

5B Am. Jur. Pl. & Pr. Forms Civil Rights § 18.13

American Jurisprudence Pleading and Practice Forms Annotated

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Civil Rights

II. Redress For Violation Of Civil Rights, Generally

B. General Forms

[Topic Summary](#) [Correlation Table](#)

§ 18.13. Complaint in federal court—Violation of civil rights and Americans with Disabilities Act of 1990—For compensatory and punitive damages, and attorney's fees

UNITED STATES DISTRICT COURT

FOR THE *[NAME OF DISTRICT]* OF *[NAME OF STATE]*

[Name of party 1],
[Title of party 1],

v.

[Name of party 2],
[Title of party 2].

Case No. *[case number]*

[Name of document]

COMPLAINT

Plaintiffs, *[names of plaintiffs]*, allege:

JURISDICTION AND VENUE

1. Plaintiffs have suffered injuries due to the wrongful actions of the Defendants, *[names of defendants]*, and this action is a case or controversy over which this court has jurisdiction under Article III of the United States Constitution.

2. This case is brought pursuant to [42 U.S.C.A. § 1983](#), with pendent state claims. Jurisdiction is based on [28 U.S.C.A. § 1331](#) and [§ 1343](#). This court has jurisdiction over the state law claims.

3. Venue is proper in this court under [28 U.S.C.A. § 1391\(b\)](#), because the claims for relief arose in this District.

4. Plaintiffs have complied with *[citation of state statute]*, the *[name of state]* tort claims statute, in that they timely filed their tort claim with the *[name of state]* Board of Control. The claim was denied on *[date of denial]*.

PARTIES

5. Decedent, *[name of deceased]* (“Decedent”), is represented in this litigation by the Estate of *[name of deceased]*. The successor in interest and personal representative for decedent is *[his/her] [wife/husband], [name of spouse]*. Decedent was at all times mentioned incarcerated at the Substance Abuse Treatment Facility (“SATF”) at *[location of facility]*. Decedent died as a result of the unlawful actions of the above-named Defendants. Decedent brings this complaint for relief through his Estate and *[his/her] [wife/husband], [name of spouse]*, who is *[his/her]* successor in interest, *[his/her] [son/daughter], [name of child]* and *[his/her] [son/daughter] [name of child]*.

6. Plaintiffs, *[names of decedent's immediate family members]*, are residents of *[name of city], [name of state]*. They bring their claims for relief as successors in interest to the Estate of *[name of decedent]* as defined in *[citation of state statutes]*.

7. Defendants, *[names of other children of decedent]*, are children of Decedent, and are named solely as nominal defendants. Each could join as a plaintiff, but does not wish to do so.

8. During all times mentioned, Defendant *[name of director 1]* was the Director of the *[name of state]* Department of Corrections (“DC”), a government agency funded by the taxpayers of *[name of state]* to incarcerate and punish those who are convicted of felonies committed within *[name of state]*. The DC is a recipient of federal financial assistance as defined by 42 U.S.C.A. § 2000d (“Title VI”) and the regulations promulgated by the United States Departments of Justice and Health and Human Services implementing that statute. The DC is under an obligation to obey the laws of *[name of state]* and the United States. As a condition of receiving federal financial assistance, DC has an obligation to obey civil rights laws, including 42 U.S.C.A. §§ 2000d et seq., 42 U.S.C.A. §§ 2000cc-1 et seq., *[citation of state statute]* and the regulations that implement those laws, including an obligation not to discriminate by race, national origin, color or ethnic group identification. Defendant *[name of director 1]* is sued in *[his/her]* individual capacity and as a former employee of the DC. At all times mentioned, Defendant *[name of director 1]* acted within the course and scope of *[his/her]* employment and under color of law.

9. As Director of the DC, Defendant *[name of director 1]* was responsible for the administration and application of statewide DC policies, and was ultimately responsible for the operation of all of *[name of state]*'s prison facilities, including SATF. Defendant *[name of director 1]* was responsible for decisions concerning staff employment and training, and the preparation, selection and implementation of policies, procedures and guidelines concerning the protection of prisoners from medical, physical, and psychiatric abuse. Defendant *[name of director 1]* was also responsible for the conduct of the employees and contractors at SATF, including SATF custodial and medical staff. The decisions made regarding policies for the protection of inmate physical safety, and the medical and psychiatric policies by Defendant *[name of director 1]* directly affected the Decedent's ability to be safe from physical abuse, and medical and psychiatric indifference and abuse.

10. Defendant, *[name of director 2]*, is and at all times mentioned was the Director of Health Services for the DC. *[He/She]* is sued in *[his/her]* individual capacity and as an employee of DC. At all times mentioned, Defendant *[name of director 2]* was responsible for policies and practices regarding the delivery of health care services to inmates which had a direct impact on inmates in the custody of DC.

11. Defendant, *[name of warden]*, acted under the supervision of Defendant *[name of director 1]*. In the capacity of Warden, Defendant *[name of warden]* was responsible for the daily operation of the mentioned prison. Defendant *[name of warden]* is sued in *[his/her]* individual capacity and as an employee of the DC. At all times mentioned, Defendant *[name of warden]* acted within the course and scope of *[his/her]* employment and under color of law. Defendant *[name of warden]* was responsible for the implementation of policies and procedures related to the role of custody staff in the protection and treatment of inmates at SATF, and was responsible for the conduct of the employees and contractors at SATF, including SATF custodial and medical staff. Defendant *[name of warden]* was also responsible for: the training, supervision and discipline of custody staff regarding

issues of the proper protection and treatment of inmates at SATF; ensuring access to interpreters for mono-lingual inmates; the discipline of staff whose negligence or misconduct contributed to an inmate's physical or mental mistreatment, death, or suicide; ensuring custody staff received mental health training and ethnic sensitivity training; ensuring adequate mental and medical staffing at SATF; compliance with the Suicide Prevention and Response Program Policies and Procedures; the Corrective Action Plan; implementation and compliance with hunger strike protocols; and, ensuring, along with the Chief Psychologist the availability of sufficient escorts to allow emergency access of clinicians to inmates.

