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10 Attorneys for Plaintiffs

11
12 IN THE UNITED STATES DISTRICT COURT
13 NORTHERN DISTRICT OF CALIFORNIA

14 MARCIANO PLATA, OTIS SHAW, RAY)
15 STODERD, RAYMOND JOHNS, JOSEPH)
LONG, LESLIE RHOADES, GILBERT)
16 AVILES, PAUL DECASAS, STEVEN)
BAUTISTA, CLIFFORD MYELLE and)
17 all others similarly situated,)
18 Plaintiffs,)
19 v.)

20 GRAY DAVIS, Governor, B. TIMOTHY)
21 GAGE, Director, Department of)
Finance, ROBERT PRESLEY,)
22 Secretary, California)
Youth and Adult Correctional)
23 Agency, CALIFORNIA DEPARTMENT)
OF CORRECTIONS, TERESA ROCHA,)
24 acting Director Department of)
Corrections, SUSANN STEINBERG,)
25 M.D., Deputy Director for Health)
Care Services, DANIEL THOR, M.D.,)
26 ANGELA COOPER, R.N., ANDREW)
LUCINE, M.D., TAM BUI, M.D., DONALD)
27 CALVO, M.D., SHANKAR RAMAN, M.D.,)
BRIAN YEE, M.D., DARRELL SMITH, M.D.,)
28 MEREDITH ALDEN VAN PELT, M.D.,)

No. C-01-1351 TEH
**FIRST AMENDED
COMPLAINT
CLASS ACTION**

1 BHAVIESH SHAH, M.D., ANDREW)
 WONG, M.D., DANIEL FULLER, M.D.,)
 2 MICHAEL SONGER, M.D., MARTIN)
 LEVIN, M.D., JOSEPH SIEGEL, M.D.,)
 3 SERGEANT RANDALL DAVIS, EDGAR)
 CASTILLO, M.D., K. NGUYEN, M.D.,)
 4 MOHAN SUNDARESON, M.D., DR.)
 CLINTON, SANFORD HEPPS, M.D.,)
 5 STEPHEN WYMAN, M.D., LOUIS)
 RICHNAK, M.D., RICHARD SANDHAM,)
 6 M.D., C. PARK, DDS., DR. WILLIAMS,)
 J. KOFOED, M.D., JOSEPH TOURELLA,)
 7 M.D., MTA MICHAEL FARRINGER,)
 GLENN A. MUELLER, ROSEANNE)
 8 CAMPBELL, DENEICE MAYLE, and)
 DOES I - V,)
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 10 Defendants.)
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I. NATURE OF ACTION

1. Plaintiffs are ten California state prisoners who have been seriously injured because of defendants’ deliberate indifference to their serious medical needs in violation of the cruel and unusual punishment clause of the Eighth Amendment to the United States Constitution. They bring this civil rights action on behalf of themselves and all other California prisoners because the medical care system operated by the CALIFORNIA DEPARTMENT OF CORRECTIONS (CDC) does not and, with current systems and resources, cannot properly care for and treat the prisoners in its custody. These unconstitutional conditions have caused widespread harm, including severe and unnecessary pain, injury and death. Such conditions also have denied prisoners with some disabilities access to prison programs, services and activities in violation of the Americans with Disabilities Act (ADA) and § 504 of the Rehabilitation Act (§ 504). Because defendants know that plaintiffs and all other prisoners live under conditions creating an unreasonable risk of future harm but have not responded reasonably to this dire situation,

1 they seek an injunction compelling defendants to immediately furnish them and the class
2 they represent with constitutionally adequate medical care.

3 2. Plaintiffs Decasas and Stoderd and the subclass they represent are each an
4 “individual with a disability,” as that term is defined in § 504, and a “qualified individual
5 with a disability,” as that term is defined in the ADA, and have been denied access to the
6 programs, services and activities of the CDC because of defendants’ failures to adequately
7 treat and/or monitor their serious medical conditions, in violation of § 504 and the ADA.
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11 **II. JURISDICTION**

12 3. The jurisdiction of this Court is invoked pursuant to 28 U.S.C. §§ 1331 and
13 1343. Plaintiffs seek declaratory and injunctive relief under 28 U.S.C. §§ 1343, 2201 and
14 2202, 29 U.S.C. §794a and 42 U.S.C. §§ 1983 and 12101 et seq.
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17 **III. VENUE**

18 4. Venue is proper under 28 U.S.C. § 1391(b), because a substantial part of the
19 events giving rise to plaintiffs’ claims occurred within the Northern District of California.
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22 **IV. INTRADISTRICT ASSIGNMENT**

23 5. Actions giving rise to venue of this case in the Northern District of California
24 occurred in Marin and Monterey Counties. Accordingly, pursuant to Local Rule 3-2(c),
25 this case arises in the San Francisco Division.
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1 **V. PARTIES**

2 A. Plaintiffs

3 (1) *Marciano Plata*

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5 6. Plaintiff Marciano Plata is a prisoner incarcerated at Salinas Valley State Prison
6 at Soledad, California, with very limited ability to communicate in English. Defendants
7 were deliberately indifferent to his serious medical needs because they failed to provide
8 adequate care and treatment for injuries he sustained as a result of several falls.

9
10 7. On or around November 28, 1997, Mr. Plata fell while working in the kitchen
11 at Calipatria State Prison, injuring his right knee, back and head. Mr. Plata was examined
12 by a Medical Technical Assistant (MTA), defendant DOE I, who did not provide Mr. Plata
13 with any treatment or a referral to a physician. Upon information and belief, DOE I did
14 not facilitate transport assistance for Mr. Plata and Mr. Plata was forced to walk back to
15 his cell unaided, which resulted in exacerbating the pain from his untreated injuries.

16
17 8. Although following his November 28, 1997 injury Mr. Plata submitted a written
18 request for medical attention, he was not seen by a doctor or any other medical staff
19 member. On or about December 4, 1997, Mr. Plata fell at work again after his injured
20 right knee locked and/or buckled. He further injured his head and back and aggravated his
21 knee injury. Mr. Plata was temporarily unable to move. Mr. Plata was taken to the
22 infirmary where x-rays were taken. Among other things, he was referred to the
23 orthopedist. Mr. Plata continued to experience knee pain and problems along with
24 headaches and dizzy spells.

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28 9. On December 17, 1997, Mr. Plata was examined by Charles C. Lai, M.D., an

1 orthopedist. Dr. Lai noted that Mr. Plata had a positive McMurray Sign of the right knee.
2 A positive McMurray Sign means that there was an occurrence of a cartilage click during
3 manipulation of the knee, and is indicative of an injury or tear to the meniscus, a shock-
4 absorbing cartilage in the middle of the knee. Dr. Lai prescribed Motrin, said that Mr.
5 Plata should be medically unassigned (i.e., not work) for two weeks, and said that he
6 would re-examine Mr. Plata in two weeks.
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9 10. The meniscus injury or tear caused Mr. Plata sharp pain, and other problems,
10 such as the locking and buckling of the knee. On December 23, 1997, Mr. Plata went to
11 the prison medical clinic in an attempt to receive medical treatment for his continuing
12 knee, head, and back pain. At the clinic, an MTA, defendant DOE II, denied Mr. Plata
13 care or treatment, stating that “there’s nothing we can do.”
14

15 11. On or about December 25, 1997, Mr. Plata was directed by his work
16 supervisor, correctional officer, defendant DOE III, to report back to work in the prison
17 kitchen. Although Mr. Plata informed his supervisor that he was medically unable to
18 work, DOE III required plaintiff to work, despite Dr. Lai’s December 17, 1997 order that
19 Mr. Plata not work for two weeks. After starting work in the kitchen, Mr. Plata suffered a
20 back spasm and a buckled or locked knee, which caused him to fall. A wheelchair was
21 brought and fellow prisoner workers lifted Mr. Plata in the chair. DOE III transported Mr.
22 Plata in the wheelchair to the prison medical clinic. There, defendant DOE I told Mr.
23 Plata that nothing could be done because the doctor was not in. Mr. Plata was taken by
24 wheelchair back to his cell.
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28 12. On January 14, 1998, Dr. Lai, the orthopedist, again examined Mr. Plata. This

1 follow-up exam took place approximately two weeks later than Dr. Lai had ordered. Dr.
2 Lai again noted a positive McMurray sign and further noted that "as a matter of fact" Mr.
3 Plata's right knee pain seemed to be getting worse. The doctor stated that Mr. Plata should
4 have arthroscopic surgery of the right knee.
5

6 13. Mr. Plata did not have arthroscopic surgery of the right knee until October
7 1999, approximately 19 months after the doctor's recommendation.
8

9 14. On February 19, 1998, Mr. Plata filed an administrative grievance on CDC
10 form 602, complaining that following each of his three injuries, he did not receive adequate
11 medical treatment and requesting that he be provided appropriate medical care.
12

13 15. On March 6, 1998, a consultation with a neurologist was ordered for Mr. Plata
14 based on his complaints of headaches and dizziness.
15

16 16. Upon information and belief, as Chief Medical Officer at Calipatria, defendant
17 Martin LEVIN, M.D. had responsibility for supervision and training of the medical staff at
18 Calipatria, including the MTAs. Dr. LEVIN was responsible for establishing policies and
19 procedures to ensure that doctors' orders were ca
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21 17. On March 9, 1998, Mr. Plata was transferred from Calipatria State Prison to
22 Salinas Valley State Prison. The informal level response to the 602 he completed while at
23 Calipatria was completed that same day and stated, "transferred to another facility." Upon
24 information and belief, none of the defendants made any effort to inform officials at
25 Salinas Valley State Prison of the care requested by Mr. Plata in his 602 or took any effort
26 to ensure that his previously untreated medical condition was addressed.
27

28 18. On March 10, 1998, Salinas Valley State Prison medical staff member

1 Houghtalin conducted a review of Mr. Plata's health care records, and noted that Mr. Plata
2 should be seen within 24 hours because of a medical special need related to the order for a
3 neurological consultation. Mr. Plata was not medically examined within 24 hours. A
4 psychiatrist did see him on March 12, 1998, but simply reviewed his mental health
5 condition; there was no reference to the need for a neurological and orthopedic
6 examination.
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9 19. On or about March 18, 1998, Mr. Plata was examined at Salinas Valley State
10 Prison by a medical doctor. The doctor noted that there had been a recommendation for
11 arthroscopic surgery and ordered an orthopedic consultation.
12

13 20. On June 2, 1998, Mr. Plata was brought to the medical clinic, apparently for a
14 neurological exam. An unsigned note in Mr. Plata's health record states, "neuro exam
15 deferred today because of the count – will come tomorrow to neuro clinic." There is no
16 record of any such exam having taken place the next day, or thereafter.
17

18 21. Both before and after June 2, 1998, Mr. Plata requested to see a doctor due to
19 continuing problems with his back and knee. His requests often did not result in a medical
20 appointment, due to lockdowns at the prison.
21

22 22. On August 19, 1998, Mr. Plata was examined at Salinas Valley by Lilian I.
23 Lustman, M.D. Dr. Lustman found weakness and atrophy in Mr. Plata's right thigh. Dr.
24 Lustman failed to note that there had been a previous recommendation for arthroscopic
25 surgery on Mr. Plata's right knee, or that a neurological consultation had not been
26 completed as ordered. Dr. Lustman ordered an orthopedic consult, an MRI of Mr. Plata's
27 spine, and an x-ray of the knee.
28

1 23. On or about November 4, 1998, J.M., Wittenberg, M.D., the Salinas Valley
2 Chief Medical Officer and the warden approved the transport of Mr. Plata on November 6,
3 1998 for purposes of obtaining an MRI of Mr. Plata’s spine. The MRI was never
4 conducted.
5

6 24. On December 30, 1998, Dr. Lustman and defendant Andrew LUCINE, M.D.,
7 the Salinas Valley Chief Medical Officer, again approved Mr. Plata’s transport on January
8 8, 1999 for an MRI of his spine. This transport and procedure did not take place. On
9 January 11, 1999, Dr. Lustman and Dr. LUCINE yet again approved Mr. Plata’s transport
10 on January 15, 1999 for an MRI of his spine. This transport and procedure did not take
11 place. Warden Deneice MAYLE at Salinas Valley was responsible for ensuring that
12 prisoners were transported to medical appointments in a timely manner, and on information
13 and belief failed to develop and implement adequate policies and procedures to ensure that
14 such transportation occurred.
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17 25. On January 22, 1999, Mr. Plata went, on an emergency basis, to the medical
18 clinic at Salinas Valley State Prison because he was suffering severe headaches and
19 ringing in his head . Defendant DOE IV, an MTA acting, on information and belief,
20 without proper clinical supervision, determined that Mr. Plata should be followed up on
21 the regular medical line.
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24 26. On January 24, 1999, Mr. Plata again went, with assistance and on an
25 emergency basis, to the medical clinic at Salinas Valley State Prison medical clinic, this
26 time because his knee was very painful and his lower back hurt. An MTA noted that Mr.
27 Plata’s right knee was “very tender to touch” and swollen. The MTA stated that Mr. Plata
28

1 would see a doctor on January 25, 1999.

