

UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF KENTUCKY
NORTHERN DIVISION AT COVINGTON

WILLIAM J. BRAMBLE, JR.
5247 Madison Pike
Independence, KY 41051,

and

CLARK BYERS
5247 Madison Pike
Independence, KY 41051,

and

MARTHA CAMACHO
1419 Kendall Street
Covington, KY 41011,

and

JOHN C. CHAMBERS
829 Central Avenue
Newport, KY 41071,

and

STEVEN HALPIN
4917 Virginia Ct.
Taylor Mill, KY 41015,

and

BRYAN HUFFMAN
5247 Madison Pike
Independence, KY 41051,

and

DOUG MENNING
117 Main Street
Newport, KY 41071,

and

Case No. 2:10-CV-_____

(Judge _____)

(Magistrate Judge _____)

CLASS ACTION COMPLAINT
WITH REQUEST FOR DAMAGES,
DECLARATORY AND
INJUNCTIVE RELIEF, AND WITH
JURY DEMAND

KEN STINSON :
5549 Cleander Drive :
Cincinnati, OH 45238, :

Plaintiffs, :

vs. :

CAMPBELL COUNTY, KENTUCKY :
24 W. 4th Street :
Newport, KY 41071, :

and :

CAMPBELL COUNTY FISCAL COURT :
24 W. 4th Street :
Newport, KY 41071, :

and :

GREG BUCKLER, Individually :
Campbell County Jailer :
601 Central Avenue :
Newport, KY 41071, :

and :

DAVE FICKENSCHER, Individually :
Campbell County Jail :
601 Central Avenue :
Newport, KY 41071, :

and :

UNKNOWN DEPUTY JAILERS 1-10 :
Campbell County Jail :
601 Central Avenue :
Newport, KY 41071, :

and :

SOUTHERN HEALTH PARTNERS, INC. :
811 Broad Street, Suite 500 :
Chattanooga, TN 37402, :
Also Serve: CT Corporation :
4169 West Port Road :

Louisville, KY 40207, :

and :

DR. RON WALDRIDGE, Individually and as :
 an employee of Southern Health Partners, Inc. :
 120 E. Main Street, No. 2108 :
 Lexington, KY 40507, :

and :

BETTY DAWES, Individually and as an :
 employee of Southern Health Partners, Inc. :
 120 E. Main Street, No. 2108 :
 Lexington, KY 40507, :

and :

JOHN OR JANE DOES 1-10, Individually :
 and as employees, agents, servants or :
 contractors of Southern Health Partners, Inc., :

Defendants. :

I. INTRODUCTION

1. This is a class action Complaint for jail misconduct giving rise to civil rights, constitutional, and pendent state law, claims. Plaintiffs William Bramble, Jr., Clark Byers, Martha Camacho, John C. Chambers, Steven Halpin, Brian Huffman, Doug Menning and Ken Stinson bring this action in their individual capacities and on behalf of all individuals who, while incarcerated at the Campbell County Detention Center (“CCDC”), either before or after any adjudication of guilt, have been denied medical attention for their serious medical needs; have been denied appropriate and necessary medication prescribed by recognized medical authorities; and have been subjected to cruel and unusual punishment, all as a consequence of Defendants’ practices and policies, and neglect and deliberate indifference.

2. Upon information and belief, numerous individuals incarcerated at CCDC have been denied medical attention for their serious medical needs, and have been denied appropriate and necessary medication prescribed by recognized medical authorities as a consequence of Defendants' policies and practices, and their neglect of and deliberate indifference to these individuals' medical needs.

3. Upon information and belief, numerous individuals currently and formerly incarcerated at CCDC have been subjected to cruel and unusual punishment as a consequence of Defendants' policies and practices, and their neglect and deliberate indifference to such individuals' constitutional rights.

4. As further detailed below, there are questions of law and fact in this case common to all affected currently and formerly incarcerated individuals at the CCDC. Plaintiffs' claims are typical of those of the class, and they will fairly and adequately protect the interests of the class.

5. The abuse, mistreatment, and civil rights and constitutional violations endemic at the CCDC are currently the subject of litigation in this Court, as detailed in *Holt, et al. v. Campbell County, et al.*, Case No. 2:09-CV-00082. The Second Amended Class Action Complaint in that case is attached hereto as Exhibit A, and incorporated herein by reference.

II. JURISDICTION AND VENUE

6. Plaintiffs, and all others similarly situated, seek recovery of actual and punitive damages from Defendants under the Civil Rights Act of 1871, 42 U.S.C. § 1983, for gross and unconscionable violations of the rights, privileges and immunities guaranteed them by the Fifth, Eighth and Fourteenth Amendments of the Constitution of the United States. Accordingly, this Court has jurisdiction over this case pursuant to 28 U.S.C. § 1331 and § 1343. Plaintiffs and the other members of the class also seek declaratory and injunctive relief, as well as damages under

the pendent jurisdiction of this Court, for negligence, gross negligence, and intentional infliction of emotional distress.

7. Venue is proper in this Court under 28 U.S.C. § 1391(a), since the events giving rise to these claims occurred in this judicial district and Defendants are subject to personal jurisdiction here.

III. CLASS ACTION

8. Plaintiffs bring this jail misconduct/civil rights action as a class action pursuant to Rules 23(b)(1), (2) and (3) of the Federal Rules of Civil Procedure. The class consists of all persons who, while incarcerated at the CCDC (both prior to and after any adjudication of guilt), have been physically or mentally abused; denied medical treatment for their serious medical needs; and denied appropriate and necessary medication prescribed by recognized medical authorities, all as a consequence of Defendants' policies and practices, and neglect and deliberate indifference.

9. It is not uncommon for jail misconduct cases to be certified as class actions.¹ Moreover, a class action is superior to other available methods for the fair and efficient adjudication of this controversy because:

- (a) a multiplicity of suits with a consequent burden on the courts and defendants should be avoided;
- (b) it may be virtually impossible for all class members to intervene as parties/plaintiffs in this action;
- (c) upon adjudication of Defendants' liability, claims of the class members can be determined by this Court.

¹ See, e.g., *Doe v. Calumet City, Illinois*, No. 87C3594, U.S. District Court for the Northern District of Illinois, Eastern Division; *Diamond, et al. v. District of Columbia*, Civil Action No. 03-2005 (E.G.S.) (D.D.C., class certified March 3, 2004); *Barham v. Ramsey, and Chang, et al. v. U.S., et al.*, 217 F.R.D. 262 (2003).

10. Courts have regularly certified classes in jail misconduct cases that are analogous to these claims, *i.e.*, challenge to a policy or pattern of conduct that affects all or an ascertainable segment of an arrestee and/or incarcerated population.² For example, numerous courts on many occasions have certified classes of pre-trial detainees subjected to unlawful strip searches.³ Judge Green of the District of Columbia District Court certified a class of all current and future women inmates in the District of Columbia Department of Corrections challenging guard-on-inmate sexual misconduct and other prison conditions under Rule 23(a), 23(b)(1) and 23(b)(2).⁴

11. Class actions are particularly suitable in civil rights cases such as this one. The purposes of class actions are to (1) avoid multiplicity of actions, and (2) enable persons to assert small claims that could not be litigated individually because the costs would far outweigh any recovery.⁵ Class actions “conserve” resources by permitting an issue potentially affecting every class member to be litigated in an economical fashion.⁶ Civil rights cases “are often by their very nature class suits involving classwide wrongs.”⁷

12. The United States Supreme Court and the appellate courts have repeatedly endorsed the class action procedure as the superior method of adjudicating cases where there are numerous claims that are too small to litigate individually.⁸ Moreover, “certain types of lawsuits, *such as those in the criminal justice area*, are inherently class actions because

² *Dellums v. Powell*, 566 F.2d 167 (D.C. Cir. 1977); *Washington Mobilization Committee v. Culinane*, 400 F. Supp. 186 (D.D.C. 1975); *Savard v. Rhode Island*, 338 F.3d 23, 31 (1st Cir. 2003).

