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UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

STEVEN A. DURAN and ELAINE DURAN as Successors in Interest of JOSEPH DURAN,; STEVEN DURAN, Individually; and ELAINE DURAN, Individually,

Plaintiffs,

vs.

CDCR Correctional Officer ROY C. CHAVEZ; CDCR Correctional Officer TIMOTHY NELSON; CDCR Correctional Officer JASON R. STRONGMAN; CDCR Correctional Sergeant MARK SHEPARD; CDCR Correctional Sergeant JUAN C. CARRILLO; CDCR Correctional Lieutenant BRYAN D. McCLOUGHAN; CDCR Licensed Vocational Nurse MICHAEL; CDCR Clinical Psychologist RICHARD E. ORTIGO, Psy. D.; CDCR Staff Psychiatrist KARUNA ANAND, M.D.; CDCR Physician and Surgeon JANET YU, M.D.; Mule Creek State Prison Chief Medical Executive SCOTT A. HEATLEY, M.D.; Mule Creek State Prison Chief Executive Officer (Medical) DAVID SMILEY; Mule Creek State Prison Warden and Chief Executive Officer WILLIAM W. KNIPP; Amador County Sheriff-Coroner MARTIN A. RYAN; CASA BONITA, INC.; and Does 1 through 20.

Defendants.

_____/

NO. 2:14-cv-2048 TLN CKD

FIRST AMENDED COMPLAINT FOR VIOLATIONS OF CIVIL RIGHTS AND STATE LAW

JURY TRIAL DEMANDED

Plaintiffs complain and allege as follows:

JURISDICTION AND VENUE

1. This complaint seeks damages and attorneys' fees pursuant to Title 42 U.S.C. sections 1983 and 1988 for violations of decedent's and survivor's civil rights and violations of California State law. Jurisdiction is founded upon Title 28 U.S.C. sections 1331 and 1343. This Court has supplemental jurisdiction over Plaintiffs' state law claims pursuant to 28 U.S.C. § 1367.

2. Plaintiffs' claims arose in the County of Amador, California. Venue lies in the Eastern District of California pursuant to 28 U.S.C. § 1291(b)(2).

INTRODUCTION

3. This action arises out of the untimely and avoidable death of Joseph Damien Duran ("Duran") at Mule Creek State Prison ("MCSP") on September 7, 2013. At the time of his death, Duran had been at Mule Creek State Prison for just three days. After re-entering the CDCR system days earlier on August 30, 2013, CDCR staff recognized that he was severely mentally ill as well as suicidal. As a result, Duran was transferred to MCSP to be housed in a Mental Health Crisis Bed. Unfortunately, that transfer did not help as Duran died three days later. The circumstances of his death are as follows.

4. Duran, having undergone a surgical tracheostomy in 2007, breathed through a tracheostomy tube in his throat. On the morning of September 6, 2013, Duran's psychiatrist, inexplicably and for no apparent clinical reason, removed Duran from suicide prevention protocols just as his paranoia and overall mental health were significantly worsening. Among other things, Duran claimed he was being poisoned and was refusing his necessary psychotropic medications because he believed they had been switched. During the September 6, 2013 evening round of medications, Duran held open the food port, which is a small rectangular hinged slot in the cell door. The response by correctional staff was to blast him with chemically propelled aerosol OC pepper spray. The predictable painful and immediate effects of the OC pepper spray were magnified a hundred fold in this case due to the spray entering Duran's tracheal tube and going directly into his throat. Desperately seeking pain relief, Duran ripped out his tracheostomy tube, causing him to spit up blood.

Several nurses sought medical intervention which resulted in medical orders from two doctors to remove Duran from his cell, decontaminate him from the OC pepper spray, and intravenously administer desperately needed anti-psychotic medication.

5. Hardened by an institutional culture of callousness, the correctional officers, sergeants and a lieutenant chose to ignore the doctors' orders as well as CDCR policies and decided, instead, to leave Duran in his cell suffering from the after effects of the OC pepper spray, which was synergistically interacting with his uncontrolled mental illness. Duran received no medical attention and only infrequent observation as he was kept through the night in his contaminated cell. The level of observation was so low that it is impossible to determine the time at which Duran, attempting to alleviate his pain, packed the burning hole in his throat with spaghetti, and possibly feces, as one might pack a wound. Unfortunately, the direct result was his death as these pain relief measures also had the effect of cutting off his oxygen. There was an attempt to cover up the cause of and to conceal the fact of Duran's death. This cover up was motivated by a desire to influence the perpetually pending class action lawsuit *Coleman v. Brown*, 2:90-cv-0520 LKK DAD, involving the treatment of mentally ill inmates. Contrary to Duran's wishes and the Catholic beliefs of Duran and his parents, and before his parents were even notified of his death, Duran was cremated and his ashes were scattered at sea.

PARTIES

6. Born September 3, 1978, Joseph Duran was a 35 year old citizen of the United States at the time of his death.

7. Plaintiff Steven Duran was decedent's father.

8. Plaintiff Elaine Duran was decedent's mother.

9. Plaintiffs Steven Duran and Elaine Duran are Joseph Duran's successors in interest. (See Exhibit A - Declaration by Persons Bringing this Action as decedent's Successors in Interest.) Plaintiffs Steven Duran and Elaine Duran are also decedent's next of kin for purposes of intestate succession.

10. California Department of Corrections and Rehabilitation Correctional Officer Roy C. Chavez was at all times mentioned herein a correctional officer working at MCSP. Officer Chavez was acting under color of state law.

11. California Department of Corrections and Rehabilitation Correctional Officer Timothy Nelson was at all times mentioned herein a correctional officer working at MCSP. Officer Nelson was acting under color of state law.

12. California Department of Corrections and Rehabilitation Correctional Officer Jason R. Strongman was at all times mentioned herein a correctional officer working at MCSP. Officer Strongman was acting under color of state law.

13. California Department of Corrections and Rehabilitation Correctional Sergeant Mark Shepard was at all times mentioned herein a correctional sergeant working at MCSP. Sergeant Shepard was acting under color of state law.

14. California Department of Corrections and Rehabilitation Sergeant Juan C. Carrillo was at all times mentioned herein a correctional sergeant working at MCSP. Sergeant Carrillo was acting under color of state law.

15. California Department of Corrections and Rehabilitation Correctional Lieutenant Bryan D. McCloughan was at all times mentioned herein a correctional lieutenant working at MCSP. Lieutenant McCloughan was acting under color of state law.

16. California Department of Corrections and Rehabilitation Licensed Vocational Nurse (LVN) Michael was at all times mentioned herein a nurse working at MCSP. LVN Michael was acting under color of state law.

17. California Department of Corrections and Rehabilitation Clinical Psychologist Richard E. Ortigo, Psy. D., was at all times mentioned herein a doctor of psychology and a clinical psychologist working at MCSP. Dr. Ortigo was acting under color of state law.

18. California Department of Corrections and Rehabilitation Staff Psychologist Karuna Anand, M.D., was at all times mentioned herein a doctor of psychiatry and a staff psychiatrist working at MCSP. Dr. Anand was acting under color of state law.

19. California Department of Corrections and Rehabilitation Physician and Surgeon Dr. Janet Yu, M.D., was at all times mentioned herein a physician and surgeon working at MCSP. Dr. Yu was acting under color of state law.

20. Dr. Scott A. Heatley was at all times mentioned herein the Chief Medical Officer Executive (CME) at MCSP. Dr. Heatley was acting under color of state law. As CME, Dr. Heatley was responsible for overseeing the examination, diagnoses, prescriptions and treatment of all inmate patients at MCSP.

21. David Smiley was at all times mentioned herein the Chief Executive Officer (CEO) for health care at MCSP. CEO Smiley was acting under color of state law. The CEO is the highest-ranking health care authority within an adult CDCR institution. CEO Smiley was responsible for all aspects of delivering health care at MCSP to ensure adequate medical and mental health care for all inmates at MCSP.

22. William W. Knipp was at all times mentioned herein the Warden and CEO of MCSP. Warden Knipp was acting under color of state law. Warden Knipp was responsible for the custody and treatment of all inmates and for the training and discipline of all employees under his charge. Warden Knipp was also responsible for establishing such operational plans and procedures as required by MCSP to provide for the custody and treatment of inmates at MCSP.

23. Martin A. Ryan was at all times mentioned herein the Sheriff-Coroner of Amador County. Sheriff-Coroner Ryan was acting under color of state law.

24. Casa Bonita, INC., a corporation doing business as Casa Bonita Funeral Home, was at all times mentioned herein a Funeral Home in Stockton, California. Casa Bonita Funeral home was acting under color of state law.

25. Upon information and belief, Defendant Doe 1, the Sergeant on Duty at MCSP at or about 11:00 p.m. on September 6, 2013 (if different from Sergeant Shepard), was at all times mentioned herein a correctional sergeant working at MCSP who was acting under color of state law. The true name and identity of defendant Doe 1, the Sergeant on

Duty, is presently unknown to Plaintiff. Plaintiff will seek to amend this complaint as soon as the true name and identity of Doe 1 is ascertained.

26. Upon information and belief, Defendant Doe 2, the Administrative Officer-of-the-Day for MCSP on duty at or about 11:00 p.m. on September 6, 2013, was at all times mentioned herein an administrative officer working at MCSP who was acting under color of state law. The true name and identity of defendant Doe 2, the Administrative Officer-of-the-Day, is presently unknown to Plaintiff. Plaintiff will seek to amend this complaint as soon as the true name and identity of Doe 2 is ascertained.

27. Upon information and belief, Defendant Does 3, 4 and 5 were at all times mentioned herein individuals working at North Kern State Prison who were acting under color of state law. Defendant Does 3, 4 and 5 were responsible for negligently failing to scan or negligently failing to ensure that a copy of Joseph Duran's note expressing suicidal ideation was scanned into his medical records. This omission caused Duran's treatment team at MCSP to be deprived of critical information in the hours and days prior to his death. The true names and identities of Does 3, 4 and 5 are presently unknown to Plaintiff. Plaintiff will seek to amend this complaint as soon as the true names and identities of Does 3, 4 and 5 are ascertained.

