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ALAMEDA COUNTY
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By Deputy

SUPERIOR COURT OF THE STATE OF CALIFORNIA

IN AND FOR THE COUNTY OF ALAMEDA

UNLIMITED JURISDICTION

DANIEL RIDGE,

Plaintiff,

v.

ALAMEDA HEALTH SYSTEM, a California public entity, and DOES 1 through 50, inclusive,

Defendants.

Case No. RG17847260

Assigned for All Purposes to Judge Stephen Kaus, Dept. 19

FIRST AMENDED COMPLAINT FOR:
(1) [OMITTED]
(2) DISCHARGE BECAUSE OF DISABILITY;
(3) FAILURE TO TIMELY ENGAGE IN INTERACTIVE PROCESS IN GOOD FAITH TO REASONABLY ACCOMMODATE DISABILITY;
(4) FAILURE TO REASONABLY ACCOMMODATE DISABILITY;
(5) FAILURE TO PROVIDE MEDICAL LEAVE FOR SERIOUS HEALTH CONDITION;
(6) RETALIATION FOR EXERCISING RIGHT TO MEDICAL LEAVE;
(7) RETALIATION FOR OPPOSING DISCRIMINATION BECAUSE OF DISABILITY;
(8) FAILURE TO PREVENT UNLAWFUL DISCRIMINATION AND RETALIATION.

Amount Demanded Exceeds $10,000 (Government Code §72055)

JURY TRIAL DEMANDED

Plaintiff DANIEL RIDGE complains against defendants, and each of them, demands a trial by jury of all issues except costs and attorney fees, and for causes of action alleges[1]:

PARTIES

1. Plaintiff Daniel Ridge was employed with defendant Alameda Health System beginning in about June 2006. During that time and since, Mr. Ridge has been a citizen of the State of California. Mr. Ridge is African American.

2. Defendant Alameda Health System is a public entity in the State of California, and doing business in the state of California, including in Alameda County. On information and belief, plaintiff's personnel files are maintained in defendant Alameda Health System's office located in Oakland, California. Defendant Alameda Health System is sometimes referred to in this Complaint as "defendant AHS" or as "AHS."

3. The true names and capacities of defendants sued as Does are unknown to plaintiff. Plaintiff is informed and believes that each of the Doe defendants was responsible in some way for the occurrences and injuries alleged in this Complaint.

4. Plaintiff is informed and believes that in doing the things alleged in this Complaint, each defendant was acting as an agent or employee of every other defendant, was acting within the course and scope of this agency or employment, and was acting with the consent, permission, and authorization of each of the remaining defendants. Plaintiff is also informed and believes that all actions of each defendant alleged in this Complaint were ratified and approved by the officers or managing agents of every other defendant.

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[1] Omitted from this First Amended Complaint are the First Cause of Action and the race and color discrimination allegations of the Second, Seventh and Eighth Causes of Action because summary adjudication was granted as to these.

FACTS COMMON TO ALL CAUSES OF ACTION

5. Plaintiff Daniel Ridge began his employment as a part-time morgue attendant with defendant Alameda Health System on about June 23, 2006.

6. Throughout the entirety of his employment with AHS, Daniel Ridge worked at Alameda Health System's Highland Hospital ("Highland") located in Oakland, California, and Mr. Ridge would have continued working at that location but for the termination of his employment by AHS in about October 2015.

7. Daniel Ridge's overall job performance while working for defendant AHS was at all times satisfactory. Mr. Ridge was well-liked and respected by his co-workers, and he received numerous "thank you" notes and praise for his thoughtful and caring interactions with grieving family members in the Highland morgue ("the morgue").

8. From about June 23, 2006 until about late 2013, Daniel Ridge worked part time hours as a morgue attendant at Highland. During this time, the only other morgue employee was Lenward Cage, who had been the full-time morgue attendant at Highland (and its predecessors) for about 50 years. Mr. Cage was also African American. On information and belief, Mr. Cage took a leave of absence from his duties as full-time morgue attendant beginning in about late 2013 and continuing until Mr. Cage retired a number of months later in 2014.

9. In about late 2013, when Lenward Cage began his leave of absence, Daniel Ridge began working at least full-time hours, and often 7 days per week, as the Highland morgue attendant, yet Mr. Ridge remained classified as a "part-time" employee. During this time, Daniel Ridge was the only person actively employed as a morgue attendant at Highland, and Mr. Ridge worked so often that coworkers commented to him about how he was always there.

10. Despite working full-time hours plus a significant amount of overtime nearly every day since late 2013, Mr. Ridge remained classified as a

"part-time" employee until about January 2015. This meant that, among other things, Mr. Ridge did not receive any employee benefits, including health insurance, and continued to be paid only the part-time morgue attendant hourly rate. During this time, Mr. Ridge electronically clocked in and out each work day. On numerous occasions, Mr. Ridge saw the Lab Manager, Feuy Saechao, make changes on her computer to Mr. Ridge's time records.

11. Beginning in about late December 2013 and continuing through most of 2014, Mr. Ridge had multiple conversations with the Lab Manager and acting Lab Director, Feuy Saechao, about his long hours and the fact that he was working nearly every day. Mr. Ridge told Ms. Saechao that he would try to work as much as possible for as long as possible, but that he was expecting the birth of a child in October 2014 and did not want to continue working seven days a week after that since he would want to spend time with his infant child.

12. In about August or September 2014, as the birth of his son approached, Mr. Ridge asked Ms. Saechao why he was still classified as only "part-time," receiving only part-time pay and no benefits, even though he had been working at least full-time hours nearly every day since the end of 2013. In response, Ms. Sachao thanked Mr. Ridge for his hard work but did not give him a concrete answer about the full-time position.

13. On information and belief, around August or September 2014, Fuey Sachao posted the full-time morgue attendant position rather than offer the position to Daniel Ridge outright, even though Mr. Ridge had worked as the part-time morgue attendant with Mr. Cage at Highland Hospital for the previous 7½ years, and even though Mr. Ridge had just spent the majority of the prior year working at least full-time hours, and often 7 days per week, as the only morgue attendant at Highland. Ms. Saechao required Mr. Ridge to interview for the full-time position, which he did in about November 2014. Eventually Mr. Ridge was offered the full-time position in about December 2014 or January 2015, over a

year after he began working at least full-time hours when Lenward Cage went on leave.

14. Once Mr. Ridge was formally given the full-time morgue attendant position in about late December 2014 or early January 2015, he insisted to Ms. Saechao that he no longer be required to work 7 days per week for at least 8 hours per day. Finally, in about February 2015, AHS hired a part-time morgue attendant to work two days per week. The part-time morgue attendant's name was Julian, and based on Mr. Ridge's personal observation, Julian had a light-skinned complexion and appeared to be Caucasian.

15. During the nearly two years Daniel Ridge worked at least full-time hours as morgue attendant, he was treated differently and worse than his coworkers in the Lab and Patient Care Services.

16. During the time period from about January 2014 through his termination, Daniel Ridge repeatedly requested that he be provided with technology to facilitate the efficient performance of his job duties. Mr. Ridge discussed, on at least ten separate occasions, his need for a computer or electronic tablet (e.g., an iPad) to access the internet, and a work cell phone, with the following people: Wei Tang (Lab Supervisor), Feuy Saechao (Lab Manager and acting Lab Director), Derek Shue (Lab Manager, and later Lab Director), Robbie Masangkay (Patient Care Services Supervisor), Martha Ocampo (Lab Supervisor, and later Lab Manager), and Reshea Holman (Vice President of Patient Care Services).

17. On information and belief, Mr. Ridge was the only employee in the Highland Lab area who did not have either (1) access to a computer at his work station or (2) an access code to the Lab computers. In response to Mr. Ridge's requests for computer access, Ms. Sachao and Mr. Holman refused to provide Mr. Ridge with his own computer at his morgue work station, and Mr. Ridge was given an access code that did not work on the Lab computers. Mr. Ridge was

likewise denied an electronic tablet even though various other AHS employees at Highland were provided with them, as personally witnessed by Mr. Ridge.