12. Defendant, *[name of chief medical officer]*, was at all times mentioned the head physician at SATF, performing *[his/her]* duties under the supervision of Defendants *[names of directors]*. Defendant *[name of chief medical officer]* was responsible for the development of policies and procedures to provide prisoners at SATF with adequate medical care pursuant to the Eighth Amendment of the United States Constitution and other applicable law. Defendant *[name of chief medical officer]* was responsible for the training and supervision of medical staff at SATF to ensure they provided adequate medical care, including care that was immediately responsive to medical emergencies. Defendant *[name of chief medical officer]* is sued in *[his/her]* individual capacity and as an employee of the DC. At all times mentioned, Defendant *[name of chief medical officer]* acted within the course and scope of *[his/her]* employment and under color of law.

13. Defendants, *[names of staff physicians]*, each was at all times mentioned a physician at SATF performing *[his/her]* duties under the supervision of Defendant *[name of chief medical officer]*. Defendants *[names of staff physicians]* were responsible for the adequate provision of medical care to the inmate population at SATF pursuant to the Eighth Amendment of the United States Constitution and other applicable law. Defendants *[names of staff physicians]* are each sued in *[his/her]* individual capacity and as an employee of the DC. At all times mentioned each of Defendants *[names of staff physicians]* acted within the course and scope of *[his/her]* employment and under color of law.

14. Defendants, *[names of staff psychologists]*, were at all times mentioned psychologists at SATF performing their duties under the supervision of Defendants *[names of directors]*, and were responsible for the development of policies and procedures to provide prisoners at SATF with adequate psychological care at SATF pursuant to the Eighth Amendment of the United States Constitution and other applicable law. Each was responsible for the training and supervision of mental health care staff at SATF to ensure they provided adequate mental health care, including care that was immediately responsive to mental health emergencies such as suicidal tendencies and actions. The Chief Psychologist and the psychologists generally are responsible for ensuring the integrity and thoroughness of medical records and/or charts, and for ensuring cooperation between medical and custody staff. They are also responsible, with the Warden, for ensuring the availability of sufficient escorts to allow emergency access of clinicians to inmates, and for providing adequate mental and medical staffing at SATF. They are responsible for ensuring compliance with the Suicide Prevention and Response Program Policies and Procedures; the Corrective Action Plan; and the adherence to the hunger strike protocols. The Chief Psychologist and the staff psychologists generally were responsible for ensuring mental health assessments were adequately completed; for ensuring patients saw their case manager on a quarterly basis; for ensuring meetings were held consistent with Program Guidelines; for ensuring mentally ill prisoners had treatment plans; and for the establishment and maintenance of an interdisciplinary management model in which clinical and custody supervisory staff develop a good working relationship. Further, Defendant *[name of staff psychologist 1]* was Decedent's mental health case manager responsible for the continuity of *[his/her]* mental health care and assessment. The Chief Psychologist and other psychologists were responsible for ensuring inmates who needed it were seen daily by a psych tech, and were provided weekly clinical contact. Each is sued in his and/or her individual capacity and as an employee of the DC. At all times mentioned, each acted within the course and scope of *[his/her]* employment and under color of law.

15. Defendant, *[name of chief psychiatrist]*, was at all times mentioned the Chief Psychiatrist at SATF under the supervision of Defendant Directors, and was responsible for the development of policies and procedures to provide prisoners at SATF with adequate psychiatric care at SATF pursuant to the Eighth Amendment of the United States Constitution and other applicable law.

Defendant *[name of chief psychiatrist]* was responsible for the training and supervision of mental health care staff at SATF to ensure they provided adequate mental health care, including care that was immediately responsive to mental health emergencies such as suicidal tendencies and actions. Defendant *[name of chief psychiatrist]* was responsible for ensuring adequate mental and medical staffing at SATF. Defendant *[name of chief psychiatrist]* was responsible for ensuring compliance with the Suicide Prevention and Response Program Policies and Procedures; the Corrective Action Plan; and adherence to and implementation of the hunger strike protocols. The Chief Psychiatrist was responsible for ensuring continuity of psychiatric care; for providing psychiatric care in a timely manner; and for the establishment and maintenance of an interdisciplinary management model in which clinical and custody supervisory staff develop a good working relationship. Defendant *[name of chief psychiatrist]* is sued in *[his/her]* individual capacity and as an employee of the DC. At all times mentioned, Defendant *[name of chief psychiatrist]* acted within the course and scope of *[his/her]* employment and under color of law.

16. Defendant, *[name of psychiatrist]*, was at all times mentioned a psychiatrist at SATF under the supervision of Defendant *[name of chief psychiatrist]*. Defendant *[name of psychiatrist]* was responsible for the provision of adequate psychiatric care at SATF pursuant to the Eighth Amendment of the United States Constitution and other applicable law. Defendant *[name of psychiatrist]* is sued in *[his/her]* individual capacity and as an employee of the DC. At all times mentioned, Defendant *[name of psychiatrist]* acted within the course and scope of *[his/her]* employment and under color of law.

17. Defendant, *[name of captain]*, is, and at all times mentioned was, the Captain of D Facility at SATF, and in that capacity is an employee of the DC. At all times mentioned, Defendant *[name of captain]* acted within the course and scope of *[his/her]* employment and under color of law. Defendant *[name of captain]* was responsible for the implementation of policies and procedures related to the role of custody staff in the protection and treatment of inmates at D Facility at SATF.

18. Defendant, *[name of lieutenant]*, is, and at all times mentioned was, a Correctional Lieutenant at SATF, and in that capacity is an employee of the DC. At all times mentioned, Defendant *[name of lieutenant]* acted within the course and scope of *[his/her]* employment and under color of law. Defendant *[name of lieutenant]* was responsible for the implementation of policies and procedures related to the role of custody staff in the protection and treatment of inmates at D Facility at SATF.

19. Defendants, *[name of correctional officer 1]*, *[name of correctional officer 2]*, *[name of correctional officer 3]* are, and at all times mentioned were, employed with the DC as Correctional Officers at SATF, and in that capacity each of these Defendants was an employee of the DC. At all times mentioned, each of these Defendants acted within the course and scope of his/her employment and under color of law. Each of these Defendants had the responsibility to protect the health and safety of the inmates within *[his/her]* charge.

20. Defendants, *[name of correctional officer 4]*, *[name of correctional officer 5]*, are, and at all times mentioned were, employed with the DC as Correctional Officers at SATF, and in that capacity each of these Defendants was an employee of the DC. At all times mentioned, each of these Defendants acted within the course and scope of *[his/her]* employment and under color of law. Each of these Defendants had the responsibility to protect the health and safety of the inmates within his or her charge.