28. Upon information and belief, Defendant Does 6 through 10 were at all times mentioned herein individuals working at MCSP who were acting under color of state law. Defendant Does 6 through 10 were additional members of the custody staff who were deliberately indifferent to Duran's serious medical needs either by deliberately disobeying doctors' orders, or otherwise by ignoring known obvious risks to Duran's health and safety during September 5-7, 2013, or by failing to investigate, supervise, and discipline other individuals or by failing to implement and/or maintain constitutionally adequate policies and procedures for inmates at MCSP to obtain medical and mental health care. The true names and identities of Does 6 through 10 are presently unknown to Plaintiff. Plaintiff will seek to amend this complaint as soon as the true names and identities of Does 6 through 10 are ascertained.

29. Upon information and belief, Defendant Does 11 through 15 were at all times mentioned herein individual medical or mental health staff members working at MCSP during September 5-7, 2013 who were acting under color of state law. Defendant Does 11 through 15 were deliberately indifferent to Duran's serious medical needs when they ignored known serious risks to his health and safety by either denying treatment or by failing to investigate, supervise, and discipline other individuals in regard to Duran's medical and mental health treatment or by failing to implement and/or maintain constitutionally adequate policies and procedures in regard to medical and mental health care for inmates at MCSP. The true names and identities of Doe 11 through Doe 15 are presently unknown to Plaintiff. Plaintiff will seek to amend this complaint as soon as the true names and identities of Does 11 through 15 are ascertained.

30. Upon information and belief, Defendant Does 16 through 20 were at all times mentioned herein individuals working for CDCR during September 5-7, 2013 who were acting under color of state law, or individuals working for the Amador County Sheriff-Coroner's Office and acting under color of state law. Defendant Does 16 through 20 were involved the investigation and cover up of Duran's death and were responsible for covering up the unlawful conduct of the other Doe defendants and the named defendants identified herein, or knowingly and actively participated in the failure to notify Duran's next of kin of his death.

COMPLIANCE WITH GOVERNMENT TORT CLAIM PROCEDURES

31. As a pre-requisite to the state law claims alleged herein against State of California employees/agents, Plaintiffs Steven and Elaine Duran filed governmental claims with the Victims Compensation and Government Claims Board on February 13, 2014.

32. By correspondence from the California Victims Compensation and Government Claims Board dated March 28, 2014, these claims were rejected.

33. This action has been filed within six months of the rejection by the California Victims Compensation and Government Claims Board rejection, as required by law.

34. As a pre-requisite to the state law claims alleged herein against the County of Amador and its employees/agents, Plaintiffs Steven Duran and Elaine Duran filed governmental tort claims with the County of Amador on June 9, 2014.

35. By correspondence from the County of Amador dated July 17, 2014, the claims have been acknowledged but not acted upon.

36. Since more than forty-five days have passed since Plaintiffs filed their claims with the County of Amador, those claims may be deemed rejected by operation of law.

FACTUAL ALLEGATIONS

Factual Background

37. At the time of his death, the decedent, Joseph Damien Duran ("Duran"), was thirty-five years of age. He was five feet, eight inches tall and weighed approximately one hundred and seventy pounds.

38. Duran's parents, Steven and Elaine Duran, raised him from the age of five, when they adopted him. They called him Joey. The Durans were a typical, loving middle class family. When Duran was a young boy, his father regularly took him fishing and coached him in Little League. Steven and Elaine Duran maintained a loving relationship with Duran into his adulthood in spite of the complications posed by Duran's mental health issues.

39. Since his teen years, Duran suffered from significant mental health problems. His diagnoses included bipolar disorder, deppression, psychotic disorder not otherwise specified (NOS) and antisocial personality disorder. He also suffered from a seizure disorder and hallucinations, particularly auditory hallucinations.

40. Duran's mental health issues caused significant behavioral problems and problems with authority. As a result, he had various interactions with the law and with the criminal justice system. On multiple previous occasions beginning in 1997, Duran was in the custody of the California Department of Corrections.

41. Other manifestations of Duran's mental health problems included aggrandized notions of self, delusional thinking, self-medicating with illegal drugs and

reluctance to take prescribed drugs. On a handful of previous occasions, Duran had been hospitalized in psychiatric inpatient hospitals.

42. CDCR recognized Duran as a mentally ill inmate. During previous incarcerations, Duran received treatment through the Mental Health Services Delivery System. His CDCR records show his treatment providers' knowledge of his previous diagnoses, psychiatric hospitalizations and suicidality. Duran's previous psychiatric inpatient hospitalizations were referenced in his medical and mental health records that were maintained by CDCR. Duran also had a seizure disorder, of which his treatment team at CDCR was aware, and had previously suffered head traumas which appeared to contribute to his mental health problems.

43. Duran had been treated with a cornucopia of psychotropic medications, including Thorazine, Neurontin, Prolixin, Artane, Seroquel, Remerin and Carbamazpine.

44. Duran had a known history of suicidality, suicide attempts, suicidal ideation and self-harming behavior. While previously CDCR's custody, Duran had been placed on suicide watch. Almost all of the previous suicidal scenarios envisioned or communicated by Duran, including those on which he acted while in CDCR custody, involved cutting himself; none involved his stoma.

45. In July 2007, as a result of a throat injury, Duran underwent a tracheal stenosis surgical procedure. As a result, he breathed through a tracheostomy tube in his throat. The tracheostomy site was an ongoing source of pain, discomfort, medical complications and communication problems, among other issues. In 2012, Duran underwent a follow up surgical procedure at the site of his stoma.

46. The tracheostomy caused communication problems and limited Duran's ability to communicate orally. However, Duran was able to manipulate his tracheostomy tube so that he could speak in a soft whispery voice. He needed to supplement his speech with the use of non-verbal communication tactics including hand gestures and written notes, particularly when having any problem with his tracheostomy tube.

47. It was known that inmates with tracheotomies, particularly those with mental health and/or behavioral issues, had a physical condition which required consideration in the decision to use force, or other coercive measures.

48. MCSP lacked established protocols and consistent practices for the documentation of on-call activities by medical and mental health staff. Adequate documentation is a necessary component of adequate care. This failure was known to and the result of inadequate supervision by Knipp, Dr. Heatley and Smiley and does 11-15.

49. MCSP lacked established protocols and consistent practices for the contemporaneous and complete documentation of treatment notes by medical and mental health staff. Adequate contemporaneous documentation is a necessary component of adequate care. This failure was known to and the result of inadequate supervision by Knipp, Dr. Heatley and Smiley and does 11-15.

50. The correctional staff routinely ignored or refused to effectuate medical orders resulting in inmates suffering physical harm and gratuitous suffering. This was known to and the result of poor supervision by Knipp and does 1-2, and 6-10.

51. The CDCR, as a result of the class action suit filed in 1990, *Coleman v. Brown, et al.*, 2:90-cv-0520 which is pending in the United States District Court for the Eastern District of California, was obligated to effect a great deal of change in CDCR's treatment of mentally ill inmates. As a part of that action, the CDCR policy regarding the use of force against mentally ill inmates, including the use of chemical agents and specifically OC pepper spray against mentally ill inmates, as well as the issue of preventable suicide by mentally ill inmates, was under active Court scrutiny. Because of Coleman, the defendants were aware that the use of force policy (including the use of chemical agents) at MCSP had to factor in an inmate's mental illness. Additionally *Coleman* put them on notice that suicide precautions and preventative steps had to be clearly delineated and followed by staff. It also put the defendants on actual notice about the importance and consequences of having inadequate communications between correctional and medical/mental health staff. *Coleman* also resulted in numerous reporting and investigative obligations which were

triggered by various specific incidents, including what were potentially inmate suicides. Despite these reviews and legal obligations, Defendants Knipp, Dr. Heatley and Smiley failed to take appropriate actions as alleged herein.

2013: Duran Re-enters CDCR

52. On August 30, 2013, Duran re-entered CDCR at the North Kern State Prison (NKSP) reception center and underwent an initial health screening. A nurse documented his physical and mental health conditions, including his tracheostomy stoma, history of seizures and mental illness. Daily tracheostomy suctioning was ordered. Duran reported that he was hearing voices in his head and that he had thoughts of hurting himself. He was referred for additional mental health evaluation.

53. A staff psychiatrist again placed Duran in the Mental Health Services Delivery System at the Correctional Clinical Case Management System level of care. Duran reported visual hallucinations. He was prescribed Prozac, Thorazine and Hydroxyzine.

54. On or about September 2, 2013, Duran gave a note to correctional staff at NKSP which read: "I need 2 speak 2 a phyciatrist [*sic*]. I am not doing 2 good. I'll go downstairs if I got to [*sic*]. My head is not clear right now. I'm in pain. I AM SUICIDAL" (emphasis in original).

55. Subsequent CDCR reviews of this incident claim that Duran's note expressing suicidal ideation was not scanned into "eUHR" or "SRE" until September 10, 2013 and that this omission resulted in a lack of vital information for his treatment team in the critical days and hours preceding his death.

56. On September 2, 2013, Duran was placed in a holding cell under suicide watch.

57. According to CDCR's Mental Health Services Delivery System Program Guide, an inmate is placed on suicide watch when the inmate is at risk of suicide and is in immediate danger of self-injurious behavior.

58. Under a clinician-ordered suicide watch, an inmate wears a safety (no-tear) smock/gown with no ID band on the wrist. All furniture is removed from the cell aside from

a safety no-tear mattress and the inmate is to be either continuously observed or monitored under intervals not to exceed 15 minutes.

59. On September 3, 2013, Duran underwent another suicide risk evaluation. The evaluation specifically noted that Duran reported both a desire to die and a plan to kill himself. Accordingly, he was recognized to pose both a long term and immediate risk of suicide (described as high chronic risk and high acute risk).

60. Because of Duran's condition, the decision was made to send Duran to MCSP where he could be housed in a Mental Health Crisis Bed. Duran was cleared for transport to a Mental Health Crisis Bed at MCSP. On or about September 4, 2013, he was transferred to MCSP.

61. Upon arrival at MCSP, and specifically based on his previous suicidal ideation, Duran was admitted to the Correctional Treatment Center where he was assigned to a Mental Health Crisis Bed in a single-occupant cell. MCSP documentation reflected that Duran was being placed in a Mental Health Crisis Bed specifically because of both the high chronic risk and high acute risk of suicide that he posed.

