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UNITED STATES DISTRICT COURT

SOUTHERN DISTRICT OF CALIFORNIA

RAKHSHANDA TALIB-GRACE, , individually and on behalf of the Estate of Karim Talib, Decedent; ALI TALIB, individually and on behalf of the Estate of Karim Talib; AHMED TALIB, individually and on behalf of the Estate of Karim Talib; SHERVONE PRYOR, individually and on behalf of the Estate of Karim Talib; ANDRE PRYOR, individually and on behalf of the Estate of Karim Talib, Plaintiffs, vs. SAN DIEGO COUNTY, a Governmental Entity; NAPHCARE a Delaware Limited Liability Company; HASSAN QURESHI, M.D., individual; JAMES VELTMEYER, M.D.; KIEKO FUKUE, individually; TONY UNDERWOOD, individually; THERESA PALAFOX, individually; BIANCA BATES, individually; REX PADILLA, individually; EDGAR	Case No.: '25CV3698 AJB DEB **COMPLAINT FOR DAMAGES** 1. **Deliberate Indifference to a Substantial Risk of Harm to Health (42 U.S.C. § 1983, 14th Am. of U.S. Constitution)** 2. ***Monell*-Failure to Train (42 U.S.C. §1983)** 3. ***Monell*- Unconstitutional Custom, Practice and Policy (42 U.S.C. §1983)** 4. ***Monell*- Ratification (42 U.S.C. §1983)** 5. **Violations Of Title II Of The Americans With Disabilities Act And The Rehabilitation Act** 6. **Elder and Dependent Adult Abuse per W&I §15657** 7. **Negligence – (State)** 8. **Bane Act C.C. 52.1 Et Seq. (State)** 9. **Failure to Summon Medical Care (California Government Code § 845.6)** **DEMAND FOR JURY TRIAL**

TIMPUG, individually and DOES 1
through 10 inclusive,

Defendants.

PRELIMINARY STATEMENT

1. Plaintiffs, on behalf of deceased Karim Talib, hereinafter referred to as "TALIB" or "Mr. Talib", an inmate at the San Diego Central Jail hereinafter referred to as "SDCJ", operated by the San Diego County Sheriff's Department, bring this action against the County of San Diego ("COUNTY"), jail medical staff DOES 1-5, jail deputy staff and supervisors DOES 6-8, mental health clinician DOE 9 and San Diego Central Jail Management and employees including DOES 9 through 10 for monetary damages to redress for MR. TALIB's injuries and death resulting from Defendants' deliberate indifference to his constitutional rights and liberties. Plaintiffs bring this action under the Fourteenth Amendment of the United States Constitution and the Civil Rights Act of 1871, as codified at 42 U.S.C. § 1983, for injuries and death suffered because of the Defendants' substantial and deliberate indifference to TALIB's health and welfare while in their custody.

2. Plaintiffs further bring their 14th Amendment Deliberate indifference claim under the recent 9th Circuit Court of Appeals decision in *Gordon v. County of Orange et* al. *888 F.3d 1118*. Plaintiffs also state a claim against the Defendants for a failure to establish policies, procedures and training which resulted in the subject incident. This is a civil action seeking damages against the Defendants for committing acts under color of law, and depriving Mr. TALIB of rights secured by the Constitution and laws of the United States (42 U.S.C. § 1983). Defendants COUNTY, NAPHCARE, correctional nurses and medical staff DOES 1 through 5, jail deputy staff and supervisors DOES 6 through 8, San Diego Central Jail management and employees including DOES 9 through 10, were deliberately indifferent by, without limiting other acts and behaviors: failing to provide

1 medical care, failing to follow their own established medical care and treatment
2 protocol; failing to protect Mr. TALIB from harm; failing to provide necessary
3 and appropriate medical treatment and, failing to provide necessary and
4 appropriate personnel needed for the health and welfare of Mr. TALIB, who at the
5 time of injury, was a pretrial detainee at the San Diego Central Jail, in San Diego
6 County, California. Defendants deprived Mr. TALIB's rights as guaranteed by the
7 Fourteenth and Eighth Amendments to the Constitution of the United States
8 against cruel and unusual punishment.

9 3. Plaintiffs also bring their claim under the Elder and Dependent Adult
10 Neglect and Abuse section §15657). Mr. Talib was an elderly and/or dependent
11 adult within the meaning of Welfare and Institutions Code section 15610.27 and
12 15610.23, respectively. At all times relevant, he was in the custody, care, and
13 control of employees of Defendants COUNTY, its Sheriff's Department, medical
14 services contractor NAPHCARE, a mental health clinician identified as KIEKO,
15 and DOES 1-10 inclusive, while confined in the San Diego County Main Jail
16 Facility.

17 4. The Defendants including jail correctional and medical staff at the
18 San Diego Central Jail, management and employees violated Mr. TALIB's
19 constitutional rights and were deliberately indifferent by, without limiting other
20 acts and behaviors: (1) deliberately ignoring and failing to heed to Mr. Talib's
21 serious medical condition, to wit, his dementia, repeated episodes of incontinence
22 without any responsive effort to clean himself, inability to consume meals,
23 inability to consume medication, and minimal or absent responses to attempts by
24 other detainees and Defendants to communicate with him; (2) ignoring Mr.
25 TALIB's visibly worsening mental and physical health; (3) failing to properly
26 respond to obvious signs that Plaintiff was in need of urgent medical care prior to
27 his death, and even more critically in failing take his vitals and/or keep him in
28 close observation and monitoring; (4) failing to respond to fellow-detainees

repeated pleas to check up on and provided medical treatment on Mr. TALIB's behalf; and (5) failure to hospitalize and refer to a higher level of care. As a consequence of the defendants' actions and omissions, Mr. TALIB suffered, deteriorated, and was injured physically, and died, and which action constituted a clear deprivation of his constitutional rights.

JURISDICTION AND VENUE

5. This action is filed under the Due Process Clause of the Fourteenth Amendment of the United States Constitution, pursuant to 42 U.S.C. § 1983, and under state laws to redress injuries suffered by the plaintiff at the hands of defendants.

6. By government claim forms dated August 8, 2025, pursuant to Government Code §911.2*,* San Diego County, through its Clerk of the Board of Supervisors, was sent a Notice of Claim regarding violations of Plaintiffs' constitutional rights. The claim stated the time, place, cause, nature, and extent of the plaintiff's injuries.

7. This Court has jurisdiction over the federal civil rights claim pursuant to 28 U.S.C. §§ 1331 and 1343. This Court has supplemental jurisdiction over any state-law claims pursuant to 28 U.S.C. § 1367(a).

8. At all relevant times, Mr. TALIB was an inmate at the San Diego Central Jail operated by the San Diego County Sheriff's Department.

9. Venue is proper in this Court pursuant to 28 U.S.C. § 1391(b) and (c).

PARTIES

10. At all times relevant to this complaint, Plaintiff, Rakshanda Talib-Grace, is the adult daughter of Mr. TALIB, and is an individual residing in Ohio.

11. At all times relevant to this complaint, Plaintiff, Ali Talib, is the adult son of Mr. TALIB, and is an individual residing in Ohio.