2 27. On January 25, 1999, Dr. Lustman saw Mr. Plata. Dr. Lustman could not
3 conduct an examination, assessment, or provide treatment, because Mr. Plata's health care
4 records were not available. Dr. Lustman ordered that Mr. Plata be brought back to the
5 clinic for an examination, with his records, on January 27, 1999.

6
7 28. Mr. Plata was not brought back to the clinic for an examination on January 27,
8 and was not seen by any doctor until May 1999.

9
10 29. On February 16, 1999, Mr. Plata was transported to the hospital at Corcoran
11 State Prison where a CT Scan of his lumbar spine was performed. On information and
12 belief, no doctor had ordered such a procedure. Thomas W. MacLennan, M.D., who
13 analyzed the CT Scan, concluded that an MRI should be considered to exclude left-side
14 disc herniation, if indicated clinically. After Dr. MacLennan's conclusions were provided
15 in writing, Dr. Embree, who, on information and belief, never examined Mr. Plata
16 determined that an MRI was not clinically indicated. Dr. Embree was unaware of or
17 ignored the order and repeated approvals that had been obtained for an MRI by Salinas
18 Valley doctors, and grossly failed to properly document his conclusion.

19
20 30. On or about March 30, 1999, Dr. Lustman and defendant Dr. LUCINE
21 approved an orthopedic consultation on April 9, 1999 for Mr. Plata. This consultation did
22 not take place.

23
24 31. On May 10, 1999, Mr. Plata was seen by an orthopedist, who saw him in
25 response to the order for such an examination that a doctor had made approximately 14
26 months before, on March 18, 1998. The orthopedist recommended arthroscopic surgery
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1 for Mr. Plata's right knee, the same recommendation that had been made sixteen months
2 earlier in January 1998.

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4 32. On August 2, 1999, Mr. Plata was again seen by the orthopedist, this time in
5 response to the order for such an examination that Dr. Lustman had made approximately
6 one year before, on August 19, 1998. The orthopedist repeated his recommendation for
7 arthroscopic surgery.

8
9 33. Upon information and belief, in October 1999, a medical doctor, defendant
10 DOE V, authorized Mr. Plata's transfer to a community hospital for surgery without
11 informing Mr. Plata of the medical condition that necessitated the surgery and without
12 providing him with notice of the surgery. On October 6, 1999, Donald Pompan, M.D.,
13 performed surgery on Mr. Plata for repair of his right knee medial meniscus tear with
14 pathological medial plica. Mr. Plata was discharged from the community hospital the same
15 day his surgery was performed and was returned to the infirmary at Salinas Valley State
16 Prison. The personnel at Salinas Valley required Mr. Plata to walk on his surgically
17 repaired knee from the infirmary to the housing unit, causing him severe pain and swelling.

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20 34. Dr. Pompan had ordered that he see Mr. Plata one week after the surgery.
21 Upon information and belief, this never took place; there is no documentation in the health
22 care record indicating that it did. On October 19, 1999, defendant Dr. LUCINE wrote that
23 Mr. Plata was to be seen by the orthopedist and indicated that treatment was appropriate
24 until the next exam. No additional exam took place by the orthopedist.

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27 35. Mr. Plata requested medical care for the swelling in his knee and received
28 none. Mr. Plata received no post-surgery follow-up care from the orthopedist or physical

1 therapy from medical or other staff at Salinas Valley. On approximately February 22,
2 2000, Mr. Plata informed defendant nurse Angela COOPER that he was not receiving any
3 post-operative care and treatment and that he was in pain. Nurse COOPER did not provide
4 post-operative care. Upon information and belief, she also failed to report the lack of post-
5 operative care to an appropriate physician or to take any other steps to ensure that Mr.
6 Plata received post-operative care.
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9 36. On March 2, 2000, a doctor examined Mr. Plata and ordered that he be seen by
10 Dr. Pompan, the orthopedist.

11 37. On May 31, 2000, Mr. Plata again saw a doctor, but because the doctor could
12 not speak Spanish and a translator was not available a full assessment could not be done.
13

14 38. On June 2, 2000, Mr. Plata was seen again by the doctor who saw him on May
15 31. The doctor among other things ordered that Mr. Plata's right knee be x-rayed and that
16 he see the orthopedist for follow-up. Mr. Plata had not seen the orthopedist since the
17 October 1999 surgery. The x-ray was done on June 14, 2000, but no orthopedic exam
18 was conducted.
19

20 39. On January 19, 2000, Mr. Plata filed a 602 regarding the September and
21 October appointments. Mr. Plata also complained of the failure of the prison medical staff
22 to provide post-operative care for his knee. This 602 was initially screened out (e.g.,
23 rejected) because there was no informal level response. An undated informal level
24 response signed by Dr. Paul Pavlovic, M.D., stated "you will be ducated soon for M.D.
25 line." Mr. Plata received a copy of this appeal from the Inmate Appeals office which only
26 stated the date on which it was received at the First Level. Mr. Plata appealed this
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1 response to the Director's Level and received a response stating that the form must first be
2 completed through the Second Level. Mr. Plata has no recourse now to exhaust the
3 administrative remedies on either 602 he filed.
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5 40. Mr. Plata was seen by a physical therapist for his knee on or about May 1,
6 2001, only after defendant Daniel THOR, M.D., in March 2001 had conducted a special
7 review of Mr. Plata's file based on his knowledge that counsel was coming to visit Mr.
8 Plata, and after the filing of the original complaint in this action on April 5, 2001. Mr.
9 Plata continues to suffer from serious headaches, and problems with his knee and back.
10

11 41. Defendants Dr. THOR and Dr. LUCINE were or are the Health Care Managers
12 or Acting Health Care Managers at Salinas Valley at all times relevant to Mr. Plata's
13 allegations. These doctors were or are responsible for supervising and training the medical
14 staff at Salinas Valley, including the MTAs. Upon information and belief, these doctors
15 knew that Mr. Plata, a patient needing orthopedic consult, surgery and follow-up, was not
16 receiving timely and adequate medical care. These doctors were responsible for the
17 inadequate policies and procedures that led to inadequate medical care for Mr. Plata and
18 other prisoners. Upon information and belief, defendants THOR and LUCINE knew that
19 these inadequate policies and procedures would cause injury to Mr. Plata. These
20 defendants failed to provide the necessary oversight to prisoners being returned after same-
21 day surgical procedures at community hospitals to ensure that the prisoners did not suffer
22 further injury. These defendants did not ensure that there were adequate procedures for
23 post-operative care for Mr. Plata and others like him at Salinas Valley.
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28 (2) *Otis Shaw*

1 42. Plaintiff Otis Shaw is a 52-year-old prisoner at the California Medical Facility
2 in Vacaville. Mr. Shaw suffers from end stage renal disease and requires kidney dialysis
3 three times a week. Previously, Mr. Shaw was incarcerated at San Quentin. On or about
4 April 12, 2000, he was sent to Novato Community Hospital where he received an operation
5 to insert a synthetic graft into his arm to facilitate dialysis. He was returned to the prison
6 infirmary at San Quentin for post-operative care. Two weeks later, on April 28, 2000,
7 defendant Dr. Tam BUI explicitly noted that Mr. Shaw's wound was still oozing. Dr. BUI
8 made no effort to determine why, and ordered that Shaw be moved out of the in-patient
9 unit of the infirmary. Dr. BUI did not direct that any other medical personnel at San
10 Quentin provide care to Mr. Shaw's arm. Mr. Shaw was placed in an unsanitary cell in
11 another part of the infirmary.
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15 43. Mr. Shaw filed a 602 in April 2000 regarding his transfer from the San Quentin
16 infirmary while his surgical wound was still draining, complaining about the fact that he
17 was not receiving assistance in cleaning and dressing the wound. The appeal was
18 answered on June 13, 2000, and states "the department shall only provide medical services
19 which 'are based on medical necessity . . . determined by the attending physician to be
20 reasonable.' Title 15 §3350 (a)(10). Accordingly, housing moves are also accomplished."
21

22
23 44. Mr. Shaw received no further nursing care for his wound. Mr. Shaw was
24 forced to attempt to clean the wound and change the bandages himself. Because of the
25 wound's location on his upper arm, it was impossible for him to use both hands to do this
26 task. As a result, he was not able to change the dressings competently. Defendant Dr. BUI
27 did not examine Mr. Shaw after discharging him from the in-patient unit of the infirmary.
28

1 Dr. BUI looked through the small window of the unsanitary cell door once during the time
2 that Mr. Shaw was housed in that cell. Ten days after Dr. BUI ordered Mr. Shaw
3 transferred to the unsanitary cell, the still-oozing wound became more seriously infected.
4
5 On May 8, 2000, the infection resulted in Mr. Shaw's transfer to Novato Community
6 Hospital for two weeks, until May 25, 2000. The oozing of the wound and the onset of
7 serious infection risked rendering the graft unusable.
8

9 45. Upon information and belief, as Health Care Manager at San Quentin,
10 defendant Dr. Donald CALVO knew that there was inadequate post-surgical care for Mr.
11 Shaw and/or others like him and that the absence of this care injured prisoners. Dr.
12 CALVO failed to adequately supervise and train staff and failed to put in place procedures
13 to ensure that Mr. Shaw and others like him would receive medically appropriate care.
14 Upon information and belief, Dr. CALVO knew that this failure did and would result in
15 injury to prisoners.
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18 46. After filing of the complaint in this case, Mr. Shaw was subjected to adverse
19 action by defendants. On April 25, 2001, Mr. Shaw was placed in Administrative
20 Segregation at San Quentin on the basis of information that prison officials had possessed
21 for seven years stating that Mr. Shaw was an associate of the Black Guerrilla Family gang.
22 Prior to the filing of this complaint, and despite defendants' knowledge of Mr. Shaw's
23 association, Mr. Shaw had not been sent to Administrative Segregation because of this
24 affiliation from the time he was incarcerated for his most recent offense (beginning April 7,
25 2000) until the time this lawsuit was filed. Instead, the Classification Services
26 Representative had rejected Mr. Shaw's placement in segregation on the basis of this
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1 information and he had been housed in the general population at San Quentin throughout
2 his current commitment, without incident. Despite the defendants' knowledge of his
3 association, Mr. Shaw also had been housed in the general population for a prior
4 commitment at two other institutions from May 5, 1994 until he was paroled on February
5 25, 1995.
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8 47. Upon information and belief, defendants' action to place Mr. Shaw in
9 Administrative Segregation on the basis of his long-known association is pretextual and
10 intended to punish him for participating in this lawsuit. Upon information and belief, these
11 actions were taken in retaliation for the filing of this lawsuit. This action adversely
12 affected Mr. Shaw's medical treatment. On Thursday May 3, 2001, Mr. Shaw missed his
13 scheduled dialysis treatment because his Administrative Segregation custody status
14 required an escort and there was no available custody staff to escort him. Failure to
15 undergo dialysis adversely affects Mr. Shaw's health.
16

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18 (3) *Raymond Stoderd*

19 48. Plaintiff Raymond Stoderd is a prisoner at California State Prison-Corcoran
20 who suffers from AIDS and chronic pain syndrome, which is treated with methadone. Mr.
21 Stoderd experienced deliberate indifference to his serious medical needs because prison
22 officials abruptly discontinued that treatment at least eight times, leaving him in severe
23 pain, and causing him to suffer withdrawal, an extremely painful condition which involves
24 uncontrolled shaking, vomiting, insomnia, headaches, dizziness, hot flashes, sweats, chills
25 and loss of appetite. These side effects of abrupt withdrawal from methadone are well
26 known in the medical community and were known to the medical personnel at Corcoran.
27
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1 49. Mr. Stoderd was first diagnosed with neuropathy, a painful condition which
2 causes damage to the peripheral nerves, in February 1998, while at Corcoran. Methadone
3 was prescribed by Corcoran medical staff. The prescription was written for 30 days and
4 had to be renewed after each 30-day period. One prescription expired on or about August
5 12, 1998. Mr. Stoderd did not receive a renewal until September 2 and consequently went
6 through withdrawal.
7
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9 50. The symptoms caused by withdrawal significantly affected Mr. Stoderd's daily
10 living activities. Until Mr. Stoderd suffered the first withdrawal due to the abrupt
11 discontinuation of methadone he had a prison job. As a result of the withdrawal, however,
12 he was unable to perform his job adequately, he received poor work performance reports
13 and he was subsequently deemed unable to work. Prior to the first withdrawal episode Mr.
14 Stoderd played sports in the prison yard; this was impossible for him to do during and after
15 the first withdrawal episode. During one episode he had to terminate a visit with his wife
16 and children because he was nauseated and vomiting, suffering extreme pain and was
17 unable to sit up. He was forced to give up his position as Executive Chairman of the
18 Men's Advisory Council (MAC) and as a MAC representative because he was consistently
19 unable to attend meetings or to move around enough to communicate with other prisoners.
20 Mr. Stoderd was not able to walk to the chow hall to eat and instead had to rely on meals
21 being delivered to his cell. During a later episode Mr. Stoderd was unable to eat or sleep
22 or go to the yard.
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27 51. Mr. Stoderd filed several 602s regarding the inappropriate and repeated
28 discontinuation of his prescribed methadone, and did not receive responses to most of