³ *Maneely v. City of Newburgh*, 208 F.R.D. 69 (S.D.N.Y. 2002) (certification granted to class challenging policy of conducting blanket strip searches of pretrial arraignment prisoners); *Mack v. Suffolk County*, 191 F.R.D. 16, 17 (D. Mass. 2000) (certification granted to class of female arrestees challenging a policy of subjecting all female arrestees to blanket strip searches); *Johns v. DeLeonardis*, 145 F.R.D. 480 (N.D. Ill. 1992) (class certified where approximately twenty-five women was subjected to illegal strip search by Chicago police officers in a police raid).

⁴ *Women Prisoners of District of Columbia Department of Corrections v. District of Columbia*, 877 F. Supp. 634, 635 (D.D.C. December 13, 1994).

⁵ *E.g.*, *Crown, Cork & Seal Co. v. Parker*, 462 U.S. 345-349 (1983).

⁶ *General Telephone Co. of Southwest v. Falcon*, 457 U.S. 147, 155 (1982).

⁷ *East Texas Motor Freight, Inc. v. Rodriguez*, 431 U.S. 395, 405 (1977).

⁸ *See, e.g.*, *Phillips Petroleum Co. v. Shutts*, 472 U.S. 797 (1985); *Blackie v. Barrack*, 524 F.2d 891, 899 (9th Cir. 1975), cert. denied, 429 U.S. 816 (1976).

individual wrongs can be righted only by institutional reforms affecting an entire class of people.”⁹

13. Plaintiffs will fairly and adequately protect the interests of all class members. They are members of the class and their claims are typical of the claims of all class members. Plaintiffs will aggressively pursue the interests of the entirety of the class. Plaintiffs’ interests in obtaining injunctive relief and actual and punitive damages for the violations of their constitutional rights and privileges are consistent with, and not antagonistic of, those of any other persons within the class.

14. Class counsel will adequately represent the class. Counsel are experienced in handling class action litigation. For purposes of treatment of the class claims under Rule 23(b)(3), the class is manageable, notice to the class can be readily achieved, and the issue of how to treat individual damages does not predominate over the other issues raised by Plaintiffs’ claims, making class treatment of these claims superior to any other approach.

15. Given the circumstances of their incarcerations, as detailed below, Plaintiffs allege that Defendants have a policy, custom and/or practice of denying inmates medical attention for their serious medical needs; and denying appropriate and necessary medication prescribed by recognized medical authorities.

16. Such conduct violates such individual’s rights under the Fifth, Eighth and Fourteenth Amendments to the United States Constitution; violates 42 U.S.C. § 1983; and violates K.R.S. 441.025, 501 K.A.R. 3:060, and 501 K.A.R. 3:090(20). The only question that remains to be resolved is whether Plaintiffs and the members of the class are entitled to declaratory and injunctive relief, and to an award of compensatory and punitive damages and, if so, the extent of such an award.

⁹ Herbert B. Newberg and Alba Conte, *Newberg on Class Actions* (4th ed. 2002) § 25:25 (emphasis added).

IV. PARTIES

A. Plaintiffs

17. William Bramble, Jr. is a citizen and resident of Kenton County, Kentucky.
18. Clark Byers is a citizen and resident of Kenton County, Kentucky.
19. Martha Camacho is a citizen and resident of Kenton County, Kentucky.
20. John C. Chambers is a citizen and resident of Campbell County, Kentucky.
21. Steven Halpin is a citizen and resident of Kenton County, Kentucky.
22. Bryan Huffman is a citizen and resident of Kenton County, Kentucky.
23. Doug Menning is a citizen and resident of Campbell County, Kentucky.
24. Ken Stinson is a citizen and resident of Hamilton County, Ohio.

B. Defendant Campbell County

25. Defendant Campbell County, at all times mentioned herein, employed, and was responsible for the establishment of policies, customs, and practices governing the employment, training, supervision, and conduct of the officers and employees of the CCDC.

26. Defendant Campbell County, at all times mentioned herein, had a responsibility to establish policies, procedures, and customs that ensured the rights of individuals detained at the CCDC were protected, to ensure that measures were put in place to correct any known violations of inmate rights, and to not acquiesce to violations of individual's rights that were ongoing at the CCDC.

27. Defendant Campbell County, at all times mentioned herein, failed to ensure the rights of individuals detained at the CCDC were protected, failed to ensure that measures were put in place to correct any known violations of individual's rights, and willingly acquiesced to violations of individual's rights that were ongoing at the CCDC.

28. Defendant Campbell County, at all times mentioned herein, had actual knowledge of individual's rights violations stemming from numerous media reports, the volume of violations committed by its employees, agents, or servants, the severity of injuries inmates endured and continue to endure at the CCDC, and the frequent reports made by its employees, agents, or servants concerning individual's rights violations to supervisors and other appropriate bodies.

29. Defendant Campbell County violated its ministerial responsibilities including the training of deputy jailers in intake of prisoners, overseeing careful and informed medical screening of incoming prisoners, implementing the medical safety procedures enumerated in 501 KAR 3:090, supervising mandatory in person surveillance of every inmate pursuant to 501 KAR 3:060, supervising administration of necessary medications to inmates pursuant to 501 KAR 3:060, and providing a safe and habitable jail but which duties the Defendant breached all to the pain, suffering, detriment, and damage of the Plaintiffs and the Plaintiff class.

C. Defendant Campbell County Fiscal Court

30. Defendant Campbell County Fiscal Court, at all times mentioned herein, was responsible for providing and maintaining safe, secure, and clean conditions in the CCDC, and for providing a facility that complied with Ky. Rev. Stat. § 441.055 and regulations enacted pursuant thereto but which duties the Defendant breached to the detriment and damage of the Plaintiffs and the Plaintiff class.

31. Defendant Campbell County Fiscal Court, at all times mentioned herein, had a responsibility to establish policies, procedures, and customs that ensured the rights of individuals detained at the CCDC were protected, to ensure that measures were put in place to correct any known violations of inmate rights, and to not acquiesce to violations of inmate rights that were ongoing at the CCDC.

32. Defendant Campbell County Fiscal Court, at all times mentioned herein, failed to ensure the rights of individuals detained at the CCDC were protected, failed to ensure that measures were put in place to correct any known violations of inmate rights, and willingly acquiesced to violations of inmate rights that were ongoing at the CCDC.

33. Defendant Campbell County Fiscal Court violated its ministerial responsibilities including the training of deputy jailers in intake of prisoners, overseeing careful and informed medical screening of incoming prisoners, implementing the medical safety procedures enumerated in 501 KAR 3:090, supervising mandatory in person surveillance of every inmate pursuant to 501 KAR 3:060, supervising administration of necessary medications to inmates pursuant to 501 KAR 3:060, and providing a safe and habitable jail, but which duties the Defendant breached all to the pain, suffering, detriment, and damage of the Plaintiffs and the Plaintiff class.

34. Defendant Campbell County Fiscal Court, at all times mentioned herein, had actual knowledge of individual's rights violations stemming from numerous media reports, the volume of violations committed by its employees, agents, or servants, the severity of injuries inmates endured and continue to endure at the CCDC, and the frequent reports made by its employees, agents, or servants concerning individual's rights violations to supervisors and other appropriate bodies.

D. Defendant Greg Buckler

35. Defendant Greg Buckler was, at all times mentioned herein, acting individually and/or in his official capacity as Jailer of Campbell County, and as such established policies either formally or by custom and practice, and was responsible for the employment, training, supervision, and conduct of the officers and employees of the CCDC.

36. Defendant Greg Buckler, at all times mentioned herein, had a responsibility to establish policies, procedures, and customs that ensured the rights of individuals detained at the CCDC were protected, to ensure that measures were put in place to correct any known violations of individual's rights, and to not acquiesce to violations of individual's rights that were ongoing at the CCDC.

