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UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

SAN JOSE DIVISION

K.D., a Minor by and through her Guardian ad Litem, JAMES DE LA PENA, and as Successor in Interest to KRISTA DeLUCA, Deceased,

Plaintiff,

vs.

COUNTY OF SANTA CRUZ, SANTA CRUZ SHERIFF'S OFFICE, SHERIFF-CORONER JIM HART, UNDERSHERIFF JEREMY VERINSKY, CHIEF DEPUTY JEFF MARCH, LIEUTENANT KELLY KENT, CALIFORNIA FORENSIC MEDICAL GROUP, INC., and DOES 1 to 25,

Defendants.
_____________________________________/

Case No.

COMPLAINT FOR WRONGFUL DEATH AND DAMAGES BASED ON:

1. **42 U.S.C. § 1983, Wrongful Death;**
2. **42 U.S.C. § 1983, Survival; and**
3. **Negligence**

JURY TRIAL DEMANDED

JURISDICTION

1. This action arises under 42 U.S.C. § 1983. Jurisdiction is conferred upon this Court by 28 U.S.C. §§ 1331 and 1343. This Court also has supplemental jurisdiction over Plaintiff's state-law cause of action under 28 U.S.C. § 1367.

2. Venue is proper in the Northern District of California pursuant to 28 U.S.C. § 1391(b) because the unlawful acts and practices alleged herein occurred in the County of Santa Cruz, California, which is within this judicial district.

PARTIES

3. Plaintiff K.D., is the minor child of the Decedent, KRISTA DeLUCA. She is represented in her individual capacity by her Guardian ad Litem, JAMES DE LA PENA. Plaintiff is a citizen of the United States residing in the County of Santa Cruz, California. As the sole heir, K.D. is the successor-in-interest to DeLUCA, and is represented in her capacity as the successor in interest by her Guardian ad Litem DE LA PENA.

4. Defendant COUNTY OF SANTA CRUZ ("COUNTY") is a local governmental entity duly organized and existing under the laws of the State of California, and is responsible for the actions, omissions, policies, procedures, practices and customs of its various agents and agencies, including Defendant SANTA CRUZ SHERIFF'S OFFICE ("SCSO"). The COUNTY and the SCSO operate the Santa Cruz County Main Jail ("Jail"), located at 259 Water Street, Santa Cruz. Defendant JIM HART is the COUNTY's Sheriff-Coroner, Defendant JEREMY VERINSKY is the SCSO's Undersheriff, Defendant JEFF MARCH is the SCSO's Chief Deputy and head of its Corrections Bureau, and Defendant KELLY KENT is an SCSO lieutenant assigned to supervise the day-to-day operations of the Jail. Each is sued in his individual capacity as a supervisor who either directed his subordinates, set in motion a series of acts by his subordinates, or knew or reasonably should have known and failed to stop acts by his subordinates that deprived the Plaintiff or the Decedent of a constitutional right, as alleged herein.

5. Defendant CALIFORNIA FORENSIC MEDICAL GROUP, INC. ("CFMG") is a private, for-profit, medical services corporation qualified to do business in California. As

alleged herein, as a cost-cutting measure on September 17, 2012, the COUNTY and the SCSO contracted with CFMG, purportedly to provide medical services to the Jail's inmates. In doing the acts alleged herein CFMG, and its agents and employees, acted under color of state law as the agent of the COUNTY and SCSO.

6. Plaintiff is ignorant of the true names and capacities of Defendant DOES 1 through 25, and therefore sues these Defendants by such fictitious names. Plaintiff is informed and believes and thereon alleges that each DOE so named was employed by Defendant COUNTY, the SCSO or CFMG at the time of the conduct alleged herein and acted within the course and scope of that employment and under color of state law. On information and belief, each Defendant DOE was responsible for the training, supervision and/or conduct of the Jail employees and/or agents alleged herein and was either negligent, recklessly indifferent to, or deliberately indifferent to the medical condition of the Decedent, and is therefore responsible for and caused the acts and injuries alleged herein. Plaintiff will amend this complaint to state the names and capacities of Defendants sued herein as DOES 1 through 25 when they have been ascertained.