18. Having access to the internet via either a computer or electronic tablet would have enabled Mr. Ridge to perform necessary research for his job like, for example, looking up the acronyms describing various medical conditions relating to dead bodies delivered to the morgue. Since he was not provided with computer access or a tablet, Mr. Ridge had no choice but to go to the Highland library, located on a different floor, in order to use the internet connection there to perform any needed research.

19. Mr. Ridge frequently needed to leave the morgue to perform his job duties. This included, among other things, delivering gurneys or specimen containers to other floors of Highland, auditing patients on two separate hospital floors, disposing of human medical waste, and picking up cleaning supplies. Mr. Ridge requested that he be provided with a "work" cell phone to speed up his response time to calls for the morgue. Mr. Ridge only had access to an old land line telephone in the morgue, and whenever he was paged, he would have to return to the morgue to call back using the land line there.

20. Daniel Ridge's repeated requests for a work cell phone and access to a computer or electronic tablet were repeatedly ignored or dismissed, and Mr. Ridge was never provided with any of them. In response to his requests, Mr. Ridge was repeatedly told that he allegedly did not "need" the requested technology, or that AHS was "looking into it," or that there was "not enough money in the budget." Reshea Holman instead instructed Mr. Ridge to use Mr. Ridge's personal cell phone for work related matters if he was outside of the morgue, and Mr. Ridge was required to leave his personal cell phone number listed on the dry erase message board outside of the morgue in case he needed to be contacted.

21. Despite knowing that Mr. Ridge temporarily had to leave the

morgue at times to perform his job duties and refusing to provide Mr. Ridge with either a work cell phone or internet access, Ms. Saechao, Ms. Ocampo, and Mr. Masangkay nevertheless criticized Mr. Ridge for not always answering the morgue land-line telephone. This included the time period from about August 2015 until October 2015, when Mr. Ridge was required to perform patient care 'audits,' which required him to visit up to about 125 patients daily spread throughout four departments on two levels of Highland, and interview them about their level of satisfaction with the care they received.

22. During the nearly two years that Daniel Ridge worked at least full time hours as the Highland morgue attendant, he made repeated and ongoing complaints to AHS management about health and safety issues, including potential violations that he witnessed. Mr. Ridge's complaints involved concerns about health and safety risks not only for himself and their effect on his own serious health conditions, but also for coworkers and patients throughout Highland Hospital.

23. Beginning in about early January 2014, AHS changed its procedure for the storage and disposal of the formaldehyde used while preserving specimens ("specimen formaldehyde") in the morgue. The procedural protocol for disposal of specimen formaldehyde prior to January 2014 involved manually separating any human medical waste (e.g., body parts) from the formaldehyde it was preserved in, then incinerating the human waste, then chemically neutralizing the formaldehyde and turning it back into water, and then disposing of the water down a drain. This process was called specimen decanting ("decanting").

24. Beginning in about January 2014, AHS protocol at Highland changed and no longer allowed the disposal of neutralized formaldehyde down any drain. Instead, the new AHS protocol required Mr. Ridge to manually separate the human medical waste and then pour the formaldehyde into a 55

gallon drum ("drum") located in the autopsy room. The drum and separate, uncovered containers of formaldehyde-soaked human medical waste were stored right next to the doorway joining the autopsy room and the morgue viewing room, and were located only about 5 to 8 feet away from Mr. Ridge's desk in the morgue viewing room.

25. By about the second week in January 2014, after decanting specimens on multiple days, Mr. Ridge began to suspect that his continued exposure to formaldehyde fumes ("fumes") was having adverse affects on his health. During the time period from January 2014 until about the summer of 2015, Mr. Ridge complained verbally about his exposure to these fumes, on average, at least twice per month to, among other people, Wei Tang and Feuy Saechao, as well as complaining to just about everyone in the Lab who worked with Mr. Ridge. At first, Mr. Ridge complained mainly about inhalation of the fumes and the resulting adverse physical symptoms he experienced.

26. Mr. Ridge complained about adverse physical effects that included, but were not limited to: light-headedness (including feeling dizzy and faint), shortness of breathe, loss of appetite, ongoing loss of sleep, and blurred vision. On one occasion, a pathologist working in the morgue named Dr. Li even witnessed Mr. Ridge getting woozy and nearly fainting, and Dr. Li recommended that Mr. Ridge take a break outside of the morgue to get away from the fumes.

27. The length of time Mr. Ridge was exposed to these fumes affected the amount of time it took Mr. Ridge to recover, and it would typically take until the following day before his symptoms cleared up significantly. However, the physical symptoms returned each time Mr. Ridge decanted specimens.

28. During the first month after the decanting protocol was changed in January 2014, Mr. Ridge complained to Mr. Tang and requested, on a number of occasions, respiratory equipment that was health code compliant, but in response Mr. Tang either ignored or dismissed Mr. Ridge's requests.

29. In about February or March 2014, after it became clear that Mr. Tang was not going to address Mr. Ridge's complaints about formaldehyde exposure, Mr. Ridge went up the AHS chain of command and complained to Ms. Sachaeo, the Lab Manager and acting Lab Director at that time. Mr. Ridge once again complained about inhaling the fumes and requested code compliant respiratory equipment. After ignoring or dismissing numerous complaints by Mr. Ridge, Ms. Sachaeo eventually told Mr. Ridge to "go to Home Depot and buy a mask," referring to a flimsy cotton mask that costs about ten dollars. Mr. Ridge then used that type of cheap cotton mask while decanting, but the mask had little to no effect reducing the adverse physical symptoms he continued to experience.

30. Daniel Ridge's work station was located in the morgue viewing room and consisted of a small desk, a chair, a land line telephone, and a log containing identification information about the dead bodies in the morgue. The dimensions of the morgue viewing room were about 25 feet in length by 15 feet in width, with about a 10 foot high ceiling. There were a total of four doors in the morgue viewing room ("viewing room"), with one door on each wall. One door served as the morgue entrance and connected the viewing room to the outer Lab hallway, one door connected the viewing room to the morgue refrigerator in which dead bodies and their belongings where kept, one door connected the viewing room to the autopsy room, and one door connected the viewing room to a storage room. The autopsy room was also connected to the pathology room through a door on the wall opposite to the wall connecting the autopsy room to the viewing room.

31. Ventilation in the morgue viewing room and the adjoining storage room was limited to air coming in and out from the doors connecting the viewing room to the Lab hallway and to the autopsy room. There were no air vents in the walls or ceiling of the morgue viewing area or its adjoining storage room, which

doubled as a break room for the morgue attendant. There was a single air vent, which was about 18 inches by 10 inches in size, in the autopsy room wall above the door connecting the viewing room to the autopsy room.

32. The lack of ventilation in the viewing room and autopsy room, where Mr. Ride performed the decanting process, was in stark contrast to the ample ventilation provided to pathologists. The pathology room housed about a 5 foot by 3 foot "hooded" area located right next to an industrial sized vent that would suck up the formaldehyde fumes from specimens. Pathologists entered this hooded area whenever they had to perform work with specimens preserved in formaldehyde.

33. Throughout his employment with AHS, Mr. Ridge was repeatedly told by the Lab Supervisor, Manager, and Director that he must keep the doors to the morgue viewing room, storage room, and autopsy room open at all times while he was physically present in the morgue area. On information and belief, Mr. Ridge's supervisor and manager did this so they could look into the morgue from the hallway and see what Mr. Ridge was doing.

34. The Lab Supervisor, Manager, and Director insisted that Daniel Ridge keep these doors open even though Highland's branch of the Alameda County Sheriff's Department required that the door connecting the morgue viewing area to the Lab hallway remain closed and locked in order to preserve the chain of custody for evidence. Personal items belonging to the dead bodies of suspected homicide victims constituted evidence, and these items were stored near the corresponding dead bodies in the morgue's refrigerator. Despite the Sheriff Department's repeated requests to Mr. Ridge to keep the morgue door closed and locked, Ms. Saechao nevertheless insisted that Mr. Ridge keep the door open.