62. On September 5, 2013, Duran was seen by a nurse-practitioner, a psychologist and a psychiatrist. Duran specifically told the nurse that he wanted to commit suicide. The nurse recorded the suicidal ideation in Duran's medical records and Duran was placed on suicide precautions.

63. According to CDCR's Mental Health Services Delivery System Program Guide, an inmate is placed on suicide precautions when the inmate is at high risk of attempting self-injurious behavior but is not in immediate danger. An inmate's placement on suicide precaution, like suicide watch, calls for visual behavioral checks by nurses at staggered intervals not to exceed 15 minutes in length.

64. Also on September 5, 2013, Duran was assessed by Pyschiatrist Dr. Anand. Dr. Anand diagnosed Duran with Psychotic Disorder not otherwise specified (NOS); Mood Disorder; Polysubstance Disorder in remission; and Adjustment Disorder with disturbance of emotions and conduct. Noting Duran's recent suicide threat and history of mental illness,

Dr. Anand renewed Duran's suicide precautions for the next 24 hours, beginning at 3:00 p.m. that day. Dr. Anand apparently recognized the need to review Duran's C-file for diagnostic clarification and memorialized in Duran's records her intent to do so, but failed to do so prior to Duran's death, which occurred less than two days later.

65. Dr. Anand noted that Duran was receiving sub-therapeutic levels of his psychotropic medication yet took no action to correct the dosage or ameliorate the consequences of under-medication, despite Duran's obviously deteriorating mental state.

66. Also on September 5, 2013, Duran was assessed by Psychologist Dr. Richard Ortigo. Dr. Ortigo noted that Duran met the criteria for inclusion in the Mental Health Services Delivery System and assignment to a Mental Health Crisis Bed.

67. At approximately 7:00 p.m. on September 5, 2013, Duran requested his psychotropic medications but was told it was not yet medication time. At approximately 9:00 p.m., when offered his medications he refused them, delusionaly stating "I don't believe those are my meds."

Duran's Death on September 6, 2014

68. The next morning, on September 6, 2013, Duran similarly refused his scheduled morning medications. He further refused to voluntarily be handcuffed and leave his cell ("cuff up") in order to attend his treatment team meeting. The meeting was held in his absence.

69. Dr. Ortigo prepared Duran's mental health treatment plan on September 6, 2013. In that treatment plan, Dr. Ortigo identified himself as the Interdisciplinary Treatment Team leader and Case Manager/ Primary Clinician and Dr. Anand as Duran's Psychiatrist.

70. According to Dr, Anand, when the IDTT met, a team which included at least one representative from the correctional side, a Sgt. Cooper, it was specifically discussed and agreed upon that because of his tracheotomy and precarious mental state that OC spray would not be used on Duran. This was never memorialized in writing nor and the defendants involved in the use of force deny having heard this from Sgt. Cooper or being aware of the IDTT determination in this regard. This failure to communicate and document

was the foreseeable consequence of the inadequate supervision by Knipp, Dr. Heatley and Smiley and does 1, 2, and 6-15.

71. Dr. Ortigo ordered that Duran remain in Mental Health Crisis Bed placement for ongoing evaluation and treatment. Dr. Ortigo specifically noted that although Duran had been relatively calm, compliant and communicative in his interviews the previous day, he was currently "much worse, anxious, agitated, restless, frantic, refusing to cuff up in order to be removed from his cell for morning rounds.... He has also been refusing his meds and refusing to eat, communicating his belief that his food and medication are poisoned. Keyhea watch was initiated this date."

72. Dr. Ortigo's order for Duran to be monitored on "Keyhea" watch from that point forward indicated that Dr. Ortigo was considering initiating a petition to involuntarily medicate Duran pursuant to Penal Code section 2602. However, this order was meaningless since MCSP lacked protocols for monitoring inmates for Keyhea criteria due to a failure by CEO Smiley, Dr. Heatley, Warden Knipp and does 6-15, to implement such protocols at MCSP. The need for these protocols should have been obvious to any reasonable administrator.

73. Dr. Ortigo recognized that Duran required highly structured in-patient psychiatric care and 24-hour nursing supervision. However, while he specifically noted Duran's risk factors for self-injurious and assaultive behavior, he failed to note Duran's obvious risk of suicide.

74. Similarly, while Dr. Ortigo recognized that Duran was actually in a worse state than he was when he was originally put on suicide precautions, Dr. Ortigo only ordered that Duran be monitored for "Keyhea" criteria and did not otherwise address Duran's declining state of mental health.

75. Upon information and belief, neither Dr. Anand nor anyone on the nursing staff followed through with Dr. Ortigo's order for "Keyhea monitoring" in regard to Duran or even seemed to be aware of the fact that such monitoring had been ordered.

76. At 12:35 p.m. on September 6, 2013, a nurse observed Duran remove his tracheostomy tube and reinsert it approximately two minutes later. This observation was recorded in Duran's medical records. Dr. Anand was notified that Duran had removed and reinserted his tracheostomy tube.

77. It is universally known by health care professionals that the removal and reinsertion of a tracheostomy tube creates an immediate risk of infection and greatly increases the risk of injury to the area around the stoma.

78. At 3:30 p.m., Dr. Anand memorialized a progress note indicating that Duran was verbalizing paranoia and fear of correctional officers and that, per the nursing staff, he had been up all night using the call light "with some demands or other." Dr. Anand ordered that Duran's suicide precautions be continued for the next 24 hours and ordered that Duran be "monitor[ed] for violence towards others due to his paranoia."

79. However, Dr. Anand countermanded that order approximately half an hour later, before it even went into effect. Despite the obvious signs that Duran's existing mental and physical condition put him at significant risk of harming himself and/or committing suicide, Dr. Anand discontinued the order for suicide precautions and instead placed Duran on purported "violence precautions."

80. This was the second time at MCSP that Duran was given a doctor's order for non-existent protocols. Placing an inmate on "violence precautions" neither a term nor protocol appearing in either MCSP or CDCR sanctioned policies or procedures. Dr. Anand apparently used a term which had meaning in her former pre-CDCR employment situation.

81. Further evidencing the endemic lack of communication between MCSP staff, no one asked what it was Dr. Anand meant by "violence precautions."

82. Dr. Anand did not document any clinical rationale for discontinuing suicide precautions for Duran, who had shown himself to be at a high risk of both chronic and acute risk for suicide. Dr. Anand discontinued Duran's suicide precautions without adequately determining whether they were no longer required. Dr. Anand did not clinically examine Duran before removing him from suicide precautions. She had not received any reports from

medical, mental health or correctional staff suggesting that Duran's condition had in any way improved or changed. She did not even bother to review Duran's C-file (something that she recognized just the day prior that needed to be done) before removing Duran from suicide precautions and placing him on non-existent "violence precautions."

83. Dr. Anand failed to document a psychiatric assessment of the *Keyhea* criteria for involuntary medication as ordered by Dr. Ortigo.

84. Under suicide precautions, Duran was being checked every 15 minutes. However, once Duran was switched over to non-existent "violence precautions," these welfare checks ceased.

85. It was obvious to any psychiatrist working in a correctional setting that Duran needed to be either continuously observed or at the least checked every 15 minutes under suicide precautions. Dr. Anand should have, at a minimum, maintained the frequent observation of Duran, rather than removing him from suicide precautions and thereby ordering the 15 minute welfare checks to cease.

86. At 5:00 p.m. on September 6, 2013, Duran pounded on his cell door and pleaded for his medication. He was told he would have to wait until the next round of medications, at 9:00 p.m.

87. At approximately 8:30 p.m., Officer Nelson, Officer Chavez and LVN Michael began the evening medication rounds. During medication rounds, a nurse accompanied by one or more correctional officers distributes scheduled medications to inmates in their cells.

88. When Officer Nelson, Officer Chavez and LVN Michael reached Duran's cell, Duran initially agreed to take his medication and placed his hands through the open food port in his cell door.

89. According to MCSP documentation, Duran then reportedly refused to cuff up and refused to remove his hands from the food port, which is an approximate 12 inch by 4.5 inch rectangular, hinged slot through which meals are passed to inmates and through which inmates place their hands in order to be cuffed up.

90. Sergeant Shepard was called to the scene and arrived prior to the use of force against Duran.

91. After receiving Sergeant Shepard's non-verbal approval (a nod), but without giving Duran any warning, Officer Chavez inexplicably unloaded his oversized MK-9 can of Oleoresin Capsicum pepper spray ("OC pepper spray") by spraying it directly at Duran's face and neck, which were pressed up against the open food port on his cell door. An MK-9 is a 16.9 ounce nitrogen propelled aerosol delivery device which is trigger operated and which is fully effective at up to 12 feet. A significant amount of OC pepper spray went directly into Duran's throat through his tracheostomy tube.

92. OC pepper spray is a potent inflammatory agent. It irritates and damages the eyes, membranes, bronchial airways, and the stomach lining. It works by causing pain at the sites that it touches.

93. Inhalation of OC pepper spray creates an immediate known health risk. It inflames the airways, causing swelling and restriction. No training or product use guides would have suggested that it was appropriate to apply OC pepper spray directly into a person's tracheostomy tube. CDCR has no written protocol for decontaminating OC pepper spray from a tracheostomy stoma.

94. There were no discussions about alternate or lesser uses of force or whether there was even any need to use force prior to Officer Chavez deploying the pepper spray.

95. After Duran was blasted with pepper spray, he recoiled and Officer Chavez closed the food port.

96. Duran immediately began to exhibit the expected signs of physical distress from the OC pepper spray, including reacting to intense pain at his tracheostomy site and having difficulty breathing and further difficulty communicating. Based on these signs of distress, it was obvious that Duran was in need of immediate and emergent medical treatment. Officer Chavez, Officer Nelson and LVN Michael saw Duran in obvious distress following the deployment of OC pepper spray and knew that he was in need of immediate medical treatment.

97. Although it was obvious that Duran needed immediate medical treatment due to pepper spray going directly into his throat through his tracheostomy tube, Officer Chavez, Officer Nelson and LVN Michael did not take necessary steps to secure medical treatment for Duran. The failure to obtain medical assistance for Duran was not only inhumane, but was also contrary to pertinent and clearly written CDCR rules regarding the use of OC pepper spray.

