mental health crises that can explode into self-harm, suicide attempts, or suicide. Combined with inadequate staffing

of deputies to provide protection to inmates at risk of self-harm, the many inadequacies in mental health services at the Jail have resulted in an epidemic of suicide attempts. Since 1995, when defendant Anderson took office as El Paso County Sheriff, there have been at least 142 suicide attempts in the Jail. There have been at least four successful suicides in that period, including two in 2001.

43. The following paragraphs set forth specific examples of how the acts and omissions of the defendants have led to, and pose a continuing risk of leading to tragic consequences for mentally ill prisoners in the Jail.

Michael Lewis, May, 1998

44. On May 7, 1998, five days after he first began hallucinating and displaying other signs of psychosis, pre-trial detainee Michael Lewis died while struggling against the restraints on the Jail's restraint board. (See paragraph 1.)

Prisoner No. 1, April, 1999

45. Prisoner No. 1 was already visibly disturbed when she arrived at the Jail for an alcohol violation in 1999. She told deputies that she had recently been raped twice. She made suicidal statements, and deputies put her in an isolation cell. After she attempted to hurt herself, deputies stripped her naked, laid her face-down on the bare concrete floor, handcuffed her behind her back, and shackled her legs at the ankles. They returned to her cell 15 minutes later and strapped her into a restraint chair, still naked. A male deputy took a photograph, staring at her through the camera's viewfinder far longer than necessary for a simple Polaroid shot. For the next five hours she remained strapped in the chair, naked, in full view of the male deputies, and screaming in terror as she re-experienced the traumatic fear and helplessness she endured

when she was held immobile and raped. Deputies paged the on-call mental health worker four separate times, but she did not arrive until more than 3 hours after the prisoner was strapped into the restraint chair.

Andrew Spillane, May, 2000

46. On May 10, 2000, pre-trial detainee Andrew Spillane died in the Jail as a result of seizures caused by delirium tremens and pepper spray. Mr. Spillane had arrived at the Jail at 7 am that morning, already displaying symptoms of psychosis as a result of alcohol withdrawal. Instead of being sent to the hospital or even the Jail's infirmary to receive immediate medical attention, he was housed in a regular cellblock of the Jail. The Coroner's report states that by mid-afternoon, he still had not received medical attention, and guards put him in a special detention cell "for his unruly behavior," which the Coroner said was caused by early stages of delirium tremens. By 5:20 pm, Mr. Spillane finally received some medication and was transferred to the Jail's infirmary. But his delirium and agitation got worse. Jail deputies again treated his agitation as a behavioral problem instead of a medical one. They removed him from the Jail's infirmary and confined him again in a special detention cell, where his agitation increased. They decided to remove him from the special detention cell to put him in restraints. He was unable to obey their commands, however, and they pepper sprayed him. When the first dose had no effect, they sprayed him again. He died shortly afterwards.

Steven Phelps, March, 2001

47. Stephen Phelps arrived at the Jail in the early morning hours of March 23, 2001. The intake nurse learned of his past history of suicide attempts and reported that he was "elusive" to many questions in the initial psychiatric assessment. He was sent to the mental

health cellblock with full suicide precautions, and the nurse sent a referral form to the mental health staff. Pursuant to that referral, Mr. Phelps was interviewed several days later by one of the Jail's "mental health professionals," an unlicensed counselor with no more than a bachelor's degree. At that time, the counselor determined that Mr. Phelps was not suicidal. She cleared him for transfer to the Jail's general population with a uniform, bedding, hygiene items, and all his permitted property. The form states "no other mental health services at this time." The next day, Mr. Phelps hanged himself with his bedsheet.

Brian Bennett, November, 2001

48. In the fall of 2001, Brian Bennett, a 22-year-old pretrial detainee with a diagnosis of bipolar disorder and schizoaffective disorder, was receiving antipsychotic and mood-stabilizing medication. In late October, however, while he was confined in the segregation unit under 23-hour-a-day lockdown for a disciplinary violation, he refused to continue taking his medication. On the morning of November 1, the Jail's mental health staff decided to transfer him to an inpatient psychiatric hospital. There was no available bed, however, so he was placed on a waiting list. Instead of transferring him to the Jail's infirmary where he could have medical supervision, Jail staff left him confined in the segregation unit. On the afternoon of November 1, he hanged himself with his pants. Investigation revealed that the staff had failed to perform the required 15-minute checks.

Prisoner No. 2, November, 2001

49. In mid-November 2001, Prisoner No. 2, a pretrial detainee, was placed on "suicide watch" in the mental health cellblock at CJC. Nevertheless, without staff noticing or intervening, he broke off a piece of his artificial leg, sharpened the edge, and used it to cut his

wrists. He then began climbing the stairs and, in a suicide attempt, plunged head first from an elevated portion of the mental health unit. He suffered serious injuries to his head and neck.