21. The names of other officers, health care providers, medical lab personnel, staff and other DC personnel involved in the incidents out of which this Complaint arises, and those officers, staff and personnel responsible for supervision, training, and determination of policy whose acts or omissions were material to the unlawful death of the Decedent are at this time unknown to Plaintiffs, and consequently Plaintiffs sue these Defendants under the fictitious names of DOES 1 through 50, inclusive. Plaintiffs will amend this Complaint to allege the true names and capacities when ascertained. Plaintiffs are informed and believe and on that basis allege that each of the fictitiously named Defendants is liable in the manner set forth below for the acts and omissions concerning the events and happenings referred to, which proximately caused damages and injuries to Plaintiffs.

22. The named Defendants are sued in their individual capacities and as employees of *[name of state]*. At all times mentioned, the named Defendants were acting within the course and scope of their employment and under state law.

23. Plaintiffs are informed and therefore believe and on that basis allege that at all times and places mentioned each of the Defendants was the agent, representative and/or employee of the remaining Defendants, and was at all times and places mentioned acting within the purpose and scope of that agency, representation and/or employment except for those Defendants named solely as necessary parties: *[names of necessary party defendants]*.

24. The events giving rise to this Complaint occurred in *[name of county]*, *[name of state]*, within the jurisdiction of the United States District court for the Eastern District of *[name of state]*.

FACTUAL ALLEGATIONS COMMON TO ALL CLAIMS FOR RELIEF

25. The allegations in this section are alleged on Plaintiffs' information and belief and on that basis are alleged to be true.

Decedent's Background

26. The Decedent was born on *[date of birth]*, in Punjab Province, India. He was a life-long practicing Sikh, and a priest in the Sikh religion. Mr. Singh's religious dietary restrictions prohibited eating meat or eggs, and from eating any other food that was on the same plate as meat. Also, his religious practice included the wearing of a beard and turban, and never cutting his hair. Mr. Singh's only language was the Punjabi language; he did not speak, read or write in English.

27. At *[number of years]* years of age, the Decedent was an “elder” within the meaning of *[citation of state statute]*.

Conditions of Incarceration

A. General Summary

28. The events described in this Complaint occurred from *[beginning date of events]*, until the Decedent's death on *[date of death]*, at the *[name of state]* Department of Correction's facility (“SATF”) in *[name of city]*, *[name of state]*, where the Decedent was incarcerated following his convictions for violations of *[citation of state statute]* in *[month of convictions]* *[year of convictions]*.

29. At SATF, the Decedent was housed in a “sensitive needs unit,” Facility D5, which included inmates who were either disabled or required protective custody. The Decedent was assigned to this unit because he was disabled and in a wheelchair because of a deformed left foot, did not speak English, and had a conviction for child molestation.

30. In the early stage of his incarceration in Facility D5, the Decedent went to the dining hall regularly and treated other inmates with respect. He always wore his turban, and was extremely neat and clean. Despite the language barrier, the Decedent was friendly and well-behaved. Many inmates liked him for his gentle ways. As a disabled prisoner, he was entitled to the assistance of other inmates who had been trained to assist the disabled. It was essential to his profound and deeply felt religious beliefs, and to his priesthood, that he eat a vegetarian diet, shower before prayers, read from his religious texts, and pray frequently.

31. Throughout his incarceration at SATF, the Decedent never received the level of medical and mental health diagnosis, medication or treatment he needed and which Defendants were constitutionally required to provide. Because of the way he was treated by the Defendants, the Decedent gradually exhibited increasing signs of severe depression and possible suicidal ideation, yet a comprehensive treatment plan for his physical and mental health was never developed. Instead, because of the nature of his conviction, his ethnicity, and his religious beliefs, he was deliberately either mistreated or ignored by the Defendants.

32. Throughout his incarceration, the Decedent repeatedly refused his legal mail because it was in English. Each time he refused his mail, he received a disciplinary violation instead of being provided with an interpreter who could read his mail for him. As a consequence, he was ignorant of his legal status except when his appellate lawyer communicated with him through an interpreter.

33. Throughout the relevant time period, the Decedent was the target of physical abuse and verbal harassment as a result of his conviction, his nationality and his religion, as well as his physical and lingual disabilities.

34. Despite his requests and those of medical staff, the Decedent was never able to get a vegetarian diet at SATF, and various correctional officers, including but not limited to Defendant *[name of correctional officer 4]*, would often interfere in his efforts to be served only vegetables at meal times. As a consequence the Decedent gradually lost weight and his physical and mental health deteriorated.

B. Chronological History of Medical, Mental and Physical Abuse

35. On *[date of placement]*, the Decedent was placed in administrative segregation because he had defecated on himself and refused to wash. This occurred on subsequent occasions as well, probably as a result of the Decedent's medical condition. However, he was never provided a translator to explain why this was occurring, or why he was subject to the subsequent disciplinary action or process.

36. On *[date of beating]*, the Decedent was beaten in his cell by inmate *[name of inmate]*. Inmate *[name of inmate]* had a history of assaulting other inmates, and he was placed in the Decedent's cell knowing that he had this history and that he was likely to physically assault the Decedent, who weighed less than *[number of pounds]* pounds and who was disabled. As a result of this assault, the Decedent was confined to his quarters and then cleared for a return to general population on *[date of return]*. It is unknown who was responsible for placing inmate *[name of inmate]* in the Decedent's cell.

37. On *[date of discipline]*, the Decedent was disciplined again for defecating on himself. He was disciplined without being present at the disciplinary proceeding because it was said he needed assistance to attend and no assistant was available, nor was a translator available. The disciplinary hearing was informed that the Decedent was unable to care for his basic human needs and should be rehoused in a more medically appropriate setting. The Decedent was referred to the clinic, but the doctor,

Defendant *[name of physician 1]*, refused to see him. No one took action on the request that more appropriate medical housing be found for the Decedent.

38. Staff were aware that after *[date of beating]* the Decedent was unable to care for himself, would not leave his cell for meals, and was taken to his shower by a volunteer inmate. Again, it was observed that the Decedent needed to be transferred to a medical facility.

39. By *[date of admission]*, the Decedent had been admitted to the Correctional Treatment Facility (CTF) at *[location of facility]* for psychiatric problems, including depression and a refusal to eat. A mental health assessment was conducted without use of a translator, a process that could not provide accurate or thorough information. The Decedent was diagnosed with depression and prescribed a minor tranquilizer.