37. Defendant Greg Buckler, at all times mentioned herein, failed to ensure the rights of individuals detained at the CCDC were protected, failed to ensure that measures were put in place to correct any known violations of individual's rights, and willingly acquiesced to violations of individual's rights that were ongoing at the CCDC.

38. Defendant Greg Buckler, at all times mentioned herein, had actual knowledge of individual's rights violations stemming from numerous media reports, the volume of violations committed by employees, agents, or servants, the severity of injuries inmates endured and continue to endure at the CCDC, and the frequent reports made by employees, agents, or servants concerning individual's rights violations to him personally, to supervisors and to other appropriate bodies.

39. Defendant Greg Buckler violated his ministerial responsibilities including the training of deputy jailers in intake of prisoners, overseeing careful and informed medical screening of incoming prisoners, implementing the medical safety procedures enumerated in 501 KAR 3:090, supervising mandatory in person surveillance of every inmate pursuant to 501 KAR 3:060, supervising administration of necessary medications to inmates pursuant to 501 KAR 3:060, and providing a safe and habitable jail, but which duties the Defendant breached all to the pain, suffering, detriment, and damage of the Plaintiffs and the Plaintiff class.

E. Defendant Dave Fickenscher

40. Defendant Dave Fickenscher at all relevant times was the First Deputy Campbell County Jailer, is an agent and an employee of the CCDC and is required to abide by United States laws and regulations; Kentucky laws and regulations; the United States Constitution; and the Kentucky Constitution when executing duties as a Jailer.

41. Defendant Dave Fickenscher, was at all times mentioned herein acting individually and/or in his official capacity as a jailer of Campbell County, and as such established policies either formally or by custom and practice, and was responsible for the employment, training, supervision, and conduct of the officers and employees of the CCDC.

42. Defendant Dave Fickenscher, at all times mentioned herein, had a responsibility to establish policies, procedures, and customs that ensured the rights of individuals detained at the CCDC were protected, to ensure that measures were put in place to correct any known violations of inmate's rights, and to not acquiesce to violations of individual's rights that were ongoing at the CCDC.

43. Defendant Dave Fickenscher, at all times mentioned herein, failed to ensure the rights of individuals detained at the CCDC were protected, failed to ensure that measures were put in place to correct any known violations of inmate's rights, and willingly acquiesced to violations of inmate's rights that were ongoing at the CCDC.

44. Defendant Dave Fickenscher, at all times mentioned herein, had actual knowledge of inmate's rights violations stemming from numerous media reports, the volume of violations committed by employees, agents, or servants, the severity of injuries inmates endured and continue to endure at the CCDC, and the frequent reports made by its employees, agents, or servants concerning inmate's rights violations to supervisors and other appropriate bodies.

45. Defendant Dave Fickenscher violated his ministerial responsibilities including the training of deputy jailers in intake of prisoners, overseeing careful and informed medical screening of incoming prisoners, implementing the medical safety procedures enumerated in 501 KAR 3:090, supervising mandatory in person surveillance of every inmate pursuant to 501 KAR 3:060, supervising administration of necessary medications to inmates pursuant to 501 KAR 3:060, and providing a safe and habitable jail, but which duties the Defendant breached all to the pain, suffering, detriment, and damage of the Plaintiffs and the Plaintiff class.

F. Defendants Unknown Deputy Jailers 1-10

46. Defendants Unknown Deputy Jailers 1-10 were at all times mentioned herein acting individually in their capacities as Deputy Jailers of Campbell County, and as such established or implemented policies either formally or by custom and practice, and were responsible for the employment, training, supervision, and conduct of the officers and employees of the CCDC, or for the ministerial execution of said policies.

G. Defendant Southern Health Partners, Inc.

47. Defendant Southern Health Partners, Inc. is a Delaware corporation duly organized and authorized to conduct business in the Commonwealth of Kentucky and whose principal office address is 811 Broad Street, Suite 500, Chattanooga, TN 37402 and whose registered agent is the CT Corporation, 4169 Westport Road, Louisville, Kentucky 40207.

48. Defendant Southern Health Partners, Inc. employs the medical professionals responsible for attending to the medical needs of inmates of the CCDC, and as such established policies either formally or by custom and practice, and was responsible for the employment, training, supervision and conduct of persons responsible for medical care of inmates at the CCDC, and participated in the mistreatment of Plaintiffs as described herein.

49. Defendant Southern Health Partners, at all times mentioned herein, had actual knowledge of individual's rights violations stemming from numerous media reports, the volume of violations committed by its employees, agents, or servants, the severity of injuries inmates endured and continue to endure at the CCDC, and the frequent reports made by its employees, agents, or servants concerning inmate rights violations to supervisors and other appropriate bodies.

H. Defendant Dr. Ron Waldrige

50. Defendant Dr. Ron Waldrige is employed at 120 East Main Street #2108, Lexington, KY 40507, was an agent and an employee of Southern Health Partners, Inc. for all times relevant, and was charged with various duties to provide care for inmates in the CCDC.

51. Defendant Dr. Ron Waldrige frequently reviewed and signed off on over 200 medical charts in under 40 minutes without thoroughly reviewing inmate medical records.

52. Defendant Dr. Ron Waldrige told other Southern Healthcare employees to stop contacting him about inmates who frequently sought medical care despite knowing that the inmates were in serious need of medical treatment.

53. Defendant Dr. Ron Waldrige denied medical care to inmates despite having knowledge that a medical condition existed and cited the CCDC policy and procedure as a rationale for denying medical care he knew to be medically necessary. Specifically, Dr. Ron Waldrige denied a mammogram to an inmate known to have a lump in her breast despite the inmate's numerous requests for medical attention. Dr. Waldrige cited the CCDC policy and claimed that it restricted access to a mammogram until 40 years of age.

54. Defendant Dr. Ron Waldrige oversaw medical care and is believed to be the head physician at the CCDC responsible for ensuring Plaintiffs and the Plaintiff class received medical care and medications.

55. Defendant Dr. Ron Waldrige had supervisory responsibility over medical staff with inferior qualifications and he had knowledge of ongoing issues with medical care, inmate rights violations, individual deaths from deprivation of medical care, and inmates whose medical conditions worsened from deprivation of medical care. Despite Dr. Ron Waldrige's knowledge, he acquiesced to the ongoing issues with medical care.

I. Defendant Betty Dawes

56. Defendant Betty Dawes is employed at 120 East Main Street, #2108, Lexington, KY 40507, was an agent and an employee of Southern Health Partners, Inc. for all times relevant, and was charged with various duties to ensure care was provided for inmates in the CCDC.

57. Defendant Betty Dawes supervised Josh Ernest, Tonya Maxwell and other medical staff members with the knowledge that improper medications were dispensed to inmates, that medical care was withheld from inmates in serious need of treatment, that improper medical care was provided to inmates, and that other violations had occurred.

58. Defendant Betty Dawes acquiesced to, approved, or implemented the violations that employees under her supervision committed.

59. Defendant Betty Dawes participated in, approved, directed or implemented retaliation against employees who reported violations of inmate rights. Specifically, Betty Dawes altered, or directed employees under her supervision to alter, termination reports of employees that reported inmate rights violations.

60. Defendant Betty Dawes, at all times mentioned herein, had actual knowledge of inmate rights violations stemming from numerous media reports, the volume of violations committed by employees, agents, or servants, the severity of injuries inmates endured and

continue to endure at the CCDC, and the frequent reports made by its employees, agents, or servants concerning inmate rights violations to supervisors and other appropriate bodies.