35. Although the drum of formaldehyde was sealed with a lid when not in use, Mr. Ridge was exposed to unfiltered fumes during the decanting process,

including: while he was straining human medical waste from the solution, while pouring the solution into the barrel, and while handling formaldehyde-soaked human medical waste. Due to the poor ventilation and 5 to 8 foot proximity to his desk, Mr. Ridge was exposed to lingering fumes even after he finished decanting, and to fumes exuding from the open containers of formaldehyde-soaked human medical waste.

36. Mr. Ridge estimates he spent at least 8 to 12 hours per week decanting specimens during the period from January 2014 until about May of 2015, at which time he was finally issued proper code compliant respiratory equipment. Despite his repeated and ongoing complaints to the Lab Supervisor, Manager, and Director, Mr. Ridge had no choice but to continue to inhale these fumes for about 17 months while he spent, on average, at least 5 to 6 hours per day working within 10 feet of the drum and the open containers of formaldehyde-soaked human medical waste.

37. Mr. Ridge made every effort to decant specimens later in the work day or on weekends during hours when the rest of the Highland Lab was understaffed. Mr. Ridge decanted specimens at those times out of courtesy to the other workers in the Lab, since fumes would spread through the open morgue door and into the adjoining Lab hallway.

38. Despite Mr. Ridge's best efforts to decant specimens during less staffed times, other Lab workers noticed and repeatedly complained to him about the smell from these fumes. When other AHS employees entered the morgue, they often times covered their nose and mouths with their hands, and often left abruptly after their business there was concluded.

39. During the nearly two years Daniel Ridge worked at least full-time hours as the Highland morgue attendant, Mr. Ridge made repeated complaints to AHS management about health and safety concerns relating to the dead bodies stored in the morgue. Mr. Ridge's complaints included, among other

things, concerns about the leakage of bodily fluids on gurneys and floors, exposure to mold growing on the bodies, and exposure to dangerous and contagious viruses and bacteria.

40. As dead bodies were delivered to the morgue, they were supposed to be temporarily stored in the morgue refrigerator until the decedent's family could be notified. The family would then have to pay the requisite fee and the decedent's body would be released for pickup. If the decedent had no known family, or if the family could not afford the release fee, then the decedent would become an "indigent case" and Alameda County would have to pay for removal. Mr. Ridge estimates that about one-third of the bodies that were delivered to the morgue from January 2014 until the summer of 2015 were "indigent cases," and the average amount of time it would take before these indigent case bodies were removed from the morgue ranged anywhere from a few weeks to a few months, and sometimes as long as 6 to 9 months.

41. The morgue refrigerator at Highland had enough storage slots to hold about 9 adult bodies (not including additional body parts), but could hold up to about 15 adult bodies by storing additional bodies on gurneys. When the refrigerator hit its maximum storage capacity of about 15 bodies, then any additional bodies delivered to the morgue were temporarily stored on gurneys in the morgue viewing room.

42. Daniel Ridge estimates that during the period from January 2014 until his termination, the morgue refrigerator was filled to maximum capacity and there was at least one dead body being temporarily stored on a gurney in the morgue viewing area, on average, about 3 days per week. During this time period, the average number of bodies stored on gurneys in the morgue viewing room at any given time was about 2-3, with the highest number of bodies on gurneys in the morgue viewing room reaching about 8-10 (at which point some of these excess bodies were stored on gurneys in the autopsy room as well).

43. If excess bodies were being stored on gurneys in the viewing room when family members wanted to view a decedent, then Mr. Ridge would have to wheel the excess bodies from the viewing room into the autopsy room in order to clear the viewing room out for family usage. This resulted in Mr. Ridge having to constantly shuttle gurneys with dead bodies back and forth between the viewing room and the autopsy room.

44. Not all of the bodies delivered to the morgue arrived in body bags. From the beginning of Mr. Ridge's employment with AHS in June 2006 until about May 2015, dead bodies arriving to the morgue from the Highland Emergency Room or Intensive Care Unit were not in body bags. This lack of encapsulation resulted in the continuous spilling and seepage of bodily fluids from the corpses onto their gurneys and the floor. Some of the bodies that arrived to the morgue were too big to fit into the body bags used by AHS. Further, the body bags that AHS used were made from flimsy material that sometimes ripped, and eventually soaked through, resulting in similar spillage of bodily fluids. This spillage occurred everywhere the bodies were moved to or stored, including the morgue refrigerator, viewing room, and the autopsy room.

45. The seeping of bodily fluids onto the morgue floor was exacerbated by the fact that AHS did not employ additional morgue attendants to ensure 24/7 coverage of the morgue. The shift for morgue attendants was scheduled from about 10 am to 6:30 pm, thus leaving no one in the morgue to attend to overnight deliveries of dead bodies. On information and belief, it was standard practice at other Bay Area morgues not run by AHS to have a morgue employee work during the night shift, ensuring round-the-clock coverage for the delivery of bodies. Among other things, this was important for tissue harvesting, which required specific storage and refrigeration information to determine tissue viability.

46. On information and belief, Highland Hospital had one of the busiest

trauma centers in the East Bay. The Highland morgue also received bodies delivered from at least two other hospitals run by Alameda Health System: Fairmont Hospital and John George Psychiatric Hospital. As a result, more bodies were constantly arriving to the morgue.

47. If a patient died at Highland Hospital outside of the morgue attendant's regular hours, then the Highland nursing supervisor would have to use her key to allow delivery of the body into the morgue. When these after hour deliveries occurred, if the morgue refrigerator was filled to capacity, then bodies would be left in the morgue viewing room on a gurney and remain there until morning, often times without a body bag or anything else to prevent the seeping of blood or other bodily fluids onto the floor. There were also multiple occasions when Mr. Ridge would arrive to work in the morning and find a gurney with a dead body on it waiting in the hallway just outside of the locked morgue door. Mr. Ridge complained to the Lab Supervisor and Manager about these after hour deliveries, but he was repeatedly told that there was "not enough budget" to employ an overnight morgue attendant.

48. The spilling and leaking of bodily fluids from dead bodies was not only due to a lack of body bags, but also due to the fact that bodies would occasionally be delivered to the morgue with intravenous tubes still attached to them and with needles and other hospital "sharps" still lying on the gurneys. Mr. Ridge complained to his supervisor and manager about these repeated violations of health and safety standards, which not only contributed to the unsanitary conditions of the morgue, but increased the risk of cross contamination throughout the hospital. Nothing was done in response to Mr. Ridge's complaints until about May 2015.

49. Since not all of the bodies arrived to the morgue in body bags, Mr. Ridge was forced to use sheets from the storage room both as covers for the bodies, as well as to try and staunch the seeping bodily fluids to prevent further

spilling onto the gurneys and morgue floors.

50. Daniel Ridge also complained to his supervisors about the risk of contamination of sterilized specimen containers, which were stored in the morgue's autopsy room within a few feet of the autopsy table. Mr. Ridge was concerned that these sterilized specimen containers, which were provided to other departments throughout the hospital, could get contaminated by bodily fluid splatter while removing organs during autopsies.

51. On information and belief, documentation exists showing that the Highland morgue had not been sanitized during the 10 years prior to when Mr. Ridge started working at least full-time hours in January 2014. The morgue attendants were not provided with any supplies or equipment to clean, much less sterilize. On information and belief, cleaning and sterilization of the morgue fell under the responsibility of Highland's Environmental Services ("EVS") department.

52. During the years when Daniel Ridge worked part time as the morgue attendant, he never personally saw Lenward Cage cleaning in the morgue, nor did Mr. Ridge see any evidence that Mr. Cage cleaned. During that time, ff the morgue viewing room needed cleaning, Mr. Ridge would use a mop and hot water to wash the floor before family members viewed the decedent.