12. At all times relevant to this complaint, Plaintiff, Ahmed Talib, is an

1 adult son of Mr. TALIB, and is an individual residing in Ohio.
2 13. At all times relevant to this complaint, Plaintiff, Shervonne Pryor, is
3 an adult daughter of Mr. TALIB, and is residing in Ohio.
4 14. At all times relevant to this complaint, Plaintiff Andre Pryor, is an
5 adult son of Mr. TALIB, and is residing in Pennsylvania.
6 15. At all times relevant to this complaint, Karim Talib, hereinafter
7 referred to as "TALIB" was a non-convicted inmate, also known as a pretrial
8 detainee, who was examined prior to booking at the San Diego Central Jail, in San
9 Diego, California.
10 16. Defendant County of San Diego, hereinafter known as "COUNTY",
11 is a governmental entity, a public entity, form unknown, existing under the laws of
12 the State of California and acting through individuals to establish its policies and
13 is capable of being sued under federal law.
14 17. The San Diego County Sheriff's Department is a duly organized
15 subsidiary of COUNTY and responsible for supervising and operating the San
16 Diego Central Jail, a correctional facility, and ensuring the health and safety of all
17 inmates and pretrial detainees incarcerated in its corrections facilities.
18 18. At all relevant times to this complaint, Naphcare, hereinafter referred
19 to as "NAPHCARE" is a private corporation, incorporated in the state of Alabama
20 and that acts through individuals to establish its policies and that is capable of
21 being sued under federal law. NAPHCARE, through a contract with the
22 COUNTY, provides correctional healthcare services at the San Diego Central Jail,
23 a COUNTY jail located in downtown San Diego.
24 19. At all times relevant to the complaint, Defendant James Veltmeyer,
25 M.D, hereinafter referred to as "Defendant Dr. VELTMEYER" was employed in
26 the capacity of correctional physician at the San Diego Central Jail and was a duly
27 authorized employee and agent of Defendant COUNTY and/or NAPHCARE, and
28 was acting within the course and scope of his perspective duties as a supervising

1 physician or responsible physician in the jail with the complete authority and
2 ratification of his principal, Defendant COUNTY and/or NAPHCARE. Defendant
3 Dr. VELTMEYER is being sued in his individual capacity.
4 20. At all times relevant to the complaint, Defendant "Hassan Qureshi,
5 M.D", hereinafter referred to as "Defendant Dr. QURESHI" was employed in the
6 capacity of correctional physician at the San Diego Central Jail and was a duly
7 authorized employee and agent of Defendant COUNTY and/or NAPHCARE, and
8 was acting within the course and scope of his perspective duties as a correctional
9 physician in the jail with the complete authority and ratification of his principal,
10 Defendant COUNTY and/or NAPHCARE. Defendant Dr. QURESHI is being
11 sued in his individual capacity.
12 21. At all times relevant to the complaint, Defendant Kieko Fukue,
13 hereinafter referred to as "Defendant FUKUE" was employed in the capacity of an
14 "MHC" or a mental health clinician at the San Diego Central Jail and was a duly
15 authorized employee and agent of Defendant COUNTY and/or NAPHCARE, and
16 was acting within the course and scope of his perspective duties as a mental health
17 a staff with the complete authority and ratification of his principal, Defendant
18 COUNTY and/or NAPHCARE. Defendant FUKUE is being sued in his individual
19 capacity.
20 22. At all times relevant to the complaint, Defendant Tony Underwood
21 hereinafter referred to as "Defendant UNDERWOOD" was employed in the
22 capacity of a nurse practitioner at the San Diego Central Jail and was a duly
23 authorized employee and agent of Defendant COUNTY and/or NAPHCARE, and
24 was acting within the course and scope of his perspective duties as a nurse
25 practitioner in the jail with the complete authority and ratification of his principal,
26 Defendant COUNTY and/or NAPHCARE. Defendant UNDERWOOD is being
27 sued in his individual capacity.
28 23. All times relevant to the complaint, Defendant Theresa Palafox,

1 hereinafter referred to as "Defendant PALAFOX" was employed in the capacity
2 of "MHC" or a mental health clinician at the San Diego Central Jail and was a
3 duly authorized employee and agent of Defendant COUNTY and/or NAPHCARE,
4 and was acting within the course and scope of his perspective duties as a
5 correctional physician in the jail with the complete authority and ratification of his
6 principal, Defendant COUNTY and/or NAPHCARE. Defendant PALAFOX is
7 being sued in his individual capacity.

8 24. All times relevant to the complaint, Defendant BIANCA BATES,
9 hereinafter referred to as "Defendant BATES" was employed in the capacity of
10 certified nurse's assistant (CNA) at the San Diego Central Jail and was a duly
11 authorized employee and agent of Defendant COUNTY and/or NAPHCARE, and
12 was acting within the course and scope of his perspective duties as a CNA in the
13 jail with the complete authority and ratification of her principal, Defendant
14 COUNTY and/or NAPHCARE. Defendant BATES is being sued in his individual
15 capacity.

16 25. All times relevant to the complaint, Defendant Edgar Timpug
17 hereinafter referred to as "Defendant TIMPUG" was employed in the capacity of
18 licensed vocation nurse (LVN) at the San Diego Central Jail and was a duly
19 authorized employee and agent of Defendant COUNTY and/or NAPHCARE, and
20 was acting within the course and scope of his perspective duties as a LVN in the
21 jail with the complete authority and ratification of her principal, Defendant
22 COUNTY and/or NAPHCARE. Defendant TIMPUG is being sued in his
23 individual capacity.

24 26. At all times relevant to the complaint, Defendant Rex Padilla hereinafter
25 referred to as "Defendant PADILLA" was employed in the capacity of
26 Supervising Registered Nurse (SRN) at the San Diego Central Jail and was a duly
27 authorized employee and agent of Defendant COUNTY and/or NAPHCARE, and
28 was acting within the course and scope of his perspective duties as a correctional

physician in the jail with the complete authority and ratification of his principal, Defendant COUNTY and/or NAPHCARE. Defendant PADILLA is being sued in his individual capacity.

27. At all times relevant to the complaint, Defendant DOE “1”, hereinafter referred to as “Defendant DOE 1” was employed in the capacity of a supervising Charge Nurse and who authorized TALIB’s clearance and discharge from the “MOB” -Medical Observation Bed unit on July 18 and 19, 2025 and was a duly authorized employee and agent of Defendant COUNTY and/or NAPHCARE, and was acting within the course and scope of his/her perspective duties as supervising charge nurse with the complete authority and ratification of his/her principal, Defendant COUNTY and/or NAPHCARE. Defendant DOE 1 is being sued in his/her individual capacity.

28. Defendants, hereinafter referred to as “DOE 2”, is employed in his/her capacity as a Supervising Charge Nurse who was informed of TALIB’s physical and mental decline, incapacity, and overall inability to care for himself on July 25, 2025 from Mental Staff Zairehy Perez and upon information and belief made further recommendations that TALIB remains in the Administrative Segregation/ Separation unit. Defendant is duly authorized employee and agent of Defendant COUNTY/NAPHCARE and was acting within the course and scope of their perspective duties as inmate jail staff in the San Diego Central Jail with the complete authority and ratification of their principal, Defendant COUNTY, and/or NAPHCARE. Defendants “DOE 2” are being sued in their individual capacity.