Prisoner No. 3, December, 2001

50. Prisoner No. 3, who has been diagnosed with bipolar disorder, was a prisoner in the CJC on December 29, 2001. Incident reports written by deputies state that at 7:45 pm, he reported hearing voices and said he was in crisis and becoming suicidal. The medical unit paged mental health workers, but they did not respond. More than two hours later, at 10:05, deputies made the decision to dress him in a suicide gown and lock him in a special detention cell while they awaited instructions from mental health. During the next hour, as deputies failed to conduct the required 15-minute checks, the prisoner's condition deteriorated. At 11:18, a deputy finally checked and reported that the prisoner had been smearing feces in the cell and had scrawled "I need the toilet" in feces on the window of the cell door. Deputies resumed their 15-minute checks, but they left the prisoner in the filthy toiletless cell for more than an hour. At 12:08, a deputy noted that the prisoner again was "smearing feces on wall." Deputies did not intervene until 12:23, when the prisoner began cutting his arm with a metal switch plate cover that he managed to remove and then sharpened on the brick wall. The Jail's mental health staff never arrived. The prisoner was finally taken to the hospital, and then to the state mental hospital.

51. Over the next several weeks, Prisoner No. 3 bounced back and forth several times between the state mental hospital and the Jail. During his second stay at the jail, he became suicidal again and was placed in a different special detention cell, supposedly for his protection. In this cell, too, he managed to remove a metal cover plate, and he began cutting himself again. After returning again from the state hospital, he was placed in a medical holding cell at the

Metro facility, where he opened an electrical box and began cutting himself with a piece of wire. He was then moved to another special detention cell, where he managed to break a light bulb and started to cut himself with the broken glass. The prisoner was then placed in a restraint chair, where he remained for the next 18 hours. Security guards, not mental health workers, made the decision to release him from the chair.

Prisoner No. 4, January, 2002

52. Prisoner No. 4 is a young woman who has been jailed and hospitalized numerous times as a result of her serious mental health problems. Her medical records show diagnoses of bipolar disorder with psychotic features and schizoaffective disorder. She has a history of multiple confinements in the Jail's special detention cells, has been in restraints multiple times, including at least one time in the Jail's restraint chair.

53. During a stay in the Jail in mid-January, 2002, the mental health staff determined that she should be sent to the state mental hospital, but she was placed on a waiting list because there were no beds available. Instead of housing her in the infirmary under medical supervision, however, the Jail assigned her to the regular cellblock for female prisoners. Over the next several days, she manifested bizarre and dangerous behavior that confirmed the need for inpatient psychiatric care, which she did not receive.

54. Deputies decided she was suicidal. Without calling mental health, they took her clothes, gave her a suicide gown, and put her in a special detention cell. A few hours later, deputies determined that she was no longer suicidal. They released her from the special detention cell, again without consulting with mental health.

55. Three days later, a deputy looked in her cell and reported that she was "lying on the floor, naked, covered in food and making engine noises." The spoon from the evening meal was missing. It was in her vagina. She was taken to the infirmary, where the spoon was removed. Her medical records show that she told the nurses that she heard voices that told her to put the spoon in her vagina. Instead of keeping her in the infirmary under medical observation, staff returned her immediately to the cellblock. Mental health was not contacted.

56. Upon return to the cellblock, deputies made the decision to put her in a special detention cell. She said she would scratch her eyes out. When she started to do so, deputies put her in restraints but did not call mental health. A few hours later, without consulting medical or mental health personnel, deputies determined that the threat had subsided, and they released her again into the regular cellblock.

57. The next day, an incident report states that she shoved a styrofoam food container into her vagina. A nurse and a mental health worker arrived that evening and administered medication but did not move her to the infirmary. Ultimately, she was admitted again to the state hospital.

FACTS RELATING TO NAMED PLAINTIFFS

Mark Shook

58. Plaintiff Mark Shook began receiving psychiatric care before he reached adolescence. He has been diagnosed as suffering from Asperberger's Syndrome, a form of autism, as well as bipolar disorder. Before he arrived at the Jail, he was regularly taking Zyprexa and Serzone prescribed by his psychiatrist. Once at the Jail, he went for several weeks without access to any medications. After three weeks, Shook finally saw the medical doctor, not a

psychiatrist, who would not prescribe his regular medications because they were not on the Jail's formulary.

James Robillard

59. Plaintiff Robillard's medical records state that he was "actively suicidal" when he arrived in August, 2000. He has suffered from mood swings and has been diagnosed with bipolar disorder.

60. Before he was incarcerated, Plaintiff Robillard regularly took Paxil, which helped to control his symptoms. The Jail continued his prescription for the next eight months, on the condition that Robillard supply his own medications. By the spring of 2001, however, Robillard could no longer pay for the medications, and the Jail refused to continue the prescription. Robillard was referred to the Jail psychiatrist to recommend a different drug, and an accompanying note states "CMS will pay for the next 14 days of Paxil only." The decision to discontinue Paxil was not made for medical reasons.

61. In January, 2001, when Mr. Robillard received a sentence of two years, he lost control of his emotions. The Jail's incident report states that he said he would kill himself. As deputies tried to control him, he hit his head against the wall and cursed and cried. Deputies first placed Robillard in full body "fetal position" restraints and then in the restraint chair for almost three hours. Although the incident report states that Mr. Robillard was suicidal, no medical or mental health personnel were involved in the decision to initiate or to discontinue the use of the restraint chair. No mental health worker arrived during the nearly three hours Robillard spent in the restraint chair.