7. Each Defendant proximately caused and is otherwise responsible for the unlawful conduct and resulting harm by, among other things, personally participating in the conduct, or acting jointly and in concert with others who did so, by authorizing, acquiescing, condoning, acting, omitting or failing to take action to prevent the unlawful conduct, by promulgating or failing to promulgate policies and procedures pursuant to which the unlawful conduct occurred, by failing and refusing to initiate and maintain proper and adequate policies, procedures and protocols, and by ratifying and condoning the unlawful conduct performed by agents and officers, deputies, medical providers and employees under their direction and control.

8. Whenever and wherever reference is made in this Complaint to any act by Defendants, each Defendant was the agent of the others, was acting within the course and scope of this agency, and all acts alleged to have been committed by any one of them

shall also be deemed to mean the acts and failures to act of each named Defendant and DOE Defendant individually, jointly or severally, and as failing to intervene to prevent the wrongful conduct of another and the resulting injury to Plaintiff or the Decedent.

EXHAUSTION OF ADMINISTRATIVE REMEDIES

9. Plaintiff has complied with all applicable requirements for the state-law causes of action. Through her guardian ad litem, without counsel, Plaintiff filed the required claim pursuant to Cal. Gov't Code § 910 timely, which was denied on December 17, 2015, making this lawsuit timely. Subsequently, Plaintiff filed an amended claim through her guardian ad litem, with counsel, prior to the expiration of the six-month statutory period. That claim, which is the operative claim for the purposes of this litigation, has not been acted upon. As more than 45 days have passed since the filing of the amended claim, this lawsuit is therefore both ripe and timely under each tort claim.

STATEMENT OF FACTS

The COUNTY and the SCSO Contract Inmate Health Care to CFMG

10. As a cost-cutting measure, on or about September 17, 2012, the COUNTY, through its policymakers including the County Board of Supervisors, upon recommendation by then Sheriff-Coroner Phillip Wowak, contracted with CFMG to replace the Santa Cruz County Health Services Agency (SCCHSA) as the provider of inmate medical services at the Jail. The approximately $3,000,000 yearly contract was projected to save the COUNTY approximately $1,500,000 per year in inmate medical services.

11. The COUNTY hired CFMG to provide these services with objective and subjective deliberate indifference to CFMG's extensive history of allegations and lawsuits over inadequate medical care. If not already known to the COUNTY, the SCSO and its policy makers, minimal due diligence would have exposed this history. After CFMG took over medical services at the Jail, inmates died at a shocking and unprecedented rate and generated a public outcry.

12. According to state Department of Justice records, at least 72 persons committed suicide in the last decade while held in a jail served by CFMG. CFMG's population-adjusted rate for suicide and drug overdose deaths is approximately 50 percent higher than in other county jails. Most persons who died in such cases were, like DeLUCA, pretrial detainees. At least three other county's grand juries have criticized the company's role in inmate deaths. A company spokesperson has admitted that the company has settled six lawsuits in five years. Several more are pending, including a lawsuit in CFMG's home town of Monterey where the plaintiffs recently obtained a far reaching preliminary injunction enjoining CFMG's unconstitutional practices. See Hernandez v. County of Monterey, N.D. Cal. Case No. 5:13-cv-02354-PSG, Order, April 15, 2015.

13. KRISTA DeLUCA's death was not an isolated incident. Over recent years, Defendants have allowed conditions at the Jail to deteriorate, causing an environment where standards for health care are deliberately ignored and protocols for inmate safety disregarded. After an unprecedented five deaths at the Jail during an eleven-month period from August 2012 to July 2013 (there have been two more since that date) a Santa Cruz County Grand Jury formally investigated the Jail's policies and practices. In May 2014, the Grand Jury released its report, finding, among other facts, that overcrowded conditions in the main jail housing units made difficult for correctional officers to follow policies and monitor inmate safety, that there was a lack of consistent enforcement of rules and regulations by correctional officers, that record keeping requirements were lax and many procedures went undocumented, that the COUNTY provided inadequate counseling time with inmates, and that inmate safety was at risk because the COUNTY failed to have a comprehensive protocol manual or individualized inmate treatment plans at the Jail. The Grand Jury released a follow up report on "Medical Services at the Jails" in 2015, and a third report on this death on June 8, 2016.