29. Defendant, hereinafter referred to as “DOES 3-5” are employees of defendant COUNTY and/or NAPHCARE, and at all times relevant to the complaint were employed in the capacity of medical staff the San Diego Central Jail. DOES 3-5 are duly authorized employees and agent of Defendant COUNTY and/or NAPHCARE and were acting within the course and scope of their perspective duties as medical staff in the San Diego Central Jail with the complete

1 authority and ratification of their principal, Defendant COUNTY and/or
2 NAPHCARE. Defendant “DOES 3-5” are sued in their individual capacity.
3 30. Defendants, hereinafter referred to as “DOES 6-8”, are employees of
4 Defendant COUNTY, and at times relevant to the complaint were employed in the
5 capacity of correctional deputies and/or supervisors either as sergeant or
6 Lieutenant at the San Diego Central Jail. DOES 6-8 are duly authorized
7 employees and agents of Defendant COUNTY and were acting within the course
8 and scope of their perspective duties as medical staff in the San Diego Central Jail
9 with the complete authority and ratification of their principal, Defendant
10 COUNTY. Defendants DOES 6-8 are being sued in their individual capacities.
11 31. Defendant, hereinafter referred to as “DOES 9-10”, are other
12 employees of NAPHCARE, COUNTY and/or other entities responsible for
13 reviewing the correctional and medical and healthcare to Mr. TALIB and upon
14 information and belief, condoning, ratifying, and deeming all actions and/or
15 inaction by the medical and custody staff to have been within the custody and
16 medical policies in effect at the time of the incident. DOES 9-10 are also acting as
17 policy makers and are duly authorized employees and agent of Defendant
18 NAPHCARE, and/or Defendant COUNTY, and was acting within the course and
19 scope of their perspective duties as a policy maker at the San Diego Central Jail
20 with the complete authority and ratification of their principal, Defendant
21 NAPHCARE and/or COUNTY. Defendant “DOE 9-10” are being sued in their
22 individual and official capacity.
23 32. At all times mentioned herein, Defendants COUNTY and NAPHCARE
24 were the employers of all other named Defendants and had the legal duty to
25 oversee and supervise their hiring.
26 33. At all relevant items to this complaint, COUNTY had
27 *non-delegable* responsibility and duty to provide constitutionally adequate
28 medical and mental healthcare to all inmates including Mr. TALIB at the San

1 Diego County jails. This means that even when COUNTY contracts out its health
2 and mental health care to outside private, for-profit entities such as NAPHCARE,
3 COUNTY remains responsible for ensuring that its contractor such as
4 NAPHCARE ensures that its policies, procedures, and practice of inmate medical
5 and mental health care is within constitutional guidelines and provided in a safe
6 manner to its inmate population.

7 **FACTUAL ALLEGATIONS**

8 34. At all times relevant to this complaint, Mr. TALIB was an 82-year-
9 old African American male, suffering from early onset of dementia, hypertension,
10 bowel and urinary incontinence, and was mobility impaired due to his frail
11 condition requiring the full-time use of a wheelchair.

12 35. On or about August 5, 2024, Mr. TALIB was arrested for a physical
13 assault incident involving a roommate of his at a senior care facility he resided.

14 36. He was initially booked at the San Diego County Jail and remained
15 there as part of his pending criminal case.

16 37. On December 24, 2024, as part of his criminal plea, Mr. TALIB was
17 deemed incompetent to stand trial and transferred to Metro State Hospital for
18 competency restoration per PC 1370.

19 38. On or about May 14, 2025, after an evaluation by the "FED", for a
20 NSL consideration, TALIB was found to be "NSL" meaning he was determined to
21 have no substantial likelihood to gain competency.

22 39. Further on or about May 23, 2025 due to Mr. TALIB's
23 neurocognitive disorder, the State specifically recommended he would be placed
24 in a mental health facility where he will be "best served and cared for by qualified
25 professionals." It was noted he previously resided at a senior living facility where
26 he received full assistance with his ADLS' (activities of daily living), medication
27 management and enrichment activities. It was recommended by the state clinician,
28 Jovanna Santomoro that Mr. TALIB be transferred to a similar facility to the

1 senior facility he was resided in. This recommendation was contained in the
2 "Recommended Continuing Care Plan/Discharge Summary" which also became
3 part of the Mr. TALIB electronic health records at the San Diego County Jail.
4 40. On May 24, 2025, Mr. TALIB was transferred back to the San Deigo
5 County Jail.
6 41. From May 27, 2025 to July 19, 2025, Mr. Talib was housed in the
7 medical unit, also referred to as the "MOB" or Medical Observation Bed unit, or
8 as 3/MED, of the San Diego Central Jail. The level of medical care provided to
9 inmates at the MOB is equivalent to infirmary level care. Apparently, he was
10 transferred to the MOB because of severe "failure to thrive" and not being able to
11 care for himself, despite a state recommendation that he would have to be cared
12 for by a facility equipped with handling senior living.
13 42. According to Dr. VELTMEYER, who oversaw his overall care at the
14 MOB, he noted that TALIB's admitting diagnosis to be FTT, fall risk, wheelchair
15 bound, needed help going to the bathroom, was incontinent both bowel and
16 bladder, ADA mobility impaired related to advanced age, frailty, memory
17 impairment. TALIB was oftentimes only alert and oriented as to his person, but
18 not as to the time, location and situation, meaning that he only knew his name but
19 was unable to indicate the time, the fact that he was in jail nor the reason for being
20 in jail.
21 43. Further, MOB is reserved for inmates who have disabilities that
22 require handicap accommodation but not direct nursing care. Patients admitted to
23 the MOB will have a 24-hour individualized care plan which will identify the
24 patient's needs/problems, interventions and anticipated outcomes. Patients are
25 monitored for signs of life such as patients, behavior, patients' movement, chest
26 rise and fall every hour and document the hourly checks in the MOB electronic
27 health record. Frequent vital signs monitoring and food intake & output is based
28 on the nurse's assessment of the patient's clinical needs and physician order.

44. An MOB charge nurse is responsible for all medical observation beds with at a minimum a once a shift or as needed rounds conducted by the same nurse. The nurse is also responsible for assessing the general condition for the unit, the general conditions for the patient and assessing individual patients' complaints. Separately, there is routine monitoring by medical staff of the MOB.

45. According to the State Hospital Returnees County jail policy *at no point in time* after an inmate returns from a state hospital should that inmate ever be housed into a segregation unit. A watch commander or designee by health staff completing an assessment for placement into a segregation unit must be immediately alerted if an inmate is somehow transferred to a segregation unit.

46. At all times relevant to the complaint, Mr. TALIB was determined to be a fall-risk and was wheelchair bound the entire time he was housed at the San Diego Central Jail.

47. While Mr. TALIB was housed in the Medical Unit, fellow inmate Edgar Duarte observed that Mr. Talib was wheelchair bound, needed constant attention and care, and medical staff regularly needed to help him change his diaper.

48. At all times relevant to this complaint, due to mental and physical limitations described above, Mr. TALIB could not carry out normal activities or protect his rights and was a dependent adult.

49. From May 19 to July 19, 2025, MOB staff routinely observed Mr. TALIB require assistance with changing his diapers and assistance with activities of basic daily living.

50. Toward the end of his MOB stay, TALIB was still suffering from confusion, incontinence, was still mobility impaired requiring a wheelchair and still needed assistance with his activities of daily living.

