IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 1:12-cv-01144-RPM

RAYMOND VEGA, Personally and as Personal Representative of the Estate of Jose Martin Vega, deceased,

Plaintiff,

vs.

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

Defendants.

AMENDED COMPLAINT AND JURY DEMAND

Plaintiff Raymond Vega, personally and as Personal Representative of the Estate of Jose Martin Vega, deceased, ("Plaintiff") 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, 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 alleged below, Vega suffered from serious mental illnesses during his incarceration at ADX, to which Defendants exhibited persistent and deliberate indifference, and that as a result were not properly treated, as constitutionally required. 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 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 Jose Martin Vega ("Vega"). Raymond Vega is a resident of New York. His address is 5510 58th Street, Apt 2b, Corona, New York, 11368.

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 Vega while he was housed at ADX Florence, including on May 1, 2010, the date of 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

7. ADX is the most secure federal penitentiary in the United States. Staff at ADX often refer to it as the "Alcatraz of the Rockies." ADX was built to house prisoners whom the BOP claims present the greatest threats to the correctional staff or to other prisoners. The allegations set forth below in paragraphs 8 through 11 describe both current conditions at ADX and conditions at ADX during all other times relevant to this action.

8. ADX currently houses approximately 450 men. Upon information and belief, ADX housed a comparable number of men at the time of Vega's death. At any given time, these prisoners are housed at ADX in nine different maximum-security housing units, which are divided into six security levels: the Control Unit; the disciplinary Special Housing Unit ("SHU"); so-called "Range 13," an ultra secure and isolated four-cell wing of the SHU in which the BOP houses prisoners it thinks require confinement with virtually no human contact; four so-called "General Population" Units ("Delta," "Echo," "Fox," and "Golf" Units), the Special Security Unit ("H" Unit); and two units ("Joker" Unit and "Kilo" Unit) that in recent years have been used as transitional housing units for prisoners who have entered the so-called "Step-Down Program," in which they can earn their way out of ADX and into a lower security classification.

9. Depending on which unit they are in, prisoners spend at least 20, and as many as 24, hours per day locked alone in their cells. The cells measure approximately 12 feet by 7 feet, and have solid walls that prevent prisoners from viewing the interiors of adjacent cells or having direct contact with prisoners in adjacent cells. All ADX cells have solid steel doors with a small closable slot. Cells in all units other than H, Joker, and Kilo units also have an interior barred

wall with a sliding door, which together with the exterior door forms a sally port in each cell. Each cell is furnished with a concrete bed, desk, and stool, and a stainless steel combination sink and toilet. Cells in all units other than H, Joker, and Kilo units include a shower with an automatic shut-off valve. 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 which is designed to ensure that prisoners cannot see anything outside of their cells other than the building and sky. Many cells, except those in the SHU, are equipped with a radio and television that offers religious and educational programming, along with some general interest and recreational programming. Televisions often are withheld from prisoners as punishment. Meals are delivered three times a day. With few exceptions, prisoners in most ADX units are allowed out of their cells only for limited social or legal visits, some forms of medical treatment, visits to the "law library" (essentially a cell with a specialized computer terminal that provides access to a limited range of federal legal materials) and a few hours a week of indoor or outdoor recreation.

10. With the possible exception of four-cell Range 13, the Control Unit is the most secure and isolated unit currently in use at ADX. Prisoners in the Control Unit are isolated from the other prisoners at all times, even during recreation, for extended terms often lasting six years or more. Their only meaningful contact with other humans is with ADX staff members. The compliance of Control Unit prisoners with institutional rules is assessed monthly; a prisoner is given "credit" for serving a month of his Control Unit time only if he maintains clear conduct for the entire month. As detailed below, Defendants provide no mental health care or psychotropic medication to Control Unit prisoners. Given their complete lack of access to mental health care,

seriously mentally ill prisoners confined in the Control Unit frequently have behavioral issues caused by their mental illness. Such conduct often results in the loss of credit for Control Unit time served, thus extending the prisoner's time in the extreme isolation of the Control Unit, sometimes for years.

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 programs are designed based upon a punishment philosophy rather than a control philosophy. The behavior of mentally ill prisoners, in particular, deteriorates very rapidly when they are placed into programs designed to punish rather than to control unacceptable behaviors.