98. Sergeant Shepard, who was present and witnessed Officer Chavez spray Duran in the face and throat with OC pepper spray, failed to take control of the situation by intervening and rationally assessing the situation, including considering alternative courses of action.

99. Duran was rendered unable to effectively communicate due to the pain and burning at the site of his stoma and the fact that no one gave him any paper to communicate in writing. Accordingly, he was left with no means of effectively communicating with either correctional officers or medical staff during the ensuing medical emergency. Duran had no means of explaining himself and could only visibly demonstrate the pain and physical distress that he was suffering.

100. According to MCSP documentation, Duran reportedly refused to cuff up and leave his cell for decontamination outside of the cell.

101. The usual method for decontamination of OC pepper spray to an inmate in his cell would be to remove him from the cell and take him to a decontamination station (a shower or cage) and rinse, flush, or otherwise treat the affected area with copious amounts of water. However, these decontamination procedures obviously do not envision a person having been sprayed with OC pepper spray directly into his stoma. Given the obvious difficulty of removing OC pepper spray from an open tracheostomy stoma site without drowning the person who has been sprayed, the use of OC pepper spray at such a location poses clear and obvious danger. It was, in this case, an inexplicable choice.

102. Sergeant Shepard called Lieutenant McCloughan, who was the on-duty Watch Commander, to the scene. Lieutenant McCloughan arrived and, contrary to CDCR's

rules regarding OC pepper spray decontamination, did not direct his subordinates to decontaminate Duran or to have him be medically treated.

103. Instead, the decision was made to leave Duran in his cell and let him deal with the effects of the OC pepper spray himself.

104. In the immediate aftermath of Duran being OC pepper sprayed, various staff observed Duran coughing up blood and attempting to alleviate the searing pain at his tracheostomy stoma site caused by the OC pepper spray. Specifically, they observed Duran removing his tracheostomy tube, placing his finger in the stoma, and rubbing the area vigorously. These observations put Officer Chavez, Officer Nelson, Sergeant Shepard, Lieutenant McCloughan and LVN Michael, who were all present, on direct notice that Duran was experiencing a medical emergency and needed immediate medical care. However, Officer Chavez, Officer Nelson, Sergeant Shepard, Lieutenant McCloughan and LVN Michael each failed to secure or provide necessary medical care for Duran.

105. At 10:10 p.m., approximately an hour and a half after Duran was sprayed with OC pepper spray, a nurse finally called Dr. Yu, who was serving as the Medical Officer of the Day on September 6, 2013, to notify her of the situation.

106. After receiving the nurse's call, Dr. Yu in turn contacted her superior, the chief medical officer, Dr. Heatley, to assist her in medically assessing and addressing Duran's situation.

107. Dr. Heatley chastised Dr. Yu for even calling him concerning Duran's medical condition and directed her to, if the stoma was more than a month old, have nursing staff simply clean it out and reinsert the tube. On information and belief, Dr. Heatley made it clear to Dr. Yu that he was not to be bothered again with Duran's problems, even though under the institutional protocol it would have been Dr. Heatley's responsibility to contact correctional staff management regarding a failure to implement medical directives. Further, Dr. Heatley made it clear to Dr. Yu, who was a relative newcomer to MCSP, that

this was not a situation for her to be concerned with. On information and belief Dr. Heatlley did not document his discussion with Dr. Yu as required by CDCR regulations.

108. After consulting with Dr. Heatley by telephone, Dr. Yu ordered the nursing staff to have Duran evacuated from the cell, to remove and clean his tracheostomy tube, to clean the stoma site, and to reinsert the tracheostomy tube. Dr. Yu ordered that Duran be monitored for respiratory distress.

109. Dr. Yu did not properly document these or any of her subsequent telephonic interactions regarding Duran, as mandated by the CDCR, on a 2229 form. Neither Dr. Heatley (not surprisingly given the allegations of paragraph 107 above), Smiley, Knipp or does 11-15 faulted Yu for these omissions.

110. At 10:35 p.m., a nurse called Dr. Anand, Duran's treating psychiatrist, who likewise ordered that Duran be removed from his cell for decontamination. Dr. Anand further ordered that Duran be placed in a holding cell and administered 10 mg of Zyprexa intramuscularly. Zyprexa is an anti-psychotic medication.

111. A nurse relayed to custody staff the doctors' orders that Duran be removed from his cell, medicated intramuscularly and decontaminated from the OC pepper spray.

112. Custody staff became argumentative with the nurses and dismissive of the doctors' orders and refused to comply with the orders. Specifically, a nurse or nurses approached and relayed the doctors' orders to each of the following individuals: (1) Officer Strongman; (2) the Sergeant on Duty (Doe 1); and (3) Lieutenant McCloughan.

113. At the same time the nurse was relaying the doctors' orders to custody staff, Officer Strongman, the Sergeant on Duty (Doe 1) and Lieutenant McCloughan each observed Duran to be showing signs of physical distress including difficulty breathing and spitting up blood. They also observed Duran having difficulty communicating. Based on their observations of Duran's physical distress it was obvious that he needed immediate medical treatment.

114. Officer Strongman, the Sergeant on Duty (Doe 1) and Lieutenant McCloughan each refused, individually and collectively, to comply with the orders given by

Duran's doctors to evacuate him from the contaminated cell for decontamination and medication. Specifically, upon information and belief, Officer Strongman verbalized a decision to leave Duran in the cell and the Sergeant on Duty and Lieutenant McCloughan, each knowingly acquiesced to Officer Strongman's verbalized decision.

115. The Administrative Officer-of-the-Day (Doe 2) was also consulted and briefed on Duran's deteriorating physical and mental condition, including his respiratory distress and the fact that he was spitting up blood after being sprayed with OC pepper spray at the site of his tracheostomy stoma. The Administrative Officer-of-the-Day (Doe 2) was notified of the two doctors' orders that Duran be evacuated from the cell and decontaminated and medicated. This information directly put the Administrative Officer-of-the-Day on notice and with direct knowledge that Duran needed immediate medical care. Despite having such knowledge, the Administrative Officer-of-the-Day ratified the correctional staff's disregard of the doctors' orders and their refusal to remove Duran from the cell for medical treatment.

116. Despite the doctors' orders to evacuate Duran from his cell and decontaminate him, Sergeant Shepard, who has no medical training, arbitrarily decided that Duran had sufficiently decontaminated himself and that custody staff should ignore the doctors' orders. Lieutenant McCloughan and the Administrative Officer-of-the-Day acquiesced to this decision made by Sergeant Shepard.

117. Custody staff's refusal to evacuate Duran from his cell for decontamination was reported to nursing staff. However, at MCSP there existed no written or unwritten policies or guidelines for medical staff to take upon learning that correctional staff was choosing to ignore the doctors' orders.

118. No member of the correctional staff, including Officer Strongman, Sergeant Shepard or Lieutenant McCloughman, attempted to speak with either physician whose orders they were blatantly disregarding about Duran's situation or the reasons why they were choosing to ignore the doctor's orders.

119. Correctional staff and medical staff observed Duran remove his tracheostomy tube for a second time that day, and observed him put his finger and foreign objects, including food, into his stoma as if to pack a wound. Staff actually observed food protruding from the stoma opening. Both medical staff and correctional staff had to be aware of the inherent danger of Duran's placing foreign objects into his stoma and thereby obstructing his airway. Still, no one from the correctional staff did anything to secure or permit badly needed proper medical or psychiatric treatment.

120. Thereafter, a nurse called Dr. Yu, the Medical Officer-of-the-Day, to report that custody staff had refused to comply with the doctors' orders and that Duran was still in his cell and having obvious difficulty breathing. Dr. Yu, who was a relative newcomer to MCSP, showed her rapid inoculation to institutionalized indifference when she responded "If the inmate is walking around, how can he be in distress?" Dr. Yu instructed the nurse not to call again unless it was important, and she was not contacted again regarding Joseph Duran until after his death.

121. Although Dr. Yu was specifically advised that her earlier orders were not being followed by custody staff and that Duran was having difficulty breathing in his cell, she inexplicably took no action. Although she had obviously recognized her previous orders as being necessary for Duran's health and safety, she failed to take any steps toward putting these previous orders into effect once notified that they were not being followed. Instead, despite the fact that she was serving as the Medical Officer-of-the-Day, she consciously removed herself from her role as a medical professional obligated to provide care for Duran during this emergency situation.

122. Over the next several hours, Duran was monitored without sufficient frequency or regularity. Regardless, both correctional staff and medical staff continued to be aware that Duran was exhibiting symptoms indicating that he was suffering pain in and around the site of his tracheostomy stoma as well as respiratory and other physical distress. Additionally, Duran continued to exhibit signs that he was obviously suffering from severe,

unchecked mental illness. Inexplicably, all staff present continued to ignore his obvious need for medical treatment and psychiatric intervention.

123. During morning medication distribution at 5:07 a.m. on September 7, 2013, a nurse and a correctional officer noticed Duran unresponsive and not breathing on the floor in his cell.

124. It appeared to responding medical personnel that Duran, who was naked, had been dead for a significant period of time suggesting that the required monitoring of Duran in his cell had not occurred.

125. Staff members including Officer Strongman donned Personal Protective Equipment and entered the cell.

126. Correctional officers began Cardiopulmonary resuscitation ("CPR") on Duran at 5:17 a.m. after being requested to do so by nurses. These resuscitation efforts continued for several minutes, but were obviously fruitless from the point of inception due to the significant length of time that had already passed. These already fruitless efforts were further frustrated by nursing staff's fumbling attempts to locate misplaced or absent items such as a CPR backboard and a replacement tracheostomy tube.

127. Duran was pronounced dead at approximately 5:40 a.m. on September 7, 2013.

Aftermath and Cover-Up

128. In connection with both internal and external reports and investigations generated in the aftermath of Duran's death, several individuals deliberately gave false or incomplete statements. This was done in an attempt to avert or deny responsibility on the part of the involved persons for Duran's death.

129. Dr. Janet Yu authored "MCSP-Initial Inmate Death Report" on September 10, 2013. In this report, Dr. Yu failed to honestly and accurately report the events and circumstances leading up to Duran's death.

130. The result of Dr. Anand's central role in Duran's death coming out in the report was not termination or discipline, not a report to the medical board, but instead her

promotion to the position of chief psychiatrist. On information and belief this promotion required and was only obtained with the approval of Knipp, Heatley and Smiley.