51. However despite such a long list of restrictions and limitations requiring constant assistance from medical staff, Mr. TALIB was discharged by

1 charge nurse DOE 1 into an administrative segregation unit with minimal
2 assistance and observation.
3 52. Against policy restrictions, on July 19, 2025, custodial staff
4 transferred Mr. Talib by wheelchair to 7/E, an administrative segregation unit, and
5 placed in Cell #5. No watch commander was notified.
6 53. Approximately a day after Mr. TALIB was moved to Unit 7/E, the
7 entire unit began to smell like feces and other detainees in the unit began yelling
8 to Defendants' employees because they believed Mr. TALIB was unwell.
9 54. During the approximately one-week period between Mr. Talib being
10 transferred to 7E and his being pronounced dead on July 28, 2025, inmate Owerrie
11 Bacon spoke with custody and medical staff and informed them that he believed
12 Mr. Talib needed help and *should not be* in an administrative [1]separation unit. Mr.
13 Bacon also attempted to speak to Mr. Talib directly but found he was
14 unresponsive. Mr. Bacon believes other inmates also raised concerns about Mr.
15 Talib to custodial and medical staff.
16 55. Similarly, for one week Mr. TALIB was housed in Unit 7E, inmate
17 Maurice Vasquez attempted to ask Mr. Talib if anything was wrong, but Mr. Talib
18 did not respond. Mr. Vasquez also told custody officers that Mr. Talib was not
19 doing well and should be removed from the unit. Mr. Vasquez saw staff change
20 Mr. TALIB's diaper a single time on the date he was first brought to Unit 7E.
21 56. Inmate Larry Lightning was housed in Cell 4 adjacent to Mr.
22 TALIB's cell. Mr. Lightning only heard Mr. TALIB speak once to indicate that he
23 did not want to go to the dayroom that day. Mr. Lightning attempted to speak to
24 Mr. TALIB on multiple locations, but Mr. TALIB never responded to him
25 verbally. Mr. Lightning never observed anyone changing Mr. TALIB's diaper
26 when he soiled himself. Mr. Lightning also observed medical staff attempts to
27
28

[1] The county changed the former name from "segregation" to "separation" which was merely an esthetic change leaving the segregation nature of the unit unchanged.

1 speak to Mr. TALIB, but he never heard Mr. TALIB respond verbally.
2 57. On or about July 25, 2025, Mental health worker Zairhey Perez, upon
3 a referral from the deputy evaluated Mr. TALIB for wellness check and noted that
4 deputies informed her that TALBI had been defecating on himself and he "won't
5 change his diapers", that he had been laying on his feces and there is feces
6 everywhere in his cell. Perez noted that TALIB was unable to explain his
7 symptoms, suffered from depression and just mumbled in response to questions.
8 58. MHC Perez then contacts nurse DOE 2 about TALIB presentation
9 and his inability to care for himself, however DOE 2 makes no recommendation to
10 remove him, nor to transfer him back to the MOB or even transfer him to an
11 outside facility capable of meeting his needs.
12 59. Apparently, TALIB was removed from his cell a single time so that a
13 cleaning team could clean his cell but immediately returned to his cell inside the
14 administrative segregation unit.
15 60. However, upon his return to his, Mr. TALIB still had fecal matter on
16 his shirt, diaper, and wheelchair, indicating that Defendants did not give Mr.
17 TALIB a shower or otherwise clean him at all while he was out of the cell despite
18 his immobile and unsanitary condition. According to other inmates the cell still
19 smelled of feces when Mr. TALIB was returned.
20 61. Prior to and during the approximately one-week Mr. TALIB was in
21 the administrative segregation unit, nurses would distribute pills in the unit three
22 times per day.
23 62. Specifically, after his July 25th evaluation by MH Perez who noted
24 TALIB's decompensation and inability to care for himself, Defendant TIMPUG,
25 authored several medication refusals on July 26 and July 27th despite his lack of
26 capacity to refuse anything much less medication. No competency assessment was
27 conducted nor was TALIB referred to a medical provider by TIMPUB.
28 63. On July 27 at 11:02 am, Dr. QURESHI evaluates TALIB on a "Stat

1 Care" basis and noted that TALIB is being currently monitored for possible failure
2 to thrive or grave disability but is unsure whether he is consuming food." It is
3 unclear who and with what frequency TALIB was being "monitored" while
4 housed in an administrative segregation unit with minimal monitoring. Dr.
5 QURESH did not order TALIB to be reinstated to the MOB unit nor to be sent out
6 for a higher level of care, nor order to take his vital signs.
7 64. Inmate Mr. Vasquez observed approximately sixteen (16) uneaten
8 food trays, enough for numerous days of meals, accumulated in Mr. TALIB's cell.
9 Mr. Vasquez also observed pills still in their containers, tipped over pill
10 containers, and scattered pills sitting on the desk of Mr. TALIB's cell. Mr.
11 Vasquez saw nurses enter Mr. TALIB's cell but only to distribute pills. He never
12 saw nurses take Mr. TALIB's vital signs nor assess him for competency to refuse
13 medication as was noted in numerous refusals during the days preceding his
14 demise.
15 65. Other than when custodial staff removed Mr. Talib from the unit so
16 that a cleaning team could clean his cell on or about July 25, 2025, Mr. TALIB
17 did not leave his cell and did not use the 50 minutes permitted each detainee to go
18 into the dayroom during his time in Unit 7/E. He also did not leave his cell to
19 shower.
20 66. Sometime in the evening of July 27, 2025, inmate Maurice Vasquez
21 observed Mr. TALIB moaning in the fetal position in his cell. Mr. Vasquez
22 attempted to speak to Mr. TALIB but he was unresponsive. Mr. Vasquez got the
23 attention of a deputy, DOES 6-8, and asked that they do something to help Mr.
24 TALIB.
25 67. At approximately 8:00 or 9:00 pm on July 27, 2025, Deputy Klein
26 saw that Mr. TALIB was in distress and called for medical attention and for a
27 supervising deputy.
28 68. The supervising deputy, DOES 6-8 was not seen to do anything about

1 Mr. TALIB's distress.
2 69. On the evening of July 27, 2025, a mental health clinician, believed
3 to be Defendant FUKUE knocked on Mr. Talib's cell door and ask him if he was
4 eating or if he was suicidal. Inmate Bacon observed Mr. TALIB through the door
5 and saw that he was on his side facing the door and that he did not respond to the
6 mental health clinician at any time before she left his cell. No competency
7 assessment was conducted nor a proper suicide/grave disability assessment which
8 would have alerted any provider that Mr. TALIB was both physical and mentally
9 decompensating, requiring an escalation of his care or an immediate referral to an
10 outside facility.
11 70. Subsequently in the evening of July 27th, Defendant PALAFOX,
12 also a mental health clinician who was yet again referred to by another housing
13 deputy to see TALIB for a wellness check, after FUKUE' lack of any apparent
14 intervention to TALIB's condition. She also noted the smell of feces and urine, he
15 was laying in bed but oddly noted "not to be in crisis and distress", although no
16 vital signs were taken to ascertain whether he was or not in medical distress. She
17 notes he was soiled, malodorous and had uneaten food around him. She further
18 notes, he presented disheveled, mute, no eye contact, withdraw, uncooperative,
19 depressed, impoverished thoughts, slow. PALAFOX apparently contacted the
20 MOB and noted that they had no available beds and a waitlist of three other
21 inmates. No competency assessment was conducted nor a proper suicide/grave
22 disability assessment which would have alerted any provider that Mr. TALIB was
23 both physically and mentally decompensating, requiring an escalation of his care
24 or an immediate referral to an outside facility. Irrespective of the unavailability of
25 any MOB beds, TALIB should not have been left unmonitored without taking his
26 vital signs.
27 71. PALAFOX also notes that floor deputies DOES 6-8 do not have
28 documented TALIB's meal refusals yet it was evident that the floor deputies