V. NATURE OF DEFENDANTS' CONDUCT

61. Defendants, individually and in conspiracy with one another, engaged in the conduct described below under color of the law of the Commonwealth of Kentucky and Campbell County. The offenses described below resulted from the failure of Defendants to employ qualified persons for positions of authority, and/or to properly train and supervise the conduct of such persons after their employment, and/or to properly fund ongoing CCDC operations to provide conditions and medical care that meet constitutional standards, and/or to promulgate appropriate operating policies and procedures either formally or by custom and practice to protect the constitutional rights of the citizens of the Commonwealth of Kentucky. Defendants' conduct was intentional or grossly negligent, and was indicative not only of deliberate indifference to, but active malice and a total and reckless disregard for, the constitutional and common law rights of Plaintiff and the Plaintiff class, justifying an award of punitive damages in addition to the actual damages which Plaintiff and the Plaintiff class are entitled to recover.

62. The nature of Defendants' conduct is also detailed in the jail misconduct/civil rights litigation presently before this Court, in Case No. 2:09-cv-00082, *Holt, et al. v. Campbell County, Kentucky, et al.* The Second Amended Class Action Complaint in that case is attached hereto as Exhibit A and incorporated herein by reference.

63. Additionally, the following former employees of CCDC will testify to numerous violations of individuals' constitutional and civil rights under Kentucky and federal law, while those individuals were held at the CCDC:

A. Witness Tracy John-Cristello

64. Tracy Cristello was employed as a Deputy Jailer at the CCDC.

65. Tracy Cristello witnessed guards knowingly violate CCDC regulations by placing too many inmates into one cell.

66. The number of inmates per cell so greatly exceeded regulations that inmates were forced to sleep on the floor.

67. Tracy Cristello witnessed other guards knowingly attempting to conceal violations of CCDC regulations when the Kentucky Department of Corrections visited the CCDC.

68. Only when attempting to conceal these violations from the Kentucky Department of Corrections would guards remove inmates from the overcrowded cells so that the number of inmates per cell complied with the regulatory limits.

69. The CCDC's violation of prison regulations governing the number of inmates per cell creates unsanitary and unsafe conditions for the inmates.

70. CCDC guards have a custom of filing incident reports that deliberately leave out pertinent information concerning violations of CCDC policies and procedures.

71. Tracy Cristello believes based on her observations that the head of the CCDC directs guards to leave out material information from incident reports.

72. On or about September 9, 2009, an inmate attacked Tracy Cristello.

73. During the struggle, Tracy Cristello suffered a concussion and other injuries.

74. After the incident, Tracy Cristello's supervisor would not allow her to file a report. Instead, Deputy Ragle filed a report in place of Tracy Cristello's report.

75. Tracy Cristello read both the original report and the official report filed by Deputy Ragle.

76. Several allegations made in the original report that were damaging to the CCDC were removed from the official report.

77. These allegations include, but are not limited to, faulty equipment that never relayed a request of assistance, which resulted in a delay in response by other deputy jailers to help subdue an inmate using physical force.

78. The CCDC has a policy requiring deputy jailers to use the least amount of force necessary to subdue an inmate.

79. Tracy Cristello has frequently witnessed deputy jailers knowingly use excessive force in violation of this policy.

80. These incidents were never documented in incident reports.

81. Tracy Cristello has observed deputy jailers planting evidence in inmates' cells.

82. These deputy jailers planted evidence in order to get inmates to act out in response, giving the deputies an excuse to use force against inmates.

83. Command staff was aware of these practices through letters they had received regarding these issues.

84. Tracy Cristello observed that the CCDC knowingly deprived inmates of necessities to maintain their personal hygiene.

85. For about 3 months, some inmates were not provided toothbrushes, toothpaste, deodorant, soap or other toiletries.

86. Tracy Cristello frequently complained about these conditions to her superiors.

87. Tracy Cristello was approached by a former inmate (believed to be Viola Sims) that disclosed to her details concerning the death of her former cellmate (believed to be Lisa Jones).

88. Lisa Jones had complained to jailers at the CCDC for 3 days that she felt as if she was dying.

89. Despite these pleas for help, deputy jailers and CCDC medical staff deprived Lisa Jones of necessary medical attention.

90. Lisa Jones subsequently died at a hospital.

91. Tracy Cristello witnessed inmates in need of medical attention go weeks without seeing a doctor.

92. Tracy Cristello witnessed Southern Healthcare Providers and its agents consistently deny medical care to inmates.

93. Tracy Cristello heard medical staff member comment that they were not wasting their time getting inmates' medications.

94. Tracy Cristello witnessed an inmate having a seizure and reported the inmate's condition to the medical staff at the CCDC.

95. Despite the urgency of the inmate's condition, the medical staff responded to the inmate in distress in an unreasonable amount of time.

96. Tracy Cristello witnessed an inmate in grave condition laying on the floor of his cell.

97. The inmate's face was grey; he was nonresponsive and appeared to be near death.

98. Despite notifying the medical staff of the urgency of the situation, the inmate did not receive medical attention for at least 30 minutes.

99. The inmate died.

100. After this inmate's death, CCDC top officials issued a gag order in an attempt to prevent the dissemination of information surrounding the inmate's death to the public.

101. From her personal experience as a deputy jailer at the CCDC, Tracy Cristello believes that the issues described above are part of the culture and custom of the CCDC.

102. Tracy Cristello also believes that the head supervisors of the CCDC are aware of these issues and they knowingly disregard them.

B. Witness Amber Schmidt

103. Amber Schmidt was formerly employed as a Deputy for the CCDC.

104. During her time at the CCDC, Amber Schmidt witnessed the CCDC's medical staff poorly treat inmates.

105. Amber Schmidt was on duty and witnessed Inmate Penny's seizure medication being withheld from her, causing her to suffer multiple seizures.

106. Inmate Tucker suffers from several serious health problems, including but not limited to, heart disease, high blood pressure, anxiety, asthma and poor circulation.

107. Amber Schmidt was on duty and witnessed that at least one or two pills were missing from Inmate Tucker's daily medication doses.

108. As a result of not receiving the proper medication, Inmate Tucker suffered several health complications.

109. Inmate Krauss had been diagnosed with breast cancer.

110. Amber Schmidt was on duty and witnessed the medical department display no sense of urgency in scheduling a doctor's appointment for Inmate Krauss even though she was in constant pain.

111. Amber Schmidt recalls an inmate was pregnant when she arrived at the jail.

112. After several weeks of incarceration, this inmate began to complain every day of constant pain, cramps and bleeding. However, she was given no medical attention from the CCDC's medical department.

113. After weeks of complaining and not receiving treatment, this inmate miscarried.

114. The medical department confirmed the miscarriage in the women's restroom.

115. Amber Schmidt was on duty and witnessed the misuse of the holding area known as the HOLE.

116. The HOLE is sometimes used for discipline and inmates are kept in the HOLE for weeks at a time.

117. The HOLE is kept in such an unsanitary state that Deputies will not enter.

118. The unsanitary conditions include, but are not limited to, a bed bug infestation.

119. Inmates that were kept in the HOLE would only be treated for bed bugs once.

120. Inmates were only given water and a cup of bleach to clean their own cells.

121. Amber Schmidt observed that the female dorm had a lice and nits infestation.

122. The cause of this infestation was that the showerhead in the booking area was not working properly.

123. This in turn made it impossible for new inmates to be deloused.

124. Amber Schmidt believes that the poor medical attention given to the inmates has allowed illnesses to spread throughout the CCDC and to Deputies and other CCDC employees.

125. Amber Schmidt believes that new deputies do not receive the proper training before going on duty.

C. Witness Babette Volski

126. Babette Volski was an employee of the CCDC from August 2004 until April 2010.

127. Babette Volski worked as a Deputy on the floor for one and a half years and then was promoted to Population Coordinator.

128. During her employment with the CCDC, Babette Volski heard numerous complaints from the inmates regarding abuse by the staff.