1 them. The intermittent nature of the discontinuations precluded Mr. Stoderd from
2 appealing his complaint to the Director's Level. After filing one 602, dated October 7,
3 1998, his methadone prescription was reinstated and it was therefore unnecessary to appeal
4 the 602 to the next level. However, the prescription was later discontinued again, but by
5 then it was too late to appeal the previously filed 602.
6

7
8 52. Defendant Dr. Shankar RAMAN ordered abrupt discontinuation of Mr.
9 Stoderd's methadone prescription several times despite knowing both the risk of
10 withdrawal symptoms and that Mr. Stoderd had previously suffered severe withdrawal
11 symptoms. Mr. Stoderd filed another 602, dated June 22, 1999, in which he complained of
12 one of Dr. RAMAN's orders to discontinue the methadone prescription. Dr. RAMAN, in
13 the response to the 602 dated July 22, 1999, confirmed his decision to order abrupt
14 discontinuation of the methadone. Mr. Stoderd requested a Second Level Review, stating
15 that since the discontinuation order, on May 28, 1999, he had suffered three painful
16 withdrawal episodes and his health had deteriorated further. By the time he reached the
17 Director's Level he had been prescribed a suitable pain medication by another doctor. Dr.
18 RAMAN refused to renew the prescription, however, forcing Mr. Stoderd to seek out the
19 other doctor in order to continue to receive the medications that he needed. Mr. Stoderd
20 therefore requested assignment to a different doctor. Mr. Stoderd has no recourse now to
21 exhaust the administrative remedies on either 602 he filed.
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25
26 53. Through letters from Mr. Stoderd's counsel to defendant Dr. Brian YEE, the
27 Health Care Manager at Corcoran, Dr. YEE was made aware of the repeated abrupt
28 discontinuations of Mr. Stoderd's methadone prescription, but did nothing. As the Health

1 Care Manager at Corcoran, Dr. YEE failed to adequately supervise and train staff and put
2 in place procedures so that Mr. Stoderd and others similarly situated would receive
3 medically appropriate care. Defendant Dr. YEE specifically failed to stop defendant Dr.
4 RAMAN's practice of suddenly and repeatedly discontinuing methadone treatment for
5 Stoderd.
6

7
8 54. Mr. Stoderd suffers continuing effects of the repeated methadone
9 discontinuations and resulting withdrawal episodes. He has AIDS, a disease which attacks
10 the immune system. Any physical stress negatively affects the immune system's ability to
11 ward off opportunistic infections. His overall health is worse now than before suffering
12 the withdrawal episodes. In addition, he is unable to sit for long periods and is not able to
13 engage in any physically challenging activities.
14

15 (4) *Raymond Johns*

16
17 55. Plaintiff Raymond Johns is a 76 year-old condemned prisoner at San Quentin.
18 He is blind in his left eye and partially blind in his right eye due to cataracts. He has
19 experienced deliberate indifference to his serious medical needs because of delays in
20 obtaining care, and because prison doctors refused to order or undertake corrective surgery
21 to remove the cataracts until Mr. Johns loses vision in both eyes.
22

23 56. On August 13, 1999, a San Quentin medical doctor referred Mr. Johns for an
24 exam by an eye specialist, based on the doctor's suspicion that Mr. Johns had a cataract.
25

26 57. On February 17, 2000, more than six months after the referral was made, Mr.
27 Johns was seen by an eye specialist. The specialist, defendant Darrell SMITH, M.D.,
28 noted Mr. Johns' complaint of blinding headaches while reading, diagnosed a left eye

1 cataract, prescribed an eye patch as needed for headaches, and ordered a follow-up visit in
2 one year.

3
4 58. Mr. Johns, however, continued to suffer due to the cataract, and he again
5 requested to be seen by a doctor. On June 26, 2000, Mr. Johns was seen at sick call based
6 on his complaint of double vision. San Quentin medical staff concluded that his eyes
7 should be re-checked by a specialist.
8

9 59. Mr. Johns was not seen by the specialist as recommended. After several weeks
10 of waiting, and because he continued to suffer from the cataract, Mr. Johns again asked to
11 see a doctor about his condition. On August 11, 2000, he was seen by another prison
12 doctor, who noted Mr. Johns' complaint of continuing problems, including poor vision and
13 headaches. The doctor again referred Mr. Johns to the eye clinic for a specialist exam.
14

15 60. Mr. Johns was not seen by the specialist in the San Quentin eye clinic until
16 October 26, 2000, four months after the referral in June and ten weeks after the August
17 referral. During the October 26, 2000 exam, defendant Dr. SMITH, an ophthalmologist
18 hired by San Quentin, told Mr. Johns that corrective surgery would not be performed until
19 Mr. Johns was blind in both eyes, and that even then only one eye would be corrected. Dr.
20 SMITH wrote in Mr. Johns' health care record that Mr. Johns should be seen again in a
21 year and further wrote "[left eye] cataract surgery in future."
22

23
24 61. On September 20, 2000, Mr. Johns filed an administrative appeal seeking
25 corrective surgery to restore his eyesight. On November 11, 2000, Mr. Johns filed another
26 such appeal. As the informal response a prison staff member wrote, "Sick call doctor
27 cannot force eye specialist to give surgery which he feels isn't warranted." Mr. Johns then
28

1 submitted the appeal to the first level. On or about December 20, 2000, defendant
2 Meredith Alden VAN PELT, M.D., responded to the appeal by stating, “Inmate refused to
3 be interviewed on December 20, 2000. I personally discussed findings with Dr. D. SMITH
4 ophthalmological (sic) consultant plus reviewed his findings outlined in the chart. Dr.
5 SMITH’s decision stands – no surgery on your left cataract until vision is compromised in
6 your rt. eye. This decision is compatible with Title 15.” Mr. Johns, however, never
7 refused to be interviewed. On information and belief, Mr. Johns’s housing unit was on
8 lockdown at that time.

11 62. Mr. Johns subsequently resubmitted the appeal to the second level of review.
12 In February 2001, defendant Dr. CALVO responded by stating that the appeal had been
13 cancelled because Mr. Johns had refused to be interviewed during the first level review
14 process. Dr. CALVO, as Health Care Manager at San Quentin, is responsible for
15 developing and implementing the policy preventing Johns from receiving adequate care.

17 63. On or about February 16, 2001, after receiving the second level response, Mr.
18 Johns appealed to the third or Director’s Level or review. On or about May 25, 2001, Mr.
19 Johns received a letter from the Chief of Inmate Appeals instructing him that his appeal
20 must be completed through the Second Level before it could be processed at the Director’s
21 Level. However, because the appeal had been cancelled at the second level based on the
22 erroneous assertion that Mr. Johns had refused to participate in an interview regarding the
23 appeal, Mr. Johns could not obtain a second level response. On or about May 28, 2001,
24 Johns wrote to the Inmate Appeals Coordinator at San Quentin asking for instruction on
25 how to proceed with his appeal. On or about June 5, 2001, the San Quentin inmate appeals
26
27
28

1 office wrote, “[t]he appeal you have attached was addressed at the 2nd level if you are
2 dissatisfied then forward to 3rd level.” On or about June 25, 2001, Mr. Johns wrote to the
3 Inmate Appeals Coordinator at San Quentin requesting that his appeal be forwarded to the
4 next level. On or about June 28, 2001, the appeal was returned to Mr. Johns with the
5 comment that failure to cooperate cancels the appeal.
6

7
8 64. On or about June 7, 2001, following the filing of the initial complaint in this
9 action, Mr. Johns was informed by a doctor in the eye clinic that surgery was appropriate
10 for his right eye, but that it was too expensive to also operate on the right eye. The doctor
11 also told Johns that the operation still had to be approved by the medical authorization
12 review process at the prison.
13

14 (5) *Joseph Long*

15 65. Plaintiff Joseph Long is a 24-year-old paraplegic who is a prisoner at Pleasant
16 Valley State Prison. Due to unreasonable delays by defendants in assessing and treating a
17 bladder stone and chronic bladder infections, he experienced unnecessary pain from
18 urinary tract infections that also led to urinary incontinence. In June 2000, while Mr. Long
19 was incarcerated at Wasco State Prison Reception Center, defendant Dr. Bhaviesh SHAH
20 assessed Mr. Long and referred him to a urologist due to his history of bladder stones.
21 Neither Dr. SHAH, nor any other medical personnel at Wasco State Prison took any further
22 steps to ensure that Mr. Long was actually seen by a urologist for the four months he was
23 incarcerated at that facility. During this time, Mr. Long suffered from pain from his
24 bladder stone and urinary tract infections. Despite his complaints about these problems
25 and about the ineffectiveness of the antibiotics given to him, he never was examined by a
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1 specialist. Between June and December 2000 Long filed a 602 to which he never received
2 a response. Long filed a second 602 on December 16, 2000, requesting that he be seen by
3 a urologist immediately for evaluation of his chronic infections and for surgery to remove
4 the bladder stones.
5

6 66. Mr. Long was transferred from Wasco to Salinas Valley State Prison on
7 October 27, 2000, where he continued to have urinary tract and bladder infections and to
8 complain about the debilitating pain of the infections and his need for further medical
9 attention. Defendant Dr. Andrew WONG prescribed antibiotics to treat Mr. Long's
10 infections but did not refer him to a urologist. Dr. WONG pursued this course of treatment
11 despite the fact that Mr. Long exhibited persistent signs of infection and that Mr. Long
12 complained of acute pain and had a history and symptoms of bladder stones.
13

14 67. Mr. Long filed a third 602 on or about January 16, 2001. Defendant Dr.
15 Daniel FULLER reviewed Mr. Long's case in response to a January 29, 2001 letter from
16 Long's counsel. He stated that tests did not indicate the presence of bladder stones, but
17 ordered further tests. He failed to ensure that Mr. Long was examined by a specialist.
18

19 68. Mr. Long did not receive an examination by a urologist until April 11, 2001.
20 On that date he underwent surgery at the Corcoran State Prison Acute Care Hospital. The
21 surgeon, Dr. Dwivedi, removed a large bladder stone and expressed his opinion to Mr.
22 Long that if Mr. Long was not paralyzed from the waist down he would have been unable
23 to withstand the pain caused by such a large stone. After a week in the Corcoran hospital,
24 Mr. Long was transferred to Salinas Valley State Prison, and then on May 9 to Pleasant
25 Valley State Prison. Mr. Long informed the doctor on his yard at Pleasant Valley upon
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1 arrival that he had undergone bladder stone surgery and was scheduled for a follow-up
2 examination. He was scheduled to have a follow-up examination with the surgeon on May
3 16, but this examination did not take place until May 30.
4

5 69. As the Health Care Manager at Wasco State Prison during the time period
6 relevant to Mr. Long's claims, defendant Dr. Michael SONGER failed to adequately
7 supervise and train staff and to put in place procedures so that Mr. Long would receive
8 medically appropriate care. Upon information and belief, Dr. SONGER knew that the
9 system in place at Wasco was failing to ensure that prisoners referred to specialists were
10 seeing specialists on a timely basis and that this failure was injuring prisoners.
11

12 70. Defendant Dr. Daniel THOR had personal knowledge of Mr. Long's medical
13 condition. As the Chief Medical Officer at Salinas Valley State Prison, Dr. THOR failed
14 to ensure that Mr. Long and others similarly situated received adequate treatment. Dr.
15 THOR failed to adequately supervise and train staff and to put in place procedures so that
16 Mr. Long would receive medically appropriate care. Upon information and belief, Dr.
17 THOR knew or should have known that the system in place at Wasco was failing to ensure
18 that prisoners who required specialized treatment and follow-up care were receiving the
19 required medical attention on a timely basis and that this failure was injuring prisoners.
20
21

22 71. The First Level response to the 602s that Mr. Long filed on or about December
23 16, 2000, was received by Mr. Long on or about June 15, 2001. It approved a referral to
24 an outside urologist on a "non-emergent basis," and stated that it would occur within the
25 next 60 days. The response ignored the fact that Mr. Long had received the surgery in the
26 six months it took to answer the 602. Mr. Long never received a response to the 602 he
27
28

1 filed on January 16, 2001.