131. As MCSP sits in Amador County, it fell upon the Amador County Sheriff-Coroner to determine the cause of Duran's death. MCSP employees including Dr. Yu, Sergeant Carrillo, Dr. Heatley and/or CEO Smiley, deliberately reported false information to the Amador County Sheriff-Coroner's Office for use in the official reporting of Duran's death. In particular the defendants sought to minimize the role that the pepper spraying of Duran played in his death. Their short run goal was to avert, deny and minimize responsibility for Duran's unnecessary death.

132. The Amador County Sheriff-Coroner's Office initially determined the cause of death to be "Asphyxia" and classified the death as a suicide. These determinations were based in large part on deliberately misleading information provided by MCSP staff and in particular Sgt. Carrillo and Dr. Heatley.

133. A copy of the revised and inclusive death certificate is attached hereto as a part of Exhibit A.

134. Subsequently, however, Warden Knipp, Dr. Heatley, CEO Smiley and other higher-ranking officials, including Does 16-20, adopted a more convenient characterization of Duran's death- that it was not really a suicide, and not the result of the OC pepper spray, but rather, the psychiatric equivalent of an accident.

135. In a desperate attempt to obfuscate the facts concerning Duran's death defendants Warden Knipp, Dr. Heatley, CEO Smiley and other higher-ranking officials, including does 16-20 refused to allow any of the MCSP staff (correction, medical or mental health) to be interviewed by any of the staff of the Division of Healthcare Services (DHCS) conducting the *Coleman* Court mandated review of Duran's death, triggered by it initially being reported as a quasi-suicide. This is and was unprecedented in the history of those suicide reviews. The reason for this lack of cooperation is easy to understand in that the initial finding of the DHCS' suicide investigation concluded that this was in fact more likely a homicide committed by CDCR staff. On information and belief, defendants Warden

Knipp, Dr. Heatley, CEO Smiley and other higher-ranking officials, including does 16-20 forced, using all resources available, caused significant changes to be made in the report finally submitted to the Court, to either minimize or eliminate any reference to the use of force (OC spray) as a cause and to eliminate the suggestion that Duran's death was a homicide.

136. Duran's death occurred at a particularly inconvenient time for the CDCR and its administrators, coinciding with evidentiary hearings in the long-running and bitterly contested *Coleman* action, *Coleman v. Brown, et al.*, 2:90-cv-0520, pending in the United States District Court for the Eastern District of California. *Coleman* is a class-action lawsuit originally filed in 1990 which has successfully challenged and effected a great deal of change in CDCR's treatment of mentally ill inmates. At the time of Duran's death, CDCR officials including CEO Smiley, Dr. Heatley, Warden Knipp and Does 16-20 were acutely aware that the incident had the potential to directly affect the then ongoing *Coleman* proceedings. The circumstances surrounding Duran's death implicated CDCR's policies regarding the use of force (including chemical agents and specifically OC pepper spray) against mentally ill inmates, as well as the issue of preventable suicide by mentally ill inmates, both of which were hotly contested issues in *Coleman*. If it became known that Duran's death was the result of gratuitous use of OC pepper spray against a severely mentally ill inmate, then that would dramatically underscore CDCR's problems with its use of force policy as it relates to mentally ill inmates. If the death was also classified as a suicide, then that would, in addition to implicating the use of force policies, highlight the department's woefully inadequate policies in regard to suicide prevention for mentally ill inmates. For these reasons, it would have been particularly troublesome for the details of Duran's death to break at this particular time, and there was a fear that Duran would become the face associated with its tragically systemic failures in regard to the treatment of mentally ill inmates.

137. In an attempt to avoid these potential problems, Warden Knipp, Dr. Heatley and CEO Smiley and Does 16-20 used at least two specific strategies in an attempt to cover

up and delay the breaking news of the details of Duran's death. First, various internally generated and intentionally obscure MCSP investigations and reports were created and/or altered in manners so as to cover up what really happened. Second, said officials consciously avoided finding and notifying Duran's next of kin, his parents Steven and Elaine Duran, of his death. Needless to say, the family would not be asking any questions regarding their son's death if they were not even aware of it.

138. In September of 2013, the contact information of Steven and Elaine Duran, including their telephone number, was easily obtainable online or using the telephone book. CDCR additionally had access to confidential databases.

139. No one at CDCR made an adequate, reasonable, or diligent attempt as required by California law to locate Duran's next of kin.

140. The Amador County Sheriff-Coroner's Office took custody of Duran's remains from CDCR on or about September 7, 2013. Defendant Martin A. Ryan, Amador County Sheriff-Coroner, also failed to make an adequate, reasonable, or diligent attempt as required by California law to locate Duran's next of kin.

141. Duran's body was eventually transported to Casa Bonita Funeral Home in Stockton, California. The Casa Bonita Funeral home did not make any attempt to locate Duran's next of kin. On September 24, 2013, the Casa Bonita Funeral Home cremated his remains, without having attempted to make contact with a single family member. Duran's ashes were scattered at sea off the coast of Marin County, California.

142. Warden Knipp, Dr. Heatley and Does 16-20 falsely represented in reports that Duran's next of kin could not be located. These officials then, on information and belief enlisted the help of and conspired with officials of the Amador County Sheriff-Coroner's Office, including Sheriff-Coroner Ryan, and with the Casa Bonita Funeral Home, to avoid notifying Duran's family of his death. The reason for the plan to delay or totally avoid having Duran's family notified was to avoid the family's inquiring into the circumstances of Duran's death - a frequent occurrence once the family becomes aware of a death involving both excessive force and negligence and indifference to medical care. Upon information and

belief it was also clear to the co-conspirators that there was a strong possibility that questions regarding the circumstances of the death would lead to the possibility of Duran's death being more properly categorized as a homicide rather than a suicide, leading to adverse professional, political and potential criminal consequences for all of the co-conspirators. Warden Knipp and Does 16-20, along with the Amador County Sheriff-Coroner's Office and the Casa Bonita Funeral Home each individually and collectively failed to make any attempts to locate Steven and Elaine Duran. Due to its income-generating contract with CDCR, Casa Bonita Funeral Home had an obvious interest in going along with CDCR officials' cover up of this incident and in purposefully avoiding the location and notification of Steven and Elaine Duran of their son's death.

143. Duran was Catholic. Steven and Elaine Duran are also Catholic. Had Steven and Elaine Duran been notified of Duran's death as required by law prior to the cremation of his body and disposal of his remains, they would have arranged for a proper Catholic burial with funeral and mass services for Duran. The cremation of Duran's body and scattering of his ashes at sea was not in accord with their Catholic beliefs which were likewise held by Duran. In particular, the scattering of his ashes was directly contrary to the tenets of the Catholic Church. The Durans were also deprived of their familial rights and religious obligations to hold funeral services and observe the sacraments relating to death, including mass services, a funeral liturgy, the rite of committal, and the final commendation (absolution).

144. In addition, had Steven and Elaine Duran been notified of Duran's death as required by law prior to the cremation of his body and disposal of his remains, they could have and would have arranged for a second autopsy to be performed. Because Steven and Elaine Duran did not learn of their son's death until after his body had already been cremated, they were denied this important opportunity to obtain forensic evidence in support of their wrongful death action which they were entitled to bring under California state law.

145. Steven and Elaine Duran only learned about their son's death when they were contacted on January 8, 2014 by a reporter from the Sacramento Bee who had learned of

Duran's death through confidential sources. The Bee reporter was able to find and contact Steven and Elaine Duran, whose names were on their son's death certificate, by the simple expedient of telephoning people in the Los Angeles area named Steven Duran.

CLAIMS FOR RELIEF

FIRST CAUSE OF ACTION

Excessive Force
(Violation of the Eighth Amendment to the U.S. Constitution: Survival Action- 42 U.S.C. §1983)
(Against Officer Chavez and Sergeant Shepard)

146. On behalf of decedent Duran, Plaintiffs re-allege and incorporate by reference paragraphs 1 through 145, as though fully set forth herein.

147. The actions of Officer Chavez, in conjunction with those of Sergeant Shepard, in deploying OC pepper spray directly into decedent Duran's tracheostomy stoma without any warning and without any consideration or discussion of reasonably available alternate uses of force was malicious and sadistic and was done for the purpose of causing harm.

148. The actions of Officer Chavez and Sergeant Shepard as alleged herein interfered with the enjoyment of decedent Duran's civil rights as guaranteed by the Eighth Amendment to the U.S. Constitution.

149. As a direct and proximate result of said acts by Officer Chavez, decedent Duran suffered the damages alleged herein, including but not limited to unreasonable interference with his personal liberty, physical pain and suffering, emotional distress, mental anguish, and loss of his life

150. The aforementioned acts by Officer Chavez were willful, intentional, wanton, reckless, and/or accomplished with a conscious disregard of decedent Duran's rights entitling Plaintiffs to an award of exemplary and punitive damages.

SECOND CAUSE OF ACTION

Excessive Force
(Violation of the Cal. Constitution Art. I §§ 1, 13 and Cal. Civil Code § 43: Actionable under Cal. Civil Code § 52.1(b)/Bane Act)
(Against Officer Chavez and Sergeant Shepard)

151. On behalf of decedent Duran, Plaintiffs re-allege and incorporate by reference paragraphs 1 through 150, as though fully set forth herein.

152. The actions of Officer Chavez and Sergeant Shepard, as alleged herein, interfered with the exercise and enjoyment of Joseph Duran's civil rights guaranteed by Article I, §§ 1 and 13 of the California Constitution. Specifically, Defendants Officer Chavez and Sergeant Shepard interfered with Joseph Duran's rights using threats, intimidation and coercion when Officer Chavez, acting with Sergeant Shepard's acquiescence and approval, blasted Duran's face and neck with OC pepper spray.

153. Defendants' actions constituted an excessive use of force, a violation of Joseph Duran's right to bodily integrity, and further interfered with Joseph Duran's personal rights as guaranteed by California Civil Code § 43.

154. As a direct and proximate result of Defendants' actions and/or omissions, Joseph Duran suffered unreasonable interference with his personal liberty, physical injury, pain and suffering, humiliation, emotional distress and other injuries.