The Imprisonment of the Mentally Ill

12. Correctional officials and mental health professionals have known for more than 200 years that extended periods of confinement in isolation can be psychologically damaging, and can be particularly harmful to individuals with pre-existing mental illness. Beginning in 1790, when sixteen isolation cells were constructed at Philadelphia's Walnut Street Jail, correctional officials and mental health professionals have regularly studied and acknowledged the dangers of prolonged confinement in isolation. It is well understood that extreme isolation

for even a few weeks can result in psychosis, social withdrawal, insomnia, depression, hallucinations, rage, aggression, self-mutilation, and contemplation of suicide.

13. In early America, confinement in isolation was viewed as a more humane alternative to corporal punishment; its proponents thought it would inspire "penitence" through self-reflection. In 1829, Eastern State Penitentiary in Philadelphia opened, employing the "Pennsylvania model" of almost complete isolation. This model sought to prohibit all contact between prisoners, utilizing cells with individual exercise yards and solid doors that were primitive versions of those now inhabited at ADX.

14. The detrimental effects of extreme isolation under the Pennsylvania model soon became apparent. For example, following his 1842 visit to Eastern State Penitentiary, Charles Dickens expressed concern about the facility and the extreme isolation of its prisoners, noting that "this slow and daily tampering with the mysteries of the brain [was] immeasurably worse than any torture of the body." America's first experiment with extended confinement in isolation was declared by contemporary observers such as Alexander de Tocqueville as "fatal" for most prisoners because "[i]t devours the victim incessantly and unmercifully," did not successfully reform prisoners, and caused "[t]he unfortunate creatures submitted to this experiment [to] wast[e] away."

15. Because of its adverse effects on prisoners, the Pennsylvania model was quickly abandoned by many states during the nineteenth century. In 1890, one hundred years after the first isolation cells were constructed at the Walnut Street Jail, the Supreme Court concluded:

> [E]xperience demonstrated that there were serious objections to [extended confinement in isolation]. A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them,

> and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community. It became evident that some changes must be made in the system.

In re Medley, 134 U.S. 160, 168 (1890).

16. In 1913, Eastern State Penitentiary at long last abandoned its system of complete isolation and allowed prisoners at least some regular human interaction. Shortly thereafter, in *Commonwealth ex rel. Elliott v. Francies*, 58 Pa. Super. 270 (Pa. Super. Ct. 1914), a Pennsylvania court ordered that individuals who had been incarcerated at Eastern State Penitentiary in error were to be "absolutely" rather than "conditionally" discharged before the end of their sentences due to the severity of the punishment and based upon "just and humane principles." In 1933, the warden at Eastern State Penitentiary called for the facility's closure, noting that the system utilized at Eastern State could not effectively reform the prisoners incarcerated there.

17. The anecdotal observations of the past have been confirmed by modern science. For example, as early as the 1960s electroencephalography ("EEG") examinations demonstrated the slowing of brain waves of prisoners confined in isolation for longer than a week. A landmark study in the 1970s showed that subjects in solitary confinement often experienced impaired functioning of the brain waves associated with the ability to control emotions and key cognitive functions. Similarly, a 2011 study demonstrated that after only a week of solitary confinement, prisoners showed decreased EEG activity, indicative of increased stress, anxiety, and depression.

18. The BOP has housed prisoners at ADX since late 1994. Upon information and belief, the forced solitude of the Control Unit has remained more or less unchanged since shortly

after ADX opened. In the 18 years since ADX, the BOP has never commissioned or conducted a study of the effects of the conditions of confinement at ADX in general or the Control Unit in particular on prisoners' mental health. Indeed, the ADX psychology department does not even maintain reference works on such effects, or any other materials that would educate prisoners about how to avoid the catastrophic psychological effects often caused by extended confinement in isolation.

19. Despite the mountains of anecdotal and empirical data confirming the impact on mental health of extended isolated confinement, the BOP regularly assigns to ADX prisoners who suffer from serious mental illnesses, and fails to maintain an adequate program to diagnose and treat the serious mental illnesses created and exacerbated by the conditions of confinement there.

ADX Florence and Its Treatment of the Mentally Ill

20. 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.

21. The BOP's written procedures for transferring prisoners to ADX state that prisoners "currently diagnosed as suffering from serious psychiatric illnesses should not be referred for placement at… ADX." BOP Program Statement 5100.08, "Prisoner Security Designation and Custody Clarification," Chapter 7, p.18. This prohibition is widely ignored by Defendants.