2 (6) *Leslie Rhoades*

3
4 72. Plaintiff Leslie Rhoades is a prisoner at the California Medical Facility. Mr.
5 Rhoades has suffered from severe pain in his left hip since a car accident, which occurred
6 in 1996. This condition has made it extremely difficult for him to walk. In December
7 1997, while Mr. Rhoades was incarcerated at Calipatria State Prison, an x-ray was taken
8 which was negative as to damage to the hip bone. But on examination the hip was still
9 found to be subluxating. Additionally, Mr. Rhoades was experiencing swelling and pain in
10 his hip and lower back. At the time of his initial x-ray and examination, Mr. Rhoades was
11 not receiving treatment or medication for his pain.
12

13
14 73. Mr. Rhoades filed a 602 on January 14, 1998, regarding swelling around his
15 hip and lower back and requesting medications for the pain and to bring down the swelling.
16 Mr. Rhoades also requested transfer to a medical facility. The informal response stated
17 that he was scheduled to see the doctor who would evaluate his requests. Mr. Rhoades
18 filed another 602 on April 1, 1998, again asking for consideration of his request to be
19 transferred to a medical facility due to the pain and swelling in his hips and lower back.
20 The request was denied at the informal level due to a lack of documentation from the Chief
21 Medical Officer. Mr. Rhoades was not informed how he could get such documentation.
22 He filed another 602 on May 4, 1998, requesting an orthopedic evaluation, medication for
23 his swollen hip and transfer to a medical facility.
24

25
26
27 74. On July 9, 1998, a CDC orthopedist, Dr. David Smith, wrote that Mr.
28 Rhoades' hip was dislocated, with the hip visibly popping in and out of the socket. Dr.

1 Smith determined that Mr. Rhoades required a stabilization procedure or possibly a total
2 hip replacement. Dr. Smith then began requesting on a nearly monthly basis that an MRI
3 scan be conducted to determine the appropriate course of treatment. Dr. Smith also
4 continually requested that Rhoades be transferred to a CDC hospital facility for treatment.
5

6 75. On August 5, 1998, Mr. Rhoades filed a 602 regarding the delay in receiving
7 the chrono recommending a transfer to the California Medical Facility. The informal level
8 response granted the request and stated that he would receive the chrono in approximately
9 seven to ten days. On October 16, 1998, Mr. Rhoades filed a 602 complaining of pain in
10 his hip and a lack of meaningful medical attention and requesting that recommended
11 diagnostic tests be performed in order to allow his transfer to a medical facility. The
12 appeal was screened out as a duplicate appeal to his appeal filed on May 4, 1998. The
13 First Level response to that appeal, dated November 9, 1998, stated that the tests were
14 pending approval and scheduling.
15
16

17
18 76. While the MRI for Mr. Rhoades was eventually approved in December 1998, a
19 December 21, 1998 appointment was cancelled by the Watch Commander because the
20 regular transportation team was busy. Defendant Dr. Martin LEVIN failed to ensure that
21 the MRI was rescheduled during the next six months.
22

23 77. Mr. Rhoades filed a 602 on March 26, 1999, requesting a transfer to a medical
24 facility in order to have his medical needs met. It was screened out at the first level as a
25 duplicate appeal.
26

27 78. Finally, on June 25, 1999, Mr. Rhoades was taken for an MRI. However, one
28 of the guards accompanying Mr. Rhoades walked too close to the MRI machine and had

1 his weapons sucked into the MRI's magnet, breaking the machine and preventing the MRI
2 examination.

3
4 79. Mr. Rhoades filed a 602 on July 7, 1999, complaining of deliberate
5 indifference in the CDC medical care system. The appeal was screened out at the First
6 Level as an abuse of the appeal procedure. Mr. Rhoades did not have an MRI scan until
7 July 16, 1999, despite continuing requests from Dr. Smith, and only after his attorney met
8 with Mr. Rhoades at Calipatria and made a request, dated June 10, 1999, to the Chief
9 Medical Officer.

10
11 80. On August 9, 1999, Mr. Rhoades filed a 602 requesting information about the
12 July x-rays and MRI scans. The First Level response stated that the appeal was granted
13 and that copies of the test reports had been requested and that he would have a follow-up
14 evaluation with Dr. Smith on September 9, 1999. Mr. Rhoades filed another 602 on
15 August 23, 1999, requesting that constitutional violations within the CDC medical care
16 system be remedied and, specifically, that procedures be implemented in order to prevent
17 delays in access to medical care. The appeal was screened out at the First Level as a
18 duplicate appeal.

19
20
21 81. Defendant Dr. LEVIN did not ensure that the MRI results were discussed with
22 Mr. Rhoades in a timely manner. No appointment was set up to present and discuss the
23 MRI results with him until October 7, 1999. Mr. Rhoades was then informed that the MRI
24 confirmed what the December 1997 x-ray had already found, that the hip bone was not
25 damaged. However, Mr. Rhoades' left hip continued to pop in and out and cause severe
26 pain. In addition, the right hip had begun to do the same thing.

1 82. Mr. Rhoades was told by Dr. Smith that he did not know what was causing the
2 hip to subluxate, but further x-rays would be taken. Defendant Dr. LEVIN told Mr.
3 Rhoades that x-rays would be taken on November 4, 1999, showing “subluxation views” of
4 the hips. Dr. LEVIN stated that the doctor must do the manipulation of the hips to show
5 the subluxations. He stated that “this is not an x-ray procedure that can just be done
6 simply by the technician.” Despite Dr. LEVIN’s knowledge that a physician needed to
7 perform the x-ray procedure in order to obtain meaningful views, he did not ensure that
8 this took place. The x-rays were taken without any assistance by a physician. The
9 technician was not able to take an x-ray of Rhoades’ hips in the subluxated position due to
10 the fixed position of the x-ray machine. Despite the fact that the x-rays were not
11 appropriate for diagnosing subluxation, upon review of the x-rays that were taken, Dr.
12 Smith concluded that the hips were no longer subluxating.

13
14
15
16 83. In December 1999, Rhoades was transferred to CIM to obtain a second opinion
17 by another orthopedist. He was seen by Dr. Pospisic who recommended that surgery be
18 performed to repair the hip condition and that Mr. Rhoades be given a wheelchair so that
19 he would not have to walk. Mr. Rhoades used the wheelchair for the remainder of his time
20 at CIM. In January 2000, Mr. Rhoades was examined by a consulting doctor at Riverside
21 General Hospital who said that surgery would not help repair the condition, but
22 recommended an MRI for assistance in assessment of the condition. The MRI was done
23 two months later in March 2000. Defendant Dr. Joseph SIEGEL, acting Chief Medical
24 Officer at CIM, then reported that the working diagnosis was atrophy of the left gluteus
25 minimus muscle. In June 2000, Mr. Rhoades was examined by another Riverside General
26
27
28

1 Hospital consulting doctor who agreed that surgery would not be helpful, but that Mr.
2 Rhoades should have physical therapy in order to determine which muscles were damaged.

3
4 84. Mr. Rhoades was transferred back to Calipatria State Prison in October 2000.
5 Upon his arrival at Calipatria no medical guidelines were in place to make sure that Mr.
6 Rhoades was not forced to undertake activity inconsistent with his medical condition.
7
8 Instead, defendant Sergeant Randall DAVIS forced Mr. Rhoades to walk from the
9 reception area to his housing unit, a distance of over 100 yards. This was allowed to
10 happen even though Sergeant DAVIS was notified by the MTA and by Mr. Rhoades that
11 he had not walked for over nine months, and even though a wheelchair was available in the
12 central health clinic for Mr. Rhoades to use. With no effective intervention by the medical
13 staff, Mr. Rhoades was handcuffed and, using a cane for assistance walked from the
14 reception area to his housing unit. The next morning his left hip, leg and foot were
15 swollen and he was unable to get out of bed to go to meals for the next two days.

16
17
18 85. When Mr. Rhoades was transferred to Calipatria, it took over a month for Mr.
19 Rhoades' medical records to be forwarded from CIM to Calipatria. During this time
20 period, no progress was made in diagnosing and treating his condition and Mr. Rhoades
21 continued to experience severe pain.

22
23 86. Although the Riverside General Hospital doctors and Dr. David Smith, the
24 Calipatria orthopedist, recommended that Mr. Rhoades undergo physical therapy in order
25 to assess and to treat the damage to his hip muscles, Mr. Rhoades was housed at Calipatria,
26 a prison without a physical therapy program. Defendant Dr. LEVIN approved transfer to a
27 medical facility where Mr. Rhoades could obtain physical therapy.
28

1 87. As the Chief Medical Officer at Calipatria, defendant Dr. Martin LEVIN failed
2 to adequately supervise and train staff and failed to put in place procedures so that Mr.
3 Rhoades would receive medically appropriate care. Mr. Rhoades's condition was
4 specifically known to Dr. LEVIN and Dr. LEVIN failed to take action to address Mr.
5 Rhoades's medical condition with appropriate diagnosis and treatment. Upon information
6 and belief, Dr. LEVIN knew that the failure to provide appropriate medical care to Mr.
7 Rhoades caused his condition to deteriorate and forced him to suffer significant pain.

10 88. Mr. Rhoades was transferred to the California Medical Facility on May 2,
11 2001, arriving on May 11. As of June 24, 2001, Mr. Rhoades had not been seen by any
12 physician about his hip and lower back problems.

14 89. As the acting Chief Medical Officer at California Institution for Men,
15 defendant Dr. Stephen WYMAN failed to adequately supervise and train staff and put in
16 place procedures so that Rhoades would receive medically appropriate care.

18 (7) *Gilbert Aviles*

19 90. Plaintiff Gilbert Aviles is a prisoner at the Substance Abuse Treatment Facility
20 (SATF) who transferred from Wasco State Prison Reception Center to SATF on June 18,
21 1999. He is a paraplegic who requires the use of a catheter to relieve his bladder, either an
22 in-dwelling "foley" (which remains in the body for extended periods) or single use type.
23 From the beginning of his incarceration in October 1998 through August 1999, at both
24 Wasco and SATF, he used an in-dwelling foley catheter. During this time period,
25 physician orders in Mr. Aviles's medical records stated that his catheter was to be changed
26 every 14 days. However, at both Wasco and SATF his catheter was in fact not changed for
27
28

1 periods of two months or more, causing him to suffer severe urinary tract infections which
2 required at least two hospitalizations. Further, some of the catheters provided at Wasco
3 were past their expiration dates. For example, Mr. Aviles was provided with a catheter at
4 Wasco on or about June 4, 1999 that had an expiration date of February 1999. When the
5 catheter balloon broke upon insertion, another catheter was provided by a nurse at Wasco
6 with an expiration date of March 1995. This catheter was left in for two months until Mr.
7 Aviles was hospitalized on or around August 3-6, 1999 with a urinary tract infection.
8
9

10 91. Mr. Aviles has become increasingly resistant to antibiotics due to the frequent
11 bladder and urinary tract infections. While ill from the urinary tract infections, Mr. Aviles
12 was unable to eat many meals, or to take part in social or recreational programs, including
13 daily yard time.
14

15 92. As the Health Care Managers at Wasco and SATF, defendant Dr. Michael
16 SONGER and defendant Dr. Edgar CASTILLO failed adequately to supervise and to train
17 staff. They also failed to put in place procedures so that Mr. Aviles would receive
18 medically appropriate supplies in a timely manner. Drs. SONGER and CASTILLO were
19 responsible for appropriately managing medical supplies and should have ensured that
20 catheters were not being supplied to prisoners, including Mr. Aviles, in a manner
21 inconsistent with their intended use. The failure of Dr. SONGER and Dr. CASTILLO to
22 provide new catheters to prisoners requiring them on a timely basis has resulted in
23 infection and injury to prisoners, including Mr. Aviles.
24
25
26

27 93. Since the filing of the *Plata* complaint on April 5, 2001, Mr. Aviles has been
28 subject to adverse actions by defendants. On or about April 20, 2001, Mr. Aviles was

1 transferred from SATF to CMF after plaintiffs' counsel had repeatedly requested that he be
2 evaluated to determine if an impending transfer from an accessible cell to a gymnasium
3 was appropriate. However, upon his arrival at CMF, Mr. Aviles was informed that CMF
4 staff did not have any information about why he was sent there. While at CMF, Mr.
5 Aviles's ability to function in a gym setting was not evaluated and he was transferred back
6 to SATF during the week of May 28.
7

8
9 94. Upon return to SATF Mr. Aviles was placed immediately in a triple bunk in
10 the gym, which was inaccessible to him, and as a result he spent the night in his
11 wheelchair. He was then transferred to a cell not accessible for wheelchair users in
12 violation of CDC policy, where he spent several days. In order to maneuver his wheelchair
13 so that he could access the toilet Mr. Aviles had to wait until his cell door was opened by
14 SATF custodial staff. He was subsequently required to sign a chrono stating that it was
15 acceptable to him to be housed in an inaccessible cell temporarily. He was told that if he
16 did not sign the chrono he would be placed in Administrative Segregation. Mr. Aviles is
17 currently housed in the gym at SATF, despite the fact that his ability to function there has
18 not been adequately evaluated and that Mr. Aviles has repeatedly raised concerns that gym
19 housing is inaccessible to him. Upon information and belief, these actions were taken in
20 retaliation for the filing of this lawsuit.
21

22
23
24 95. At Wasco, Mr. Aviles filed a 602 on February 23, 1999, complaining that
25 MTAs at Wasco had refused to change his catheter. He stated that in four months at
26 Wasco, his internal catheter was changed only once after he had been hospitalized for a
27 urinary tract infection. Mr. Aviles did not receive a response on the informal level, and he
28

1 failed to receive a response to the appeal he filed on March 28,1999 at the first formal
2 level.