1 should have documented his meal refusals pursuant to hunger strike policies from
2 firsthand observation of the numerous uneaten meals. Properly documented meal
3 refusals would have triggered a policy for grave disability and food monitoring
4 much earlier than when PALAFOX noted it on the 27th.
5 72. As FUKUE was preparing to leave the unit, inmate Lightning got her
6 attention and told her that Mr. TALIB should be moved back to the medical unit
7 because he was unwell. However, Lightning's request was ignored as TALIB
8 remained in his cell in his dire state.
9 73. The next morning, on July 28, 2025, at approximately 8:00 am, Mr.
10 Vasquez observed Mr. TALIB lying on his bed without a blanket, in a fetal
11 position, eyes wide open, and lifeless. Mr. Vasquez observed that Mr. Talib's
12 diaper was full and his buttocks were partially exposed.
13 74. Mr. Vasquez told a deputy, DOE 6, 7, or 8, that he thought Mr.
14 TALIB was dead and that they should get medical.
15 75. The Deputy responded that that a nurse would arrive soon to do a
16 "pill call."
17 76. When a male nurse Defendant Edgar TIMPUG and/or DOE 3
18 entered the unit, Mr. Vasquez told him that Mr. TALIB was dead in cell 5.
19 77. However, TIMPUG and/or DOE 3 responded that he needed to
20 continue dispensing pills and would check on Mr. TALIB during the pill call
21 78. He continued dispensing pills and no one checked on Mr. TALIB for
22 approximately another fifteen (15) minutes. TIMPUG and/or DOE 3 dispensed
23 medication to Cell 1 which was Vasquez' cell, then to Cell 2, then Cell 3, then
24 Cell 4 and finally to TALIB's cell, 5. However, to Vasquez' utter surprise
25 TIMPUG merely placed a pill container on the tray slot of Talib's cell door
26 without checking on his welfare and began to walk away. Vasquez then
27 immediately yells at TIMPUB and/or DOE 3 that TALIB needed urgently to be
28 checked on. However, TIMPUB and/or DOE 3 ignored Vasquez's alerting him to

TALIB's dire condition.

79. Finally, a custody deputy entered TALIB's cell and realized TALIB was dead. They proceeded to take his dead body out of the cell and placed him in front of cell 4 and additional deputies arrived on scene and attempted to perform CPR.

80. The deputies' efforts were unsuccessful as it was evident from the condition and stiffness of TALIB's body that he had been dead for a while.

81. Mr. TALIB was pronounced dead at 9:10 a.m. on July 29, 2025.

82. Mr. TALIB's nude body was left on the ground in front of Cell 4 for several hours in the view of other inmates who were distressed by the sight of Mr. TALIB's body.

83. MR. TALIB was the seventh person to die in a San Diego County jail in the year of 2025.

84. Throughout MR. TALIB's time in Defendants' custody, Defendants repeatedly acted with deliberate indifference to apparent and substantial risks of harm to Mr. TALIB's health.

FIRST CLAIM FOR RELIEF

Deliberate Indifference to a Substantial Risk of Harm

1 2 3 **to Health - 14th Amendment of the U.S. Constitution (Against Defendants QURESHI, M.D., VELTMEYER, M.D.; FUKUE, UNDERWOOD, PALAFOX, BATES, PADILLA, TIMPUG, and DOES 1-10)**

4

5 85. Plaintiffs repeat and re-allege each and every allegation in paragraphs 6 1 through 84 of this Complaint with the same force and effect as if fully set forth 7 herein.

8 86. From the time Mr. TALIB was booked into the San Diego Central 9 Jail until the time he died, the Defendants repeatedly denied Mr. TALIB proper 10 medical care in repeated violation of his 14th Amendment constitutional rights.

11 87. All Defendants were constructively and actually informed that Mr. 12 TALIB suffered from dementia, required a wheelchair for mobility, was not able 13 to communicate well verbally, was incontinent, and was 82-years-old thus 14 requiring close medical monitoring to ensure responsive care for his activities of 15 daily living. Mr. TALIB's health problems were exacerbated by the fact that he 16 was unable to consume meals or his medication, presented frequent incontinence 17 coupled with an inability to clean himself, and generally exhibited an inability to 18 communicate with other persons. Mr. TALIB's health injuries, suffering, and 19 death could have been avoided by more careful monitoring and observation as 20 meal trays and medication "piled up" outside of Mr. TALIB's cell untouched for 21 days on end.

22 88. All of the Defendants knew there was a substantial risk to Mr. 23 TALIB's health if his medical needs went untreated. Defendants observed his 24 condition worsening and failed to take steps to abate the risk ignoring pleas from 25 Mr. TALIB's fellow detainees who also witnessed his deterioration.

26 89. Despite Mr. TALIB's frequent incontinence resulting in his person 27 being persistently soiled with fecal matter, creating an obvious and urgent need 28 for medical and hygienic intervention, and despite Mr. Talib's observable

1 inability, due to known cognitive impairment and medical conditions, to eat his
2 meals or take his prescribed medications, Defendant did little to abate the known
3 risks to Mr. Talib's health.
4 90. Defendants QURESHI, M.D., VELTMEYER, M.D. FUKUE,
5 UNDERWOOD, PALAFOX, BATES, PADILLA, TIMPUG Does 1-10 were
6 aware or should have been aware of Mr. TALIB's visible decline and dangerous
7 fluctuations of his vital signs. Nevertheless, Defendants FUKUE, and Does 1-10
8 each failed to refer Mr. TALIB to higher level care and failed to order increased
9 observation and monitoring including monitor his vital signs.
10 91. More Specifically, Defendants QURESHI, M.D., VELTMEYER,
11 M.D. FUKUE, UNDERWOOD, PALAFOX, BATES, PADILLA, TIMPUG, and
12 Does 1-10 were deliberately indifferent to Mr. TALIB's medical needs on through
13 out his incarceration when they failed to take Mr. TALIB's vitals and failed to
14 refer Mr. Talib to a higher level of care after observing him groaning on the floor
15 and in a state necessitating medical and hygienic intervention. Defendants DOE 1
16 through 8 then were informed about and directly observed Mr. TALIB in need of
17 immediate medical care and left Mr. TALIB unmonitored in his cell where he died
18 hours later.
19 92. Similarly, Defendant QURESHI, M.D., VELTMEYER, M.D.
20 FUKUE, UNDERWOOD, PALAFOX, BATES, PADILLA, TIMPUG, was also
21 deliberately indifferent to Mr. TALIB's medical needs by failing to assess that he
22 was gravely disabled. Additionally, Defendant QURESHI, M.D., VELTMEYER,
23 M.D. FUKUE, UNDERWOOD, PALAFOX, BATES, PADILLA, TIMPUG was
24 deliberately indifferent by failing to order Mr. TALIB be referred to higher level
25 care or close monitoring even as evidence mounted that Mr. TALIB's mental and
26 physical condition was decompensating. Defendant QURESHI, M.D.,
27 VELTMEYER, M.D. FUKUE, UNDERWOOD, PALAFOX, BATES,
28 PADILLA, TIMPUG failure to order Mr. TALIB be referred to higher level care

or close monitoring rises to the level of deliberate indifference particularly after Mr. TALIB failed to respond to her assessment and various inmates requesting that Mr. Talib needed to return to a medical unit given his condition.

93. As a result of the repeated denial of proper constitutional medical care, Mr. TALIB needlessly suffered in an unresponsive, unhygienic state covered in his own fecal matter and unable to eat or take medication for days on end until Mr. TALIB ultimately died in Defendants' custody.

94. The Defendants, acted with deliberate indifference Mr. TALIB's serious health conditions and medical needs by ignoring him and failing to provide proper medical attention.

95. Because Mr. TALIB is deemed to be a pretrial detainee, the Defendants' acts of deliberate indifference in failing to provide medical care to treat Mr. TALIB's serious medical conditions, constitutes cruel and unusual punishment in violation of the Due Process Clause of the Fourteenth Amendment of the Constitution.

96. All individual Defendants were deliberately indifferent to the serious medical needs of Mr. TALIB. It should be adequately clear that any reasonable corrections officer, jail staff, and/or medical practitioner would comprehend that by denying medical care, Mr. TALIB was exposed to undue suffering, which, ultimately, proved devastating and caused Mr. TALIB's death. The Defendants knowingly and intentionally denied MR. TALIB proper medical care by failing to monitor and treat him, or transfer him to a hospital for proper care, resulting in his death in Defendants' custody.