62. Restraints are permissible only for the minimum amount of time that is necessary to control the emergency that justifies their use. The Jail's incident report fails to document a continuing need for use of the restraint chair. On the contrary, the deputies who performed fifteen-minute checks repeatedly noted nothing more than Mr. Robillard "sitting quietly."

Dennis Jones

63. Plaintiff Jones has been continuously confined in the jail since September, 2001. He has been diagnosed as bipolar, suffers from depression and anxiety, and has in the past considered suicide. Before he entered the Jail, he was prescribed a combination of Neurontin and valproic acid, which were successful in controlling his symptoms. For nearly a month after his incarceration he was denied any medication at all for his mental illness. When the Jail doctor finally gave him a prescription, he was limited to valproic acid only. The dosage he received was not sufficient to provide relief, but his request for an adjustment was refused. Blood samples taken for the purpose of monitoring the levels of his medication have been taken too soon or too long after his dose of medication, therefore rendering the blood test inaccurate and ineffective.

64. The named plaintiffs have diagnoses of serious mental illnesses that can require inpatient psychiatric care, and, if not properly treated, can lead to attempts at self-harm and suicide. As individuals with serious mental illness, the named plaintiffs have been harmed in the past and face a substantial risk of harm in the future because of the custom, pattern, practice, and usage of the defendants challenged here.

DEFENDANTS' ACTIONS AND DELIBERATE INDIFFERENCE

65. The mental health needs of the Jail's prisoners have long been known to defendants and their staff, and defendants have full knowledge of the facts and the unconstitutional conditions set forth herein. In maintaining and failing to correct these conditions, defendants have acted, and continue to act, with deliberate indifference to plaintiffs' and the class' health, safety, and serious mental health needs, and to the risk that the named plaintiffs and the plaintiff class will suffer serious psychiatric harm, physical injury, or death.

66. In the course of litigation over the death of Michael Lewis on the Jail's restraint board, see Paragraph 1, the Jail's mental health system was evaluated by Richard Belitsky, M.D., of the Department of Psychiatry at the Yale University School of Medicine. In a written report submitted in 2001, Dr. Belitsky found "serious problems with the provision of mental health services at CJC," including inadequate mental health staffing, inadequate oversight of the mental health program, and inadequate provision for emergency psychiatric evaluation of prisoners. Defendants have received copies of Dr. Belitsky's report. They are aware of Dr. Belitsky's findings and of the circumstances he describes, but have taken little corrective action.

67. The former medical services provider requested additional funding to enhance health care staffing at the Jail, including mental health staffing, but the defendants repeatedly rejected such requests.

68. Defendants have been named in at least four lawsuits in which some or all of the Jail conditions as set forth herein were described. They also received a notice of claim stating the facts alleged in paragraph 45.

69. The conditions of confinement set forth in this Complaint result in the unnecessary and wanton infliction of pain, physical and psychological injury and imminent risk of serious injury or of death that is unrelated to any legitimate penological purpose. Defendants have acquiesced in and ratified these conditions, which amount to an official custom or policy of the defendants.

INJUNCTIVE AND DECLARATORY RELIEF

70. An actual and immediate controversy exists between the plaintiffs and the defendants. Plaintiffs contend that the conditions of confinement described herein are unconstitutional. Defendants contend that the conditions of confinement described herein are constitutional. Plaintiffs and the class are therefore entitled to a declaration of rights with respect to this controversy.

71. Defendants have acted, and continue to act, under color of state law to deprive plaintiffs of their constitutional rights. Plaintiffs are suffering irreparable injury, and will continue to suffer irreparable injury, as a result of the conditions described in this Complaint, unless those conditions are enjoined by this Court. Plaintiffs have no plain, adequate or speedy remedy at law, and are entitled to injunctive relief against defendants pursuant to 42 U.S.C. § 1983.

EXHAUSTION OF ADMINISTRATIVE REMEDIES

72. Each named plaintiff has exhausted all administrative remedies available to him.

FIRST CLAIM FOR RELIEF
(Violation of Eighth and Fourteenth Amendments)

73. Plaintiffs incorporate paragraphs 1 through 72, above.

74. By subjecting the named plaintiffs and the class members in their custody to the conditions set forth herein, with full knowledge of those conditions, defendants have acted, and continue to act, with deliberate indifference to their health, safety, and serious mental health needs, and have subjected them to cruel and unusual punishment, in violation of the Eighth and Fourteenth Amendments to the United States Constitution.

WHEREFORE, plaintiffs respectfully request that the Court:

75. Certify this action as a class action;

76. Enter a judgment declaring that defendants' actions described herein are unlawful and violate plaintiffs' and the plaintiff class' constitutional rights;

77. Permanently enjoin defendants, their subordinates, agents, employees, and all others acting in concert with them from subjecting plaintiffs and the plaintiff class to the conditions set forth in this Complaint;

78. Grant plaintiffs their reasonable attorney fees and costs pursuant to 42 U.S.C. § 1988 and other applicable law; and

79. Grant such other relief as the Court considers just and proper.