129. The command staff of the CCDC was aware of these complaints but took no action.

130. Babette Volski witnessed a deputy repeatedly poking an inmate in the chest while multiple command staff was present, yet no action was taken to prevent this mistreatment until Babette Volski intervened.

131. Babette Volski has observed the poor housing conditions in the CCDC, including but not limited to, mold and bed bug infestation.

132. Babette Volski has observed the administration of poor medical treatment.

133. On several occasions, Babette Volski has brought to the attention of the command staff and administration the poor medical treatment.

134. On several occasions, Babette Volski has observed members of the command staff and administration making comments about the poor medical treatment and how the CCDC would not be held liable.

135. Babette Volski has observed inmates being denied their mandatory once a week visit, in violation of their civil rights.

136. Babette Volski brought this concern to the command staff and administration citing cell movement as the reason for the inmates losing their visitation privileges.

137. Babette Volski has also witnessed problems in the areas of recreation, isolation showers, phone call privileges, and suicide checks.

138. Babette Volski believes that there is a problem with the booking process.

139. Babette Volski bases this belief on the fact that almost every employee in charge of booking has been written up for not keeping up with the suicide checks and records.

140. On multiple occasions, Babette Volski has stated that, "If no one is able to do it properly then maybe it is not the individuals but the process itself [that is flawed]."

141. Babette Volski's recommendations were ignored and she was advised that, "If you cannot do the job then someone else can."

142. These irregular booking procedures have lead to the CCDC receiving several warnings from the Kentucky Department of Corrections.

143. No new booking procedure is in place.

144. On multiple occasions, Babette Volski has heard the command staff make comments about not caring about inmates.

145. On multiple occasions, Babette Volski has observed inmates receiving the wrong medication or none at all.

146. Babette Volski has discussed all the above issues with her command staff and/or administration.

147. On April 5, 2010, Babette Volski advised the CCDC that she wished to end her employment on April 30, 2010 because of the above issues she had with the CCDC.

D. Witness Mark West

148. Sergeant Mark West was employed by the CCDC from April 2007 until March 2010.

149. During his time working for the CCDC, Sgt. Mark West witnessed several illegal acts. These acts include but are not limited to unsanitary conditions and improper medical treatment of inmates.

150. On or about May 8, 2009, Sgt. Mark West was the Supervisor on duty the evening of inmate Ernest Dunaway's death.¹⁰

151. On or about the above date, at approximately 4:00 pm, Deputy Music was contacted by Nurse Danielle to respond to medical. There, Nurse Danielle requested that he assist her with Ernest Dunaway because he was on the floor of his cell and required assistance getting back into his bunk.

152. Upon arriving at Ernest Dunaway's cell (cell 137) Deputy Music observed him lying on the floor on his left side.

153. Nurse Danielle then asked Ernest Dunaway "what was wrong" and told him, "You can't be acting like this, you get out in two days."

154. After this exchange, Nurse Danielle and Deputy Music assisted Ernest Dunaway back into his bunk.

155. Once in bed, Ernest Dunaway showed signs of distress. He visibly had trouble breathing, as it was heavily labored and he forced vocalizations.

156. Ernest Dunaway then made a comment that he believed that he had suffered a stroke earlier that day.

157. This prompted Nurse Danielle to examine Ernest Dunaway's facial muscles and she advised him that he needed to elevate his feet with a rolled up blanket.

158. Nurse Danielle then assisted Ernest Dunaway with elevating his feet.

159. After this, both Deputy Music and Nurse Danielle exited the cell and Nurse Danielle advised Ernest Dunaway to remain in his bunk.

¹⁰ Dunaway's Estate is a Plaintiff in the case challenging CCDC practices presently before this Court, *Holt, et al. v. Campbell County, et al.*, Case No. 2:09-CV-0082.

160. On or about the above date, at approximately 5:15 pm, Deputy Larkin was serving dinner.

161. Ernest Dunaway was still in his bunk and refused to eat.

162. After this, both Inmate Shawn Dise and Inmate Randall Stevens, Ernest Dunaway's cellmates for the past several days, began wrapping up the sandwich from Ernest Dunaway's tray so that he could eat it later.

163. Both stated that Ernest Dunaway had not been eating very much for the past several days and often did not eat his meals when they first arrived.

164. Shawn Dise stated that both he and Randall Stevens had been saving food from their trays to give to Ernest Dunaway.

165. On or about the above date, at approximately 6:00 p.m., Sgt. Mark West responded to Deputy Larkin's medical emergency call in cell 137.

166. Deputy Ely and Sgt. Mark West arrived at cell 137 at about the same time.

167. Upon entering the cell, both observed Ernest Dunaway lying in his bunk on his left side with his right arm across his chest and his left arm extended off the bunk.

168. Deputy Larkin and Deputy Music were already present in cell 137 standing just off to the side of the bunk, having discovered Ernest Dunaway laying awkwardly in his bunk with no pulse.

169. Deputy Ely then contacted Nurse Danielle to respond to cell 137. Nurse Danielle arrived shortly thereafter.

170. Upon her arrival, Nurse Danielle advised that Ernest Dunaway needed to be removed from his bunk and placed on the floor so she could examine him.

171. Deputy Music and Deputy Larkin then removed Ernest Dunaway from his bunk and placed him on the floor of the cell.

172. Following Nurse Danielle's brief examination, she, Deputy Ely and Sgt. Mark West administered C.P.R. to Ernest Dunaway and prepared to utilize an A.E.D. (Artificial Electronic Defibrillator).

173. After approximately four compressions, Newport Fire and E.M.S. arrived.

174. The A.E.D was never used because one of the E.M.T.'s explained that Ernest Dunaway was in a "non-shockable" state according to their monitors.

175. Ernest Dunaway was pronounced dead shortly thereafter.

176. Defendant Lt. Colonel David Fickensher, who had arrived during the resuscitation process, then took pictures of Ernest Dunaway's dead body using his personal cell phone before the coroner arrived.

177. Sgt. Mark West then informed Defendant Lt. Col. David Fickensher that Nurse Danielle knew that Ernest Dunaway was suffering from a health condition but that she ignored the symptoms and failed to take the proper action.

178. Nurse Danielle was never reprimanded.

179. After the above incident, Shawn Dise and Randall Stevens told Sgt. Mark West and Sgt. Plummer that Ernest Dunaway had appeared weak for the past couple of days and had trouble moving around inside the cell.

180. Both Shawn Dise and Randall Stevens stated that they had been helping Ernest Dunaway with basic tasks like getting dressed and moving from his bunk to other areas of the cell.

181. Both Shawn Dise and Randall Stevens stated that Ernest Dunaway had told them that he thought he may have had a stroke within the past couple of days because he left side was very weak.

182. Sgt. Mark West believes that Nurse Danielle was on medication that impaired her judgment.

183. Sgt. Mark West has witnessed on several occasions, Nurse Danielle slurring her speech and having “drowsy eyes” while on duty.

184. Defendant Lt. Colonel David Fickensher oversees the medical department on the jail side of operations and Defendant Betty Dawes is the person in charge of the LPN, RN and Medical Techs.

185. Sgt. Mark West has heard Defendant David Fickensher say, “[he] makes the decisions if someone stays employed or is fired in the medical department.”

186. Defendant David Fickensher must approve any inmate transported to the hospital.

187. Sgt. Mark West states that these people in charge knew of Nurse Danielle’s drug problem but did nothing.

188. Sgt. Mark West has heard from Defendant David Fickensher that decisions on whether to send inmates to the hospital were based on the hospital bill, ensuring that Defendant Campbell County did not pay for an inmate’s medical bills if they were to be incarcerated for a short period of time, with no regard for the severity of the inmate’s condition.

189. Sgt. Mark West has witnessed several inmates suffering and heard from Defendant David Fickensher that the reason was because the county did not want to pay for the treatments they needed.

190. Sgt. Mark West has observed Mr. Buckler tell LPN Jamie Winters not to send an inmate that needed medical attention to the hospital.