97. Had the Defendants and their employees, agents, and servants, not acted with deliberate indifference to the obvious and serious health needs of Mr. TALIB, and provided prompt medical attention, he would not have suffered his injuries and would be alive.

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98. Such acts and omissions of the Defendants violated Mr. TALIB's constitutional rights guaranteed under 42 U.S.C. § 1983, and the Eighth and Fourteenth Amendments to the United States Constitution. The Defendants knew that failing to treat his worsening medical problems would lead to a catastrophic injury, and he did suffer such an injury and, as a result, died.

99. Additionally, Defendants failed to perform their mandatory duty under California Government Code § 845.6 to provide medical care to Mr. TALIB even though Defendants had actual knowledge that the he needed urgent medical care for his serious medical conditions comprising of his dementia as complicated by his other physical and mental conditions. Plaintiffs, as Mr. TALIBS' successor-in-interest, are authorized to maintain this cause of action.

100. Accordingly, Defendants each are liable to Plaintiffs for compensatory and punitive damages under 42 U.S.C. § 1983, including pain and suffering, past and future medical expenses, and loss of enjoyment of life, and reasonable attorney's fees.

SECOND CLAIM FOR RELIEF

***Monell*-Failure to Train (42 U.S.C. §1983)**

(Against Defendants COUNTY and NAPHCARE)

101. Plaintiffs repeat, re-state, and incorporate each and every allegation in paragraphs 1 through 100 of this Complaint with the same force and effect as if fully set forth herein.

102. Defendant COUNTY knew that Mr. TALIB was suffering from a worsening chronic medical condition and that the San Diego Central Jail was not equipped to care for seriously ill patients, patients with severe disabilities, and/or patients with serious mental health issues. Defendant County further knew that such patients could not be properly observed and monitored in general population, much less in the administrative segregation unit. Given the known limitations of the San Diego Central Jail, it was obvious that jail medical staff would need

1 special training in order to care adequately for medically unstable patients and to
2 assess when such patients should be transferred to the hospital and/or housed in
3 the jail's medical unit.
4 103. The San Diego Central Jail nursing staff had not been trained
5 adequately in monitoring, documenting, and assessing patients' medical conditions
6 within the confines of a limited-care facility such as the San Diego Central Jail,
7 and that this failure to train led to a substantial and, ultimately, lethal denial of
8 needed care to Mr. TALIB.
9 104. Despite Defendant COUNTY's Sheriff's Department's Medical
10 Services Division policy requiring nursing staff identify any patients having a
11 medical or psychiatric condition that requires special housing, Defendant
12 COUNTY and Defendant NAPHCARE each failed to train the San Diego Central
13 Jail physicians, mental health clinicians and and nursing staff adequately so as to
14 recognize that, given his condition, Mr. TALIB required special housing and
15 escalated care.
16 105. Despite Defendant COUNTY's Sheriff's Department's Medical
17 Services Division policy requiring that Patients who have been found
18 "Incompetent to Stand Trial" and subsequently refuse treatment be reported to
19 their attending psychiatrist and conservator, Defendant County and Defendant
20 Naphcare each failed to train San Diego Central Jail staff so as to adequately
21 respond to incompetent medical refusals.
22 106. Despite Defendant COUNTY's Sherrif's Department's Medical
23 Service Division policy requiring that a physician (MD) or registered nurse (RN)
24 shall evaluate all medical emergencies, provide Basic Life Support (BLS) and
25 request appropriate transportation in response to such emergencies, Defendant
26 COUNTY and Defendant NAPHCARE each failed to train the San Diego Central
27 Jail doctors and nursing staff adequately so as to effectively recognize and
28

respond to medical emergencies within the detention facilities, such as that suffered by Mr. TALIB.

107. Despite Defendant COUNTY's Sherrif's Department's Medical Service Division policy requiring that specialty health care services shall be provided to meet a patient's medical/mental health needs, Defendant COUNTY and Defendant NAPHCARE each failed to train the San Diego Central Jail doctors and nursing staff adequately so as to provide specialty health care services where necessary for patients, such as Mr. Talib.

108. Despite Defendant COUNTY's Sheriff's Department's Medical Service Division policy requiring that biomedical waste and biohazardous waste (including "feces") shall be disposed of consistent with state and federal regulations, Defendant COUNTY and Defendant WELLPATH each failed to train the San Diego Central Jail doctors and nursing staff adequately so as to ensure that biomedical waste is properly disposed of, resulting in circumstances whereby Defendants left Mr. TALIB stewing in his own fecal material for days at a time prior to his death in Defendants' custody.

109. Defendant COUNTY and Defendant NAPHCARE had policies of relying on medical professionals without training them on how to implement proper procedures for documenting, monitoring, managing, and assessing inmates for medical instability within the confines of the Jail. These failures amount to deliberate indifference.

110. As a result of the failures by COUNTY and NAPHCARE to adequately train and implement policies, Mr. Talib was caused undeserved pain and agony and ultimately died.

THIRD CLAIM FOR RELIEF

***Monell*-Unconstitutional Custom and Practice (42 U.S.C. §1983)**

(Against Defendants COUNTY and NAPHCARE)

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111. Plaintiffs hereby repeat, re-state, and incorporate each and every allegation in paragraphs 1 through 110 of this Complaint with the same force and effect as if fully set forth herein.

112. On and for some time prior to July 29, 2025, Defendants COUNTY and NAPHCARE deprived Mr. TALIB of the rights and liberties secured to him by the Fourth, Eighth, and Fourteenth Amendments to the United States Constitution, in that said defendants and their supervising and managerial employees, agents, and representatives, acting with reckless and deliberate indifference to the rights and liberties of Mr. TALIB of persons in his class, situation, and comparable position in particular, knowingly maintained, enforced and applied an official recognized county custom, policy, and practice of: housing inmates with serious mental illness and/or serious disabilities in administrative segregation without consideration of mental health and/or medical professionals' input, Acting deliberately indifferent to the serious medical needs of inmates and newly booked inmates when defendants failed to take any meaningful corrective measures despite being previously placed on notice of their egregious practices resulting in prior deaths. The following is a list of *Monell* violations:

(a) housing inmates with serious mental illness and/or serious disabilities in administrative segregation without consideration of mental health and/or medical professionals' input;

(b) Failing to implement policies and procedures on basic symptom recognitions and assessment of inmates who are in medical distress, and mental health conditions;

(c) Routinely failing to train detention staff and medical staff on the symptoms and assessment of inmates suffering from serious and chronic medical conditions such as dementia.

(d) Inadequately supervising, training, controlling, assigning, and disciplining employees including COUNTY Jail medical and correctional staff;

1 (e) Routinely neglecting and ignoring gravely ill inmates and enabling the
2 custom and practice of medically distressed detainees relying upon themselves or
3 their fellow detainees to seek emergency medical treatment;
4 (f) Routinely failing to seek prompt follow-up care for known medical issues
5 that pose a serious risk to an inmate's health;
6 (g) Engaging in the custom and practice of discriminating against chronically
7 ill inmates and/or mentally ill inmates and withholding emergency medical
8 treatment until an inmate is at a near-death condition;
9 (h) Routinely preventing inmates access to medical doctors, due to a custom
10 and practice of a failed booking policy;
11 (i) Routinely failing to manage inmates with mental health conditions, and/or
12 chronic medical conditions;
13 (j) Routinely failing to hospitalize patients and or refer to higher level of care
14 when need; and
15 (k) Routinely failing to properly implement protocols for managing the
16 medical care for inmates with chronic medical conditions.
17 113. By reason of the aforementioned policies and practices of
18 Defendants, MR. TALIB suffered severe injuries and died.
19 114. Defendants COUNTY and NAPHCARE, together with various other
20 officials, whether named or unnamed, had either actual or constructive knowledge
21 of the deficient policies, practices and customs alleged in the paragraphs above.
22 Despite having knowledge as stated above, these Defendants condoned, tolerated,
23 and through actions and inactions thereby ratified such policies. Said Defendants
24 also acted with deliberate indifference to the foreseeable effects and consequences
25 of these policies with respect to the constitutional rights of Mr. TALIB and other
26 individuals similarly situated.
27 115. By perpetrating, sanctioning, tolerating, and ratifying the
28 outrageous conduct and other wrongful acts, Defendants COUNTY and

NAPHCARE, acted with an intentional, reckless, and callous disregard for the well-being of Mr. TALIB and his constitutional as well as human rights.