155. Defendants' violations of decedent's rights as guaranteed by California Civil Code § 52.1 (Bane Act) entitles Plaintiffs to compensatory and punitive damages and attorneys' fees as provided for in §§ 52.1(b) and 52 and requested herein.

156. The aforementioned acts and/or omissions of said Defendants were willful, intentional, wanton, reckless and/or accomplished with a conscious disregard for decedent's rights as secured by Civil Code § 52.1, thereby entitling Plaintiffs to an award of punitive damages under § 52(b)(1).

THIRD CAUSE OF ACTION

Deliberate Indifference to Serious Medical Needs, Health and Safety (Violation of the Eighth Amendment to the U.S. Constitution: Survival Action- 42 U.S.C. §1983)

(Against Chavez, Nelson, LVN Michael, Strongman, Sergeant Shepard, Lieutenant McCloughan, Dr. Anand, Dr. Heatley Dr. Yu and Does 1thru15.)

157. On behalf of decedent Duran, Plaintiffs re-allege and incorporate by reference paragraphs 1 through 156, as though fully set forth herein.

158. Defendants Officer Chavez, Officer Nelson, LVN Michael, Officer Strongman, Sergeant Shepard, Lieutenant McCloughan, Dr. Anand, Dr. Heatley, Dr. Yu and Does 1 through 15 knew that decedent Duran was in danger of serious harm to his health and safety, including being at obvious risk of committing suicide, due to (1) his transfer from NKSP to MCSP for placement in a Mental Health Crisis Bed for ideating suicide; (2) various documentation in both his medical records and C-file, including, but not limited to, a September 3, 2013 suicide evaluation, which specifically noted that he had reported both a desire to die and a plan to kill himself, and that he was estimated to pose both a high chronic risk of suicide and a high acute risk of suicide; and (4) the physical and mental distress described herein that he was obviously suffering from following the deployment of OC pepper spray directly into his tracheostomy stoma, including the fact that he had ripped out his tracheostomy tube, coughed up blood, packed his stoma as one would pack a wound, and the fact that he had not been decontaminated from the OC pepper spray. Defendants Officer Strongman, Sergeant Shepard and Lieutenant McCloughan additionally knew that Duran was in danger of serious harm based on the doctors' orders that they ignored.

159. The medical and psychiatric symptoms and reported suicidal impulses by decedent Duran that Defendants ignored were obvious and immediate threats to his health and safety.

160. Despite knowing that Joseph Duran was in danger of serious harm to his health and safety, Defendants failed to provide him with necessary evaluation and treatment or failed to take action to provide him with necessary evaluation and treatment.

161. Defendants' acts and/or omissions as alleged herein, including but not limited to the failure to provide Joseph Duran with timely and adequate medical care, psychiatric care and/or take other measures to protect him from serious harm, constituted deliberate indifference to Joseph Duran's serious medical needs, health and safety.

162. As a direct and proximate result of Defendants' conduct, decedent Joseph Duran experienced the damages alleged herein, including but not limited to physical pain and suffering, emotional distress, mental anguish, and loss of his life.

163. The aforementioned acts and/or omissions of the individually named Defendants were malicious, reckless and/or accomplished with a conscious disregard of decedent's rights thereby entitling Plaintiffs to an award of exemplary and punitive damages according to proof to punish the wrongful conduct alleged herein and to deter such conduct in the future.

FOURTH CAUSE OF ACTION

Supervisory Liability based on Customs, Practices or Policies
(Survival Action- 42 U.S.C. §1983)

(Against Dr. Heatley, CEO Smiley, Warden Knipp and Does 6 through 15)

164. On behalf of decedent Duran, Plaintiffs re-allege and incorporate by reference paragraphs 1 through 163, as though fully set forth herein.

165. The aforementioned acts and/or omissions of Defendants in being deliberately indifferent to Joseph Duran's serious medical needs, health and safety and in violating decedent's civil rights were the direct and proximate result of customs, practices or policies, or the lack thereof, of Dr. Heatley, CEO Smiley Warden Knipp and Does 6 through

166. Such customs, practices, polices and/or procedures include, but are not limited to, an ongoing pattern of deliberate indifference to the serious medical needs and health and safety of MCSP inmates, including the following: a failure to ensure implementation of appropriate medical and emergency treatment plans; a failure to act upon clearly life-threatening symptoms and reports and/or clear suicidal impulses or gestures; a failure to provide appropriate staffing and training at MCSP for providing inmates with adequate medical and psychiatric treatment; a failure to implement a policy to ensure that staff would contact and summon emergency medical and/or psychiatric treatment in a timely manner; a failure to create and/or implement guidelines that must be followed to remove inmates from existing suicide precautions; a failure to create and/or implement protocols for Keyhea monitoring; a failure to create, implement and/or ensure that staff follow policies,

guidelines or steps to be taken when medical staff observe custody staff choosing to ignore orders given by an inmate's medical doctors; a failure to adequately train and supervise employees and/or agents to prevent the occurrence of the constitutional violations alleged herein; and a failure to promulgate appropriate policies or procedures or take other measures to prevent the constitutional violations alleged herein.

167. As a direct and proximate result of the aforementioned customs, practices, policies and/or procedures of said Defendants, or as a result of Defendants' failure to promulgate appropriate policies or procedures, decedent Joseph Duran suffered the damages alleged herein, including but not limited to physical pain and suffering, emotional distress, mental anguish, and loss of his life.

FIFTH CAUSE OF ACTION

Failure to Supervise, Investigate and Discipline

(Survival Action- 42 U.S.C. §1983)

(Against Sergeant Carrillo, Lieutenant McCloughan, Dr. Yu, Dr. Heatley, CEO Smiley, Warden Knipp and Does 1, 2 and 6 through 20)

168. On behalf of decedent Duran, Plaintiffs re-allege and incorporate by reference paragraphs 1 through 167, as though fully set forth herein.

169. The constitutional violations by Defendants as alleged herein occurred as a result of the failure of Defendants Sergeant Carrillo, Lieutenant McCloughan, Dr. Yu, Dr. Heatley, CEO Smiley, Warden Knipp and Does 1, 2 and 6 through 20 to adequately supervise, investigate and discipline employee conduct.

170. Defendants Sergeant Carrillo, Lieutenant McCloughan, Dr. Yu, Dr. Heatley, CEO Smiley, Warden Knipp and Does 1, 2 and 6 through 20 failed to adequately supervise, investigate and discipline subordinate employees in regard to preventing deliberate indifference to the serious medical needs, health and safety of inmates at MCSP. Said Defendants' failure to supervise, investigate and discipline employees amounted to deliberate indifference to inmates' right to be free of deliberate indifference to their serious medical needs, health and safety.

171. As a direct and proximate result of the aforementioned failure to supervise, investigate and/or discipline, decedent Duran suffered the damages alleged herein, including

but not limited to physical pain and suffering, emotional distress, mental anguish, and loss of his life.

SIXTH CAUSE OF ACTION

Substantive Due Process- Loss of Parent/Child Relationship
(Violation of the Fourteenth Amendment
to the U.S. Constitution: 42 U.S.C. §1983)

(Against Defendants Officer Chavez, Officer Nelson, LVN Michael, Officer Strongman, Sergeant Shepard, Sergeant Carrillo, Lieutenant McCloughan, Dr. Anand, Dr. Heatley, CEO Smiley, Dr. Yu, Warden Knipp and Does 1, 2 and 6 through 20)

172. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 171, as though fully set forth herein.

173. The acts and/or omissions of Defendants Officer Chavez, Officer Nelson, LVN Michael, Officer Strongman, Sergeant Shepard, Sergeant Carrillo, Liuetenant McCloughan, Dr. Anand, Dr. Heatley, Dr. Yu and Does 1, 2 and 6 through 20 as alleged herein, in using excessive force and/or being deliberately indifferent to the serious medical needs of decedent Duran by failing to summon or provide Joseph Duran with medical care, psychiatric care and/or take other measures to prevent his death after noticing his suicidal impulses, suicidal condition and/or need for medical attention, resulted in Duran's suicide and/or death, which deprived Plaintiffs Steven Duran and Elaine Duran of their liberty interest in the parent-child relationship in violation of their substantive due process rights as defined by the First and Fourteenth Amendments to the United States Constitution.

174. Such conduct by said Defendants "shocks the conscience."

175. As a direct and proximate result of said Defendants' conduct, Plaintiffs suffered injuries and damages as alleged herein including pain and suffering and emotional distress.

176. The aforementioned acts and/or omissions of the individually named Defendants were willful, wanton, malicious, reckless, and oppressive, thereby justifying an award of exemplary and punitive damages to punish the wrongful conduct alleged herein and to deter such conduct in the future.

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SEVENTH CAUSE OF ACTION
Wrongful Death
(Cal. Code of Civil Procedure § 377.60 et seq.)
(Against Defendants Officer Chavez, Officer Nelson, LVN Michael, Officer Strongman, Sergeant Shepard, Lieutenant McCloughan, Dr. Anand,Dr, Heatley, Dr. Ortigo and Dr. Yu and Does 1 through 15)

177. On behalf of decedent Duran, Plaintiffs re-allege and incorporate by reference paragraphs 1 through 176, as though fully set forth herein.

178. Plaintiffs Steven Duran and Elaine Duran are the parents of the decedent Joseph Duran, who has no surviving spouse or surviving children or issue of children.

179. The acts and/or omissions by Defendants Officer Chavez, Officer Nelson, LVN Michael, Officer Strongman, Sergeant Shepard, Lieutenant McCloughan, Dr. Anand, Dr. Ortigo, Dr. Heatley, Dr. Yu and Does 1 through 15 as detailed below directly and proximately caused the wrongful death of Joseph Duran and were the direct and proximate cause of Plaintiffs' injuries entitling Plaintiffs to recover damages pursuant to Code of Civil Procedure section 377.60 et seq.

a. Wrongful Death: Professional Negligence/ Medical Malpractice (Survival Action- Cal. Code Civ. Proc. § 377.60 et seq.)
(Against Defendants Dr. Ortigo, Dr. Anand, Dr. Heatley *Dr. Yu, and Does 3 through 5 and 11 through 15)*

180. The medical and/or psychiatric care rendered by Dr. Anand, Dr. Ortigo, Dr. Heatley and Dr. Yu and Does 3 through 5 and 11 through 15 was at a minimum negligent and did not comply with professional standards of care for such treatment, proximately causing Plaintiffs' injuries.