3
4 96. Mr. Aviles wrote to Wasco Warden Candelaria on June 28, 1999, complaining
5 of inadequate medical care by Wasco staff and stating, among other things, that Wasco
6 medical staff had failed to provide him with all the catheters ordered by the doctors at San
7 Joaquin Community Hospital. He also informed the Warden that he had filed several 602s
8 without receiving a response, and that he could not pursue those administrative remedies
9 due to his illness and hospitalization.
10

11 97. On July 21, 1999, Mr. Aviles filled out a sick call slip, stating that he had been
12 using his current catheter for over two months and he had not been given the type of
13 catheters ordered by the doctor at SATF. Mr. Aviles did not receive a response to this
14 request for assistance, and filed a 602 on the same issue. He did not receive a response to
15 this 602.
16

17
18 98. Mr. Aviles filed another 602 on September 16, 1999 at SATF, complaining that
19 he had not been given replacement catheters in a timely manner, and that he had been
20 given catheters after the expiration dates had passed. Mr. Aviles stated that these catheters
21 had caused bladder infections and hospitalization.
22

23 (8) *Paul Decasas*

24 99. Plaintiff Paul Decasas is a 34 year-old former prisoner who on or about July
25 18, 2001 was paroled from SATF. During the term on which he paroled, Mr. Decasas had
26 been previously housed at CIM and the California Rehabilitation Center. Mr. Decasas has
27 a serious seizure disorder.
28

1 100. While at CIM from approximately October 5, 2000 through approximately
2 January 10, 2001, Mr. Decasas was housed in the prison's infirmary because of his seizure
3 disorder, specifically for adjustment of his anti-seizure medications. Although his seizure
4 disorder had not been brought under control, defendant Dr. Mohan SUNDARESON and
5 defendant Dr. CLINTON, who treated Mr. Decasas in the prison infirmary, allowed and/or
6 permitted Mr. Decasas to be transferred to SATF, even though that facility does not have
7 an inpatient facility. Neither Dr. SUNDARESON nor Dr. CLINTON wrote a discharge
8 summary when Mr. Decasas was discharged from the CIM hospital, so there was no
9 summary setting forth the admitting diagnosis or course of treatment, and additional
10 treatment needs. Included among these factors were the necessity of orders or suggestions
11 by the two doctors for certain medications to be in liquid form and that Mr. Decasas be
12 examined by a neurologist. These actions were deliberately indifferent to Mr. Decasas's
13 serious medical condition and caused him to suffer harm.

14 101. As Health Care Manager at CIM, defendant Dr. Sanford HEPPS, failed to
15 ensure that Mr. Decasas receive adequate treatment and failed to adequately supervise and
16 train staff and put in place procedures so that Mr. Decasas would receive medically
17 appropriate care.

18 102. Mr. Decasas was transferred to SATF to participate in a civil addict drug
19 treatment program; his release from prison was tied to his completion of this program.
20 After his transfer to SATF on or about January 10, 2001, Mr. Decasas began to experience
21 frequent seizures. He experienced seizures documented by SATF medical staff on
22 January 18, January 25, February 1, February 6, February 9, February 13, February 15,

1 February 18, February 19, February 24, March 22, March 29, April 2, April 17, April 19,
2 May 7, May 9, May 10, and May 15. His condition was not properly monitored or treated
3 by defendant Dr. K. NGUYEN, his treating physician at SATF, and he frequently was not
4 given his prescribed medications; as a result, he continued to experience seizures. As a
5 result of inadequate medical care, Mr. Decasas was denied access to the benefits of the
6 treatment program.
7
8

9 103. Mr. Decasas uses a bite stick to protect his tongue during seizures. During
10 one seizure, Mr. Decasas shattered his bite stick. A nurse refused to replace the bite stick,
11 although Mr. Decasas was at risk for having seizures at any time.
12

13 104. As Health Care Manager at SATF, defendant Dr. Edgar CASTILLO failed to
14 ensure that Mr. Decasas receive adequate treatment and failed to adequately supervise and
15 train staff and put in place procedures so that Mr. Decasas would receive medically
16 appropriate care.
17

18 105. Since the filing of the original complaint on April 5, 2001, Mr. Decasas has
19 been subject to improper actions by defendants. During a medical appointment on or about
20 May 10, 2001, defendant Dr. NGUYEN, Mr. Decasas's treating physician, asked Mr.
21 Decasas why Mr. Decasas was suing him. On or about June 12, 2001, Dr. NGUYEN
22 asked Mr. Decasas to sign a release in order to obtain confidential medical files from non-
23 Department of Corrections facilities so that the doctor could investigate a suspicion that
24 Mr. Decasas's seizures were based on a mental health problem. Dr. NGUYEN had never
25 asked Mr. Decasas to sign such a form in the five months he had been at SATF, nor had
26 any of the doctors who treated him at the hospital at CIM. Upon information and belief,
27
28

1 the actions described in this paragraph were taken in retaliation for the filing of this
2 lawsuit.

3
4 (9) *Steven Bautista*

5 106. Plaintiff Steven Bautista is a prisoner at California State Prison – Lancaster.
6 At about 12:00 noon on January 29, 1999, while incarcerated at High Desert State Prison,
7 Mr. Bautista developed a priapism, a painful, persistent, and abnormal penile erection,
8 unaccompanied by sexual desire or excitation. The priapism was the result of Mr. Bautista
9 taking Trazodone (also known as Desyrel) which, on December 16, 1999, had been
10 prescribed for treatment of major depression by defendant Dr. Louis RICHNAK, a
11 psychiatrist employed by the prison. Dr. RICHNAK prescribed this medication without
12 informing Mr. Bautista of the possible side effects, which include priapism, and did not
13 obtain Mr. Bautista’s informed consent for the medication.
14
15

16 107. On the morning of January 30, 1999, with the painful priapism persisting, Mr.
17 Bautista sought medical attention, and at approximately 10:30 a.m. he was brought to the
18 prison’s infirmary. Since it was a Saturday, no doctors were present at the prison. While
19 Mr. Bautista was at the infirmary, MTA Wyman spoke by phone with defendant Richard
20 SANDHAM, M.D. regarding Mr. Bautista’s condition. Dr. SANDHAM was told that the
21 priapism had lasted for approximately 23 hours at that point.
22
23

24 108. Defendant Dr. SANDHAM failed to adequately treat Bautista’s medical
25 condition. Dr. SANDHAM failed to personally examine Mr. Bautista on January 30.
26 Despite the lengthy duration of the priapism to that point, Dr. SANDHAM only directed
27 that Mr. Bautista stop taking the Trazadone, apply ice packs to his genital area and take
28

1 Motrin. At 11:00 a.m. Mr. Bautista was returned to his cell, having been told that he
2 would be seen by Dr. SANDHAM the next day.

3
4 109. However, defendant Dr. SANDHAM did not see or evaluate Mr. Bautista on
5 Sunday, January 31, 1999. Mr. Bautista continued to suffer from the priapism.

6 110. On Monday, February 1, 1999, defendant Dr. SANDHAM saw Mr. Bautista.
7 However, Dr. SANDHAM failed to document Mr. Bautista's subjective complaint, or his
8 own objective observations, assessment, or plan. Instead, he merely issued orders for
9 application of ice to the genital area for twenty minutes, to be repeated the next morning,
10 and for Robaxin, a medication commonly prescribed in an attempt to relieve muscular-
11 skeletal discomfort. He also ordered that Mr. Bautista be cell fed.

12
13 111. At about 3:00 p.m. on Tuesday, February 2, 1999, Mr. Bautista was again
14 brought to the prison emergency room. Mr. Bautista was suffering terrible pain.
15 Defendant Dr. SANDHAM noted that the priapism had started 96 hours earlier. He
16 prescribed Terbutaline, but this did not reverse the priapism. Dr. SANDHAM then spoke
17 to Gordon L. Nitz, M.D., a consulting urologist who recommended pseudoephedrine,
18 which was given by means of Sudafed; this medication was also ineffective. Mr. Bautista
19 was admitted to the prison infirmary.

20
21
22 112. The next day, February 3, 1999, Bautista was finally transported to the office
23 of Dr. Nitz, the urologist. Dr. Nitz tried various therapies to relieve the priapism, including
24 multiple puncture wounds and direct injection of epinephrine into the penis, but was not
25 successful in relieving the condition. Dr. Nitz informed Mr. Bautista that he would
26 probably not get erections again following reduction of the priapism because of the length
27
28

1 of time the condition had persisted. Dr. Nitz also indicated to Mr. Bautista that he (the
2 doctor) did not understand why defendant Dr. SANDHAM had not adequately reacted to
3 what Dr. Nitz termed an emergency problem as soon as Mr. Bautista had made Dr.
4 SANDHAM aware of the priapism.
5

6 113. Later on February 3, 1999, Mr. Bautista was admitted to a hospital. On
7 February 4, 1999, surgery was performed by Dr. Nitz to relieve the priapism. Bautista was
8 left with permanent impotence and disfigurement, resulting in exacerbation of his
9 depressive state. He continues to suffer serious urological problems including pain and
10 difficulty urinating.
11

12 114. Defendant Dr. SANDHAM provided inadequate medical care to Bautista
13 because acute priapism is a urological emergency requiring prompt intervention so as to
14 prevent the possibility of impotence. Dr. SANDHAM's failure to personally examine Mr.
15 Bautista until approximately 48 hours after first becoming aware of the emergency
16 condition was an inexcusable delay, as was the doctor's failure to consult with a urologist
17 until approximately 96 hours after the priapism began. These failures, upon information
18 and belief, allowed Mr. Bautista's condition to deteriorate in such a way that it resulted in
19 permanent damage that he would not have suffered had he received prompt attention.
20
21
22

23 115. Mr. Bautista filed a 602 regarding this matter on or about February 16, 1999,
24 but never received a response. Mr. Bautista has no further recourse through administrative
25 remedies.
26

27 116. As the Health Care Manager at High Desert State Prison, defendant Dr.
28 PARK did not adequately supervise and train staff. He also failed to put in place

1 procedures so that Mr. Bautista would receive medically appropriate care. Upon
2 information and belief, Dr. PARK was responsible for ensuring that all medical personnel
3 at High Desert advise prisoners of the potential side-effects of drugs. Upon information
4 and belief Dr. PARK knew that a failure to implement a disclosure requirement could
5 result in prisoners suffering unexpected and debilitating side-effects from drugs prescribed
6 to them. Upon information and belief, Dr. PARK also bears responsibility for policies on
7 when outside specialists must be contacted to intervene in emergency conditions, including
8 policies that would have ensured that Mr. Bautista promptly saw a urologist after onset of
9 his priapism.

10
11
12
13 117. Since the filing of the *Plata* complaint defendants have had at least one
14 improper discussion with Mr. Bautista regarding his involvement in the lawsuit. On April
15 18, 2001, less than two weeks after *Plata* was filed, Mr. Bautista had a classification
16 committee hearing at California State Prison - Sacramento regarding his need for continued
17 administrative segregation placement due to protective custody concerns. Several prison
18 officials were present at the hearing. During the hearing Chief Deputy Warden Rosario
19 reviewed Mr. Bautista's Central file and asked him if he was filing a lawsuit against the
20 Department of Corrections and Mr. Bautista replied affirmatively. Captain Vance asked
21 what lawsuit Mr. Bautista was involved in; Chief Deputy Warden Rosario replied that it
22 was *Plata v. Davis*. Captain Vance had not heard of *Plata* and asked what lawsuit it was.
23 Chief Deputy Warden Rosario then told him that it was the "black blanket that fell upon
24 the CDC medical." Chief Deputy Warden Rosario then asked Mr. Bautista what had
25 happened to him. Mr. Bautista responded that he had suffered a side effect from a
26
27
28

1 psychiatric medication and had undergone two operations as a result. Chief Deputy
2 Warden Rosario then proceeded to discuss Mr. Bautista's safety concerns. Upon
3 information and belief, the comments to Mr. Bautista were intended to intimidate him.
4

5 (10) *Clifford Myelle*

6 118. Plaintiff Clifford Myelle is incarcerated at Folsom State Prison. He suffers
7 from degenerative disc disease, a very painful condition which was originally diagnosed in
8 October 1991 and that began causing, during the summer of 1998, increasingly severe
9 pain, numbness in his legs, and urinary retention problems. Mr. Myelle has suffered
10 excessive delays in having his condition diagnosed and treated.
11

12 119. On August 31, 1998, while incarcerated at California State Prison - Solano
13 (Solano), Dr. Neely examined Myelle and ordered that he receive an urgent orthopedic
14 consult. However, an urgent consult did not take place; an orthopedist did not see Myelle
15 until October 3, 1998, more than a month after the referral.
16

17 120. On October 3, 1998, Myelle was seen by defendant John KOFOED, M.D., an
18 orthopedist. Dr. KOFOED ordered X-rays and an MRI. The X-rays were performed on
19 October 9. The MRI was not done until December 4, 1998; it showed degenerative disc
20 disease and two areas of disc protrusion, one of which impacted nerve roots.
21

22 121. On February 5, 1999, Mr. Myelle filed a 602 appeal requesting an
23 appointment with defendant Dr. KOFOED in order to discuss the results of the MRI.
24

25 122. On February 20, 1999 defendant Dr. KOFOED re-examined Myelle. Dr.
26 KOFOED referred Myelle to a neuro-orthopedic specialist for a surgical evaluation. On or
27 about March 17, 1999, the Solano prison medical authorization review committee
28

1 approved Dr. KOFOED's request that Mr. Myelle be evaluated by a neurosurgeon.