116. Furthermore, the policies, practices, and customs implemented and maintained and still tolerated by Defendants COUNTY and NAPHCARE were affirmatively linked to and were a significantly influential force behind Mr. TALIB's injuries and death.

117. As a direct and legal result of Defendants' acts, Plaintiffs have suffered damages, including, without limitation, past pain and suffering, loss of enjoyment of life, and compensatory damages. Such damages including attorneys' fees, costs of suit, and other losses not yet ascertained. Additionally, Defendants are liable to Plaintiffs for compensatory damages under 42 U.S.C. § 1983.

FOURTH CLAIM FOR RELIEF

Monell-Ratification (42 U.S.C. §1983)

(Against Defendants COUNTY and NAPHCARE)

118. Plaintiff hereby repeats, re-states, and incorporates each and every allegation in paragraphs 1 through 117 of this Complaint with the same force and effect as if fully set forth herein.

119. Defendants COUNTY and NAPHCARE and their employees had either actual or constructive knowledge of the deficient policies, practices, and customs alleged in the paragraphs above. Despite having knowledge as stated above, these Defendants condoned, tolerated and through actions, and specifically, through the finding and conclusions of any incident review(s) examining and evaluating the events leading up to Mr. TALIB's injuries and death on July 28, 2025, and have ratified all conduct vis-à-vis Mr. TALIB from named defendants, including Defendants Doe 1 through 10.

120. Defendants also acted with deliberate indifference to the foreseeable effects and consequences of the act of ratifying all personnel's conduct with

1 respect to the constitutional rights of Mr. TALIB and other individuals similarly
2 situated.

3 121. By perpetrating, sanctioning, tolerating, and ratifying the outrageous
4 conduct and other wrongful acts, Defendants COUNTY, NAPHCARE, and their
5 agents acted with an intentional, reckless, and callous disregard for the well-being
6 of Mr. TALIB and his constitutional as well as human rights.

7 122. As a direct and legal result of Defendants' acts, Plaintiffs have
8 suffered damages, including, without limitation, past pain and suffering, loss of
9 enjoyment of life, and compensatory damages. Such damages including attorneys'
10 fees, costs of suit, and other losses not yet ascertained.

11 **FIFTH CLAIM FOR RELIEF**

12 **VIOLATIONS OF TITLE II OF THE AMERICANS WITH**
13 **DISABILITIES ACT AND THE REHABILITATION ACT**
14 **(42 U.S.C. § 1983) (ALL DEFENDANTS)**

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16 123. Plaintiffs hereby repeats, re-states, and incorporate each and every
17 allegation in paragraphs 1 through 122 of this Complaint with the same force and
18 effect as if fully set forth herein.

19 124. Plaintiffs make a claim for disability discrimination against
20 Defendants and, pursuant to 42 U.S.C. § 1983, for violating Title II of the
21 Americans with Disabilities Act (ADA) (public entities). Title II of the ADA
22 prohibits disability-based discrimination by any public entity. *See* 42 U.S.C. §§
23 12131-12132; 28 C.F.R. § 39.130; and 28 C.F.R. §35.130.

24 125. Section 504 of the Rehabilitation Act prohibits discrimination
25 against an individual based on disability by any program or entity receiving
26 federal funds. *See* 29 U.S.C. §§ 794(a), (b)(1)(A), (b)(1)(B), and (b)(2)(B).

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126. These disability anti-discrimination laws impose an affirmative duty on public entities to create policies or procedures to prevent discrimination based on disability.

127. Mr. TALIB was disabled as defined in 42 U.S.C. § 12102 and 42 U.S.C. §§ 12131, 28 C.F.R. §§ 35.108, as he suffered intellectual, developmental and mental illness impairments that substantially limited one or more of his major life activities. As he suffered from dementia and related cognitive impairments and also required a wheelchair for transportation, and was therefore an individual with a disability as defined by the Act, in that these impairments substantially limited one or more of his major life activities.

128. Defendant COUNTY is a program or entity that receives federal financial assistance.

129. Defendant COUNTY is a public entity as defined by Title II of the ADA.

130. Defendant COUNTY's jail, the San Diego Central Jail, is a facility and its operation comprises a program of service for purposes of Title II of the ADA.

131. Mr. TALIB was an individual qualified to participate in or receive the benefit of COUNTY's services, programs, or activities, such as receiving adequate in-custody medical care.

132. Mr. TALIB was abused because of his disabilities by Defendants COUNTY and NAPHCARE and their agents and employees at the San Diego Central Jail.

133. Mr. TALIB was abused when he was denied medical and psychiatric treatment for his known and visible physical and mental health conditions. He suffered due to his disabilities, which was known to Defendants COUNTY, NAPHCARE, and their agents and employees, and the abuse of Defendants COUNTY, NAPCHARE and their agents and employees. Such abuse and denial

of medical treatment by Defendants COUNTY, NAPHCARE and its agents and employees were in spite of Mr. TALIB's disabilities. Such abuse constitutes discrimination against individuals based on their disability in violation of the Rehabilitation Act and Title II of the ADA.

134. Defendant COUNTY failed to provide adequate medical services or to hospitalize and admit Mr. TALIB on Welfare and Institutions Code § 5150 hold specifically for the care and treatment of his medical needs and mental and physical disabilities.

135. Defendants COUNTY, NAPHCARE, and their agents and employees, showed a deliberate indifference towards Mr. TALIB and his medical needs when:

(a) Defendants failed to provide any management and treatment specific to his mental and physical disabilities as well as his obvious presentation of signs of mental and physical decompensation.

(b) Defendants failed to comply with Welfare and Institutions Code § 5150 when presented with a known and visibly unstable patient refusing meals and medication.

(c) Defendants showed a bias towards treating his mental illness impairment when Defendants failed to send him to an outside facility capable of providing Mr. TALIB with a higher level of care in response to his disabilities.

(d) Defendants further discriminated against Mr. TALIB by failing to provide a non-abusive, safe treatment environment at the San Diego Central Jail generally, and, as a result, Mr. TALIB suffered severely and ultimately died.

136. Plaintiffs bring this claim individually, seeking damages for the violation of Mr. TALIB's rights. Plaintiffs also seek attorney's fees and costs.

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SIXTH CLAIM FOR RELIEF

ELDER ABUSE and DEPENDANT ADULT ABUSE

(Welf. & Inst. Code §15657 et seq.)

(Against all Defendants)

137. Plaintiffs hereby repeat, re-state, and incorporate each and every allegation in paragraphs 1 through 136 of this Complaint with the same force and effect as if fully set forth herein.

138. Defendants DOES 1 through 5 were correctional nurses and/or health care providers, and Defendants DOES 6 through 8 were jail deputy staff, each of whom had caretaking and custodial responsibilities for TALIB while he was in custody. Said Defendants, and each of them, were responsible for providing medical care, monitoring, observation, and/or basic custodial assistance to TALIB. At all relevant times, these Defendants had actual and constructive knowledge of Decedent's serious medical conditions and vulnerability due to advance age, cognitive impairment, and physical infirmity, yet failed to take reasonable steps to provide necessary care, supervision, and protection, thereby permitting neglect, deterioration, and injury to occur.

