IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No.

RAYMOND VEGA, on behalf of Jose Martin Vega, deceased,

Plaintiff,

vs.

BLAKE R. DAVIS and certain additional unknown agents of the United States Bureau of Prisons,

Defendants.

COMPLAINT AND JURY DEMAND

Plaintiff ("Plaintiff") Raymond Vega complains as follows against defendants Blake R. Davis and certain additional unknown agents of the United States Bureau of Prisons (sometimes collectively "Defendants").

NATURE OF THE ACTION

1. This is a *Bivens* action for damages based on the abuse and wrongful death of Jose Martin Vega ("Vega"), who at the time of his death in May 2010 was an inmate at the United States Penitentiary - Administrative Maximum, in Florence Colorado ("ADX" or "ADX Florence"). As further alleged below, Vega suffered from a serious mental illness during his incarceration at ADX, to which Defendants exhibited persistent and deliberate indifference, and that as a result was not properly treated, as constitutionally required. Because of Defendants' violations of Vega's constitutional and other rights, Vega died in an incident determined by the

Fremont County, Colorado, coroner to have been a suicide. Vega's death was preventable, and was the result of Defendants' actions and failures to act, all in violation of the rights guaranteed by the United States Constitution.

JURISDICTION AND VENUE

2. This Court has jurisdiction over this *Bivens* action pursuant to 28 U.S.C. § 1331(a).

3. Venue is proper in the District of Colorado under 28 U.S.C. § 1391(b), because a substantial part of the acts or omissions that give rise to Plaintiff's claims occurred in the District of Colorado.

PARTIES

4. Plaintiff Raymond Vega is the brother of the Jose Martin Vega. Raymond Vega is a resident of New York. His address is 6223 64th St., Middle Village, New York 11379.

5. At certain relevant times defendant Blake R. Davis was the Warden at ADX Florence. As Warden of ADX Florence, Mr. Davis maintained physical custody of Jose Vega while he was housed at ADX Florence, including on May 1, 2010, the date of Jose Vega's death.

6. Defendants also include certain additional unknown agents of the United States Bureau of Prisons ("BOP") whose acts and omissions, upon information and belief, caused or contributed to Vega's suffering and death. The names and titles of these individuals, and their specific acts and omissions, are unknown to Plaintiff at this time, but will be included in amended pleadings as and when additional information become available to Plaintiff.

ALLEGATIONS

ADX and Its Control Unit

7. ADX is the most secure federal penitentiary in the United States. It was built to house prisoners who are claimed to present the greatest threats to correctional staff or to other prisoners.

8. At any given time, between 400 and 500 prisoners are housed at ADX. Prisoners are housed in nine different housing units, divided into five security levels: Control Unit, Special Security Unit, Special Housing Unit, four General Population Units, and two Intermediate/Transitional Units.

9. The Control Unit is one of the most secure and isolated units currently in use at ADX Florence. Prisoners in the Control Unit have been sentenced to long term segregation and have little or no contact with other prisoners for extended periods of time. Prisoners in the Control Unit are isolated from the other prisoners at all times, even during recreation. Many prisoners in the Control Unit are in "solitary confinement," with their only contact with other humans being the prison guards.

10. Depending on which unit they are in, prisoners spend at least 20, and as much as 24, hours per day in their individual cells, which measure approximately 12 feet by 7 feet. The cells have solid walls, thereby preventing prisoners from viewing the interiors of other cells or having direct contact with prisoners in adjacent cells. The cells have solid doors with a small slot at the base through which food is delivered twice a day. Each cell is furnished with a bed, desk and stool made of poured concrete, toilets and showers with automatic shut-off valves and sinks without water taps. The beds are usually dressed with a thin mattress and blankets over the

concrete. Each cell contains a single window, approximately 42 inches tall and 4 inches wide, which allows entry of some natural light but ensures that the prisoners cannot see much outside of their cells other than the building and sky. Many cells, except those in the Special Housing Unit, are equipped with a remotely-controlled radio or television that offers religious and educational programming. These are often withheld from prisoners as punishment.

11. Defendants make a determined and calculated effort to dominate the prisoners at ADX through the use of disciplinary techniques that include the use of extended periods of solitary confinement in the Control Unit and threats of punitive measures such as the withholding of privileges (e.g., access to a television set, access to the in-house "commissary" where inmates can purchase food and other items, access to the telephone, prompt delivery of inbound mail, etc.). In addition, physical abuse of unruly or even assertive prisoners by the correctional staff at ADX is routinely used to create fear and demonstrate the dominance of the correctional staff.

ADX Florence and Its Treatment of the Mentally Ill

12. The BOP, a division of the United States Department of Justice, is charged with establishing policies and regulations for all U.S. penitentiaries and other types of prison facilities that are safe, humane, and secure.

13. BOP procedures state that "inmates currently diagnosed as suffering from serious psychiatric illnesses should not be referred for placement at ... ADX." BOP Program Statement 5100.08, "Inmate Security Designation and Custody Clarification," Chapter 7, p. 18.