191. The Fire Captain of Newport EMS, not an employee of the CCDC or Southern Health Partners, overturned Greg Buckler's decision.

192. Normally, the Fire Captain would not be allowed in the medical department but was allowed in by Lt. Webber.

193. The Fire Captain was allowed in the medical area because Defendant Greg Buckler was the President of the Northern Kentucky Firefighters Association and knew the Fire Captain.

194. Sgt. Mark West has also observed the mistreatment of inmate Lisa Jones.

195. Sgt. Mark West observed that Lisa Jones had a fan blowing on her, prompting him to ask her if she was ok.

196. Lisa Jones responded, "You need to look at this."

197. Lisa Jones then produced two cups that were both half filled with a reddish, jell-o like substance.

198. When asked what the substance was, Lisa Jones replied "lung matter" and that she did not want to die in jail.

199. Lisa Jones also stated that she needed her breathing treatment and needed to go to the hospital.

200. This prompted Sgt. Mark West to contact Nurse Danielle and relay to her what he had seen.

201. Nurse Danielle then told Sgt. Mark West to pull Lisa Jones out of her cell so that she could be given her breathing treatment.

202. Lisa Jones was finally transported to the hospital but died shortly thereafter.

203. Sgt. Mark West believes that Lisa Jones was denied proper medical attention because she was a convicted felon and because of Defendant Campbell County's practice of not paying an inmate's medical bills to save the budget.

204. Sgt. Mark West has observed the unsanitary conditions inside the CCDC.

205. Sgt. Mark West has observed toilets backing up in cell 205 and at least three other cells. In these cells feces, urine and toilet paper had backed up into the cell. The resulting smell was unbearable.

206. Sgt. Mark West contacted "Steve with maintenance" to look into these issues.

207. Sgt. Mark West was told that Steve was not going to look into the problems with the toilets and that the inmates would have to wait because the Jailers Conference was in Covington, KY and Mr. Buckler wanted Steve to deal with getting items for the conference before dealing with the sanitary conditions of the cells.

208. Sgt. Mark West pleaded that not responding promptly to the toilet problem made everyone's job harder.

209. Steve replied, "I'm doing what I was told to do by Greg [Buckler]."

210. Sgt. Mark West has also observed that the CCDC has a major mold problem.

211. The mold problem was a constant issue that had caused many health problems among the inmates.

212. Greg Buckler had twenty-five cells painted over by the inmates in those cells. The inmates were promised pizza and soft drinks for their work.

213. Sgt. Mark West has brought the mold problem to the attention of the Command Staff several times but no action has ever been taken.

214. Sgt. Mark West observed that the mold was coming through the paint in the Back Pod.

215. The Back Pod has been painted twice since Sgt. Mark West was employed with the CCDC and this is the only action that has been taken to prevent or eliminate the mold problem.

216. Sgt. Mark West has observed the jail also has a rust problem that is the result of the mold problem not being properly treated.

217. His superiors had instructed Sgt. Mark West that every time the Kentucky Department of Corrections was coming, he should have trustees clean and paint and have maintenance fix problems before an inspection.

218. Sgt. Mark West has observed Southern Health Partner employees conduct themselves unprofessionally.

219. Specifically, Sgt. Mark West has observed LPN Amanda Pangallo act unprofessionally.

220. Sgt. Mark West observed LPN Amanda Pangallo tell inmates if they had a problem with the medical staff then they could take it up with Deputy Brown. Deputy Brown was her boyfriend at the time.

221. Sgt. Mark West has observed Med Tech Tonya Maxwell berate inmates.

222. Med Tech Tonya Maxwell also told Sgt. Mark West that she had given an inmate the wrong medication.

223. Sgt. Mark West advised Med Tech Tonya Maxwell to report the mistake to her supervisor.

224. However, when Sgt. Mark West checked with Med Tech Tonya Maxwell's supervisors about her conduct they said that they would take care of it but never did.

225. Because of this, the inmates complained more and generally made the CCDC staff's jobs more difficult.

226. Sgt. Mark West has heard Tracy Evans and Betty Dawes discussing how they had given inmate John Blackburn too much "neurontin."

227. Because of this, John Blackburn was brought to medical to be observed.

228. During this time, Sgt. Mark West observed John Blackburn exhibit abnormal behavior.

229. Defendant Greg Buckler hires ex-police officers that have no experience in a correctional facility.

230. Defendant David Fickensher and Defendant Greg Buckler's leadership and poor hiring habits have resulted in a lack of training, inmate complaints, sickness, acts of violence, health hazards, hazardous living conditions and death.

E. Witness Amberly White

231. Amberly White was employed as a licensed practitioner nurse with Southern Health Partners at the CCDC from January 8, 2009 until December 3, 2009.

232. To the best of her knowledge, Amberly White was the longest tenured medical staff member at the CCDC, despite having only one year experience.

233. Josh Ernest and Betty Dawes were responsible for seeing that Southern Health Partner employees provided healthcare to individuals detained at the CCDC in compliance with the contract between Southern Health Partners and the CCDC, and in compliance with applicable law.

234. Individuals detained at the CCDC frequently told Amberly White that she was the only nurse doing her job.

235. Individuals detained at the CCDC also told Amberly White that other members of the medical staff did not do their jobs, did not provide proper medical care and ignored their medical issues.

236. While fulfilling her duties a nurse practitioner at the CCDC, Amberly White witnessed the medical staff withhold medical treatment from inmates based on the severity of the crime the inmate had committed, with no medical justification for doing so.

237. Further, Amberly White also observed the medical staff withhold medical treatment in order to save money for the CCDC's budget.

238. Additionally, medication was withheld from inmates for a medically unreasonable amount of time.

239. Amberly White observed Defendant Dr. Ron Walldridge, a physician with the CCDC, perform his duties recklessly.

240. On several occasions, Defendant Dr. Ron Walldridge signed off on close to 200 medical charts in about under 40 minutes.

241. Amberly White observed Defendant Dr. Ron Walldridge deny an inmate (believed to be Wilma Fox) a mammogram despite Dr. Ron Walldridge's knowledge of a lump in her breast.

242. Defendant Dr. Ron Walldridge's justification for denying the mammogram was that regulations did not require an inmate to receive a mammogram until age 40.

243. Amberly White witnessed an inmate, known to be suffering from jaundice, beg for medical care.

244. Upon observing this, Amberly White reported it to her supervisors.

245. Amberly White's supervisors continuously disregarded the condition of the inmate.

246. Unsatisfied, Amberly White circumvented her unresponsive supervisors and reported the inmate's deteriorating health condition directly to the physician at the CCDC.

247. Two days after the inmate suffering from jaundice was released from jail, the inmate died because his medical condition had been allowed to reach such dire condition while he was detained.

248. Based on this information, Amberly White believes that the inmate was released from the CCDC because Southern Health Partners and the CCDC did not want to spend the money necessary to help this inmate.

249. But for the repeated denial of medical care, inadequate treatment and denial of the most basic medical attention, this inmate would have survived.

250. Amberly White frequently reported issues concerning inmate medical care to her direct supervisors.

251. Amberly White frequently reported issues concerning the violation of inmates' rights to her supervisors and other CCDC staff.

252. On more than one occasion, Amberly White reported the above violations to Josh Ernest.

253. Other supervisors at the CCDC were also aware that Amberly White had reported violations of inmates' constitutional rights.

254. The inmate rights violations that Amberly White reported included but were not limited to constitutional rights violations, violations of the law, denial of medical care, violations of regulations, violations of medical codes, and other violations.

255. Amberly White was terminated from employment at CCDC because she complained to officials and her supervisors of misconduct, violation of law and regulations and prisoner rights violations that she observed.

256. Amberly White was terminated in retaliation for her reporting about rights violations.

257. Southern Health Supervisors and CCDC supervisors, specifically Josh Ernest, frequently complained that Amberly White provided medical care to inmates in need of medical treatment while she visited other inmates also in need of care.