14. The Grand Jury investigations found lax standards and shocking indifference. Six of the seven Jail deaths investigated by the Grand Jury took place after

CFMG assumed responsibility for Jail medical care in September 2012, and resulted from CFMG's deliberate indifference to coordinating inmate health care with THE C0UNTY and the SCCHSA.

15. Most of the Grand Jury's recommendations, including "The Sheriff-Coroner should designate qualified personnel to oversee the medical services contract provisions and compliance with standards," and "The Sheriff-Coroner should obtain independent oversight of its jail medical services by medically qualified personnel," were rejected by the COUNTY and the SCSO.

16. Defendants had, and have a mandatory duty of care to properly and adequately hire, train, retain, supervise, and discipline its officer and medical employees so as to avoid unreasonable risk of harm to inmates. Defendants, each and all of them, failed to take necessary, proper, or adequate measures in order to prevent the violation of Decedent's and Plaintiff's rights, the suffering and death of Decedent, and injuries and damages to Plaintiff. Defendants breached their duty of care to citizens in that they failed to adequately train, supervise and discipline their medical personnel employees, in the exercise of professional standards of care of withdrawing patients; deputy sheriffs and officers, DOES 1-25, inclusive, in the proper detention and supervision of inmates undergoing withdrawals at the Jail. This lack of adequate supervisorial training demonstrates the existence of a custom, practice and policy of promoting, tolerating, and/or ratifying with objective and subjective deliberate indifference ongoing failures in monitoring inmates, including DeLUCA.

17. Defendants COUNTY and CFMG failed to promulgate appropriate policies, guidelines and procedures and have failed to rectify improper practices and customs with regard to the monitoring and treatment and/or health and safety of Jail inmates undergoing withdrawals. The failures include, but are not limited to, a failure to meet legal, national/professional and medical standards relating to the medical care of inmates by transporting them to appropriate hospitals for evaluations by licensed physicians and other

appropriate medical providers, a failure to ensure that medical professionals' recommendations regarding proper treatment setting are followed, a failure to ensure that the staff engage in proper and required welfare checks of inmates, a failure to ensure adequate medical treatment and measures are taken; a failure to maintain adequate medical staff for the Jail, and a deliberate failure to maintain adequate custodial staff for the Jail.

18. The Jail's "Chemically Dependent Inmate Policy," for example did not meet the requirements of the Title 15, Section 1213, in that it failed to specify what symptoms necessitate immediate transfer to a hospital, failed to address how chemically dependent inmates are identified other than self report or staff report, and did not incorporate any objective opiate withdrawal screening tool such as the Clinical Opiate Withdrawal Scale (COWS), a simple 11 item questionnaire that provides an objective measurement of the stage and severity of an inmate's opiate withdrawal to direct treatment decision making, and lacks other necessary provisions such as specifying procedures for transferring withdrawing inmates to a hospital.

19. The contract between the COUNTY and CFMG deliberately and foreseeably creates a conflict of interest by building in a significant financial disincentive that compromises sound medical judgment. The provision, found at page 217, provides that "CFMG will pay all hospital emergency/catastrophic medical care costs up to $15,000 per inmate for each medical/surgical inpatient episode."

20. Defendants knew the substantial risk of harm caused by inadequate medical evaluation, treatment, and monitoring policies and practices in the Jail, and consciously disregarded that danger by deliberately choosing to take steps to prevent, or even diminish, the harmful effects of theses unlawful policies and practices. Defendants were thus objectively and subjectively deliberately indifferent to the risk of harm to Decedent DeLUCA created by their documented failure to operate a constitutionally adequate protocol for monitoring opiate withdrawal symptoms of inmates.

21. The Grand Jury's findings, based on documentation reviewed, testimony heard, and observations made, and the rejection by the COUNTY and the SCSO of the principal recommendations, establish a de facto policy and/or custom on the part of policymakers for COUNTY, including but not limited to the COUNTY's Board of Supervisors and Sheriff-Coroner JIM HART, of objective and subjective reckless and deliberate indifference to the health, safety and welfare of inmates, a policy and practice resulting in the death of DeLUCA, among others, while in COUNTY custody.