2 123. Mr. Myelle, however, was not evaluated by a neurosurgeon until September
3 18, 2000, more than 18 months after the exam was ordered and approved.
4

5 124. On April 24, 1999, Mr. Myelle filed an administrative appeal with prison
6 officials requesting confirmation that an appointment had been made with the neuro-
7 orthopedic specialist. On May 1, 1999, Mr. Myelle was again seen by defendant
8 KOFOED who did not explain to Myelle why he had not been seen by the specialist. Dr.
9 KOFOED made a second referral and ordered that the evaluation be done within the next
10 30 days. This second referral was approved by the Solano medical authorization review
11 committee, but defendant Dr. Donald CALVO ordered that the consultation be scheduled
12 at a later date.
13
14

15 125. On July 6, 1999, the Solano utilization review nurse rescheduled Mr. Myelle
16 to be seen by the neurosurgeon on August 18, 1999. However, on August 8, the utilization
17 nurse was informed that the neurosurgeon who was to evaluate Mr. Myelle was no longer
18 treating state prisoners and that as a result the August 18 appointment was cancelled. The
19 nurse left a message with defendant Dr. KOFOED, asking him to decide what to do next.
20
21

22 126. On July 18, 1999, Mr. Myelle filed an administrative appeal requesting that
23 he be seen by a neurosurgeon for an evaluation. The informal level response, dated July
24 23, stated that an appointment had been made for the third week of August. He did not
25 further pursue the appeal because prison officials stated that he would be seen by the
26 doctor.
27

28 127. On August 23, 1999, Mr. Myelle filed another administrative appeal, again

1 requesting confirmation of an appointment with the specialist. On September 2, 1999, Mr.
2 Myelle received a response, dated September 2, stating that the outside neurosurgeon with
3 whom the appointment had been made was no longer seeing CDC patients and that he
4 would instead be scheduled again to see defendant Dr. KOFOED. He did not appeal this
5 response.
6

7
8 128. On September 25, 1999, Mr. Myelle was again seen by defendant Dr.
9 KOFOED, who told Mr. Myelle that he would be seen by a specialist soon. Dr. KOFOED
10 ordered that Mr. Myelle see a specialist "ASAP". On October 6, 1999, the Solano
11 utilization review process approved this consultation.
12

13 129. On November 5, 1999, Mr. Myelle was seen by Dr. Low, a non-specialist
14 medical doctor employed by contract at the medical clinic at Solano. Mr. Myelle was
15 scheduled to see Dr. Low for a medical problem unrelated to his disc disease. Dr. Low's
16 documentation of the visit states that Mr. Myelle complained of his lower back condition
17 and of difficulties voiding and evacuating. The doctor further noted that Mr. Myelle was
18 "awaiting neurosurgical eval[uation]." The doctor's notes make no mention of any
19 discussion of any transfer to another prison.
20

21
22 130. On November 5, 1999, Solano Utilization Nurse Killian wrote a note in Mr.
23 Myelle's health care record. The note states that (1) there is a two month backlog for
24 neurosurgeon consultations, (2) Mr. Myelle is pending transfer to California State Prison –
25 Folsom (Folsom) on November 8, 1999, and (3) the clinic doctor (Dr. Low) discussed the
26 case with her and advised her of Mr. Myelle's desire to transfer and to not have a medical
27 hold placed which would prohibit the transfer pending completion of medical care. Based
28

1 on this information, Nurse Killian postponed the neurosurgeon consultation.

2 131. On November 6, 1999, Mr. Myelle was again seen by defendant Dr.
3 KOFOED. Dr. KOFOED emphatically stated that Mr. Myelle should have been seen by
4 the specialist by that point because of the severity of the condition and symptoms. After
5 Mr. Myelle informed Dr. KOFOED that prison officials intended to transfer him (Myelle)
6 from Solano, Dr. KOFOED recommended a “medical hold,” an order that Mr. Myelle not
7 be transferred until he had been seen by the specialist. The Solano Chief Physician and
8 Surgeon approved the order on November 8, 1999. Upon information and belief, as Chief
9 Medical Officer at Solano, Camille Williams, M.D., had responsibility for supervision and
10 training of the medical staff at Solano.
11

12 132. On December 14, 1999, without having seen the neurosurgeon and despite the
13 doctors’ orders for a medical hold, Mr. Myelle was transferred from Solano to Folsom
14 State Prison (Folsom).
15

16 133. Since his initial diagnosis Mr. Myelle’s medical condition has progressively
17 deteriorated, including increasing difficulty urinating and painful bowel movements.
18 Myelle suffers from severe pain, including in his feet and legs when walking or climbing
19 stairs, and bladder problems.
20

21 134. On January 12, 2000, Mr. Myelle told defendant Dr. Joseph TOURELLA of
22 his continuing problems, including slow or obstructed voiding of urine. On January 19,
23 2000, an unidentified medical staff member noted in Myelle’s medical file that a
24 neurological consult had been approved but could not take place because the most recent
25 MRI report had been done eighteen months earlier. Dr. TOURELLA submitted a request
26
27
28

1 for another MRI. On March 13, 2000, Mr. Myelle again told Dr. TOURELLA of his
2 problems voiding urine.

3
4 135. On May 5, 2000, an MRI was performed on Mr. Myelle. It again showed
5 disc disease with disc protrusion resulting in contact with and/or displacement of nerve
6 roots.

7
8 136. On July 12, 2000, Mr. Myelle was taken to a neurosurgeon's office in
9 Modesto, but upon arrival was informed by clinic staff that a Folsom staff member had
10 cancelled the appointment on July 11 because no transport team was available to bring him
11 to the appointment. According to a note in the health care record, the appointment was
12 cancelled because "custody" arrived with Mr. Myelle at the neurologist's office over an
13 hour late. Plaintiff is informed and believes and therefore alleges that defendant MTA
14 Michael FARRINGER was responsible for scheduling medical appointments with outside
15 specialists and did not ensure that Mr. Myelle's appointment with the Modesto doctor was
16 completed.
17

18
19 137. On July 27, 2000, Mr. Myelle had a surgical consultation appointment but did
20 not receive a ducat (inmate pass) to go to the appointment and therefore could not see the
21 specialist. On August 16, 2000, Mr. Myelle was seen by Dr. McArthur who told plaintiff
22 that he had been scheduled for a consultation that day or the next day but the appointment
23 was cancelled due to an institution lockdown, although other inmates were transported to
24 medical appointments that day. Mr. Myelle again saw Dr. McArthur, on September 1,
25 2000, who informed him that a surgical consultation appointment had been made but that
26 custody had denied approval to transport plaintiff to the appointment.
27
28

1 138. On September 18, 2000, Mr. Myelle was finally examined by a
2 neurosurgeon. A doctor had first ordered this consult approximately 18 months earlier.
3
4 Approximately 14 months before the consult, a doctor had ordered that it take place within
5 30 days. And approximately one year before the appointment, a doctor had ordered that it
6 take place “ASAP”.

7
8 139. At the September 18, 2000 examination, Louis R. Nelson, M.D., the
9 neurosurgeon, ordered that Mr. Myelle have a discogram and post CT scan (additional
10 diagnostic tests), and said he would see Mr. Myelle again after that. The discogram was
11 not performed until January 17, 2001.

12
13 140. On September 19, 2000, Mr. Myelle filed a 602 complaining that several
14 appointments had been made with the outside neurosurgeon but that he had not been
15 transported to them, and requesting information about the process of issuing ducats to
16 inmates to notify them of outside medical appointments. The undated informal level
17 response stated that because Mr. Myelle is a lifer he is not given a ducat until the last
18 minute, and that “if CDC has the transport CO’s available they will make a good effort to
19 get you to your appointment.” He did not appeal this response.
20

21
22 141. On February 7, 2001, Mr. Myelle filed another administrative appeal,
23 requesting prompt medical attention to treat his back condition. He appealed to the Second
24 Level and the response stated that he was seen by Dr. Nelson, neurosurgeon, and that
25 follow-up treatment would be determined once results of that visit were received. Mr.
26 Myelle appealed to the Director’s Level on June 7, 2001, and that response is pending.
27

28 142. On May 9, 2001, Mr. Myelle had a follow-up appointment with the

1 neurosurgeon during which the surgeon discussed the discogram results and recommended
2 spinal disc fusion surgery. On June 8, 2001, Mr. Myelle was informed that the prison had
3 not yet received the recommendation from the neurosurgeon. Mr. Myelle continues to
4 suffer pain and other problems.
5

6 143. As the wardens at Folsom State Prison during the period when Mr. Myelle
7 has been incarcerated at that institution, defendant Glenn MUELLER and defendant
8 Roseanne Mueller failed to adequately supervise and train custody staff and to implement
9 procedures so that Mr. Myelle would be properly and timely scheduled for and transported
10 to outside medical appointments in order to receive appropriate medical care.
11

12 144. Defendants DOE VI and Dr. Sandra Hand were or are the Health Care
13 Managers or Acting Health Care Managers at Folsom State Prison at all times relevant to
14 Mr. Myelle's allegations. These doctors were or are responsible for supervising and
15 training the medical staff at Folsom. Upon information and belief, these doctors knew that
16 Mr. Myelle was not receiving timely and adequate medical care. These doctors were
17 responsible for the inadequate policies and procedures that led to inadequate medical care
18 for Mr. Myelle and other prisoners. Upon information and belief, defendants DOE VI and
19 HAND knew that these inadequate policies and procedures would cause injury to Mr.
20 Myelle.
21
22
23

24 B. Defendants
25

26 145. Defendant Gray DAVIS is the Governor of the State of California and the
27 Chief Executive of the state government. He is sued herein in his official capacity. As
28 Governor he is obligated under state law to supervise the official conduct of all executive

1 and ministerial officers and to see that all offices are filled and their duties lawfully
2 performed. DAVIS has control over the monies allocated to the CDC by submitting a
3 budget and by exercising his authority to veto or sign legislation appropriating funds.
4 DAVIS has the authority to appoint and remove the subordinate defendants named herein.
5 Defendant DAVIS retains the ultimate state authority over the care and treatment of the
6 plaintiff class.
7

8
9 146. Defendant CALIFORNIA DEPARTMENT OF CORRECTIONS operates the
10 correctional facilities that are the subject of the claims against it for violation of the
11 Americans with Disabilities Act and section 504 of the Rehabilitation Act. The
12 CALIFORNIA DEPARTMENT OF CORRECTIONS has the responsibility to take action
13 to remedy the violations of the Americans with Disabilities Act and section 504 of the
14 Rehabilitation Act, but has not done so.
15

16
17 147. Defendant B. Timothy GAGE is the Director of the Department of Finance
18 and is sued in that capacity. Mr. GAGE supervises the Department of Finance, which is
19 responsible for approving the CDC budget requests, including budget items for provision
20 of medical care.
21

22 148. Defendant Robert PRESLEY is Secretary of the Youth and Adult
23 Correctional Agency of the state of California and is sued herein in this capacity. The
24 Youth and Adult Correctional Agency supervises the operation of the CDC.
25

26 149. Defendant Teresa ROCHA is the acting Director of the CDC and is sued
27 herein in that capacity. The CDC is responsible for the operation of the California state
28 prison system, including the provision of constitutionally adequate medical care. As

1 Director, Defendant ROCHA is responsible for the operation of all the prison facilities,
2 including decisions concerning staff deployment and training that directly affect plaintiffs'
3 abilities to obtain adequate medical care.
4