258. Based on her personal observations, Amberly White believes that inmates at CCDC in need of medical care are at risk of being deprived of basic medical care.

259. Based on her personal observations, Amberly White also believes that CCDC officials are aware of or know of these serious issues regarding the medical care provided to inmates.

VI. FACTS

A. Plaintiff William J. Bramble, Jr.

260. William J. Bramble, Jr. was incarcerated at the CCDC from November 2009 through April 2010.

261. During his incarceration, various unknown deputy jailers were withholding from Bramble the necessary medication prescribed by recognized medical authorities.

262. In response to Bramble's complaints concerning the withholding of his medication, various members of the CCDC medical staff threatened that they would substitute Thorazine for Bramble's prescribed medication, so that he would be in no condition to complain.

B. Plaintiff Clark Byers

263. Clark Byers was booked into the CCDC on a misdemeanor charge about 2 years ago.

264. During the booking procedure, the desk deputy clerk told Clark Byers to put both hands on the counter. Clark Byers complied.

265. Then, a second deputy standing behind Clark Byers asked him a question.

266. Clark Byers turned to answer the deputy's question, to do so Clark Byers had to remove one of his hands from the counter.

267. Clark Byers was then immediately "bum rushed" by about 5 deputies.

268. Clark Byers was thrown to the ground, cuffed, and was beaten and kicked with no way to defend himself.

269. Further, a large deputy jumped on top of Clark Byers' back, bringing his full weight to bear, when Clark Byers was cuffed and defenseless.

270. Clark Byers was then restrained in the hand and leg cuff chair.

271. Clark Byers' cuffs were put on so tightly that his hands stayed swollen for days.

272. While Clark Byers was totally restrained in the cuff chair, a female deputy repeatedly spat in his face.

273. Clark Byers believes that a sergeant quit over this incident.

274. Clark Byers has previously sued the jail for this misconduct and received a settlement of \$3,000.

275. Clark Byers believes that he was forced to sign a non-disclosure agreement to receive this settlement, because at the time he desperately needed the money.

C. Plaintiff Martha Camacho

276. On June 21, 2010 Martha Camacho was detained at the CCDC for 5 days.

277. On the morning of June 22, 2010, Martha Camacho awoke to discover a large red mark on her left breast.

278. She showed this mark to the officer on duty but was told that there was nothing that could be done for her.

279. On June 23, 2010, the red mark on Martha Camacho's chest had tripled in size.

280. Martha Camacho again showed the officer on duty and was again told that there was nothing that they could do for her.

281. Martha Camacho was also told that she would have to put in a medical request and that it would take a week before she could see a doctor.

282. On June 24, 2010, Officer Slaughter witnessed Martha Camacho crying in her cell.

283. When asked what was bothering her, Martha Camacho showed Officer Slaughter the red mark on her breast.

284. It took Officer Slaughter 4 hours to persuade the medical staff to look at Martha Camacho.

285. Then, two nurses entered Martha Camacho's cell to examine her.

286. They stated that they did not know what the red mark was and that if Martha Camacho was still detained the next day they would consider starting her on antibiotics then.

287. Martha Camacho was released the next day and immediately admitted herself to a hospital.

288. Martha Camacho had to be hospitalized for two days.

289. Martha Camacho believes that she received inadequate medical attention while detained at the Detention Center and this resulted in the worsening of her condition.

D. Plaintiff John Chambers

290. John Chambers was arrested on the morning of June 29, 2010.

291. That afternoon, his mother telephoned the CCDC to find out what the required process was to deliver Chambers' anti-seizure medications.

292. She took those anti-seizure medications -- necessary medication prescribed by recognized medical authorities -- to the CCDC that same day, June 29.

293. Chambers received only a partial dose of his necessary anti-seizure medication that evening.

294. When Chambers informed the staff that he was missing one of his required medications, he was told that they were waiting for verification from his doctor before giving it to him.

295. When Chambers was placed in the CCDC's general population the next day, he requested a bottom bunk for fear of having a seizure and falling from the top bunk.

296. Chambers was told by the (name unknown) guard on duty that he did not believe Chambers had seizures and that Chambers would sleep where he was assigned.

297. On July 1, 2010, Chamber was transported from the CCDC to the hospital because he had been experiencing seizures. According to hospital records, Chambers had had three grand mal seizures beginning at 3:00 p.m.

298. Chambers did not arrive at the hospital until 6:09 p.m., which means the CCDC medical and guard staff took three hours to address Chambers' obviously serious medical condition.

299. Chambers' medical records indicate that his Dilantin level was 2.5 mg.

Chambers' normal average Dilantin level is 16 mg.

300. It takes several days for Dilantin levels to drop from 16 mg. to 2.5 mg. Although CCDC staff indicated that Chambers had only missed one dose of his anti-seizure medications, the reduction in Dilantin level indicates that Chambers must have missed at least five doses of his required anti-seizure medication.

301. Because Chambers had been compelled to use the top bunk, when he suffered a seizure on July 1, he fell from that height, which caused him to suffer a severe contusion on his head and to re-damage a knee he had recently had surgery on.

302. After Chambers was released from jail on July 8, he visited his orthopaedic surgeon and was told that his recovery time from the knee surgery was set back by at least a month due to this injury.

E. Plaintiff Steven Halpin

303. Steven Halpin has been detained in the CCDC since July, 2009.

304. Steven Halpin has had repeated problems receiving the proper medications.

305. Either Steven Halpin receives the wrong medications or there are medications missing from his doses.

306. Steven Halpin has had repeated problems getting a doctor's appointment when requested.

307. Steven Halpin has made repeated requests to CCDC staff to help correct these problems.

308. Steven Halpin is in extreme pain because he has not received the proper medical attention.

309. Steven Halpin believes that he was placed under “medical observation” as a punishment for reaching out to Defendant Lt. Col. Fickensher and MTA Kim to try to resolve his issues with his medications.

310. Steven Halpin believes he is being punished because he has not received any medical attention nor talked to anyone about his medications since being transferred for medical observation.

311. Steven Halpin is in such despair over his situation that he had begged, “I just want to...finish my time. I’ll stop trying to get my meds changed, I’ll even stop taking them altogether if that’s what it takes.”

F. Plaintiff Bryan Huffman

312. Bryan Huffman was detained at the Campbell County Detention Center (“Detention Center”) in cell 109.

313. Cell 109 originally had a steel table in it, which extended from the wall of the cell.

314. Prior to Bryan Huffman being placed in cell 109, the top of the table was torn off, leaving a steel support bar sticking out of the wall.

315. Bryan Huffman was assigned to the top bunk of cell 109, despite being “lower bunk restricted” because of issues with back pain.

316. Bryan Huffman’s leg gave out as he was trying to get out of the top bunk.

317. Bryan Huffman fell toward the extended steel support bar.

318. Bryan Huffman extended his arm in an effort to avoid hitting the bar with his head or neck.

319. Bryan Huffman hand struck the sharp end of the support bar and was nearly cut off. He also suffered injuries to his leg.

320. As a result, Bryan Huffman suffered major tendon and nerve damage to his hand and arm.

321. Bryan Huffman requires therapy to regain the use of his hand.

322. Bryan Huffman had a conversation with Daren, the Detention Center maintenance man for the past five years, who was told by prison officials that no inmates were supposed to be placed in cell 109 while the damaged steel table and bar were still sticking out of the cell wall.

323. Since Bryan Huffman's accident, the bar and table have been removed from cell 109.

G. Plaintiff Doug Menning

324. Doug Menning was detained in the CCDC from May 28, 2010 until June 7, 2010.

325. While detained, Doug Menning repeatedly requested medical attention from about May 28 until about June 5.

326. Doug Menning was never granted access to a doctor.

327. Doug Menning's mother was forced to bring his prescribed medication to the CCDC but the CCDC staff would not give him the medication even though Doug Menning's prescribing physician had been notified.