22. The COUNTY, through its policymakers including the Board of Supervisors and Sheriff-Coroner JIM HART, at all times relevant to the present case maintained a jail facility that was at the same time overpopulated and understaffed. Frequently, no medical provider or physician was present within the jail. Inadequate jail staffing contributed to the conditions and a de facto policy of inadequate monitoring. These conditions, known at the time to all Defendants, itself amounted to a deliberate indifference as to the constitutional right of its inmates, including DeLUCA, to adequate medical care.

The Death of KRISTA DeLUCA

23. The Decedent KRISTA DeLUCA, age 23, was addicted to opiates, but would have overcome her addiction and become clean and sober had she survived. Shortly before midnight on September 24, 2015, DeLUCA was arrested by Capitola Police Department on charges including suspicion of being under the influence of drugs, and possession of drugs and drug paraphernalia. Capitola Police transported DeLUCA to the Jail, where she was incarcerated, and therefore under Defendants' custody and control, until her death on the morning of September 29, 2015.

24. DeLUCA informed Defendants during her booking on the morning of September 25, 2015 that she would be experiencing severe symptoms from opiate withdrawal. Defendants knew she was an addict from her prior arrest history and incarcerations at that jail. Corrections staff referred DeLUCA to medical staff after correctly identifying her as an "at risk inmate" based on her "Pre-Detention Medical Evaluation."

Following the booking process Defendants placed DeLUCA into general population, Unit G, rather than into a medical ward. Shortly thereafter DeLUCA began experiencing withdrawal symptoms including vomiting, sweats, chills, headaches and general misery. Callously, Defendants did not place DeLUCA on even their minimal opiate detoxification protocol until the following evening, September 26, 2015, when she was already suffering from severe withdrawal symptoms.

25. The next day, September 27, 2015, DeLUCA informed the correctional officers that she was having shortness of breath and could not stop vomiting. A CFMG nurse examined her. DeLUCA pleaded to be taken to the hospital for evaluation by a doctor, where she could receive proper treatment. Instead, Defendants moved DeLUCA into an observation cell located in the booking area of the jail and gave her some Gaterade and breathing exercises, as if she was a reality television actor at yoga class.

26. DeLUCA's condition continued to deteriorate. Early the next afternoon, September 28, 2015, a CFMG physician's assistant (PA) was notified concerning the uncontrollable vomiting. Rather than examine the patient, however the PA prescribed an injection and left her in the Jail.

27. Later that day, Defendants moved DeLUCA to 0 Unit, which is a medical observation housing area of the jail, but is not an infirmary. DeLUCA needed IV hydration, but received nothing other than water and more Gatorade. DeLUCA's cell was located within an area that could be monitored by non-recorded video surveillance, viewable by the assigned correctional officer. Safety checks performed by the correctional officers were required only every 30 minutes. During these checks DeLUCA was observed to be getting even sicker, with uncontrolled vomiting. At 5:00 a.m., a CFMG nurse gave DeLUCA a suppository to control her vomiting, but did not even bother charting her vital signs, and again -- having been instructed not to transport inmates to the hospital on CFMG's dime -- left DeLUCA in her vomit covered cell.

28. On September 29, 2015, shortly before 7:00 a.m., Defendant Correction Officer Ballinger, who was assigned to supervise inmates in 0 Unit, found DeLUCA unresponsive. Jail staff called 911 for medical assistance. Santa Cruz Fire Department and American Medical Response arrived at the scene, and Paramedic Daniel O'Brien declared DeLUCA dead in her cell at 7:28 a.m.

29. The COUNTY's Medical Examiner, Stephany Fiore, M.D., determined the cause of DeLUCA's death to be "acute aspiration pneumonia, dehydration, and probable electrolyte imbalance due to protracted vomiting associated with opiate withdrawal." In other words, Defendants allowed this young mother to puke herself to death in a jail cell without getting her any meaningful medical attention, much less a life-saving trip to the hospital. At least CFMG saved the $15,000 hospital charge.

30. Defendants' objective and subjective deliberate and reckless indifference to withdrawing inmates generally and to DeLUCA's medical condition in particular was the actual and proximate cause of her death. Had DeLUCA been transported to Dominican Hospital as she repeatedly requested, she would not have died in the Jail. Staff at the Jail who interacted with her knew she was at serious risk of death or great bodily harm due to opiate withdrawal and failed to take the most basic steps to protect her. Instead, they placed her in an ordinary cell, leaving her isolated and alone with only a non-recorded, video monitoring system, and was checked, at best, only every 30 minutes by the jail attendant.