53. When Daniel Ridge began working at least full time hours as the morgue attendant in January 2014, Mr. Ridge complained to Wei Tang and Feuy Saechao about having to work in the unsanitary conditions in the morgue. Mr. Ridge complained about, among other things, blood and other bodily fluids accumulating on the morgue floors and gurneys.

54. Mr. Ridge's concerns about the sanitary conditions of the morgue were intensified once his son was born in October 2014. Mr. Ridge constantly worried about being exposed to viruses, bacteria, or mold in the morgue and then inadvertently bringing them home to his infant son.

55. Daniel Ridge also reported his concerns about the potential for cross-contamination to the Lab Supervisor, Manager, and Director. Mr. Ridge witnessed vacant gurneys that had been used to store dead bodies for days, weeks, and sometimes even months being taken out of the morgue and reused around the hospital without first being cleaned or sanitized. On multiple occasions, Mr. Ridge witnessed the same gurneys coming and going from the morgue numerous times, and each time the gurneys returned to the morgue, the same bodily fluids would be in the same spots on the gurneys.

56. On multiple occasions, Mr. Ridge also witnessed spots in the Lab hallway outside of the morgue area, where bodily fluids had dripped or sprayed off of a dead body while being transported on a gurney to the morgue. These spots of bodily fluid would go days, sometimes weeks, without EVS cleaning them up.

57. In response to Daniel Ridge's complaints about sanitary conditions of the morgue and his concerns about cross contamination, Mr. Ridge was told to contact EVS to clean things up. Although Mr. Ridge made numerous requests to EVS to clean up the morgue, including leaving voicemails and talking to EVS workers he would see in the halls, EVS failed to respond to any of his requests until after Sandra Williams, the EOC Manager-Safety Officer for Alameda County Medical Center, insisted EVS get involved in about May 2015.

58. As a result of EVS' refusal to clean, Mr. Ridge took matters into his own hands. He procured a mop and began using hot water, soap, or bleach to clean the morgue refrigerator, viewing room, and autopsy room on a daily basis. EVS refused Mr. Ridge's requests to be given proper sterilizing agents, so Mr. Ridge made do with what he could find.

59. Bodies stored outside of the refrigerator at close to room temperature experienced a faster rate of decomposition, and as time passed these bodies emitted increasingly pungent odors and grew visible mold. The

flimsy body bags provided by AHS did not contain the odor, and about one third of the bodies delivered to the morgue were not in body bags at all. When bodies were stored on gurneys in the morgue viewing room, they often sat mere feet away, and sometimes within arms reach, from Mr. Ridge's desk while he worked.

60. Mr. Ridge was concerned about his exposure to the mold growing on dead bodies stored just a few feet from his work station. After the morgue was tested for formaldehyde exposure in April 2015, Mr. Ridge raised the subject of testing the morgue for mold with Dr. Ng, the Director of Pathology, and Feuy Saechao. Mr. Ridge was told they would look into it. At about that same time, Mr. Ridge began noticing rodent droppings near some of the bodies in the morgue when he arrived in the morning, and he complained to EVS.

61. At times the odor from bodies decomposing in the morgue grew so pungent that it would fill the rooms and hallways adjacent to the morgue viewing room, and other Lab workers would complain to Daniel Ridge about the smell. One such example occurred when the body of a morbidly obese decedent was delivered to the morgue during about the summer of 2015. The decedent did not fit in the body bags provided by AHS, and was thus left lying on a gurney in the morgue viewing area with nothing more than a sheet covering it. As the days passed and the weather remained warm, the odor got so bad that Lab workers would cover their noses and mouths when walking through the hallways adjacent to the morgue.

62. Despite these sickening conditions, the Lab supervisor, Manager, and Director insisted that Mr. Ridge remain in the morgue at all times while working, and encouraged Mr. Ridge not to leave the morgue area for more than 10 minutes at a time, even during rest and meal breaks. On average, Mr. Ridge was told at least four times per month that he needed to stay in the morgue at all times in order to, among other things, be available to answer the morgue telephone, attend to body deliveries, and arrange viewings for the family

members of decedents. On information and belief, other workers in the Lab were free to come and go from their work stations as they pleased.

63. On one particular occasion in about April 2014, when Mr. Ridge complained to Dr. Ng about needing assistance, Dr. Ng responded by declining to help Mr. Ridge and telling him, "Mr. Ridge, I understand you're the only person back there, but I went to school for 12 years."

64. Mr. Ridge was discouraged by AHS management from leaving the morgue during any breaks he took, including rest, bathroom, and even meal breaks. On many days, Daniel Ridge was relegated to eating his lunch within mere feet from decomposing corpses, amid the formaldehyde fumes and other sickening odors. Mr. Ridge was often treated with reproach, either verbally or with disapproving looks, by his supervisor, manager, or lab director when Mr. Ridge was not physically present in the morgue when they needed him or if they had to wait a few minutes for Mr. Ridge to return.

65. Mr. Tang, Ms. Sachaeo, and Dr. Ng told Mr. Ridge to stay in the morgue despite knowing that Mr. Ridge was often called out of the morgue to perform various job duties, including delivering gurneys and specimen containers to various areas of the hospital. Even after Patient Care Services took over supervision of the morgue in about the summer of 2015, Mr. Ridge was repeatedly chastised by his supervisor at the time, Robbie Masangkay, for not being in the morgue despite Mr. Ridge having to spend up to 4 hours per day performing patient audits on other floors of the hospital as part of additional job duties given to him by Reshea Holman.

66. If he had to leave the morgue for any reason during his work hours, Mr. Ridge was required to post where he was going, his pager number, his personal cell phone number, his backup's name, and the nursing supervisor's contact information on a type of dry-erase message board next to the main morgue door. Mr. Ridge had to do this even when he was taking a bathroom

break.

67. Mr. Ridge's meal breaks were constantly interrupted by having to answer the morgue telephone, or deal with newly arriving decedents or grieving family members of decedents. Mr. Ridge was not provided uninterrupted 30 minute meal breaks for, on average, at least about 3 days per week during the time period from January 2014 through about February 2015.

68. AHS did nothing in response to Daniel Ridge's repeated and ongoing complaints about the adverse effects of his exposure to formaldehyde fumes until after Sandra Williams, the EOC Manager-Safety Officer for Alameda County Medical Center, stopped by the morgue in about February 2015. Upon witnessing the unsanitary conditions in the morgue and autopsy rooms during her first visit to the morgue, Ms. Williams told Mr. Ridge that she was going to make cleaning up the morgue her "pet project."

69. During her first visit, Sandra Williams questioned Daniel Ridge about health and safety conditions in the morgue, and Mr. Ridge watched her take photos of, among other things, the 55 gallon drum, the bodily fluid stains on the morgue floor and gurneys, and the corpses being stored on gurneys in the viewing room. While Ms. Williams was talking with Mr. Ridge and taking photos, Feuy Saechao walked into the morgue and had a shocked expression on her face when she saw Sandra Williams. Ms. Williams subsequently visited the morgue on at least a few more occasions while Mr. Ridge was working.

70. On about February 19, 2015, Daniel Ridge received treatment in the Highland ER for hypertension and extremely high blood pressure.

71. In about late February 2015, shortly after receiving treatment in the Highland ER, Mr. Ridge told Feuy Saechao about how he had to go to the ER and that he suffered from very high blood pressure, and that he would likely need to take medicine for the rest of his life to treat it.

72. On April 16, 2016, about 16 months after Mr. Ridge first began

complaining to AHS management about his health concerns, AHS finally tested the air quality in the morgue for formaldehyde exposure levels.

73. Around the same time that the air quality of the morgue was tested for formaldehyde levels, Sandra Williams created protocol requiring the morgue to be sterilized once per week, or as needed. Within about a week later, a group of EVS workers showed up to the morgue, including the EVS Manager, Supervisor, and about four EVS workers. Upon viewing the decomposing bodies and bodily fluids, the EVS Manager, who was Caucasian, asked Daniel Ridge, "who did you piss off to get this job?" The EVS crew then proceeded to sanitize only the morgue viewing room. During a prior meeting in which Mr. Ridge, Sandra Williams, and the EVS Manager, among others, were discussing sterilization of the morgue, this same EVS Manager sarcastically suggested that Daniel Ridge use sanitized hand wipes to clean the morgue refrigerator.