40. On *[date of interview]*, through an interpreter, the Decedent said he was not suicidal or depressed. The Decedent stayed at CTF until *[date of termination]* because there were no beds available in general population. It was recommended that he receive a regular diet, but no dairy. This diet was never followed. He initially refused to return to general population, but was told through an interpreter that he had to go.

41. The Decedent was put on suicide watch from *[range of dates]*. While communication was difficult, according to staff, the Decedent indicated he would not kill himself, but that he had not eaten for several days.

42. On *[date of notice]*, custody staff were notified that the Decedent had not eaten for *[number of days]* days.

43. On *[date of assessment]*, defendant psychologist *[name of psychologist 1]* did not complete a mental health assessment or conduct a suicide risk assessment of the Decedent, because of the lack of a translator. Nonetheless, the Decedent was removed from the mental health program on *[date of removal]*. Defendant psychologist *[name of psychologist 1]* did not make arrangements to conduct an assessment with a translator.

44. On *[date of assault]*, Defendant Correctional Officer *[name of correctional officer 1]* violently forced the Decedent into a shower, physically assaulting the Decedent in the process. Afterwards when the Decedent was taken to be medically cleared, he was unable to communicate because of the failure to provide a translator.

45. The following day, *[date of admission]*, Defendant *[name of physician 2]* admitted the Decedent to CTF because he was not eating. It was concluded he was on a hunger strike and suffering from starvation. The medical plan was to motivate the Decedent to care for himself better. Defendant *[name of physician 2]* did nothing to protect the Decedent; *[he/she]* did not place him on suicide watch; *[he/she]* did not ask for a complete mental health assessment; and *[he/she]* did not invoke hunger strike protocols.

46. On *[date of discharge]*, Defendant *[name of physician 3]*, the Decedent's physician, discharged him back to the yard without any treatment or plan for treatment. Defendant *[name of physician 3]*'s response to the Decedent was deliberately indifferent to his medical and mental health needs. While in the CTF, the Decedent had received a liquid diet from *[range of dates]*. Medical records noted that no one had been able to communicate with him during this time because of the language barrier.

47. On *[date of request]*, Defendant *[name of physician 4]* also requested that the Decedent be put on the yard over the objections of the watch commander, who said he should not be moved. The Decedent was transferred to the yard the same day. Defendant *[name of physician 4]* did nothing to provide for the Decedent's mental health or medical needs.

48. On *[date of extraction]*, the Decedent was violently extracted from his cell by five correctional officers, supervised by Defendants *[names of correctional officers 1]*, *[names of correctional officers 6]*, because the Decedent refused to leave his cell until resolution of issues regarding the denial of his legal mail, hearings, visits and other matters. An interpreter told him those issues would be addressed if he came out of his cell, but the Decedent refused and was “fighting”. At the time of the extraction, the Decedent weighed less than *[number of pounds]* pounds. During this cell extraction, the Decedent was brutalized and suffered injury.

49. After the cell extraction, the Decedent was readmitted to the CTF where he was put in five-point restraints and placed in an observation cell. Defendant *[name of psychologist 2]*, without use of an interpreter, conducted an examination. Based on staff statements, *[he/she]* noted that the Decedent did not shower, clean his toilet, or remove trash from his cell; and wore a turban made from a shower towel, was agitated, and believed that staff were “after him.” Defendant *[name of psychologist 2]*'s diagnosis was paranoid schizophrenia and a delusional disorder. Defendant *[name of psychologist 2]* did nothing to conduct an adequate medical assessment of the Decedent; *[he/she]* did not ask for an interpreter; *[he/she]* did not conduct a psychiatric assessment; and *[he/she]* never spoke with *[his/her]* patient.

50. On *[date of assessment]*, a mental health assessment was completed by Defendant *[name of psychologist 3]*, again without the aid of an interpreter, in which the Decedent was found to be illogical, argumentative, controlling, paranoid, and having poor insight, judgment, and reality contact. Defendant *[name of psychologist 3]* did nothing to conduct an adequate medical assessment of the Decedent; *[he/she]* did not ask for an interpreter; *[he/she]* did not conduct a psychiatric assessment; and *[he/she]* never spoke with *[his/her]* patient.

51. Also on readmission to CTF, an interdisciplinary care plan and team review concluded that the Decedent was anxious with delusional thoughts and reality distortion. It determined that all staff were responsible to help the Decedent become free from delusion. Nothing was done in response to this interdisciplinary care plan and team review.

52. The Decedent remained at CTF until *[date of termination]*. While at CTF, the Decedent's religious books were taken from him, yet one of the stated goals of treatment was to get staff to not argue with the Decedent about his religious beliefs. Recommendations were made to discuss with custody staff the Decedent's language and cultural barriers, and his adjustment disorder and safety concerns. Nothing was done to follow this recommendation, and no one ever discussed with staff the problems the Decedent was encountering. The Decedent appeared to improve when he was in the CTF. Nevertheless, on *[date of order]*, after noting his social isolation as a result of his incarceration and his language barrier, the Decedent was ordered back to his regular cell with psychiatric follow-up.

53. The Decedent was taken to the emergency room on *[date of visit]* based on a report that he had not eaten in two or three days. There was no translator available, and he was returned to his cell on a verbal order by Defendant *[name of chief medical officer]*. Defendant *[name of chief medical officer]* was aware that the Decedent had not been eating, but *[he/she]* did nothing to protect the Decedent; *[he/she]* ordered no follow-up; *[he/she]* did no assessment; *[he/she]* did not order a special diet; and *[he/she]* did nothing to help the Decedent, who was obviously in gravely deteriorating health as a result of his failure to eat.

54. On *[date of request]*, the Decedent requested a mental health intervention in a letter written in Punjabi. A consultation on *[date of consultation]* with psychologist Defendant *[name of psychologist 3]* was aborted because of the absence of an interpreter, but on *[date of assessment]*, Defendant *[name of psychologist 3]* had an interpreter and completed an assessment. A treatment plan was formulated in which the Decedent was to learn to communicate “non-verbally.” The Decedent was diagnosed as having chronic depression, an adjustment disorder, and an obsessive compulsive personality disorder with narcissistic and paranoid characteristics. The Decedent's rigidity and self-centeredness were identified as the causes for his failure to adapt. Further, as he was a vegetarian, it was noted that he needed more grains and vegetables in his diet. He was to have a follow-up every 90 days. None of this was done: the Decedent never received an altered diet, and follow-ups were not conducted every 90 days.