31. DELUCA's death was the proximate result of Defendants' failure to reasonably supervise and care for her and refusing to transport her to Dominican Hospital where she would have gotten the care she needed, especially having been on notice of her history of opiate use and heroin addiction, including while in custody.

32. At all times herein mentioned, Defendants COUNTY, SCSO and CFMG maintained policies or de facto unconstitutional customs and practices of permitting, ignoring and condoning: (1) failure of Jail personnel to provide adequate medical

evaluation and treatment for the protection of the health or safety of Jail inmates; (2) failure to properly monitor and treat inmates, which includes inadequate intake, screening, evaluation, diagnosis, referral to medical providers, including physicians, treatment plans, administration of medications, medical record keeping, staffing, communication between medical, mental health and custodial staff, housing, supervision, and access to medical health care; and (3) failure to supervise or at minimum unconstitutionally "lax supervision," failure to report, investigate, and reprimand Jail personnel for their wrongful conduct.

33. Each policy, custom or practice of Defendants COUNTY, SCSO and CFMG posed a substantial risk of serious harm to DeLUCA, and Defendants COUNTY, SCSO and CFMG, through their policymakers knew their policies, practices and customs posed this risk, given that the risk was obvious and longstanding.

34. As a result of the objective and subjective deliberate indifference, reckless and/or conscious disregard of the misconduct by Defendants COUNTY, SCSO and CFMG, through their policymakers, and/or each of them, allowed Jail personnel to continue their custom and practice of deliberate indifference unchecked, resulting in the violation of the Plaintiff's and Decedent's rights as alleged herein.

35. The acts, omissions and deliberate indifference of COUNTY decision makers, including high ranking SCSO officials, DEFENDANTS Sheriff-Coroner JIM HART, Undersheriff JEREMY VERINSKY, Chief Deputy JEFF MARCH, and Lieutenant KELLY KENT them resulted in the deprivation of Plaintiff's and the Decedent's constitutional rights. These customs, practices or policies were the legal cause of the Decedent's death and Plaintiff's injuries, and each individual Defendant acting in accord with this custom, policy or practice acted with deliberate indifference to the needs of persons such as DeLUCA, who was in the custody and care of Defendants.

DAMAGES

36. As a result of the Defendants' conduct alleged herein, Plaintiff K.D. in her individual capacity has lost the support, love and companionship of her mother. Plaintiff

was physically, mentally, emotionally and financially injured and damaged as a proximate result of DeLUCA's wrongful death, including, but not limited to, the loss of decedent's familial relationships, comfort, protection, companionship, love, affection, solace, and moral support.

37. Plaintiff has been deprived of DeLUCA's financial support. In addition to these damages, Plaintiff is entitled to recover for the reasonable value of funeral and burial expenses.

38. As a result of the Defendants' objective and subjective deliberate and reckless indifference to the Decedent's federal constitutional rights, as alleged herein, the Decedent sustained pre-death pain and suffering and lost the enjoyment of life, general damages that survive her death under federal civil-rights law and are recoverable by Plaintiff under her 42 U.S.C. § 1983 claims in her capacity as DeLUCA's successor in interest.

39. Each individual DEFENDANT and CFMG acted recklessly or with callous indifference to DeLUCA's life threatening physical and medical condition and to the Decedent's and Plaintiff's constitutional rights. Plaintiff, as Decedent's successor in interest, is therefore entitled to an award of punitive damages against each individual Defendant and against CFMG in particular.

40. Plaintiff found it necessary to engage the services of private counsel to vindicate their rights, and the rights of Decedent, under the law. Plaintiff is therefore entitled to recover all attorneys' fees incurred in relation to this action pursuant to 42 U.S.C. § 1988.

FIRST CAUSE OF ACTION

(Fourth, Eighth and Fourteenth Amendments, 42 U.S.C. § 1983)

(PLAINTIFF INDIVIDUALLY AGAINST ALL DEFENDANTS)

41. Plaintiff hereby re-alleges and incorporates by reference all preceding paragraphs of this Complaint.

42. As set forth above, the Decedent and Plaintiff were subjected to deprivation of rights by all Defendants acting under color of law of the State of California and of the County of Santa Cruz, which rights include, but are not limited to, the Fourth, Eighth and Fourteenth Amendment rights to appropriate and reasonable medical care while in custody as a Jail inmate.