74. The following week after EVS performed its initial sanitization of the morgue viewing room, only two EVS workers showed up to do the job. The week after that, only one EVS worker showed up. The next week, the EVS workers stopped showing up altogether. Mr. Ridge contacted EVS about the weekly sterilization but received no response, so he then asked EVS if he could have access to the appropriate cleaning and sterilization agents.

75. In response to Mr. Ridge's request, the EVS Manager granted Mr. Ridge access to the storage area where EVS kept its cleaning chemicals. Using these more powerful cleaning agents, Mr. Ridge commenced cleaning and sterilizing the morgue area himself in about June 2015. Due to the constant seepage of bodily fluids, Mr. Ridge would spend about 2 to 3 hours each day spraying, scrubbing and mopping the floors of the morgue viewing room, autopsy room, and pathology room.

76. Daniel Ridge made a concerted effort to keep the morgue area clean and sanitized not only for his own benefit, but for the benefit of grieving

family members and out of concern for the safety of his coworkers and hospital patients with regard to cross contamination. Mr. Ridge went the extra mile to keep things clean, and his results were complimented by pathologists, among others, who worked in the morgue.

77. Mr. Ridge also sanitized the morgue refrigerator once per week. This involved moving each corpse in the refrigerator to the autopsy room, spraying down the entire refrigerator with sterilizing chemicals, and then, since there was no suitable drain in the refrigerator, using a squeegee to manually push the mixture of chemicals and grime out of the refrigerator and into the viewing room, where he could then pressure wash it into a suitable drain.

78. On about May 18, 2015, a memo written by Steven Derman, an Industrial Hygienist Director, was issued in response to Sandra Williams' inquiries about the storage of formaldehyde in the morgue. This memo discussed the results of an "industrial hygiene survey" that was conducted in the autopsy room during decanting on about April 16, 2015. This testing measured the levels of exposure to formaldehyde while Daniel Ridge worked on specimens in the autopsy area.

79. According to this May 18, 2015 memo, the results of the April 16 testing revealed the following health and safety violations, among other things:

(1) the cumulative eight-hour weighted average exposure exceeded the permissible CAL-OSHA Action level;

(2) the cumulative eight-hour weighted average exposure exceeded the acceptable CAL-OSHA Permissible Exposure Level (PEL);

(3) several monitored exposures during the testing exceeded the CAL-OSHA fifteen minute Short Term Exposure Limit (STEL); and

(4) monitored exposures exceeded the permissible ACGIH Ceiling, which by definition is an exposure level "that should not be exceeded, even instantaneously."

80. Based on the levels of exposure found during the April 26, 2015 testing, the memo recommended the usage of "powered air purifying respirators" (PAPR) with formaldehyde cartridges. The memo recommended that these cartridges should be changed as needed but by no later than the end of each shift after usage, and respirator training should be attended at least once per year for anyone exposed to formaldehyde in the autopsy room.

81. In accordance with the health and safety guidelines discussed in the May 2015 memo, Mr. Ridge was provided a code compliant respirator to wear while decanting specimens. Mr. Ridge proceeded to decant specimens for about the first week or two after the May 2015 memo until, on information and belief, other Lab staff complained to the Lab Manager and Director about the fact that they were not also provided respirators, yet they had to inhale the fumes while walking in the halls near the morgue.

82. Within about a month after the May 2015 test results, AHS began hiring contractors to perform the decanting process. The contractors would remove the 55 gallon drum immediately after decanting and replace it with an empty drum. However, Daniel Ridge was still responsible for sealing and removing the containers filled with human medical waste. To do so, Mr. Ridge would load the sealed containers onto a dolly and roll them, via the elevator, to the lower floor of the hospital which housed the Environmental Safety department.

83. After Sandra Williams initially inspected the morgue and interviewed Daniel Ridge, Ms. Williams insisted that, among other things, all bodies arriving to the morgue must be in body bags, including those coming from the Highland ER and ICU. Once Ms. Williams got involved, all of the bodies began arriving to the morgue in body bags.

84. After Ms. Williams saw the flimsy, undersized body bags which Highland had been using, she contacted a vendor about better options.

According to what Ms. Williams told Mr. Ridge, she initially sought input from Feuy Saechao about which body bags to order, but Ms. Saechao did not know. Ms. Williams then sought input from Daniel Ridge, who, based on his knowledge and experience, had no problem helping Ms. Williams determine the proper type of body bags to order for Highland.

85. In addition to sharing his knowledge and expertise with regard to body bags, Daniel Ridge was also approached for his input regarding the new morgue being built during 2015 as part of the new Acute Care Tower at Highland Hospital. The contractors building the new morgue sought input on procedure and day to day operations of the morgue, and how that might affect the fitting and layout of the new morgue. The contractors told Mr. Ridge that they first sought input from Robbie Masangkay, but as he was unfamiliar with the day to day operation of the morgue, Mr. Masangkay directed the contractors to Mr. Ridge, who was able to answer the contractors' questions and offer advice. Daniel Ridge was terminated before he could see the new morgue open.

86. On information and belief, within a couple months after the issuance of the May 18, 2015 memo, supervision and management of the Highland morgue was transferred from the Lab to Patient Care Services, under Reshea Holman.

87. Shortly after assuming management of the morgue, Mr. Holman implemented a number of changes that affected Daniel Ridge's employment. These changes included, among other things, the following: Mr. Holman informed Daniel Ridge that he would no longer be approved for any overtime hours Mr. Ridge worked, and Mr. Holman added patient auditing as a new job duty for Mr. Ridge.

88. Mr. Holman also required Mr. Ridge to enter, on a daily basis, the identity of each dead body in the morgue into a hand-written log kept on his desk, and then fax this daily "roll call" information to AHS Social Services by

about 11 am. In order to identify some of the bodies, Mr. Ridge would have to unzip their body bags and look inside for the identification bracelet worn by the corpse, which may have been sitting and decomposing on a gurney for days or even weeks.

89. Shortly after Reshea Holman assumed supervision of the morgue, he required Daniel Ridge to perform patient auditing throughout Highland Hospital in addition to Mr. Ridge's full-time morgue duties. This auditing involved walking through four different Highland units, spread over two hospital floors, and talking with each patient about his or her treatment experience. On average, Mr. Ridge spoke with up to about 125 patients per day, and asked each patient to rate his or her treatment experience on a scale of 1 to 10, and then recorded each patient's answer. On average, Mr. Ridge spent up to four hours per day auditing patients during the period from about August 2015 until his termination, but Mr. Ridge was not authorized to be paid for any overtime hours he worked even though he was expected to complete daily auditing in addition to his full-time morgue duties.

90. After he began auditing patients, Daniel Ridge complained to hospital management about his concerns regarding the potential for cross-contamination while he was walking to and from the various areas of the hospital while auditing patients. Mr. Ridge first complained about this to Reshea Holman, then to the floor managers, and finally to the nursing supervisor. In response, Mr. Holman dismissed or ignored Mr. Ridge's stated concerns and did not implement any additional preventative steps to protect the patients, much less Mr. Ridge, from cross-contamination within the various hospital units.

91. During one of the first conversations Daniel Ridge had with Reshea Holman in about August 2015, after Patient Care Services took over supervision of the morgue, Mr. Holman walked through Mr. Ridge's entire daily schedule and discussed how Mr. Ridge should allocate his time for each activity,

despite the fact that Mr. Ridge had been working as a morgue attendant for over 9 years. Mr. Holman's tone towards Daniel Ridge during this conversation was condescending and brisk.