55. On *[date of prayer]*, Defendant *[name of psychologist 3]* observed the Decedent at prayer in his cell and concluded that he was “probably as devout as he claims,” and that he did not show any of the signs of mental illness Defendant *[name of psychologist 3]* had previously identified on *[date of examination]*. Defendant *[name of psychologist 3]* then concluded the Decedent did not need the CCCMS program and summarily discharged him from mental health treatment. Thus, Defendant *[name of psychologist 3]* had gone from diagnosing the Decedent as severely psychotic to describing him as mentally healthy within a period of slightly more than a month.

56. On *[date of assessment]*, the Decedent had a medical assessment which found he was not clinically malnourished. Through an interpreter, the Decedent said he would prefer a vegetarian diet and Defendant *[name of physician 6]* ordered a vegetarian diet for him. However, Defendant *[name of physician 6]*'s medical assessment was incorrect.

57. The Decedent went to classification on *[date of visit]*, and was told through an interpreter, *[name of interpreter]*, about his poor work record and a referral to the medical department was made for an assessment on work restrictions.

58. Also on *[date of visit]*, the Decedent was seen by Defendant *[name of psychologist 3]*, and he admitted he suffered from mild depression because he had problems getting vegetarian food and could not shower before prayers.

59. On *[date of review]*, the Decedent had his annual review. Again he requested follow-up on his vegetarian diet. The committee said this would be followed up by his counselor, *[name of counselor]*. This was never done.

60. On *[date of affirmance]*, the Decedent's conviction was affirmed by the court of appeal. Prior to the conclusion of the appellate process, the Decedent's appellate lawyer talked with SATF administration about the Decedent's need for a vegetarian diet.

61. On *[date of order]*, a physician again ordered a vegetarian diet due to the Decedent's religious practice. The Decedent was never provided with a vegetarian diet, and he continued to deteriorate because he could not eat what was provided without violating his religious beliefs.

62. On *[date of assault]*, Defendant *[name of correctional officer 3]* saw the Decedent in the dining hall with a towel on his head as a makeshift turban. Defendant *[name of correctional officer 3]* grabbed the Decedent's towel from off his head and threw it away. Defendant *[name of correctional officer 3]* also complained that the Decedent held up the food line by asking that meat be removed from his tray and that the Decedent had been told this was impermissible. Defendant *[name of correctional officer 3]* noted that someone needed to find a way to communicate to the Decedent about how the program worked in D facility.

63. On *[date of report]*, Defendant *[name of correctional officer 4]* wrote that *[he/she]* was unable to communicate with the Decedent, whose work *[he/she]* supervised. Defendant *[name of correctional officer 4]* complained that the Decedent did not do his work even though he could do personal cleaning. Defendant *[name of correctional officer 4]* gave him an unsatisfactory work performance evaluation. Defendant *[name of correctional officer 4]* was motivated by *[his/her]* dislike of the Decedent; *[he/she]* disliked him because of his conviction, his religion and his ethnic identity. Defendant *[name of correctional officer 4]* believed the Decedent was somehow associated with Islamic extremism.

64. On *[date of examination]*, Defendant *[name of correctional officer 7]* took the Decedent to medical for a check-up because he had not been going to the dining hall. The Decedent said he was no longer going to meals because he was not allowed to wear his turban there. Defendant *[name of correctional officer 7]* helped negotiate an agreement that the Decedent could wear his turban to the dining hall, remove it to have it checked and then put it back on and wear it while eating. However, this agreement was not followed by other correctional staff, which prohibited the Decedent from going to the dining hall wearing his turban. The Decedent gave up on the dining hall because his religion prohibited him from taking off his turban for any length of time.

65. On *[date of examination]*, RN *[name of nurse]* found that the Decedent was “wasting away,” noting that he was not on a hunger strike, but he was not going out to meals. She spoke with him through Defendant *[name of correctional officer 7]*. The Decedent had lost *[number of pounds]* pounds in the prior week. *[Name of nurse]* noted that the Decedent suffered “anorexia due to vegetarian diet.” Defendants' medical personnel were put on notice that the Decedent was not eating and was dying of malnutrition, but they did nothing.

66. On *[date of assault]*, Defendants *[name of correctional officer 4]*, *[name of correctional officer 5]* put inmate *[name of inmate]*, who had a history of in-custody assaults, in the Decedent's cell. The inmate then beat the Decedent. Defendant *[name of correctional officer 5]* shared, and acted on, the same dislike for and biases against the Decedent that Defendant *[name of correctional officer 4]* had.

67. When the Decedent's family came for a visit in *[month of visit]* *[year of visit]*, Defendant *[name of correctional officer 4]* closed his cell door without using an interpreter to inform him of his family's presence. Instead, Defendant *[name of correctional officer 4]* told the visiting staff that the Decedent had refused his visit.

68. On *[date of visit]*, Defendant *[name of psychologist 4]*, apparently a psychologist, without an interpreter saw the Decedent at his cell on a staff complaint. Defendant *[name of psychologist 4]* found the Decedent “praying and gesturing wildly,” but could not evaluate him absent an interpreter and recommended he be seen by a physician in a week. Defendant *[name of correctional officer 4]* erroneously concluded that, at the time, the Decedent did not present a mental health issue.

69. When his family visited him, the Decedent would show them bruises he received at the hands of guards at SATF. He said that he was given food with meat, and that sometimes the officers would kick his plate away. He told them about a particular guard who harassed him, tore up his belongings, berated him, called him “Bin Laden” and made his existence intolerable. The family had enormous difficulty visiting. They were treated badly, and sometimes they had to wait for hours. The family's attempts to find out the Decedent's status were rebuffed by staff, and throughout the Decedent's incarceration at SATF, the family was unable to obtain information about his health and well-being. In *[month and year of conversation]*, they were told that the Decedent refused to see them. The Decedent last spoke with his family on *[date of conversation]*. He told them he was dying.

70. On *[date of visit]*, Defendant *[name of psychologist 4]* again went to see the Decedent in his cell. While the Decedent stated he was not depressed and did not need mental health intervention, his hygiene was “notably decreased.” Defendant *[name of psychologist 4]* also noted that the Decedent was thin, withdrawn and refusing to eat, but erroneously found no further referral was needed. Defendant *[name of psychologist 4]* recommended discharge “when applicable” to general population.