14. Despite this, many ADX Florence inmates suffer from various mental illnesses, including depression, schizophrenia, post-traumatic stress disorder, mental retardation, and other serious mental conditions.

15. At the times relevant in this action, ADX policy does not allow prisoners, while they reside in the Control Unit, to receive medication to treat or ameliorate the effects of mental illness. As a result, these conditions of confinement virtually assure that prisoners' condition will continue to deteriorate, and that they will continue to respond to the BOP staff in ways that lengthen their time in the Control Unit's solitary confinement conditions.

16. It is common for Defendants to place an incoming prisoner taking psychotropic medication in the Control Unit, where such medication is not available.

17. BOP policies require the prison staff to "ensure that assessment and treatment planning procedures exist to identify all prisoners entering the institution with either a recent history or current symptoms of significant mental illnesses and/or risk of suicide." BOP Program Statement 5310.13, "Institution Management of Mentally Ill Inmates," p. 4. These policies provide that during the intake screening, prisoners with any of the following conditions must be referred immediately to a Mental Health Program Coordinator (a) Recent history or current symptoms of significant mental illness; (b) Signs or symptoms consistent with a possible mental disorder; (c) Use of medication for treatment of a mental illness or disorder; (d) Documented mental health designation; (e) Risk of suicide; BOP Program Statement 6340.04, "Psychiatric Services," § 9(a).

18. The Mental Health Program Coordinator is required to complete a screening report on all referred prisoners, and forward the prisoner's mental health information to relevant members of the prison staff. BOP Program Statement 5310.13, "Institution Management of Mentally Ill Inmates," p. 5. If the prisoner has extensive treatment needs, the Program Coordinator must schedule additional sessions and establish a treatment plant. *Id.*

19. BOP policies require that mentally ill prisoners be monitored on an ongoing basis to asses treatment compliance. *Id.* at 5. For certain prisoners, including those receiving psychoactive medication and those segregated for mental health reasons, mental health staff must, at a minimum, conduct a monthly interview to assess the prisoner's treatment strategy. *Id.*

20. BOP does not provide adequate mental health staffing at ADX Florence, given the size of the mental health caseload at that facility. At the relevant time, upon information and belief only two mental health professionals -- both psychologists -- were responsible for the mental health of the approximately 450 inmates housed at ADX, assisted very occasionally by a psychiatrist. As a result of inadequate staffing by mental health professionals, ADX inmates, including Jose Vega, do not have timely access to mental health professionals, particularly in times of crisis.

21. As described below, and likely as a result of the inadequate mental health staffing provided at ADX Florence, Defendants failed to screen, monitor or treat Jose Vega's mental illnesses, first diagnosed in 2004. Instead, Defendants placed Mr. Vega in ADX Florence's Control Unit, deprived him of necessary psychiatric medications, and otherwise abused and tortured him over a period of years. These actions had devastating consequences.

ADX Florence and Its Treatment of Jose Vega

22. In 1995, at the age of 20, Jose Vega was sentenced to life in prison and committed to the custody of the BOP.

23. Jose Vega was originally confined at Lewisburg United States Penitentiary ("USP Lewisburg"). On March 13, 2003 he was transferred from USP Lewisburg to Allenwood United

States Penitentiary ("USP Allenwood"). On April 5, 2004, he was transferred from USP Allenwood to ADX Florence.

24. Defendants placed Jose Vega in the Control Unit at ADX-Florence.

25. In December of 2004, upon information and belief, psychologist Marie Bailey of ADX diagnosed Jose Vega as suffering from paranoid schizophrenia.

26. In March of 2005, Jose Vega was referred to the U.S. Medical Center for Federal Prisoners in Springfield, Missouri ("FMC Springfield") for a mental health evaluation.

27. Plaintiff does not know presently know why the BOP transferred Jose Vega to FMC Springfield. Upon information and belief, however, any such transfer involves very significant expense, security risks and administrative difficulties. Moreover, ADX has on-site medical and mental health treatment facilities, and access to hospitals and other medical facilities in the vicinity of the prison, where ADX inmates are routinely transported for evaluation and treatment. Under these circumstances, and again upon information and belief, ADX inmates are transferred to FMC Springfield only when the ADX staff is confronted with serious medical issues that outstrip the capacity of ADX Florence, such as Jose Vega's serious mental illness.

28. At FMC Springfield, Jose Vega underwent a mental health evaluation. This evaluation revealed that Jose Vega had "a history of depression and antisocial personality disorder."

29. Vega remained at FMC Springfield for approximately one year. Upon information and belief, ADX inmates referred to FMC Springfield for mental health evaluation or treatment rarely remain at FMC Springfield for more than a month or two. A stay of a year at

FMC Springfield therefore suggests that the BOP itself recognized that Vega suffered from a serious mental illness requiring extended and extensive mental health treatment.

30. In 2006, the BOP transferred Jose Vega back to ADX Florence. That transfer violated BOP's written procedures which clearly state that "inmates currently diagnosed as suffering from serious psychiatric illnesses should not be referred for placement at ... ADX." BOP Program Statement 5100.08, "Inmate Security Designation and Custody Clarification," Chapter 7, p. 18.