139. Said acts and omissions constitute neglect, physical abuse, and reckless custodial neglect within the meaning of Welfare and Institutions Code sections 15610.57 and 15610.63. These Defendants acted with recklessness, oppression, and malice in conscious disregard of Plaintiff's health and safety, warranting recovery of enhanced remedies under section 15657.

140. Defendant COUNTY is vicariously liable under Government Code section 815.2 for the acts and omissions of its employees and agents, including but not limited to the aforementioned individual Defendants, who, while acting within the course and scope of their employment, committed the negligent and reckless acts alleged herein.

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SEVENTH CLAIM FOR RELIEF

Negligence

(Against all custody defendants COUNTY, DOES 6-8)

141. Plaintiffs repeat, re-state, and incorporate each and every allegation in paragraphs 1 through 140 of this Complaint with the same force and effect as if fully set forth herein.

142. Defendants, COUNTY, all named defendants, and all DOE 6-8 defendants, each have a duty to operate and manage the San Diego Central Jail in a manner so as to prevent the acts and/or omissions alleged herein. Said defendants owed Mr. TALIB, as an detainee in Defendants' custody, care and control, a duty of due care to protect his health and physical safety.

143. Defendants, were negligent and their conduct fell below a reasonable standard of care when they failed to discharge their duties as jail deputies and supervisors as to Mr. TALIB. It was foreseeable that as a result of Defendants' acts and omissions, as described above, Mr. TALIB's health would decompensate, resulting in his physical injury, suffering, and ultimately, Mr. TALIB's death. Defendants' breach proximately caused injuries and damages to Plaintiffs as claimed herein.

144. As a direct and proximate result of the aforementioned conduct of Defendants, they are liable to Plaintiffs for damages including but not limited to pain and suffering and loss of enjoyment of life.

EIGHTH CLAIM FOR RELIEF

Bane Act C.C. 52.1 Et Seq. (State)

(ALL INDIVIDUALLY NAMED DEFENDANTS)

145. Plaintiffs hereby repeat, re-state, and incorporate each and every allegation in paragraphs 1 through 144 of this Complaint with the same force and effect as if fully set forth herein.

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146. California Civil Code, Section 52.1 (*the Bane Act),* prohibits any person from using violent acts or threatening to commit violent acts in retaliation against another person for exercising that person's constitutional rights. However, under *Reese v. Cnty of Sacramento, 888 F.3d 1030, 1042-4043 (9th Cir. 2018),* the Bane Act <u>does not require</u> the "threat, intimidation or coercion' element of the claim to be transactionally independent from the constitutional violation alleged.

147. Specific intent does not require a showing that a defendant knew he was acting unlawfully; reckless disregard of the right at issue is all that is necessary. [2] *Luttrell v. Hart,* 2020 WL 5642613.

148. Here, all Defendants showed the requisite specific intent to violate Mr. TALIB's constitutional rights, through their reckless disregard for his constitutional rights.

149. Defendants acted with reckless disregard in failing to closely monitor, and treat Mr. TALIB's medical conditions as described more fully above. Defendants also acted with reckless disregard by continuing to house Mr. TALIB in general population and failing to hospitalize him or otherwise escalate his level of care despite his showing visible signs of significant physical and mental deterioration.

150. When Defendants committed the above acts, they interfered with Mr. TALIB's civil rights to be free from unreasonable searches and seizures, to be free from cruel and unusual punishment, to due process, to equal protection of the laws, to medical care, to be free from state actions that shock the conscience, and to life, liberty, and property.

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[2] Per *Luttrell*, if a Plaintiff adequately pleads a claim for deliberate indifference which requires a pleading of reckless disregard, then he was sufficiently alleged the "intent" element required for the Bane Act. Under *Reese*, "a reckless disregard for a person's constitutional rights is evidence of a specific intent to deprive that person of that right. Some courts such as *Polance v. California 2022 WL 1539784, at*4 (N.D. Cal. May 16, 2022)* have deemed the application of the Bane Act appropriate when there is a showing of deliberate indifference toward correctional inmates. (observing that "defendant who acts with deliberate indifference toward an inmate may satisfy the 'threat, intimidation, or coercion' element, as the custody context makes that violation especially coercive.")

151. Defendants knowingly deprived Mr. TALIB of his constitutional rights through acts which were inherently coercive, intimidating, and threatening, by housing him in an inappropriate cell, by failing to monitor and treat his medical and psychological conditions, failing to hospitalize him when appropriate, and/or refer him to a higher level of monitoring and care.

152. Defendants successfully interfered with the above civil rights of Mr. TALIB.

153. The conduct of Defendants was a substantial factor in causing Plaintiffs' harms, losses, injuries, and damages.

154. COUNTY is vicariously liable for the wrongful acts of their employees pursuant to section 815.2(a) of the California Government Code, which provides that a public entity is liable for the injuries caused by its employees within the scope of the employment if the employee's act would subject him or her to liability.

155. NAPHCARE is vicariously liable for the wrongful acts of their employees under California law and the doctrine of respondeat superior.

156. Defendants DOES 1-10 are personally and/or vicariously liable under California law and the doctrine of *respondeat superior*.

157. The conduct of Defendants was malicious, wanton, oppressive, and accomplished with a conscious disregard for Mr. TALIB rights, justifying an award of exemplary and punitive damages as to the Defendants and attorneys' fees under this claim.

NINTH CLAIM FOR RELIEF

Failure to Summon Medical Care per G.C. §845.6 and §844.6

(Against Defendants COUNTY, DOES 6-8)

1 158. Plaintiffs repeat, re-state, and incorporate each and every allegation
2 in paragraphs 1 through 157 of this Complaint with the same force and effect as if
3 fully set forth herein.
4 159. California Government Code § 845.6 creates an affirmative duty for
5 jail staff "to furnish or obtain medical care for a prisoner in his custody." Mr.
6 TALIB desperately required prompt medical attention from Defendants, medical
7 staff. Defendants had actual knowledge of Mr. TALIB's need for immediate
8 medical care and deliberately chose to not furnish Mr. TALIB with medical care.
9 Defendants failed to discharge the duty imposed upon them by California
10 Government Code § 845.6. As a direct and proximate result of Defendants' acts
11 and/or omissions, hereinabove described, Mr. TALIB suffered physically and
12 mentally and ultimately died.
13 160. Defendants are liable for their employees' breach of their duty to
14 summon required immediate medical care while acting in the course and scope of
15 their employment under the doctrine of *respondeat superior*.
16 **PRAYER FOR RELIEF**
17 WHEREFORE, Plaintiffs request entry of judgment in their favor and against
18 Defendants COUNTY, NAPHCARE, QURESHI, VELTMEYER, FUKUE,
19 UNDERWOOD, PALAFOX, BATES, PADILLA, TIMPUNG, and DOES 1
20 through 10, inclusive, as follows:
21 1. For compensatory damages according to proof;
22 2. For punitive damages against the individual defendants in an amount
23 to be proven at trial;
24 3. For interest;
25 4. For reasonable costs of this suit and attorneys' fees per 42 U.S.C. §1988;
26 and
27 5. For such further other relief as the Court may deem just, proper, and
28 appropriate.

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DEMAND FOR JURY TRIAL

Plaintiffs hereby demand a jury trial.

Date: December 19, 2025 THE SEHAT LAW FIRM, PLC

/s/Cameron Sehat

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