5 150. Defendant Susann STEINBERG, M.D. is the Deputy Director of the Health
6 Care Services Division of the CDC and is sued in that capacity. As Deputy Director, Dr.
7 STEINBERG is responsible for supervising the provision of medical care for all prisoners
8 within the custody of the department.
9

10 151. Defendant Daniel THOR, M.D., was at all relevant times the Health Care
11 Manager at Salinas Valley State Prison and is sued in his individual capacity. As Health
12 Care Manager, Dr. THOR is responsible for supervising the provision of adequate medical
13 care for prisoners at Salinas Valley.
14

15 152. Defendant Angela COOPER was at all relevant times a nurse at Salinas
16 Valley and is sued in her individual capacity.
17

18 153. Defendant Andrew LUCINE was at all relevant times the Health Care
19 Manager at Salinas Valley and is sued in his individual capacity. As Health Care Manager,
20 Dr. LUCINE was responsible for supervising the provision of adequate medical care for
21 prisoners at Salinas Valley.
22

23 154. Defendant Deneice MAYLE was at relevant times the warden at Salinas
24 Valley State Prison and is sued in her official capacity. As the warden at Salinas Valley,
25 MAYLE failed to adequately supervise and train custody staff and put in place procedures
26 so that plaintiff Plata was able to receive medically appropriate care.
27

28 155. Defendant Tam BUI, M.D., was at all relevant times a physician employed at

1 San Quentin State Prison and is sued in his individual capacity.

2 156. Defendant Donald CALVO, M.D., was at all relevant times the Health Care
3 Manager at San Quentin and Solano and is sued in his individual capacity. As Health Care
4 Manager, Dr. CALVO was responsible for supervising the provision of adequate medical
5 care for prisoners at San Quentin and Solano.
6

7 157. Defendant Martin LEVIN, M.D., was at all relevant times the Health Care
8 Manager at Calipatria State Prison and is sued in his individual capacity. As Health Care
9 Manager, Dr. LEVIN was responsible for supervising the provision of adequate medical
10 care for prisoners at Calipatria.
11

12 158. Defendant Shankar RAMAN, M.D., was at all relevant times a physician
13 employed at California State Prison - Corcoran and is sued in his individual capacity.
14

15 159. Defendant Brian YEE, M.D., was at all relevant times the Health Care
16 Manager at California State Prison - Corcoran and is sued in his individual capacity. As
17 Health Care Manager, Dr. YEE was responsible for supervising the provision of adequate
18 medical care for prisoners at Corcoran.
19

20 160. Defendant Darrell SMITH, M.D., was at all relevant times a contract
21 ophthalmologist hired by San Quentin State Prison and is sued herein in his individual
22 capacity.
23

24 161. Defendant Meredith Alden VAN PELT, M.D., was at all relevant times a
25 physician at San Quentin State Prison and is sued herein in her individual capacity.
26

27 162. Defendant Bhaviesh SHAH, M.D., was at all relevant times a physician
28 employed at Wasco State Prison and is sued herein in his individual capacity.

1 163. Defendant Andrew WONG, M.D., was at all relevant times a physician
2 employed at Salinas Valley State Prison and is sued herein in his individual capacity.
3

4 164. Defendant Daniel FULLER, M.D., was at all relevant times a physician
5 employed at Salinas Valley State Prison and is sued herein in his individual capacity.
6

7 165. Defendant Michael SONGER, M.D., was at all relevant times the Health Care
8 Manager at Wasco State Prison and is sued herein in his individual capacity. As Health
9 Care Manager, Dr. SONGER was responsible for supervising the provision of adequate
10 medical care for prisoners at Wasco.
11

12 166. Defendant Stephen WYMAN, M.D., was at all relevant times the Health Care
13 Manager and Chief Medical Officer at California Institution for Men and is sued in his
14 individual capacity. As Health Care Manager and Chief Medical Officer, Dr. WYMAN
15 was responsible for supervising the provision of adequate medical care for prisoners at
16 CIM.
17

18 167. Defendant Joseph SIEGEL, M.D., was at all relevant times a physician
19 employed at California Institution for Men and is sued in his individual capacity.
20

21 168. Defendant Sergeant Randall DAVIS was at all relevant times a sergeant at
22 Calipatria State Prison and is sued in his individual capacity.
23

24 169. Defendant Edgar CASTILLO, M.D., was at all relevant times the Health Care
25 Manager at SATF and is sued herein in his individual capacity. As Health Care Manager,
26 Dr. CASTILLO was responsible for supervising the provision of adequate medical care for
27 prisoners at SATF.
28

 170. Defendant K. NGUYEN, M.D., was at all relevant times a physician

1 employed at SATF and is sued herein in his individual capacity.

2 171. Defendant Sanford HEPPS, M.D., was at all times relevant to plaintiff
3 Decasas's claims the Health Care Manager and Chief Medical Officer at the California
4 Institution for Men and is sued in his individual capacity. As Health Care Manager, Dr.
5 HEPPS was responsible for supervising the provision of adequate medical care for
6 prisoners at CIM.
7

8 172. Defendant Mohan SUNDARESON, M.D., was at all relevant times a
9 physician employed at CIM and is sued in his individual capacity.
10

11 173. Defendant Dr. CLINTON, M.D., was at all relevant times a physician
12 employed at CIM and is sued herein in his individual capacity.
13

14 174. Defendant Louis RICHNAK, M.D., was at all relevant times a psychiatrist
15 employed at High Desert State Prison and is sued in his individual capacity.
16

17 175. Defendant Richard SANDHAM, M.D., was at all relevant times a physician
18 employed at High Desert State Prison and is sued in his individual capacity.
19

20 176. Defendant C. PARK, DDS, was at all relevant times the Health Care Manager
21 at High Desert State Prison and is sued in his individual capacity. As Health Care
22 Manager, Dr. PARK was responsible for supervising the provision of adequate medical
23 care for prisoners at High Desert.

24 177. Defendant Dr. Camille WILLIAMS, was at all times relevant to plaintiff
25 Myelle's claim the Chief Medical Officer of California State Prison - Solano and is sued in
26 her individual capacity. As the Chief Medical Officer at Solano, Dr. WILLIAMS failed to
27 adequately supervise and train staff and put in place procedures so that plaintiff Myelle
28

1 would receive medically appropriate care.

2 178. Defendant J. KOFOED, M.D., was at all relevant times employed as an
3 attending orthopedist at California State Prison - Solano and is sued in his individual
4 capacity.
5

6 179. Defendant Joseph TOURELLA, M.D., was at all relevant times employed as
7 a staff physician at Folsom State Prison and is sued in his individual capacity.
8

9 180. Defendant MTA Michael FARRINGER was at all relevant times employed as
10 a medical technical assistant at Folsom State Prison and was responsible for scheduling
11 medical appointments at outside facilities. He is sued in his individual capacity.
12

13 181. Defendant Glenn A. MUELLER was at relevant times the warden of Folsom
14 State Prison and is sued in his individual capacity. As the warden at Folsom, MUELLER
15 failed to adequately supervise and train custody staff and put in place procedures so that
16 plaintiff Myelle was able to receive medically appropriate care.
17

18 182. Defendant Roseanne CAMPBELL was at relevant times the warden of
19 Folsom State Prison and is sued in her individual capacity. As the warden at Folsom,
20 CAMPBELL failed to adequately supervise and train custody staff and put in place
21 procedures so that plaintiff Myelle was able to receive medically appropriate care.
22

23 183. Defendant Sandra HAND, M.D. was at all times relevant to plaintiff Myelle's
24 claim the Health Care Manager of Folsom State Prison and is sued in her individual
25 capacity. As the Health Care Manager at Folsom, Dr. HAND failed to adequately supervise
26 and train staff and put in place procedures so that plaintiff Myelle would receive medically
27 appropriate care.
28

1 184. Defendant DOE I was at all relevant times employed as a medical technical
2 assistant at Calipatria State Prison and is sued in his individual capacity.

3
4 185. Defendant DOE II was at all relevant times employed as a medical technical
5 assistant at Calipatria State Prison and is sued in his individual capacity.

6 186. Defendant DOE III was at all relevant times employed as a correctional
7 officer at Calipatria State Prison and is sued in his individual capacity.

8
9 187. Defendant DOE IV was at all relevant times employed as a medical technical
10 assistant at Salinas Valley State Prison and is sued in his individual capacity.

11 188. Defendant DOE V was at all relevant times employed as a physician at
12 Salinas Valley State Prison and is sued in his individual capacity.

13
14 189. Defendant DOE VI was at all relevant times employed as the Health Care
15 Manager at Folsom State Prison and is sued in his individual capacity. As the Health Care
16 Manager at Folsom, DOE VI failed to adequately supervise and train staff and put in place
17 procedures so that plaintiff Myelle would receive medically appropriate care.
18

19
20 **VI. CLASS ACTION ALLEGATIONS**

21
22 190. The named plaintiffs bring this action on their own behalf and, pursuant to
23 Rules 23(b)(1) and 23(b)(2) of the Federal Rules of Civil Procedure, on behalf of a class of
24 all prisoners who are now, or will in the future be, under the custody of the CDC but
25 excluding any prisoners confined at Pelican Bay State Prison.
26

27 (a) Thousands of prisoners in CDC custody suffer from serious medical
28 conditions. All prisoners are at risk of developing a serious medical condition while in

1 prison and thousands need care and treatment to prevent serious medical conditions. All
2 prisoners are entirely dependent on defendants for the provision of medical treatment. The
3 size of the class is so numerous that joinder of all members is impracticable.
4

5 (b) The conditions, practices and omissions that form the basis of this
6 complaint are common to all members of the class and the relief sought will apply to all of
7 them.
8

9 (c) The claims of the named plaintiffs are typical of the claims of the
10 class.
11

12 (d) The prosecution of separate actions by individual members of the
13 class would create a risk of inconsistent and varying adjudications which would establish
14 incompatible standards of conduct for the defendants.
15

16 (e) The prosecution of separate actions by individual members of the
17 class would create a risk of adjudications with respect to individual members which would,
18 as a practical matter, substantially impair the ability of other members to protect their
19 interests.
20

21 (f) Defendants have acted or refused to act on grounds generally
22 applicable to the class, making appropriate injunctive and declaratory relief with respect to
23 the class and subclass as a whole.
24

25 (g) There are questions of law and fact common to the members of the
26 class, including defendants' violations of the Eighth and Fourteenth Amendments to the
27 United States Constitution.
28

(h) The named plaintiffs are capable, through counsel, of fairly and

1 adequately representing the class and protecting its interests.

2 191. (a) Paul Decasas and Raymond Stoderd and other similarly situated
3
4 plaintiffs meet the requirements for certification as subclass pursuant to Fed. R. Civ. P.
5 Rule 23 (c)(4). The subclass consists of all prisoners with disabilities, except those
6 prisoners with mobility, hearing, sight, learning and developmental disabilities.

7 (b) Upon information and belief, thousands of prisoners in CDC custody
8
9 have disabilities and are denied access to CDC programs, services and activities due to
10 inadequate medical care. All prisoners are entirely dependent on defendants for the
11 provision of medical treatment. The size of the class is so numerous that joinder of all
12 members is impracticable.

13 (c) The conditions, practices and omissions that form the basis of this
14
15 complaint are common to all members of the subclass and the relief sought will apply to all
16 of them.

17 (d) The claims of Decasas and Stoderd are typical of the claims of the
18
19 entire subclass.

20 (e) The prosecution of separate actions by individual members of the
21
22 subclass would create a risk of inconsistent and varying adjudications which would
23 establish incompatible standards of conduct for the defendants.

24 (f) The prosecution of separate actions by individual members of the
25
26 subclass would create a risk of adjudications with respect to individual members which
27 would, as a practical matter, substantially impair the ability of other members to protect
28 their interests.

1 (g) Defendants have acted or refused to act on grounds generally
2 applicable to the subclass, making appropriate injunctive and declaratory relief with
3 respect to the class and subclass as a whole.
4

5 (h) There are questions of law and fact common to the members of the
6 subclass, including defendants' violations of the ADA and § 504.
7

8 (i) Decasas and Stoderd are capable, through counsel, of fairly and
9 adequately representing the subclass and protecting its interests because they are prisoners
10 confined within the CALIFORNIA DEPARTMENT OF CORRECTIONS who have been
11 discriminated against on the basis of their disabilities, through failure to provide adequate
12 medical care, and who are at risk of having future serious medical needs.
13
14

15 **VII. STATEMENT OF CLASS CLAIMS**

16 192. The medical care provided by defendants in each of California's prisons is
17 woefully inadequate and violates the constitutional rights of the named plaintiffs and the
18 plaintiff class under the Eighth and Fourteenth Amendments of the United States
19 Constitution to be free from cruel and unusual punishment. There are a multitude of
20 problems with the delivery of medical care to plaintiffs and the plaintiff class, including
21 but not limited to, the following:
22
23

24 a. MTAs are inadequately trained to perform their duties and have
25 conflicting custodial responsibilities. MTAs are the "gatekeepers" for plaintiffs' access to
26 any medical care. Prisoners who wish to be seen by a doctor must first submit a request to
27 an MTA. The first person who responds to a prisoner with an acute medical incident often
28

1 is an MTA. MTAs are often called upon to make initial medical diagnoses of prisoner
2 medical conditions. Many MTAs, however, have inadequate medical training. MTAs
3 therefore may not, and have not in the past, recognized the symptoms a patient displays
4 until that condition has become so acute as to be life threatening. MTAs are peace officers
5 and are expected to perform custodial functions which interfere with their ability to
6 provide adequate medical care.
7

8
9 b. There are insufficient numbers of qualified medical staff, including
10 physicians, nurses and MTAs.