31. Upon Jose Vega's return to ADX Florence, Defendants were required to send Mr. Vega to the Mental Health Program Coordinator for a thorough assessment of his mental health. BOP Program Statement 6340.04, "Psychiatric Services," § 9(a). The Mental Health Program Coordinator was to complete a screening report and forward the information to relevant members of the ADX Florence prison staff. BOP Program Statement 5310.13, "Institution Management of Mentally Ill Inmates," p. 5. Such a review would have shown that Jose Vega had treatment needs. Accordingly, the Mental Health Program Coordinator was required to schedule additional sessions, establish a treatment plant, and monitored Jose Vega on an ongoing basis to asses treatment compliance. *Id.* Upon information and belief, this was never done.

32. Upon Jose Vega's return to ADX Florence, Defendants placed Jose Vega back in the Control Unit.

33. When Jose Vega returned to the Control Unit at ADX Florence meant he was unable to receive medication to treat or ameliorate the effects of his mental illness.

34. Upon information and believe, ADX staff members repeatedly chained Vega unnecessarily, sometimes for periods of ten days or more. Upon information and belief, the

behavior claimed by the BOP to justify such abuse was a product of Vega's untreated mental illness, and thus was not within his control. That is, BOP agents caused Vega's conduct by failing to treat his obvious and serious mental illness, and then punished him severely for acting as he predictably did.

35. Upon information and belief, Jose Vega told other prisoners that he believed the ADX Florence guards were poisoning his food and spraying things into his vents.

36. On May 1, 2010 Jose Vega was found dead in his cell in the Control Unit at ADX Florence.

37. The coroner's report noted that Jose Vega died as a result of hanging. The investigation and autopsy indicated that his injuries were intentional and self-inflicted. The coroner's report also indicated that information received from the ADX health administrator indicated that Jose Vega "had a long psychiatric history."

38. As warden of ADX during certain periods relevant to this action, Defendant Davis was responsible for the care and safety of ADX inmates, including Vega. Upon information and belief, during relevant periods Davis visited the ADX Control Unit and spoke with inmates confined there, and through those interactions and otherwise was familiar with events occurring in the Control Unit and the condition of the prisoners confined there. Upon information and belief, Davis also was aware of discipline imposed on ADX inmates, serious medical issues among the inmates, and other information bearing on the care and well being of inmates under his custody and control, including Vega. Upon information and belief, during relevant periods Davis also had the discretionary authority to authorize the transfer of ADX inmates, including Vega, to medical facilities such as FMC Springfield, where they could be treated for mental

health problems more serious than could effectively be treated at ADX. Upon information and belief, Davis knew about or was willfully ignorant of Vega's serious medical needs, his deterioration while confined in the ADX Control Unit, the availability of constitutionally adequate mental health services at BOP medical facilities such as FMC Springfield, and the means of accessing other mental health services required by Vega. Nevertheless, Davis failed and refused to make any of those resources and medical services available to Vega. Davis also failed to prevent the abuse of Vega by ADX staff, failed to ensure that Vega was adequate fed and safely housed, failed to implement adequate suicide prevention programs at ADX, and otherwise failed to address Vega's serious, chronic and growing mental illness. As a result, Vega's mental deterioration continued, and ultimately resulted in his death. Defendant Davis' failure to discharge his obligations relating to Vega was a legal cause of Vega's death.

39. Upon information and belief, Defendants have engaged in similar misconduct with respect to other ADX inmates, some of whom have injured or killed themselves as a result, and many of whom have suffered unnecessarily and for months or years on end because of the failure of Defendants and other ADX staff members to provide constitutionally required mental health care to inmates whom they knew or should have know suffered from serious mental illnesses.

FIRST CAUSE OF ACTION
(Deliberate Indifference To Serious Medical Needs)

40. Plaintiff incorporates the preceding paragraphs of this pleading.

41. Pursuant to the Eighth Amendment to the United States Constitution, Jose Vega had the right to be free from cruel and unusual punishment and to receive proper medical care and attention while confined by the BOP.

42. Jose Vega suffered objectively serious medical needs that Defendants actually knew of but disregarded.

43. The Defendants' treatment of Jose Vega constituted a deliberate indifference to his serious medical needs in violation of the Eighth Amendment to the United States Constitution.

44. The actions of the Defendants manifested a deliberate indifference to Jose Vega's constitutional rights in violation of the Eight Amendment of the United States Constitution.

PRAYER FOR RELIEF

WHEREFORE Plaintiff prays for judgment against Defendants for:

(a) a sum to compensate Plaintiff for the suffering and death of his brother while incarcerated due to the denial of his medical needs;

(b) a sum to compensate Plaintiff for his own pain and suffering and loss of companionship as a result of the death of his brother due to the denial of his brother's medical needs;

(c) punitive damages in a sum as to deter Defendants of conduct of this nature in the future; and

(d) such other relief as this Court deems just and proper.

Plaintiff demands a trial by jury.

Dated: May 1, 2012

Respectfully submitted,

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