71. On *[date of another assault]*, Defendant *[name of correctional officer 4]* willfully slammed the Decedent's hand in the cell door, and told Defendant *[name of correctional officer 3]* not to allow the Decedent any medical care for the severe injury. Thereafter, the Decedent never left his cell, stopped eating, and steadily lost weight.

72. On *[date of request]*, Defendant *[name of correctional officer 5]* requested psychiatric intervention because the Decedent had not eaten or showered for 30 days.

73. On *[date of visit]*, Defendant *[name of psychologist 3]* went to the Decedent's cell, but did not complete an assessment because the Decedent refused to leave his cell. Previously, Defendant *[name of psychologist 6]*, apparently a psychiatrist, had refused to see the Decedent unless he came to the clinic, and since the Decedent would not leave his cell, he was not assessed. The Decedent received no treatment for his deteriorating physical and mental health, including suicide watch or appropriate protocols for a hunger strike.

74. At his annual review on *[date of review]*, the Decedent requested follow-up on the loss of his property and his previous requests for a vegetarian diet. At this review, the Decedent was again admonished for having a poor work performance. Again, nothing was done about his property, and nothing was done about his diet.

75. On *[date of contact]*, Defendant *[name of correctional officer 5]* contacted medical staff to advise them that the Decedent had not eaten for two weeks. On *[date of refusal]*, the Decedent again refused to leave his cell for a medical appointment. Defendant *[name of acting chief medical officer]*, acting chief medical officer, and Defendant *[name of physician 5]*, the yard doctor, were both notified of his refusal. They did nothing in spite of the Decedent's known deterioration.

76. On *[date of notice]*, an inmate notified administrators that the Decedent had stopped eating, and other inmates attempted to help by bringing him food. Various inmates wrote to state legislators, the Civil Rights Division of the ADA in Washington, D.C., and to The Prison Law Office, about the Decedent's plight.

77. On *[date of discovery]*, the Decedent was discovered nonresponsive in his cell. He was removed to the hospital where he died on *[date of death]*, as a result of self-starvation and cardiac arrest.

C. Specific Abuse by Defendants *[Names of Correctional Officers]*

78. For approximately a year prior to his death, and especially after the events of “9/11,” the Decedent was repeatedly and increasingly abused, threatened and insulted by Defendants *[names of correctional officers]* and others assigned to the Decedent's housing unit.

79. The Decedent was abused and harassed by Defendants *[names of correctional officers]* and others in the following ways: At some point, the Decedent was given the job of porter which he was unable to perform because of his language and physical barriers. On that basis, Defendant *[name of correctional officer 4]*, who supervised the porters, berated and harassed the Decedent, and when the Decedent could not fulfill Defendant *[name of correctional officer 4]*'s instructions, Defendant *[name of correctional officer 4]* would lock him in his cell. On occasion, defendant *[name of correctional officer 4]* told the Decedent, a Sikh priest, to take the "towel" off of his head. On another occasions, Defendant *[name of correctional officer 4]* called the Decedent a "Taliban," "Bin Laden" and "rag head." Other officers and inmates joined in this harassment.

80. In addition, Defendant *[name of correctional officer 4]* told Americans With Disabilities (ADA) inmate helpers not to give assistance to the Decedent, and harassed any ADA helper who continued to help the Decedent. *[He/She]* further told ADA helpers to fabricate records of assisting the Decedent.

81. Defendant *[name of correctional officer 4]* battered the Decedent by hitting him in the head. On a day when there had been an earthquake, Defendant *[name of correctional officer 4]* went into the Decedent's cell and threw him to the ground, and on one occasion pushed him back into his cell. The Decedent responded to this treatment by putting his hands together in prayer position, then bowed and retreated. On another occasion, Defendant *[name of correctional officer 4]* destroyed the Decedent's religious altar before which he prayed. Also, Defendant *[name of correctional officer 4]* ripped the turban off of the Decedent's head, which was then made from a sheet, and forced him to sign a trust account withdrawal to pay for the torn sheet. Defendant *[name of correctional officer 4]* would taunt the Decedent by asking him to come out of his cell, and then slamming the door before he could get out.

82. Defendant *[name of correctional officer 4]* mistreated any inmate who befriended the Decedent, and the inmates began to divide into those who were on Defendant *[name of correctional officer 4]*'s side, and those who befriended the Decedent. Defendant *[name of correctional officer 4]* had enormous power over inmates' lives. If *[he/she]* was resisted, *[he/she]* would search inmates' cells, disturb or remove their property and destroy their belongings. Defendant *[name of correctional officer 4]* engaged in a pattern of abusing many of the inmates in Facility D5, and then retaliated against them if they complained. This conduct was brought to the attention of other staff and administrators, who did nothing.

83. Defendant *[name of correctional officer 5]*, as the control booth officer, would frequently refuse to allow the Decedent to leave his cell to go eat, or to go to the yard and sit in the shade, or to leave his cell to use the telephone. Part of Defendant *[name of correctional officer 5]*'s job duties included knowing what was going on in the unit, and *[he/she]* was aware that the Decedent was not eating.

84. The administrators of SATF, including Defendant *[name of warden]*, Defendant *[name of chief medical officer]* and Does 1-10, were aware of Defendant *[name of correctional officer 4]*'s psychological instability and brutality against inmates, some of them helpless to defend themselves. Inmates filed numerous appeals alleging brutality, insults and endangering conduct by Defendant *[name of correctional officer 4]*.

85. A group of officers and other staff at SATF, called "The Green Wall," have systematically engaged in brutality, threats and intimidation of inmates. Many of these officers were previously employed at *[name of state prison]* State Prison where they learned and used abusive behaviors with administrative approval. They have exhibited a focused dislike of persons convicted of child molestation, such as the Decedent. Defendant *[name of correctional officer 4]* was a participant in Green Wall activities, and *[his/her]* motives for brutalizing the Decedent flowed from *[his/her]* shared dislike and unrestrained hostility toward persons

convicted of child molestation, and his belief that the Decedent was somehow associated with Muslim extremism. After the Decedent died, one of these officers said, “We have one less child molester to worry about.”