328. On or about June 6, Doug Menning became deathly ill.

329. Upon witnessing this the pill dispensing staff member at the CCDC started giving Doug Menning medication that was not his, nor was it prescribed by a doctor.

330. The person in charge of dispensing pills at the CCDC is not licensed to practice medicine nor prescribe medication.

331. Doug Menning had no choice but to take the medication given to him.

332. Doug Menning took 4 capsules on two separate occasion.

333. Doug Menning's condition became worse after taking these pills.

334. The CCDC staff's response to Doug Menning's condition worsening was to beat, kick and cuff him in the manacle chair.

335. Doug Menning was beaten and cuffed to the manacle chair at least 3 times.

336. On one occasion, Doug Menning was beaten and cuffed to the manacle chair for at least 6 hours.

337. Prior to one incident, deputies opened the food chute of Doug Menning's cell and fired a large can of pepper spray into the 10 x 10 cell.

338. The spray immediately covered the cell like a dense fog.

339. The justification for pepper spraying Doug Menning's cell was because he was kicking the door in an attempt to get attention because he was sick.

340. After leaving Doug Menning in his cell full of pepper spray for 3 minutes the deputies finally opened the door. They then stripped Doug Menning naked, threw him in the shower and told him not to rub his eyes.

341. Then, the deputies clothed Doug Menning and strapped him in the manacle chair.

342. Doug Menning's skin, eyes and face were so burnt that moving any part of his body caused him pain.

343. After enduring five hours in this condition, Doug Menning passed out from the pain.

344. While strapped in the manacle chair, Doug Menning's circulation was so restricted that his hands turned purple and stayed swollen for two days.

345. Doug Menning was eventually transported to St. Elizabeth Medical Center in Edgewood, KY.

346. Once there, Doug Menning's heart flat lined.

347. Doug Menning's condition was so severe at this point, that the attending physicians were considering performing heart surgery.

348. Doug Menning almost died as a result of his mistreatment at the CCDC.

349. The medical records at St. Elizabeth show that Doug Menning's medical condition existed before he arrived at St. Elizabeth.

350. Doug Menning believes that several deaths have occurred at the CCDC because the decedents suffered the same mistreatment as he suffered.

H. Plaintiff Ken Stinson

351. Ken Stinson was incarcerated at CCDC for approximately 40 days during 2010.

352. While incarcerated, Stinson was assaulted by a couple of inmates on two different occasions.

353. Following one particular assault, CCDC officials took a written statement from Stinson, and photographs of his severe head injuries.

354. Stinson's written statement includes an account of graphic sexual harassment he received from another inmate.

355. Despite the assaults and sexual harassment, CCDC failed to ensure a safe environment for Stinson.

356. After Stinson filed a charge against one of the inmates that assaulted him, within just a few days, the same inmate was allowed to roam free at the CCDC as a trusty.

357. The same inmate was responsible for serving meals to Stinson, and the inmate made it clear to Stinson that he had tampered with Stinson's food. (The inmate used a far more graphic term to describe how he had "tampered with" Stinson's meals.)

358. Moreover, during his incarceration, Stinson filed daily medical requests with the CCDC staff, very few of which were responded to.

VII. CAUSES OF ACTION: 42 U.S.C. § 1983

A. Count I

359. The preceding paragraphs are incorporated herein by reference.

360. Plaintiffs and the class treatment at the CCDC were the result of a continuing pattern of misconduct and is the result of policies, procedures, customs and practices of Campbell County, either written or unwritten, that are systematically applied at the CCDC whenever an individual is incarcerated there, including but not limited to the persistent practice of denying inmates medical attention for their serious medical needs, denying appropriate and necessary medication prescribed by recognized medical authorities, and subjecting individuals held at the CCDC to cruel and unusual punishment. Such practices constitute an arbitrary use of government power, and evince a total, intentional and unreasonable disregard for and deliberate indifference to the health, well-being and constitutional and common law rights of persons incarcerated at the CCDC, including Plaintiffs and members of the Plaintiff class.

361. As a result of the foregoing, Plaintiffs and their class, through Defendants' deliberate indifference and intentional or grossly negligent conduct, were deprived without due process of law of their right not to be subjected to cruel and unusual punishment under the 5th, 8th, and 14th Amendments to the United States Constitution in violation of the Civil Rights Act of 1871, 42 U.S.C. §1983.

362. Moreover, given the pre-existing law that clearly prohibited Defendants' conduct, Defendants' treatment of Plaintiffs and members of the Plaintiff class was intentional, wanton and malicious, and was indicative of Defendants' total and reckless disregard of and deliberate indifference to the rights of, and harm to, Plaintiffs and the members of the Plaintiff class.

B. Count II: Kentucky Statutory Claims

363. The preceding paragraphs are incorporated herein by reference.

364. By virtue of the foregoing, Defendants have knowingly and intentionally violated 501 KAR 3:090(20), 501 KAR 3:060, KRS 441.055, KRS 441.025, and KRS 441.045.

C. Count III: Intentional Infliction of Emotional Distress

365. The preceding paragraphs are incorporated herein by reference.

366. By virtue of the foregoing, Defendants, without justification, negligently or intentionally inflicted upon Plaintiffs and the Plaintiff class severe mental and emotional distress.

D. Count IV: Negligence

367. The preceding paragraphs are incorporated herein by reference.

368. By virtue of the foregoing, Defendants were negligent and grossly negligent, and violated the standards applicable to their professions, all to the damage of the Plaintiffs and the Plaintiff class.

E. Count V: Loss of Consortium

369. The preceding paragraphs are incorporated herein by reference.

370. By virtue of the foregoing, Defendants are liable for loss of consortium, companionship, aid, assistance, society, service, and love to all individual family members of the Plaintiffs and the Plaintiff class for which loss of consortium would apply.

VIII. DAMAGES

371. The preceding paragraphs are incorporated herein by reference.

372. As a consequence of Defendants' wrongful conduct, Plaintiffs and members of the Plaintiff class have been denied medical attention for their serious medical needs and appropriate and necessary medications prescribed by recognized medical authorities; and have also been subjected to cruel and unusual punishment.

373. As a result of the foregoing, Plaintiffs and members of the Plaintiff class have experienced unnecessary pain and suffering and severe and unjustified mental and emotional

distress, and are entitled to recover actual damages. Furthermore, Defendants' violations of the constitutional and common law rights of the Plaintiffs and members of the Plaintiff class were knowing, intentional, cruel, malicious, and evinced a total and reckless disregard for the rights of Plaintiffs and members of the Plaintiff class entitling them to recover punitive damages from Defendants in order to deter such conduct in the future.

IX. DECLARATORY JUDGMENT AND PERMANENT INJUNCTION

374. The preceding paragraphs are incorporated herein by reference.

375. In addition to the foregoing, Plaintiffs and members of the Plaintiff class request that this Court issue a declaratory judgment deeming unconstitutional any and all ordinances, regulations, policies, procedures, customs or practices which resulted in their incarceration under conditions in which they were denied medical attention for their serious medical needs and appropriate and necessary medication prescribed by recognized medical authorities, and further request that this Court permanently order Defendants to refrain from following or enforcing such ordinances, regulations, policies, procedures, customs or usages, and to alleviate all conditions at CCDC that contributed to the damages sustained by Plaintiffs and members of the Plaintiff class.

X. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs and the Plaintiff class they represent request:

- (a) that this action proceed as a class action under Fed. R. Civ. P. 23;
- (b) a trial by jury;
- (c) they and all members of the class be awarded actual and punitive damages;
- (d) they be granted the declaratory and injunctive relief requested herein; and
- (e) they be awarded all costs, attorney fees, pre- and post-judgment interest and all other relief to which they are entitled.

Respectfully submitted,

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