11 c. There is a lack of training and supervision of all medical personnel.

12 d. Prisoners' medical records often are disorganized and incomplete.
13
14 These records often do not accompany prisoners when they are transferred to other prisons.

15 e. There is a lack of adequate medical screening of incoming prisoners.

16 f. There are lengthy delays in accessing care, including delays to see a
17 primary physician, to obtain a referral to see a specialist, to be transported to a specialist
18 for examination after obtaining the referral, to obtain medical testing and to obtain
19 treatment. These delays are compounded when inmates are transferred to new institutions,
20 often causing further delays in the provision of medical care.
21

22 g. There are frequent failures to provide prisoners with access to care
23 altogether. Often, medical staff do not take sufficient steps necessary to make diagnoses.
24 There are often failures to provide treatment when a diagnosis or symptom is discovered.
25 Medical staff do not provide care because they do not use interpretative services to
26 communicate with prisoners who speak languages other than English.
27
28

1 h. Laboratory and other medical tests are frequently delayed, never done
2 or not reported.

3
4 i. There is untimely response to emergencies.

5 j. Correctional officers frequently interfere with the provision of
6 medical care.

7 k. There is a lack of quality control procedures, including lack of
8 physician peer review, quality assurance and death reviews. Even if deficiencies are
9 identified, there is inadequate follow-up to prevent future problems.

10
11 l. There is a lack of established protocols for dealing with chronic
12 illnesses such as diabetes, heart disease, hepatitis and HIV. The care of HIV+ inmates is
13 particularly inadequate. Problems include, but are not limited to, (i) frequent failure to
14 instruct and assist inmates in following the strict regimen needed to take their drug
15 combinations successfully, (ii) irregular, untimely, and sometimes incorrect administration
16 of medications, and (iii) failure to adequately monitor and treat secondary infections.

17
18 m. Prisoners are not informed of potential side effects of prescribed
19 medications and of the actions they should take if side effects occur.

20
21 n. Defendants are unable to recruit sufficient, competent medical staff
22 and to retain those staff who are hired.

23
24 o. Necessary medical care is often denied based solely on an inmate's
25 expected release date, even when this date is over one year away.

26
27 p. Defendants lack sufficient knowledge about the medical care system
28 to properly monitor and improve the delivery of medical care.

1 distress and other injuries. Defendant Cooper's acts were willful, intentional, wanton and
2 in conscious disregard of plaintiff's rights.

3
4 **IV.**

5 (Shaw v. Bui & Calvo)

6 (§ 1983)

7
8 205. Defendants BUI and CALVO were deliberately indifferent to plaintiff Shaw's
9 medical needs and have violated plaintiff Shaw's right to be free from cruel and unusual
10 punishment under the Eighth Amendment to the U.S. Constitution. Defendants acted
11 under color of state law and knew and should have known that their conduct or omissions
12 created an unreasonable risk of harm to Shaw. As a direct and foreseeable result of these
13 defendants' violations of plaintiff's constitutional rights, plaintiff has suffered physical
14 injuries to his arm and a resulting debilitating infection; defendants have also caused pain
15 and suffering, emotional distress and other injuries by failing to provide medically
16 appropriate treatment. Defendant BUI's acts were willful, intentional, wanton and in
17 conscious disregard of plaintiff's rights.

18
19
20 **V.**

21 (Stoderd v. Raman & Yee)

22 (§1983)

23
24 206. Defendants RAMAN and YEE have been deliberately indifferent to plaintiff
25 Stoderd's medical needs and have violated plaintiff Stoderd's right to be free from cruel
26 and unusual punishment under the Eighth Amendment to the U.S. Constitution. These
27 defendants acted under color of state law and knew and should have known that their
28

1 conduct or omissions created an unreasonable risk of harm to Stoderd. As a direct and
2 foreseeable result of these defendants' violations of plaintiff's constitutional rights,
3 plaintiff has suffered pain and suffering, emotional distress and other injuries from their
4 discontinuation of his pain medications. Defendants' acts were willful, intentional, wanton
5 and in conscious disregard of plaintiff's rights.
6

7
8 **VI.**

9 (Johns v. Smith, Calvo, & Van Pelt)

10 (§1983)

11 207. Defendants SMITH, CALVO and VAN PELT have been deliberately
12 indifferent to plaintiff Johns's medical needs and have violated plaintiff Johns's right to be
13 free from cruel and unusual punishment under the Eighth Amendment to the U.S.
14 Constitution. These defendants acted under color of state law and knew and should have
15 known that their conduct or omissions created an unreasonable risk of harm to Johns. As a
16 direct and foreseeable result of these defendants' violations of plaintiff's constitutional
17 rights, plaintiff has suffered and will continue to suffer pain and suffering, emotional
18 distress and other injuries from their refusal to correct his correctable eye condition until
19 he goes completely blind. Defendants' acts were willful, intentional, wanton and in
20 conscious disregard of plaintiff's rights.
21
22
23

24 **VII.**

25 (Long v. Shah, Wong, Fuller, Songer, & Thor)

26 (§1983)

27
28 208. Defendants SHAH, WONG, FULLER, SONGER and THOR have been

1 deliberately indifferent to plaintiff Long's medical needs and have violated plaintiff Long's
2 right to be free from cruel and unusual punishment under the Eighth Amendment to the
3 U.S. Constitution. These defendants acted under color of state law and knew and should
4 have known that their conduct or omissions created an unreasonable risk of harm to Long.
5 As a direct and foreseeable result of these defendants' violations of plaintiff's
6 constitutional rights, plaintiff has suffered and will continue to suffer permanent injury of
7 incontinence as well as pain and suffering, emotional distress and other injuries from their
8 failure to provide timely and appropriate treatment and specialist referrals. Defendants
9 SHAH, WONG, FULLER, and THOR's acts were willful, intentional, wanton and in
10 conscious disregard of plaintiff's rights.

14 VIII.

15 (Rhoades v. Levin, Davis, Siegel & Wyman)

16 (§1983)

17
18 209. Defendants LEVIN, DAVIS, SIEGEL and WYMAN have been deliberately
19 indifferent to plaintiff Rhoades's medical needs and have violated plaintiff Rhoades's right
20 to be free from cruel and unusual punishment under the Eighth Amendment to the U.S.
21 Constitution. These defendants acted under color of state law and knew and should have
22 known that their conduct or omissions created an unreasonable risk of harm to Rhoades.
23 As a direct and foreseeable result of these defendants' violations of plaintiff's
24 constitutional rights, plaintiff has suffered and will continue to suffer permanent injury to
25 his hip as well as pain and suffering, emotional distress and other injuries from their failure
26 to provide timely and appropriate treatment and specialist referrals. Defendants LEVIN
27
28

1 and DAVIS's acts were willful, intentional, wanton and in conscious disregard of
2 plaintiff's rights.

3
4 **IX.**

5 (Aviles v. Songer & Castillo)

6 (§1983)

7
8 210. Defendants SONGER and CASTILLO have been deliberately indifferent to
9 plaintiff Aviles's medical needs and have violated plaintiff Aviles's right to be free from
10 cruel and unusual punishment under the Eighth Amendment to the U.S. Constitution.
11 These defendants acted under color of state law and knew and should have known that
12 their conduct or omissions created an unreasonable risk of harm to Aviles. As a direct and
13 foreseeable result of these defendants' violations of plaintiff's constitutional rights,
14 plaintiff has suffered and will continue to suffer permanent injury as well as pain and
15 suffering, emotional distress and other injuries from their failure to provide timely and
16 appropriate treatment and supplies.
17

18
19 **X.**

20 (Decasas v. Nguyen, Castillo, Sundareson, Clinton & Hepps)

21 (§1983)

22
23 211. Defendants NGUYEN, CASTILLO, SUNDARESON, CLINTON and HEPPS
24 have been deliberately indifferent to plaintiff Decasas's medical needs and have violated
25 plaintiff Decasas's right to be free from cruel and unusual punishment under the Eighth
26 Amendment to the U.S. Constitution. These defendants acted under color of state law and
27 knew and should have known that their conduct or omissions created an unreasonable risk
28

1 of harm to Decasas. As a direct and foreseeable result of these defendants' violations of
2 plaintiff's constitutional rights, plaintiff has suffered and will continue to suffer permanent
3 injury as well as pain and suffering, emotional distress and other injuries from their failure
4 to provide timely and appropriate treatment. Defendants NGUYEN, SUNDARESON, and
5 CLINTON's acts were willful, intentional, wanton and in conscious disregard of plaintiff's
6 rights.
7

8
9 **XI.**

10 (Bautista v. Richnak, Sandham & Park)

11 (§1983)

12
13 212. Defendants RICHNAK, SANDHAM, and PARK have been deliberately
14 indifferent to plaintiff Bautista's medical needs and have violated plaintiff Bautista's right
15 to be free from cruel and unusual punishment under the Eighth Amendment to the U.S.
16 Constitution. These defendants acted under color of state law and knew and should have
17 known that their conduct or omissions created an unreasonable risk of harm to Bautista.
18 As a direct and foreseeable result of these defendants' violations of plaintiff's
19 constitutional rights, plaintiff has suffered and will continue to suffer permanent impotence
20 and disfigurement that has also caused pain and suffering, emotional distress and other
21 injuries. Defendants RICHNAK and SANDHAM's acts were willful, intentional, wanton
22 and in conscious disregard of plaintiff's rights.
23
24

25
26 **XII.**

27 (Myelle v. Williams, Kofoed, Tourella, Farringer, Campbell, Calvo, Mueller, Hand and
28 Doe VI)

(§ 1983)

213. Defendants WILLIAMS, J. KOFOED, M.D., Joseph TOURELLA, M.D., MTA Michael FARRINGER, Donald CALVO, M.D., Roseanne CAMPBELL, Glenn A. MUELLER, Sandra Hand, M.D., and DOE VI have been deliberately indifferent to plaintiff Myelle's medical needs and have violated plaintiff Myelle's right to be free from cruel and unusual punishment under the Eighth Amendment to the U.S. Constitution. These defendants acted under color of state law and knew and should have known that their conduct or omissions created an unreasonable risk of harm to Myelle. As a direct and foreseeable result of these defendants' violations of plaintiff's constitutional rights, plaintiff has suffered and will continue to suffer permanent impotence and disfigurement that has also caused pain and suffering, emotional distress and other injuries. Defendants KOFOED, TOURELLA, and FARRINGER's acts were willful, intentional, wanton and in conscious disregard of plaintiff's rights.

VIII. PRAYER FOR RELIEF

WHEREFORE, the named plaintiffs and the class they represent request that this Court grant them the following relief:

- (a) Declare the suit is maintainable as a class action pursuant to Federal Rule of Civil Procedure 23(b)(1) and 23(b)(2);
- (b) Adjudge and declare that the acts, omissions, policies, and conditions described above are in violation of the Eighth and Fourteenth Amendments, which grant constitutional protection to the plaintiffs and the class they represent;
- (c) Adjudge and declare that the acts, omissions, policies, and conditions

1 described above are in violation of the ADA and § 504;

2 (d) Preliminarily and permanently enjoin defendants DAVIS, GAGE,
3 PRESLEY, ROCHA and STEINBERG, their agents, employees and all persons acting in
4 concert with them, from subjecting the named plaintiffs and the class they represent to the
5 unconstitutional and unlawful acts, omissions, policies, and conditions described above;

6 (e) Award only the named plaintiffs monetary damages, compensatory
7 and punitive, in an amount to be determined at trial;

8 (f) Award plaintiffs the costs of this suit, and reasonable attorneys' fees
9 and litigation expenses pursuant to 42 U.S.C. § 1988, 29 U.S.C. § 794a(b), and 42 U.S.C.
10 § 12205;

11 (g) Retain jurisdiction of this case until defendants have fully complied
12 with the orders of this Court, and there is a reasonable assurance that defendants will
13 continue to comply in the future absent continuing jurisdiction; and

14 (h) Award such other and further relief as the Court deems just and
15 proper.

16 Dated: August __, 2001

17 Respectfully submitted,

18 _____
19 DONALD SPECTER

20 Attorney for Plaintiffs