92. During a phone call with Reshea Holman in about August or September 2015, Daniel Ridge mentioned his extremely high blood pressure to Mr. Holman, who replied by telling Mr. Ridge to "stop eating all those damn hogs maws and pigs feet."

93. By about September 14, 2015, Daniel Ridge was diagnosed with a medical condition similar to Post Traumatic Stress Disorder ("PTSD"), as well as depression. His doctor placed him on medical leave from work from about September 15, 2015 until October 4, 2015. During his medical leave of absence, Mr. Ridge received outpatient treatment for his PTSD and depression. Mr. Ridge returned to work after this medical leave of absence ended.

94. Shortly after he was diagnosed with PTSD and depression, Mr. Ridge discussed his PTSD condition with Feuy Sachaeo and Connie, who, on information and belief, was hired as the Lab Director in about February 2015. During the preceding months, Feuy had at times seen Mr. Ridge crying while working in the morgue, but she never asked him about it until after Mr. Ridge was diagnosed with PTSD and depression. Likewise, during one of Sandra Williams' prior visits to the morgue, Mr. Ridge was crying and asked Ms. Williams if she thought he might be suffering from some sort of PTSD.

95. In about early or mid October 2015, after Mr. Ridge had taken an excused medical leave of absence, Daniel Ridge had a one-on-one meeting with Reshea Holman. Mr. Holman began their conversation by asking Mr. Ridge, "this isn't working out, is it?" Mr. Holman then proceeded to suggest to Mr. Ridge that Mr. Ridge "should just quit," and that if Mr. Ridge did quit, Mr. Holman would not fight any claim for unemployment insurance that Mr. Ridge might make. In reply, Daniel Ridge reiterated his desire to continue to work for AHS. He told Mr.

Holman that he was considering taking additional medical leave to continue his treatment of the PTSD. Mr. Ridge explained how his prolonged exposure to the formaldehyde fumes in the morgue likely exacerbated his condition, and the combination of the fumes and his high blood pressure kept his body in a constant state of "fight or flight" mode. Mr. Ridge told Mr. Holman that even without exposure to the fumes, his doctors told him that, for the time being, the morgue might not be the best place for Mr. Ridge to work until he finished his treatment for the PTSD condition.

96. On about October 8, 2015, Daniel Ridge began suffering from chest pain and what he thought was a heart attack while working in the morgue. Mr. Ridge was taken immediately to the Highland Emergency Room for treatment for what turned out to be a severe panic attack.

97. On about October 13, 2015, Daniel Ridge visited his psychiatrist and was given a note placing him off work until October 19, 2015.

98. On about October 16, 2015, Daniel Ridge visited his psychiatrist and was given a doctor's note placing Mr. Ridge off work from October 19, 2015 until October 30, 2015. This medical leave of absence was intended to allow Mr. Ridge to seek additional outpatient treatment for his PTSD condition and depression.

99. Later on October 16, 2015, the same day that Daniel Ridge received his doctor's note placing him on medical leave, Mr. Ridge called Highland Lab's front office and spoke with the receptionist. Mr. Ridge told the receptionist that his doctor placed him on medical leave from October 19 through 30, 2015, and that Mr. Ridge would not be working those days. Mr. Ridge had never experienced any prior problems when calling in his notice for time off.

100. On October 16, 2015, Daniel Ridge also spoke on the phone with Alicia Reed, the Leave Management Coordinator for Alameda Health System,

about his need for a medical leave of absence in October 2015. Ms. Reed then sent Mr. Ridge a letter dated October 19, 2015 confirming their October 16 conversation and Mr. Ridge's desire to take a leave of absence "due to a serious health condition." Mr. Ridge had plenty of sick days saved up, but Ms. Reed confirmed that Mr. Ridge was also eligible for extended FMLA leave once he provided AHS with the necessary documentation within 15 days of October 19, 2015. Mr. Ridge was in the process of gathering that paperwork when he was terminated about 11 days later while out on excused medical leave.

101. After the completion of his medical leave of absence, Daniel Ridge returned to work in the morgue, per his usual schedule, on about Sunday, November 1, 2015. Shortly after he arrived, the nursing supervisor, accompanied by two officers from the Sheriff's Department, walked into the morgue and informed Mr. Ridge that his employment was terminated. Mr. Ridge immediately told the nursing supervisor that he had a copy of his doctor's note excusing his medical leave of absence from October 19 to 30, and that he had called before taking his leave of absence to give notice that he would be out. The nursing supervisor ignored Mr. Ridge's explanation, refused to look at his doctor's note, and asked Mr. Ridge for his building keys. Mr. Ridge was then immediately escorted by the two officers out of the morgue and Highland Hospital, in front of his on-looking coworkers.

102. After he was escorted out of the hospital, Mr. Ridge received no further communication from AHS other than a termination letter dated October 30, 2015. Mr. Ridge was never given his final paycheck. The day after he was terminated, Mr. Ridge called around to various hospital departments trying to get an explanation, but was only able to leave voicemails. AHS never responded to any of Mr. Ridge's communications.

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FIRST CAUSE OF ACTION

Discrimination Because of Disability, Race, Color, or Any Combination of the Three In Violation of Fair Employment and Housing Act

[This cause of action is omitted because summary adjudication was granted.]

SECOND CAUSE OF ACTION

Discharge Because of Disability In Violation of Fair Employment and Housing Act

[The allegations of discrimination because of race or color are omitted from this cause of action because summary adjudication was granted as to these allegations.]

As a second, separate and distinct cause of action, plaintiff Daniel Ridge complains against defendants Alameda Health System, and Does 1 through 20, and each of them, and for a cause of action alleges:

134. Plaintiff hereby incorporates by reference Paragraphs 1 through 133, inclusive, as though set forth here in full.

135. Defendants AHS, and Does 1 through 20, and each of them, discharged plaintiff Daniel Ridge because of his disabilities in violation of the California Fair Employment and Housing Act.

136. Plaintiff Daniel Ridge timely filed an administrative complaint for defendants' discharge of him because of his disabilities. The California Department of Fair Employment and Housing issued Daniel Ridge a right to sue letter, with respect to which the filing of this lawsuit is timely.

137. As a legal result of defendants' discharge of Daniel Ridge because of his disabilities, Daniel Ridge suffered and continues to suffer substantial losses in earnings and other employee benefits. Plaintiff will seek leave to amend this complaint to state the amount or will proceed according to proof at trial.

138. Plaintiff Daniel Ridge suffered emotional distress as a legal result of these defendants' discharge of him because of his disabilities, suffering and

continuing to suffer mental distress, suffering and continuing to suffer anguish as a legal result of defendants' conduct, reacting with humiliation, embarrassment, anger, outrage, disappointment, and worry, all of which is substantial and enduring. Plaintiff also suffered brain injuries as a legal result of these defendants' discharge of him because of his disabilities. Plaintiff will seek leave to amend this complaint to state the amount of these damages or will proceed according to proof at trial.

THIRD CAUSE OF ACTION

Failure to Timely Engage in an Interactive Process in Good Faith to Reasonably Accommodate Plaintiff's Disabilities In Violation of Fair Employment and Housing Act

As a third, separate and distinct cause of action, plaintiff Daniel Ridge complains against defendants Alameda Health System, and Does 1 through 20, and each of them, and for a cause of action alleges:

142. Plaintiff hereby incorporates by reference Paragraphs 1 through 141, inclusive, as though set forth here in full.

143. Defendants Alameda Health System, and Does 1 through 20, and each of them, failed to timely engage in an interactive process in good faith to reasonably accommodate plaintiff Daniel Ridge's physical and psychological disabilities, in violation of the California Fair Employment and Housing Act. Defendants' duty to engage in a good faith interactive process was ongoing and continuous. Defendants failed to engage in this process despite knowing about, as a result of numerous conversations between Mr. Ridge and AHS management, Mr. Ridge's high blood pressure and PTSD (which were exacerbated by adverse effects of unhealthy working conditions), and despite ongoing complaints by Mr. Ridge, spanning many months, about how morgue conditions contributed to his physical and psychological conditions and disabilities.