43. By reason of the aforementioned acts, these Defendants, and each of them, due to their objective and subjective deliberate indifference to Jail inmates and drug addicts generally, and to DeLUCA in particular, have violated the constitutional rights and liberty interests of Decedent DeLUCA, including those provided in the Fourth, Eighth and Fourteenth Amendments to the U.S. Constitution, giving Plaintiff the right to recover compensatory damages for the wrongful death of her mother, the Decedent.

44. Because Defendants' wrongful conduct served no legitimate law enforcement purpose and shocks the conscience, Defendants deprived Plaintiff of her rights under the Fourteenth Amendment to familial relationships without due process of law, entitling her to the special, general and punitive damages alleged above.

SECOND CAUSE OF ACTION

(Survival action: Violation of Decedent's Civil Rights

Under the Fourth, Eighth and Fourteenth Amendment, 42 U.S.C. § 1983)

(PLAINTIFF AS SUCCESSOR IN INTEREST AGAINST ALL DEFENDANTS)

45. Plaintiff hereby re-alleges and incorporates by reference herein all preceding paragraphs of this Complaint.

46. The foregoing claim for relief arose in Decedent's favor, and Decedent would have been the Plaintiff with respect to this claim if she had lived.

47. As alleged above, the Decedent was subjected to deprivation of rights by all Defendants acting under color of law of the State of California and of the County of Santa Cruz, which rights include, but are not limited to, privileges and immunities secured to

Decedent by the Constitution and laws of the United States, including the right to reasonable and appropriate medical care while in custody as a jail inmate.

48. By reason of the aforementioned acts, these Defendants, and each of them, due to their deliberate indifference to the health and welfare of Jail inmates generally and to that of DeLUCA in particular, have violated the constitutional rights and liberty interests of Decedent DeLUCA, including those provided in the Fourth, Eighth and Fourteenth Amendments to the U.S. Constitution, causing the Decedent to experience pain and suffering and to lose the enjoyment of life, damages recoverable under the Federal Civil Rights Act against all Defendants, and entitling Plaintiff to recover punitive damages against the individual Defendants and CFMG.

THIRD CAUSE OF ACTION

(Negligence)

(PLAINTIFF INDIVIDUALLY AGAINST ALL DEFENDANTS)

49. Plaintiff hereby re-alleges and incorporates by reference herein all preceding paragraphs of this Complaint.

50. Defendants, and each of them, failed to exercise ordinary care in the medical evaluation, treatment and care of the Decedent, proximately causing her death in the Jail.

51. Defendants, and their agents and employees, knew or had reason to know that DeLUCA was in need of immediate medical care and failed to take reasonable action to summon such medical care in a timely manner.

52. As a direct and proximate cause of the aforementioned acts of Defendants, Plaintiff lost the support, love, comfort and society of her mother, the Decedent, as hereinabove alleged.

PRAYER

WHEREFORE, PLAINTIFF prays for relief, as follows:

1. For general damages in a sum according to proof;
2. For special damages in a sum according to proof;

3. For punitive damages in a sum according to proof;
4. For leave to amend or supplement the Complaint as the identity of the Doe defendants is discovered and new evidence is uncovered;
5. For reasonable attorney's fees pursuant to 42 U.S.C. § 1988;
6. For cost of suit herein incurred; and
7. For such other and further relief as the Court deems just and proper.

Dated: June 10, 2016

CARTWRIGHT, SCRUGGS, FULTON & WALTHER
THE LAW OFFICES OF JOHN BURTON

/s/ G. Dana Scruggs, Esq.
G. Dana Scruggs, Attorneys for Plaintiff

JURY DEMAND

Plaintiff hereby demands a jury trial in this action.

Dated: June 10, 2016

CARTWRIGHT, SCRUGGS, FULTON & WALTHER
THE LAW OFFICES OF JOHN BURTON

/s/G. Dana Scruggs, Esq.
G. Dana Scruggs, Attorneys for Plaintiff