181. The acts and/or omissions by Dr. Anand, Dr. Ortigo, Dr. Heatley Dr. Yu and Does 3 through 5 and 11 through 15 as described herein directly and proximately caused decedent Duran to suffer the damages alleged herein, including but not limited to physical pain and suffering, emotional distress, mental anguish, and loss of his life.

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b. Failure to Summon Medical Care- Cal. Govt. Code § 845.6 (Survival Action- Cal. Code Civ. Proc. § 377.60 et seq.)
(Against Defendants Officer Chavez, Officer Nelson, Officer Strongman, Sergeant Shepard, Lieutenant McCloughan, LVN Michael and Does 1, 2 and 6 through 15)

182. Defendants Officer Chavez, Officer Nelson, Officer Strongman, Sergeant Shepard, Lieutenant McCloughan, LVN Michael, and Does 1, 2 and 6 through 15 owed Joseph Duran a duty to summon medical care.

183. Said defendants breached that duty when they had actual and constructive knowledge that Joseph Duran was in obvious physical distress following the deployment of OC pepper spray directly into his tracheostomy stoma. Based on, at a minimum, the signs that Duran was having trouble breathing and spitting up blood it was obvious to said Defendants that Joseph Duran in need of immediate medical care and yet said Defendants failed to timely respond and failed to take reasonable action to summon such care, as alleged herein, resulting in a violation of Cal. Govt. Code sections 844.6 and 845.6 and Joseph Duran's loss of life.

184. Said conduct was committed in the course and scope of said Defendants' employment.

185. As a direct and proximate cause of said Defendants' breach, decedent Joseph Duran suffered the damages alleged herein, including but not limited to physical pain and suffering, emotional distress, mental anguish, and loss of his life.

186. The actions by Defendants Officer Chavez, Officer Strongman, Sergeant Shepard, Lieutenant McCloughan and Dr. Anand were willful, wanton, malicious and oppressive, thereby justifying an award of exemplary and punitive damages to punish the wrongful conduct alleged herein and to deter such conduct in the future. Plaintiff seeks exemplary and punitive damages only against Defendants Officer Chavez, Officer Strongman, Sergeant Shepard, Lieutenant McCloughan and Dr. Anand as to this cause of action.

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EIGHTH CAUSE OF ACTION

Failure to Discharge Duty to Locate and Notify Decedent's Next of Kin
(Cal. Govt. Code §§ 815.6, 27471; Cal. Pen. Code §§ 5022, 5061;
Cal. Health and Saf. Code §§ 7104, 7104.1)
(Against Warden Knipp, Sheriff-Coroner Ryan and Does 16 through 20)

187. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 186, as though fully set forth herein.

188. Defendants Sheriff-Coroner Ryan, Warden Knipp and Does 16 through 20 owed Plaintiffs a mandatory duty under section 27471(a) of the California Government Code and sections 7104 and 7104.1 of the California Health and Safety Code to make reasonable efforts to locate Joseph Duran's next of kin before his remains were cremated.

189. Said Defendants breached this duty by failing to act with reasonable diligence in locating a family member before cremating Joseph Duran's remains.

190. As a direct and proximate cause of said Defendants' breach, Plaintiffs suffered harm and injuries described herein including emotional distress.

NINTH CAUSE OF ACTION

Negligence
(Cal. State law)
(Against Casa Bonita Funeral Home)

191. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 190, as though fully set forth herein.

192. Defendant Casa Bonita Funeral Home owed Plaintiffs a duty to make reasonable efforts to locate Joseph Duran's next of kin before cremating his remains.

193. Defendant Casa Bonita Funeral Home breached this duty by failing to act with reasonable diligence in locating Duran's next of kin or any family member before cremating Joseph Duran's remains.

194. As a direct and proximate cause of said Defendants' breach, Plaintiffs suffered harm and injuries described herein including emotional distress.

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TENTH CAUSE OF ACTION
Substantive Due Process- Notification and Burial
(Violation of the Fourteenth Amendment to the U.S. Constitution: Actionable under- 42 U.S.C. §1983)
(Against Warden Knipp, Sheriff-Coroner Ryan, Casa Bonita Funeral Home and Does 16 through 20)

195. Plaintiffs re-allege and incorporate by reference paragraphs 1 through 194, as though fully set forth herein.

196. There exists a familial right and obligation to attend to the circumstances of final rest for one's kin. This duty to properly bury one's family members is recognized as the final and ultimate familial obligation and falls within the penumbra of rights guaranteed by the Fourteenth Amendment.

197. Steven and Elaine Duran had a familial right and obligation to bury their son, Joseph Duran, and a right to do so in accordance with the Catholic beliefs held by them as well as by Joseph Duran.

198. The conduct of Defendants Warden Knipp, Sheriff-Coroner Ryan, Casa Bonita Funeral home and Does 16 through 20 in actively and willfully concealing the fact of Duran's death and/or in failing to act with reasonable diligence to locate Duran's next of kin or any family member before cremating his body and disposing of his remains deprived Steven and Elaine Duran of their familial right to bury their son.

199. Said conduct shocks the conscience.

200. As a direct and proximate result of said Defendants' conduct, Plaintiffs suffered injuries and damages as alleged herein including pain and suffering and emotional distress.

201. The aforementioned acts and/or omissions of the individually named Defendants were willful, wanton, malicious, reckless, and oppressive, thereby justifying an award of exemplary and punitive damages to punish the wrongful conduct alleged herein and to deter such conduct in the future.

VIII. PRAYER FOR RELIEF

WHEREFORE, Plaintiff prays for the following relief:

1. For compensatory, general and special damages against each Defendant, jointly and severally, in the amount proven at trial;

2. For punitive and exemplary damages against each individually named Defendant in an amount appropriate to punish Defendants and deter others from engaging in similar misconduct;

3. For costs and reasonable attorneys' fees pursuant to 42 U.S.C. § 1988 and as otherwise authorized by statute or law;

4. For such other relief, including injunctive and/or declaratory relief, as the Court may deem proper.

DATED: December 28, 2015

Respectfully submitted,

/s/ Stewart Katz
Stewart Katz,
Attorney for Plaintiff

DEMAND FOR TRIAL BY JURY

Plaintiffs demand trial by jury.

Dated: December 28, 2015

Respectfully submitted,

/s/ Stewart Katz
Stewart Katz,
Attorney for Plaintiff

Exhibit A

LAW OFFICE OF STEWART KATZ
STEWART KATZ, State Bar #127425
555 University Avenue, Suite 270
Sacramento, California 95825
Telephone: (916) 444-5678

Attorney for Plaintiffs

UNITED STATES DISTRICT COURT

EASTERN DISTRICT OF CALIFORNIA

STEVEN A. DURAN and ELAINE DURAN as Successors in Interest of JOSEPH DURAN; STEVEN DURAN, Individually; and ELAINE DURAN, Individually,

Plaintiffs,

vs.

CDCR Correctional Officer ROY C. CHAVEZ, et al.,

Defendants.

_____/

NO. 2:14-cv-2048 TLN CKD

DECLARATION BY PERSONS BRINGING THIS ACTION AS DECEDENT'S SUCCESSORS IN INTEREST

Cal. Code Civ. Proc. § 377.32

Pursuant to California Code of Civil Procedure section 377.32 and this Court's order of December 7, 2015, Plaintiffs submit this declaration in support of bringing this action as decedent's successors in interest.

I, Steven A. Duran, and I, Elaine Duran, declare as follows:

1. The claims in this action arise out of the death of the decedent, Joseph Duran.

2. Decedent Joseph Duran died on September 7, 2013, at Mule Creek State Prison in Ione, California, in the County of Amador.

3. No proceeding is now pending in California for administration of the decedent's estate.

4. There was no administration of the decedent's estate.

5. The declarants Steven A. Duran and Elaine Duran are the parents of decedent, Joseph Duran, and are his next of kin. The declarants Steven A. Duran and Elaine

Duran are the decedent's successors in interest as defined in section 377.11 of the California Code of Civil Procedure and succeed to the decedent's interest in this action.

6. No other person has a superior right to commence the action or proceeding or to be substituted for the decedent in the pending action or proceeding.

7. A certified copy of the decedent's death certificate is attached hereto.

I declare under penalty of perjury that the foregoing is true and correct of my own knowledge, and if called to do so, I could and would competently testify to the matters set forth herein. Executed this 22nd day of December, 2015, at Whittier, California.

/s/ Steven A. Duran
Steven A. Duran, Declarant

I declare under penalty of perjury that the foregoing is true and correct of my own knowledge, and if called to do so, I could and would competently testify to the matters set forth herein. Executed this 22nd day of December, 2015, at Whittier, California.

/s/ Elaine Duran
Elaine Duran, Declarant

STATE OF CALIFORNIA

CERTIFICATION OF VITAL RECORD

COUNTY OF AMADOR

JACKSON, CALIFORNIA 95642

CERTIFICATE OF DEATH

STATE OF CALIFORNIA
USE BLACK INK ONLY / NO ERASURES, WHITEOUTS OR ALTERATIONS
VS-11 (REV 3/06)

STATE FILE NUMBER: 3201303000314
LOCAL REGISTRATION NUMBER

DECEDENT'S PERSONAL DATA

1 NAME OF DECEDENT– FIRST (Given)	2 MIDDLE	3 LAST (Family)
Joseph	Damien	Duran

AKA (ALSO KNOWN AS – Include full AKA (FIRST, MIDDLE, LAST)):

4 DATE OF BIRTH mm/dd/ccyy	5 AGE Yrs	IF UNDER ONE YEAR Months	Days	IF UNDER 24 HOURS Hours	Minutes	6 SEX
[redacted]978	35					M

9 BIRTH STATE/FOREIGN COUNTRY	10 SOCIAL SECURITY NUMBER	11 EVER IN U.S. ARMED FORCES?	12 MARITAL STATUS/SRDP (at Time of Death)	7 DATE OF DEATH mm/dd/ccyy	8 HOUR (24 Hours)
California	[redacted]	[ ] YES [X] NO [ ] UNK	Never Married	09/07/2013	0540