86. Prior to the Decedent's death on *[date of death]*, the abuse he suffered was a long and continuous course of misconduct. His death resulted in the discovery of this history of abuse. An investigation of these incidents was conducted by the Office of Internal Affairs and apparently the allegations were found to not be sustained. On information and belief, Plaintiffs allege the investigation was a mere cover-up which was assisted by members of the *[name of state]* Correctional Peace Officers' Association (CPOA) acting according to the union's policies and procedures to protect their members from truthful allegations of brutality and terrorist abuse of inmates.

87. Since the Decedent's death, numerous inmates have come forward to talk about what happened to the Decedent. Because they have spoken to the Plaintiffs' lawyers about the pattern of abuse inflicted on the Decedent, as well as the lack of adequate medical and mental health care at SATF generally, they have consistently suffered serious retaliation and reprisal at the hands of guards and their supervisors at SATF.

FIRST CLAIM FOR RELIEF (Violation of 42 U.S.C.A. § 1983) Denial of Rights under the United States Constitution, Eighth and 14th Amendments; Deliberate Indifference to Medical and Mental Health Needs

88. Defendant *[name of warden]*, as Executive Director of SATF, was responsible for establishing and implementing policies, practices and procedures designed to assure that plaintiff, as an inmate, at SATF, received adequate dental/medical attention and treatment.

89. However, defendant *[name of warden]*'s policy, practice and procedure was not designed to assure that plaintiff, as an inmate, at SATF, received adequate medical attention and treatment, in that *[description of inadequate medical attention and treatment]*.

90. Thus, Defendant *[name of warden]* adopted a policy, practice, procedure which defendant *[name of executive director]* knew, or reasonably should have known would be ineffective in delivering adequate medical attention and treatment for serious needs.

91. Defendant *[name of warden]* was acting under color of state law in implementing the described practice and custom for the SATF.

92. Defendant *[name of warden]*'s conduct violated plaintiff's substantive right to due process under the 14th Amendment to the United States Constitution, in that it denied plaintiff adequate dental/medical care and treatment.

SECOND CLAIM FOR RELIEF (Violation of 42 U.S.C.A. § 1983) Failure to Train, Supervise and Discipline Employees

93. Plaintiffs incorporate by reference all of the preceding paragraphs as if set forth here in full, and as a second claim for relief allege.

94. Defendant administrative and supervisory personnel were charged by law with the selection, assignment, supervision and training of officers, psychiatrist technicians, medical staff, employees, and contracted medical practitioners of the *[name of state]* Department of Corrections. At all times material, they failed properly to train and supervise DC and SATF personnel regarding DC policy and procedures, and state and federal statutory duties to provide inmates with necessary and appropriate medical and mental health services and to respond to prisoners' apparent immediate needs for mental and or medical treatment.

95. Defendants *[names of directors]*, Defendant *[name of chief psychologist]*, Defendant *[name of chief psychiatrist]*, Defendant *[name of chief medical officer]*, Defendant *[name of warden]*, and other Defendants, knew or in the exercise of reasonable care should have known that the personnel of SATF were inadequately trained to provide necessary and appropriate mental health services to inmates with a history of severe depression or to respond to a prisoner on a hunger strike, or who refuses to leave his cell for any reason, including for meals and showers. The above-named administrative personnel negligently and carelessly trained and supervised SATF personnel in policies, procedures and other methods of providing inmates with necessary and appropriate mental health services, and to respond to a prisoner's refusal to eat. These Defendants knew or in the exercise of reasonable care should have known that the failure to train and supervise, and/or negligent training and supervision, were likely to cause injury and/or death to prisoners incarcerated at SATF. The above-named Defendants failed to properly train, monitor or supervise staff in the policies and procedures for providing necessary mental health services to inmates, and the necessary precautions to circumvent possible physical danger to inmates in their care. This lack of adequate training, monitoring, and supervision was the legal and actual cause of the death of the Decedent. The failure of Defendants to provide training and supervision regarding the statutory and constitutional duties to provide safe custody for inmates entrusted to their care, and to provide necessary and adequate mental health services amounts to gross negligence and a deliberate indifference to the safety and lives of inmates. This gross negligence was a proximate cause of the death of the Decedent.

96. The administrative and supervisory Defendants had the power and authority to discharge or reassign sworn personnel of SATF who were or were believed to be emotionally unstable, inadequately trained or experienced, untrustworthy, and prone to disregard *[his/her]* duty to protect the safety of those inmates entrusted to *[his/her]* care, or to provide necessary and adequate mental, or medical health care services which were in accordance with the sound principles of practice, or otherwise exhibited tendencies, traits of character, behavior, habits, conduct or attitudes which rendered such sworn personnel unfit or undesirable for the positions of correctional officers for assignment to duties involving contact with the inmate population sentenced to imprisonment in state prison. In spite of this knowledge and responsibility, the administrative and supervisory Defendants negligently and carelessly employed, assigned, and retained DC employees and negligently and carelessly failed to properly supervise, assign, and discipline DC employees. The acts and omissions of the above-named Defendants were malicious, fraudulent and oppressive, with the wrongful intention of injuring Plaintiffs, with an improper and evil motive amounting to malice, and in conscious disregard for their well being.

97. Further, the acts and omissions by Defendants as to the Decedent were malicious, fraudulent and oppressive, and were committed with the wrongful intention of injuring and killing the Decedent, from an improper and evil motive amounting to malice, and in conscious disregard of his rights.

98. As a result of the actions of all Defendants, the Decedent was not provided adequate or necessary medical and mental health services which resulted in the Decedent's death by starvation and caused him great physical pain and suffering, great mental pain and shock to his nervous system, and, ultimately, death.

99. The physical and emotional injuries suffered by decedent were the result of the named and unnamed Defendants' recklessness, oppression, fraud and/or malice in commission of their abuse of him. The Plaintiff Estate of the Decedent is therefore entitled to punitive damages for the pain and suffering he experienced prior to his death.

**THIRD CLAIM FOR RELIEF (Violation of 42 U.S.C.A. § 1983)
Denial of Rights Under the 14th Amendment: Family Relations**

100. Plaintiffs incorporate by reference all of the preceding paragraphs as if set forth in full, and allege as a third claim for relief:

101. By reason of the described acts and omissions, Plaintiffs suffered the loss of the family relationship with the Decedent. Defendants and each of them denied this right through a failure to train, supervise and discipline employees working under them; denied this right through a violation of the Decedent's Eighth Amendment rights; and denied this right through a failure to assist the Decedent with mental health care services and/or medical health care services in preventing his prolonged suffering and eventual death by starvation, all to Plaintiffs' damage as set forth below.