144. Defendants AHS, and Does 1 through 20, and each of them, knew about Daniel Ridge's disabilities and about the limitations those disabilities placed on his ability to perform his essential job functions in the morgue since Mr. Ridge repeatedly talked with defendants about his disabilities and medical conditions.

145. Mr. Ridge made numerous requests to defendants for reasonable accommodations necessary to allow him to perform his essential job functions in light of his known physical and psychological disabilities, including, among other things, medical leave to seek treatment, temporary transfer to another position, fixing the unsafe and unhealthy work conditions in the morgue, and respiratory safety equipment. However, in response, defendants dismissed Mr. Ridge's requests for temporary transfer and terminated Mr. Ridge while he was out on excused medical leave.

146. Defendants AHS, and Does 1 through 20, and each of them, failed to timely engage in an interactive process in good faith to reasonably accommodate Daniel Ridge by never talking with Mr. Ridge about how best to enable him to continue working in light of his physical and psychological disabilities, despite Mr. Ridge's requests for accommodations.

147. Plaintiff Daniel Ridge timely filed an administrative complaint that encompasses defendants' failure to timely engage in an interactive process in good faith to reasonably accommodate plaintiff Daniel Ridge's disabilities. The California Department of Fair Employment and Housing issued Daniel Ridge a right to sue letter, with respect to which the filing of this lawsuit is timely.

148. As a legal result of these defendants' failure to timely engage in an interactive process in good faith to reasonably accommodate plaintiff Daniel Ridge's physical and psychological disabilities, Daniel Ridge suffered and continues to suffer substantial losses in earnings and other employee benefits. Plaintiff will seek leave to amend this complaint to state the amount or will

proceed according to proof at trial.

149. Plaintiff Daniel Ridge suffered emotional distress as a legal result of defendants' failure to timely engage in an interactive process in good faith to reasonably accommodate plaintiff's physical and psychological disabilities, suffering and continuing to suffer mental distress, suffering and continuing to suffer anguish as a legal result of defendants' conduct, reacting with humiliation, embarrassment, anger, outrage, disappointment, and worry, all of which is substantial and enduring. Plaintiff also suffered brain injuries as a legal result of these defendants' failure to timely engage in an interactive process in good faith to reasonably accommodate plaintiff's physical and psychological disabilities. Plaintiff will seek leave to amend this complaint to state the amount of these damages or will proceed according to proof at trial.

FOURTH CAUSE OF ACTION

Failure to Reasonably Accommodate Disability In Violation of Fair Employment and Housing Act

As a fourth, separate and distinct cause of action, plaintiff Daniel Ridge complains against defendants Alameda Health System, and Does 10 through 30, and each of them, and for a cause of action alleges:

153. Plaintiff hereby incorporates by reference Paragraphs 1 through 152, inclusive, as though set forth here in full.

154. Defendants AHS and Does 10 through 30, and each of them, violated the California Fair Employment and Housing Act by failing to reasonably accommodate plaintiff Daniel Ridge's known physical and psychological disabilities to allow him to perform the essential duties of his job during the period from about January 2014 until Mr. Ridge was terminated while on an excused medical leave in October 2015.

155. Defendants failed to reasonably accommodate Mr. Ridge by refusing, for about 17 months, to provide him with respiratory safety equipment

to limit or prevent his exposure to formaldehyde, despite knowing about the adverse effects his exposure to the fumes was having on Mr. Ridge's physical and psychological disabilities.

156. Defendants AHS, and Does 10 through 30, and each of them, beginning in at least February 2015, were aware of Mr. Ridge's extremely high blood pressure and failed to accommodate him in a reasonable manner that would allow him to perform his essential job duties, instead confining him to the morgue for as much of the work day as possible.

157. Defendants AHS, and Does 10 through 30, and each of them, failed to reasonably accommodate Mr. Ridge by ignoring or dismissing his repeated inquiries about other temporary job positions outside of the morgue. Defendants either ignored Mr. Ridge's inquiries altogether or claimed they "would look into it," but never followed up with Mr. Ridge.

158. Defendants AHS, and Does 10 through 30, and each of them, also failed to reasonably accommodate Daniel Ridge by not allowing him to take additional reasonable and necessary leave to seek treatment for his known psychological disability. Instead, defendants terminated Mr. Ridge for allegedly not showing up to work while he was out on excused medical leave, despite Mr. Ridge giving adequate prior notice to defendants about his medical leave.

159. The implementation of reasonable accommodations would have enabled Daniel Ridge to perform his essential job functions.

160. Defendants AHS, and Does 10 through 30, and each of them, failed to reasonably accommodate Daniel Ridge during the period from about October 30, 2015 to present by discharging him for pretextual reasons to avoid reasonably accommodating his disabilities for the immediate future, on an ongoing basis, and as they might be exacerbated by additional mistreatment in the future.

161. Plaintiff Daniel Ridge timely filed an administrative complaint that

encompasses defendants' failure to reasonably accommodate his disabilities. The California Department of Fair Employment and Housing issued Daniel Ridge a right to sue letter, with respect to which the filing of this lawsuit is timely.

162. As a legal result of these defendants' failure to reasonably accommodate plaintiff Daniel Ridge's disabilities, Daniel Ridge suffered and continues to suffer substantial losses in earnings and other employee benefits. Plaintiff will seek leave to amend this complaint to state the amount or will proceed according to proof at trial.

163. Plaintiff Daniel Ridge suffered emotional distress as a legal result of these defendants' failure to reasonably accommodate his disabilities, suffering and continuing to suffer mental distress, suffering and continuing to suffer anguish as a legal result of defendants' conduct, reacting with humiliation, embarrassment, anger, outrage, disappointment, and worry, all of which is substantial and enduring. Plaintiff also suffered brain injuries as a legal result of these defendants' failure to reasonably accommodate his disabilities. Plaintiff will seek leave to amend this complaint to state the amount of these damages or will proceed according to proof at trial.

FIFTH CAUSE OF ACTION

Failure to Provide Requested Medical Leave For Serious Health Condition In Violation of Fair Employment and Housing Act

As a fifth, separate and distinct cause of action, plaintiff Daniel Ridge complains against defendants Alameda Health System, and Does 10 through 30, and each of them, and for a cause of action alleges:

167. Plaintiff hereby incorporates by reference Paragraphs 1 through 166, inclusive, as though set forth here in full.

168. Defendants Alameda Health System, and Does 10 through 30, and each of them, failed to provide Daniel Ridge with the medical leave he requested for his known serious health condition. Rather than provide Mr. Ridge with his

requested medical leave, defendants terminated him.

169. Plaintiff Daniel Ridge timely filed an administrative complaint for defendants' failure to provide him with the medical leave he requested for his serious health condition. The California DFEH issued Daniel Ridge a right to sue letter, with respect to which the filing of this lawsuit is timely.

170. As a legal result of these defendants' failure to provide Daniel Ridge with the medical leave he requested for his serious health condition, Daniel Ridge suffered and continues to suffer substantial losses in earnings and other employee benefits. Plaintiff will seek leave to amend this complaint to state the amount or will proceed according to proof at trial.

171. Plaintiff Daniel Ridge suffered emotional distress as a legal result of defendants' failure to provide him with the medical leave he requested for his serious health condition, suffering and continuing to suffer mental distress, suffering and continuing to suffer anguish as a legal result of defendants' conduct, reacting with humiliation, embarrassment, anger, outrage, disappointment, and worry, all of which is substantial and enduring. Plaintiff also suffered brain injuries as a legal result of these defendants' failure to provide him with the medical leave he requested for his serious health condition. Plaintiff will seek leave to amend this complaint to state the amount of these damages or will proceed according to proof at trial.