13 EDUCATION – Highest Level/Degree (see worksheet on back)	14/15 WAS DECEDENT HISPANIC/LATINO(A)/SPANISH? (If yes, see worksheet on back)	16 DECEDENT'S RACE – Up to 3 races may be listed (see worksheet on back)
Unknown	[X] YES Mexican [ ] NO	Mexican American

17 USUAL OCCUPATION – Type of work for most of life DO NOT USE RETIRED	18 KIND OF BUSINESS OR INDUSTRY (e.g., grocery store, road construction, employment agency, etc.)	19 YEARS IN OCCUPATION
Unknown	Unknown	Unknown

USUAL RESIDENCE

20 DECEDENT'S RESIDENCE (Street and number, or location)				
4001 Highway 104				
21 CITY	**22 COUNTY/PROVINCE**	**23 ZIP CODE**	**24 YEARS IN COUNTY**	**25 STATE/FOREIGN COUNTRY**
Ione	Amador	95640	0	California

INFORMANT

26 INFORMANT'S NAME, RELATIONSHIP	27 INFORMANT'S MAILING ADDRESS (Street and number, or rural route number, city or town, state and zip)
Tami Somara-Correctional Manager	4001 Highway 104, Ione, CA 95640

SPOUSE/SRDP AND PARENT INFORMATION

28 NAME OF SURVIVING SPOUSE/SRDP– FIRST	29 MIDDLE	30 LAST (BIRTH NAME)	
–	–	–	
31 NAME OF FATHER/PARENT– FIRST	**32 MIDDLE**	**33 LAST**	**34 BIRTH STATE**
Steven	–	Duran	Unknown
35 NAME OF MOTHER/PARENT– FIRST	**36 MIDDLE**	**37 LAST (BIRTH NAME)**	**38 BIRTH STATE**
Elaine	–	Unknown	Unknown

FUNERAL DIRECTOR/ LOCAL REGISTRAR

39 DISPOSITION DATE mm/dd/ccyy	40 PLACE OF FINAL DISPOSITION		
09/24/2013	Scattering at Sea off the coast of Marin County, CA		
41 TYPE OF DISPOSITION(S)	**42 SIGNATURE OF EMBALMER**		**43 LICENSE NUMBER**
CR/SEA	Not Embalmed		–
44 NAME OF FUNERAL ESTABLISHMENT	**45 LICENSE NUMBER**	**46 SIGNATURE OF LOCAL REGISTRAR**	**47 DATE mm/dd/ccyy**
Casa Bonita Funeral Home	FD2107	Kimberly L. Grady	09/23/2013

PLACE OF DEATH

101 PLACE OF DEATH	102 IF HOSPITAL, SPECIFY ONE	103 IF OTHER THAN HOSPITAL, SPECIFY ONE
Mule Creek State Prison	[ ] IP [ ] ERDP [ ] DOA [ ] Hospice [ ] Nursing Home/LTC [ ] Decedent's Home [X] Other	
104 COUNTY	**105 FACILITY ADDRESS OR LOCATION WHERE FOUND (Street and number, or location)**	**106 CITY**
Amador	4001 Highway 104	Ione

CAUSE OF DEATH

107 CAUSE OF DEATH — Enter the chain of events — disease, injuries, or complications — that directly caused death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE.

		Time Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death)	(A) Pending	(A1)
Sequentially, list conditions, if any, leading to cause on Line A. Enter UNDERLYING CAUSE (disease or injury that initiated the events resulting in death) LAST	(B)	(B1)
	(C)	(C1)
	(D)	(D1)

105 DEATH REPORTED TO CORONER?	109 BIOPSY PERFORMED?	110 AUTOPSY PERFORMED?	111 USED IN DETERMINING CAUSE?
[X] YES [ ] NO	[ ] YES [X] NO	[X] YES [ ] NO	[X] YES [ ] NO
REFERRAL NUMBER C2013-080			

112 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RESULTING IN THE UNDERLYING CAUSE GIVEN IN 107

113 WAS OPERATION PERFORMED FOR ANY CONDITION IN ITEM 107 OR 112? (If yes, list type of operation and date.)

113A IF FEMALE, PREGNANT IN LAST YEAR? [ ] YES [ ] NO [ ] UNK

PHYSICIAN'S CERTIFICATION

114 I CERTIFY THAT TO THE BEST OF MY KNOWLEDGE DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED	115 SIGNATURE AND TITLE OF CERTIFIER	116 LICENSE NUMBER	117 DATE mm/dd/ccyy
Decedent Attended Since (A) mm/dd/ccyy; Decedent Last Seen Alive (B) mm/dd/ccyy			
118 TYPE ATTENDING PHYSICIAN'S NAME, MAILING ADDRESS, ZIP CODE			

CORONER'S USE ONLY

119 I CERTIFY THAT IN MY OPINION DEATH OCCURRED AT THE HOUR, DATE, AND PLACE STATED FROM THE CAUSES STATED	120 INJURED AT WORK?	121 INJURY DATE mm/dd/ccyy	122 HOUR (24 Hours)
MANNER OF DEATH: [ ] Natural [ ] Accident [ ] Homicide [ ] Suicide [X] Pending Investigation [ ] Could not be determined	[ ] YES [ ] NO [ ] UNK		

123 PLACE OF INJURY (e.g., home, construction site, wooded area, etc.)

124 DESCRIBE HOW INJURY OCCURRED (Events which resulted in injury)

125 LOCATION OF INJURY (Street and number, or location, and city, and zip)

126 SIGNATURE OF CORONER / DEPUTY CORONER	127 DATE mm/dd/ccyy	128 TYPE NAME, TITLE OF CORONER / DEPUTY CORONER
Michael T. Rice	09/20/2013	Michael T. Rice, Deputy Coroner

STATE REGISTRAR	A	B	C	D	E		FAX AUTH.#	CENSUS TRACT

1 of 2

CAAMADOR02

SEAL OF THE STATE OF CALIFORNIA — EUREKA

CERTIFIED COPY OF VITAL RECORD
STATE OF CALIFORNIA, COUNTY OF AMADOR

This is a true and exact reproduction of the document officially registered and placed on file in the office of the Amador County Clerk-Recorder.

000075201

DATE ISSUED 12/16/2015

Kimberly L. Grady
KIMBERLY L. GRADY
COUNTY CLERK-RECORDER

This copy is not valid unless prepared on an engraved border displaying the date, seal and signature of the Clerk-Recorder.

AMADOR COUNTY — CALIFORNIA

STATE OF CALIFORNIA
CERTIFICATION OF VITAL RECORD

COUNTY OF AMADOR
JACKSON, CALIFORNIA 95642

3052013220769 — STATE FILE NUMBER

PHYSICIAN/CORONER'S AMENDMENT
NO ERASURES, WHITEOUTS, PHOTOCOPIES, OR ALTERATIONS

3201303000314 — LOCAL REGISTRATION NUMBER

☐ BIRTH ☒ DEATH ☐ FETAL DEATH

TYPE OR PRINT CLEARLY IN BLACK INK ONLY – THIS AMENDMENT BECOMES AN ACTUAL PART OF THE OFFICIAL RECORD

PART I INFORMATION TO LOCATE RECORD

INFORMATION AS IT APPEARS ON ORIGINAL RECORD	1A. NAME—FIRST	1B MIDDLE	1C LAST	2 SEX
	JOSEPH	Damien	DURAN	MALE
	3 DATE OF EVENT—MM/DD/CCYY	4 CITY OF EVENT	5 COUNTY OF EVENT	
	09/07/2013	IONE	AMADOR	

PART II STATEMENT OF CORRECTIONS

LIST ONE ITEM PER LINE

6 CERTIFICATE ITEM NUMBER	7 INFORMATION AS IT APPEARS ON ORIGINAL RECORD	8 INFORMATION AS IT SHOULD APPEAR
107(A)	PENDING	ASPHYXIA
107(AT)		MINUTES
107(B)		FOOD AND FECAL MATERIAL IN STOMA
107(BT)		MINUTES
107(C)		CLINICAL HISTORY OF BIPOLAR DISORDER,
		MIXED ANTI-SOCIAL AND BORDERLINE
		PERSONALITY DISORDERS AND DEPRESSION.
107(CT)		YEARS
112		TRACHEAL STENOSIS SECONDARY TO GUNSHOT
		WOUND, LEFT CONCENTRIC VENTRICULAR
		HYPERTROPHY, MODERATE SPLENOMEGALY.
113		NO
119	PENDING INVESTIGATION	SUICIDE
120		NO
121		09/07/2013
122		0518
123		MULE CREEK STATE PRISON
124		DECEDENT TORE TRACHEOSTOMY TUBE OUT AND
		STUFFED FOOD/FECAL MATERIAL IN THE STOMA
125		4001 HIGHWAY 104, IONE CA. 95640

2 of 2

DECLARATION OF CERTIFYING PHYSICIAN OR CORONER

I HEREBY DECLARE UNDER PENALTY OF PERJURY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

9 SIGNATURE OF CERTIFYING PHYSICIAN OR CORONER	10. DATE SIGNED—MM/DD/CCYY	11 TYPED OR PRINTED NAME AND TITLE/DEGREE OF CERTIFIER
▶ Brandon Cone	11/19/2013	BRANDON CONE, DEPUTY CORONER
12 ADDRESS—STREET AND NUMBER	13 CITY	14 STATE / 15 ZIP CODE
700 COURT STREET	JACKSON	CA 95642

STATE/LOCAL REGISTRAR USE ONLY

16 OFFICE OF VITAL RECORDS OR LOCAL REGISTRAR	17 DATE ACCEPTED FOR REGISTRATION—MM/DD/CCYY
▶ STATE REGISTRAR - OFFICE OF VITAL RECORDS	01/02/2014

STATE OF CALIFORNIA, DEPARTMENT OF PUBLIC HEALTH, OFFICE OF VITAL RECORDS — *DC2013000001672* — FORM VS 24A (REV. 1/08

21

CAAMADOR

CERTIFIED COPY OF VITAL RECORD
STATE OF CALIFORNIA, COUNTY OF AMADOR

This is a true and exact reproduction of the document officially registered and placed on file in the office of the Amador County Clerk-Recorder.

000075202

DATE ISSUED 12/16/2015

Kimberly L. Grady
KIMBERLY L. GRADY
COUNTY CLERK-RECORDER

This copy is not valid unless prepared on an engraved border displaying the date, seal and signature of the Clerk-Recorder.