FOURTH CLAIM FOR RELIEF (Violation of the Americans with Disabilities Act of 1990)

102. Plaintiffs incorporate by reference the preceding paragraphs as if set forth in full and as a fourth claim for relief allege:

103. The Department of Justice (DOJ) was delegated by Congress with the authority to promulgate regulations implementing the ADA. 42 U.S.C.A. § 12134(a). The DOJ's regulations provide that "all programs, services, and regulatory activities relating to law enforcement, public safety, and the administration of justice, including courts and correctional institutions" are governed by the ADA. 28 C.F.R. § 35.190(b)(6). Under the language of the ADA and the DOJ's regulations, the ADA is applicable to SATF as a state correctional institution.

104. Title II of the Americans with Disabilities Act ("ADA") prohibits the exclusion of persons with disabilities from participating in, or denying the benefits of, the goods, services, programs and activities of the entity or otherwise discriminating against persons on the basis of disability. 42 U.S.C.A. § 12132.

105. The Decedent was a disabled person as defined under 42 U.S.C.A. § 12131(1).

106. Pursuant to the obligations of the ADA, Defendants were to provide the Decedent as a mobility-impaired inmate with the means to access meals, medical services, showers, disciplinary hearings and other services.

107. Defendants failed to provide the Decedent with a requested assistant to facilitate the Decedent's access to these services, and failed to accommodate the Decedent's disability by repeatedly punishing the Decedent for not exiting his cell quickly enough to go to the day room, chow hall or for visits and instead shutting the cell door so quickly that the Decedent had to remain in his cell. On one occasion Defendants [*name of correctional officers 4*], [*name of correctional officers 5*] slammed the door on the Decedent's hand as he was trying to exit his cell.

108. On another occasion, a disciplinary hearing proceeded in the Decedent's absence despite staff's knowledge that the Decedent could not appear because there was no one to assist him in getting to the hearing. As a result the Decedent was found guilty of the charges and punished.

109. Defendants' failure to provide the Decedent with an assistant or other means of accommodation so that he could access the day room, dining hall, showers, medical services, disciplinary hearings, or visits, as set forth above, constituted unlawful and intentional discrimination on the basis of disability in violation of Title II of the ADA. Defendants' failure to comply with their obligations under the ADA contributed to the physical and mental demise of the Decedent, through isolation, intimidation, and exclusion. These acts and omissions ultimately resulted in the Decedent's death, all to Plaintiffs' damage as set forth below.

FIFTH CLAIM (Pendent State Claim under [Citation of State Statute]) ELDER ABUSE

110. Plaintiffs incorporate by reference the preceding paragraphs as if set forth in full and as a sixth claim for relief allege:

111. The Decedent was an elder within the meaning of *[citation of state statute]*.

112. As is detailed above, the Decedent was denied medical care, mental health care, and emergency services by Defendant care providers, health practitioners, and correctional staff, in violation of *[citation of state statute]*.

113. As a consequence of the abuse he suffered, the Decedent was put in imminent danger of death.

114. Further, the fear, agitation, confusion, severe depression and other forms of serious emotional distress brought about by Defendants' intimidating behavior and by Defendants' refusal to assist the Decedent was motivated by a malicious intent to agitate, confuse, frighten, or cause the serious emotional distress of an elder, Decedent. As a result of Defendants' actions and omissions, the Decedent suffered severe emotional distress in the weeks, days and hours leading to his death, in violation of *[citation of state statute]*.

115. Defendants have been guilty of recklessness, oppression, and/or malice in the commission of **elder abuse** which led to the death of the Decedent and, as a consequence, Plaintiffs are entitled to punitive damages, attorney fees, and costs.

SIXTH CLAIM FOR RELIEF (Pendent State Claim—Failure to Provide Medical Care [Citation of State Statute])

116. Plaintiffs incorporate by reference all of the preceding paragraphs as if set forth in full, and as a seventh cause of action allege:

117. Defendants each had the duty to provide immediate medical care to the Decedent who suffered a serious and obvious medical condition. Staff and other inmates repeatedly complained to Defendants that the Decedent had not eaten for a long period of time but Defendants failed and/or refused to summon any medical care to address the Decedent's serious and obvious medical condition. When medical staff was summoned to the Decedent's cell, there was no effort made to assess the Decedent's

condition and no interpreter was utilized, making communication with the Decedent impossible, and resulting in the complete failure to provide the Decedent with any adequate medical intervention.

118. Despite Defendants' actual and/or constructive knowledge of the Decedent's desperate need for medical care, Defendants failed or refused to provide the Decedent with any adequate medical assistance.

119. As a legal and proximate result of Defendants' refusal to provide adequate medical care, the Decedent suffered great physical pain, great mental pain, shock to his nervous system, and, ultimately, death, all to Plaintiffs' damage as set forth below.

120. The Defendants have been guilty of recklessness, oppression, and/or malice in the commission of the **elder abuse** which led to the death of the Decedent and, as a consequence, Plaintiffs are entitled to punitive damages, attorney's fees, and costs.

REQUEST FOR RELIEF

As a proximate result of Defendants' wrongful and unlawful actions described above, Plaintiffs request the following:

1. Mortuary, funeral and burial expenses, and incidental expenses not yet fully ascertained;
2. General damages as to the Decedent, including damages for physical and emotional pain, emotional distress, hardship, suffering, shock, worry, anxiety, sleeplessness, illness and trauma and suffering, and, for Plaintiffs the loss of the services, society, care and protection of the Decedent;
3. Punitive damages according to proof;
4. Prejudgment interest;
5. Pain and suffering and punitive damages from the individual correctional officers, medical personnel and DC staff involved for Plaintiff Estate.
6. Attorney fees and costs.
7. Such other and further relief as the court deems just and proper.

Dated: *[date of complaint]*

_____ *[Name of attorney for plaintiffs]*

Notes

West's Key Number Digest

West's Key Number Digest, [Civil Rights](#) 🔑 1301 et seq.

Legal Encyclopedias

Deprivation of rights under color of state law. [Am. Jur. 2d, Civil Rights §§ 62 et seq., 148 et seq.](#)

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