22. In reality, and at the times relevant to this action, the BOP regularly assigns prisoners to ADX even though they have well-documented histories of serious mental illnesses,

and in many cases histories showing that their mental illnesses can be controlled with proper treatment.

23. BOP policies also require that all prisoners are to be given psychiatric screening upon arrival at ADX. For example, 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 Prisoners," p. 4. During the intake screening, prisoners with any of the following must be referred immediately to the Mental Health Program Coordinator for a more thorough assessment:

- Recent history or current symptoms of significant mental illness;
- Signs or symptoms consistent with a possible mental disorder;
- Use of medication for treatment of a mental illness or disorder;
- Documented mental health designation;
- Risk of suicide.

Id.; BOP Program Statement 6340.04, "Psychiatric Services," § 9(a).

24. In reality, and at the times relevant to this action, incoming prisoners at ADX generally are given only perfunctory interviews that are wholly inadequate as a form of screening or diagnosis. The mental health "screening" provided by the facility typically consists of a few questions asked in a minute or two, often at a time when the prisoner has just completed a lengthy cross-country trip while tightly chained, and is apprehensive about his arrival at ADX. Follow-up monitoring and screening is virtually nonexistent. Even when the BOP does carry out the psychological or psychiatric screening of a new arrival, it often ignores key factors indicating

mental illness, such as, for example, the fact that the prisoner was taking medication for a serious mental illness immediately before arriving at ADX.

25. Even where prisoners at ADX are properly identified as having a serious mental illness, many are not given appropriate treatment, including either counseling or medication. If a prisoner is referred to the mental health Program Coordinator, BOP policies require adherence to the BOP's minimum criteria for follow up assessment and treatment planning. BOP Program Statement 5310.13, "Institution Management of Mentally Ill Prisoners," p. 4. The Program Coordinator is required to complete a screening report on all referred prisoners, and to forward the prisoner's mental health information to relevant members of the prison staff. Id. at 5. If the prisoner has extensive treatment needs, the Program Coordinator must schedule additional sessions and establish a treatment plan. Id.

26. In reality, and at the times relevant to this action, Defendants routinely ignore these requirements by, among other things, rarely establishing meaningful treatment plans even for prisoners who are chronically and obviously seriously mentally ill, and failing even to establish at ADX a mechanism for delivering elementary mental health services, such as private counseling, which would be a necessary element of any meaningful treatment plan for most of the seriously mentally ill prisoners at ADX.

27. Because of the particularly severe conditions of confinement in the ADX Control Unit, federal regulations require the BOP to adhere to an especially detailed set of mental health standards, including:

> The Warden may not refer an inmate for placement in a control unit… [i]f the inmate shows evidence of significant mental disorder or major physical disabilities as documented in a mental

> health evaluation or a physical examination. 28 CFR §541.41(c)(1).
>
> *Mental health services*. During the first 30-day period in a control unit, staff shall schedule the control unit prisoner for a psychological evaluation conducted by a psychologist. Additional individual evaluations shall occur every 30 days. The psychologist shall perform and/or supervise needed psychological services. Psychiatric services will be provided when necessary. Prisoners requiring prescribed psychotropic medication are not ordinarily housed in a control unit. 28 C.F.R. §541.46(i) (Emphasis added.)

28. In reality, and at the times relevant to this action, Defendants regularly placed incoming prisoners with an existing prescription for psychotropic medication in the Control Unit, where the BOP refuses to administer such medication in violation of section 541.46(i). The BOP justifies this in Orwellian fashion: it discontinues the prisoner's medication, thereby making the now non-medicated prisoner "eligible" for placement in the Control Unit. Then, when this newly "eligible" prisoner requests medication needed to treat his serious mental illness, he is told that BOP policy prohibits the administration of psychotropic medication to him so he should develop "coping skills" as a substitute for the medication being withheld. Instructing a prisoner confined in long-term segregation and who has schizophrenia or a bipolar illness to self-treat his disease with coping skills is like demanding that a diabetic prisoner learn to "cope" without insulin. Likewise, the required 30 day "individual evaluations" are in actuality rarely performed on inmates in the Control Unit.

29. BOP policies require that mentally ill prisoners be monitored on an ongoing basis to assess treatment compliance. BOP Program Statement 5310.13, "Institution Management of Mentally Ill Prisoners," p. 5. For certain prisoners, including those receiving psychotropic

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*.