SIXTH CAUSE OF ACTION

Retaliation for Exercising Right to Medical Leave For Serious Health Condition In Violation of Fair Employment and Housing Act

As a sixth, separate and distinct cause of action, plaintiff Daniel Ridge complains against defendants Alameda Health System, and Does 20 through 40, and each of them, and for a cause of action alleges:

175. Plaintiff hereby incorporates by reference Paragraphs 1 through 174, inclusive, as though set forth here in full.

176. Defendants Alameda Health System, and Does 20 through 40, and each of them, retaliated against plaintiff Daniel Ridge because he exercised his right to take medical leave for his serious health condition, a right guaranteed to him by the California Family Rights Act, codified under the California Fair Employment and Housing Act, and because these defendants anticipated Mr. Ridge might take additional such medical leave in the future for his serious health condition. This retaliation included, among other things, refusing to grant Mr. Ridge's requested medical leave for a serious health condition, adding additional job duties while refusing to authorize overtime, and discharge of Mr. Ridge.

177. Plaintiff Daniel Ridge timely filed an administrative complaint for these defendants' retaliation against him because he exercised his right to take medical leave for his serious health condition. The California DFEH issued Daniel Ridge a right to sue letter, with respect to which the filing of this lawsuit is timely.

178. As a legal result of these defendants' retaliation against Daniel Ridge because he exercised his right to take medical leave for his serious health condition, Daniel Ridge suffered and continues to suffer substantial losses in earnings and other employee benefits. Plaintiff will seek leave to amend this complaint to state the amount or will proceed according to proof at trial.

179. Plaintiff Daniel Ridge suffered emotional distress as a legal result of defendants' retaliation against him because he exercised his right to take medical leave for his serious health condition, suffering and continuing to suffer mental distress, suffering and continuing to suffer anguish as a legal result of defendants' conduct, reacting with humiliation, embarrassment, anger, outrage, disappointment, and worry, all of which is substantial and enduring. Plaintiff also suffered brain injuries as a legal result of these defendants' retaliation against him because he exercised his right to take medical leave for his serious health

condition. Plaintiff will seek leave to amend this complaint to state the amount of these damages or will proceed according to proof at trial.

SEVENTH CAUSE OF ACTION

Retaliation for Opposing Discrimination Because of Disability, Race, Color, or Any Combination of the Three In Violation of Fair Employment and Housing Act

[The allegations of discrimination because of race or color are omitted from this cause of action because summary adjudication was granted as to these allegations.]

As a seventh, separate and distinct cause of action, plaintiff Daniel Ridge complains against defendants Alameda Health System, and Does 20 through 40, and each of them, and for a cause of action alleges:

183. Plaintiff hereby incorporates by reference Paragraphs 1 through 182, inclusive, as though set forth here in full.

184. Defendants Alameda Health System, and Does 20 through 40, and each of them, retaliated against plaintiff Daniel Ridge because of his opposition to discrimination against him because of his disabilities, in violation of the California Fair Employment and Housing Act. This retaliation included, among other things, forcing Mr. Ridge to continue to work in unsafe conditions, refusing to provide requested safety equipment to Mr. Ridge, refusing Mr. Ridge's requests for temporary transfer to a position outside of the morgue, refusing to grant Mr. Ridge's requested medical leave for a serious health condition, adding additional job duties while refusing to authorize overtime, and discharging. Defendants retaliated against Daniel Ridge for opposing his discriminatory treatment by, among other things, repeatedly and continuously complaining to AHS management about his forced and repeated exposure to health and safety risks in the morgue, including complaints about those unsafe work conditions which exacerbated Mr. Ridge's serious health conditions.

185. Plaintiff Daniel Ridge timely filed an administrative complaint for

these defendants' retaliation against him because of his opposition to discrimination against him because of his disabilities. The California DFEH issued Daniel Ridge a right to sue letter, with respect to which the filing of this lawsuit is timely.

186. As a legal result of these defendants' retaliation against Daniel Ridge because of his opposition to defendants' discrimination against him because of his disabilities, Daniel Ridge suffered and continues to suffer substantial losses in earnings and other employee benefits. Plaintiff will seek leave to amend this complaint to state the amount or will proceed according to proof at trial.

187. Plaintiff Daniel Ridge suffered emotional distress as a legal result of defendants' retaliation against him because of his opposition to defendants' discrimination against him because of his disabilities, suffering and continuing to suffer mental distress, suffering and continuing to suffer anguish as a legal result of defendants' conduct, reacting with humiliation, embarrassment, anger, outrage, disappointment, and worry, all of which is substantial and enduring. Plaintiff also suffered brain injuries as a legal result of defendants' retaliation against him because of his opposition to defendants' discrimination against him because of his disabilities. Plaintiff will seek leave to amend this complaint to state the amount of these damages or will proceed according to proof at trial.

EIGHTH CAUSE OF ACTION

Failure to Prevent Unlawful Discrimination and Retaliation In Violation of Fair Employment and Housing Act

[The allegations of discrimination because of race or color are omitted from this cause of action because summary adjudication was granted as to these allegations.]

As an eighth separate and distinct cause of action, plaintiff Daniel Ridge complains against defendants Alameda Health System, and Does 20 through 40,

and each of them, and for a cause of action alleges:

191. Plaintiff hereby incorporates by reference Paragraphs 1 through 190, inclusive, as though set forth here in full.

192. During the course of his employment with AHS, Daniel Ridge was subjected to discrimination against him because of his disabilities.

193. During the course of his employment with AHS, Daniel Ridge was subjected to retaliation for his opposition to defendants' discrimination against him because of his disabilities.

194. During the course of his employment with AHS, Daniel Ridge was subjected to retaliation for exercising his right to medical leave for his serious health condition.

195. Defendants Alameda Health System, and Does 20 through 40, and each of them, failed to take all reasonable steps necessary to prevent the occurrence of unlawful discrimination and retaliation against plaintiff Daniel Ridge, all in violation of the Fair Employment and Housing Act.

196. Plaintiff Daniel Ridge timely filed an administrative complaint that encompasses defendants' failure to prevent unlawful discrimination and retaliation against him. The California Department of Fair Employment and Housing issued Daniel Ridge a right to sue letter, with respect to which the filing of this lawsuit is timely.

197. As a legal result of defendants' failure to prevent unlawful discrimination and retaliation against Daniel Ridge, Mr. Ridge suffered and continues to suffer substantial losses in earnings and other employee benefits. Plaintiff will seek leave to amend this complaint to state the amount or will proceed according to proof at trial.

198. Plaintiff Daniel Ridge suffered emotional distress as a legal result of defendants' failure to prevent unlawful discrimination and retaliation against him, suffering and continuing to suffer mental distress, suffering and continuing

to suffer anguish as a legal result of defendants' conduct, reacting with humiliation, embarrassment, anger, outrage, disappointment, and worry, all of which is substantial and enduring. Plaintiff also suffered brain injuries as a legal result of these defendants' failure to prevent unlawful discrimination and retaliation against him. Plaintiff will seek leave to amend this complaint to state the amount of these damages or will proceed according to proof at trial.

PRAYER

Wherefore plaintiff Daniel Ridge prays for judgment against defendants, and each of them, as follows:

1. For a money judgment representing compensatory damages including lost wages and earnings, retirement benefits and other employee benefits, lost earning capacity, and all other sums of money, together with interest on these amounts, according to proof;

2. For a money judgment for mental pain and anguish and emotional distress, according to proof;

3. For a money judgment for brain injuries, according to proof;

4. For prejudgment and post-judgment interest;

5. For attorney fees pursuant to California Government Code §12965(b), and any other appropriate legal authority;

6. For costs of suit; and

7. For any other relief that is just and proper.

Dated: July 8, 2019

LAW OFFICES OF PHIL HOROWITZ

by _____

Phil Horowitz
Christopher Banks
Attorneys for Plaintiff
Daniel Ridge

JURY TRIAL DEMANDED

Plaintiff demands trial by jury of all issues, except for attorneys' fees and costs.

Dated: July 8, 2019

LAW OFFICES OF PHIL HOROWITZ

by _____
Phil Horowitz
Christopher Banks
Attorneys for Plaintiff
Daniel Ridge