30. In reality, and at the times relevant to this action, ADX staff routinely ignore this written monitoring requirement. Some prisoners never leave their cells or speak with staff for months. Many such prisoners live for extended periods in squalor, in cells caked with their own feces and bodily fluids, without bathing, and in some cases without even getting out of bed. Any meaningful "monitoring" would identify and trigger intervention for such prisoners, but rarely, if ever, does ADX staff seek to remedy the fetid and unsafe living conditions of many of the mentally ill people in their custody.

31. 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 Vega, did not have timely access to mental health professionals, particularly in times of crisis.

32. The BOP's deliberate indifference to the proper diagnosis and treatment of ADX prisoners with serious mental illnesses has resulted in horrible consequences. Many prisoners at ADX interminably wail, scream, and bang on the walls of their cells. Some mutilate their bodies with razors, shards of glass, sharpened chicken bones, writing utensils, and whatever other objects they can obtain. A number swallow razor blades, nail clippers, parts of radios and televisions, broken glass, and other dangerous objects. Others carry on delusional conversations

with voices they hear in their heads, oblivious to reality and to the danger that such behavior might pose to themselves and anyone who interacts with them. Still others spread feces and other human waste and body fluids throughout their cells, throw it at the correctional staff and otherwise create health hazards at ADX. Suicide attempts are common. For example, in addition to Vega, at least five inmates have committed suicide since ADX opened.

33. For all of these reasons, and as further described below, Defendants failed to screen, monitor and treat Vega's mental illnesses, first diagnosed in 2004. Instead, Defendants placed Vega in ADX Florence's Control Unit, deprived him of necessary psychiatric medications or any meaningful mental health treatment, and otherwise abused him mentally and physically over a period of years. These actions had devastating consequences.

Background on Jose Martin Vega

34. Vega was born on August 20, 1974 in Brooklyn, New York.

35. In 1983, Vega's mother, Gloria Carattini, died as a result of a cerebral aneurism. After her death, Vega was raised by his siblings.

36. In 1989, at the age of 15, Vega dropped out of high school. He was later sent to live in a juvenile home in the Bronx.

37. In 1995, at the age of 21, Vega was sentenced to life in prison and committed to the custody of the BOP.

The Year Preceding Vega's Transfer to ADX

38. Vega was originally confined at Lewisburg United States Penitentiary ("USP Lewisburg").

39. Upon information and belief, on March 13, 2003, Vega assaulted an associate warden at USP Lewisburg. As a result Vega was immediately subdued by prison staff and placed in ambulatory restraints. He was then injected with an unknown substance which temporarily left him physically and mentally incapacitated. Vega was then stripped naked and assaulted by prison staff for a duration of at least an hour. Vega sustained a broken rib, body and head contusions, and loss of hearing in his left ear as a result of the assault by prison staff.

40. On the same day, March 13, 2003, Vega was transferred from USP Lewisburg to Allenwood United States Penitentiary ("USP Allenwood"), where he was immediately placed on suicide status. On March 25, 2003, Vega was transferred from USP Allenwood to the United States Medical Center for Prisoners in Springfield, Missouri ("MCFP Springfield"), for mental health evaluation and treatment.

41. At some time before July of 2003, Vega was transferred from MCFP Springfield back to USP Allenwood.

ADX Florence and Its Treatment of Jose Martin Vega

42. On April 5, 2004, Vega was transferred from USP Allenwood to ADX Florence, where Defendants placed him in the Control Unit.

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

44. In March of 2005, Vega was referred to MCFP Springfield.

45. Upon information and belief, the precipitating cause of this transfer was a suicide attempt by Vega, to which ADX staff responded by filling his cell with noxious gas and sending a body-armor clad team of correctional officers into his cell to subdue him.

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

47. Vega remained at MCFP Springfield for approximately one year. Upon information and belief, ADX inmates referred to MCFP Springfield for mental health evaluation or treatment rarely remain there for more than a month. A stay of one year at MCFP Springfield suggests that the BOP recognized that Vega suffered from a serious mental illness requiring extended and extensive mental health treatment.

48. In 2006, the BOP transferred Vega back to ADX Florence. That transfer violated BOP's written procedures which 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.

49. Upon Vega's return to ADX Florence, as noted above, Defendants were required to send him to the Mental Health Program Coordinator for a thorough assessment of his mental health. BOP Program Statement 6340.04, "Psychiatric Services," § 9(a). As further noted above, 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 Vega had treatment needs. Accordingly, the Mental Health Program Coordinator would have been required to schedule additional sessions, establish a treatment plan, and monitor Vega on an ongoing basis to asses treatment compliance. Upon information and belief, this was not done.

50. Upon Vega's return to ADX Florence, Defendants placed him back in the Control Unit, where the conditions ensured the deterioration of his mental health.

51. Vega's 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.

Jose Martin Vega's Allegations of Abuse

52. In July 2008 Vega filed a complaint in this Court alleging serious mistreatment by ADX staff. The complaint, as amended, is attached hereto as Exhibit A.

53. The complaint contains detailed allegations regarding the mental and physical abuse Vega suffered while in the Control Unit at ADX Florence.

54. As alleged in the complaint, and upon information and belief, ADX Florence staff repeatedly drugged Vega by narcotics or anesthetized him by injection against his will.

55. As alleged in the complaint, and upon information and belief, shortly after Vega's arrival at the ADX Florence Control Unit, ADX Florence staff began physically assaulting him.

56. As alleged in the complaint, and upon information and belief, shortly after Vega's arrival at the ADX Florence Control Unit, ADX Florence staff began sexually assaulting him.

57. Upon information and belief, these physical and sexual assaults continued until his death.

58. As alleged in the complaint, and upon information and belief, the staff at ADX Florence spread rumors that Vega was a child killer, a child molester, and an informant.

59. As alleged in the complaint, and upon information and belief, the prison staff at ADX Florence served Vega food tainted with human waste.

60. As alleged in the complaint, and upon information and belief, the prison staff at ADX Florence subjected Vega to arbitrary cell "shake downs."

61. As alleged in the complaint, and upon information and belief, the prison staff at ADX were provoking Vega to commit disciplinary infractions.

62. As alleged in the complaint, and upon information and belief, ADX staff members repeatedly chained Vega unnecessarily, sometimes for periods of ten days or more.

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

64. As alleged in the complaint, and upon information and belief, in December of 2006, Vega believed, and alleged, that he was given an extra razor in his cell and encouraged by several members of the prison staff to commit suicide.

65. As alleged in the complaint, and upon information and belief, between February and March of 2007, Vega was moved to a cell that contained a razor blade, and that a prison official commented that Vega would "get another chance," presumably to use the razor on himself.

66. As alleged in the complaint, and upon information and belief, Vega's incoming and outgoing mail had been deliberately withheld by ADX Florence staff

67. As alleged in the complaint, and upon information and belief, Vega was served food that contained pencil lead, graphite, or mace.

68. As alleged in the complaint, and upon information and belief, Vega was informed by an ADX Florence health services employee that his food was being contaminated by the feces of other inmates.

69. As alleged in the complaint, and upon information and belief, in December of 2008, Vega's access to communications with his loved ones had become limited due to his disciplinary segregation.

70. As alleged in the complaint, and upon information and belief, Vega's visiting requests were denied by the Defendants.

71. As alleged in the complaint, and upon information and belief, ADX Florence staff intentionally interfered with the familial association between Vega and his relatives, intending to deprive them of their relationship with Vega.

72. The complaint reveals Vega reported the actions of ADX Florence staff described in paragraphs 52 to 71 to Defendants.

73. The complaint shows Defendants took no action in response to Vega's complaints.

74. The complaint filed by Vega documents either serious abuse by ADX Florence staff or manifests serious delusions that were caused by mental illness and remained untreated because of Vega's confinement in the ADX Florence Control Unit and the deliberate indifference of Defendants and others to Vega's serious medical needs.

75. Vega's civil action remained pending in this court until its dismissal by Judge Weinshienk on December 15, 2008. During its pendency, Vega filed and served a number of pleadings and letters detailing further abuses by ADX staff, including a September 4, 2008 "Motion Apprising Court of Defendants [sic] Actions Obstructing [sic] Access to Courts by Acts of Retaliation." Among other things, those submissions accuse ADX staff members of tainting Vega's food, failing to feed him, interfering with his sleep, harassing him, spreading rumors

about him, drugging him and violating "his right to bodily integrity." Like Vega's complaint and December 2008 Amended Complaint, these allegations reflect either serious misconduct by ADX staff or the wild delusions of a severely mentally ill man. Either such misconduct or such delusions cry out for an investigation. Upon information and belief, however, neither Defendants nor anyone else at ADX conducted any investigation or inquiry into Vega's claims. Rather, Defendants and other ADX staff members allowed Vega to continue to deteriorate, much of the time wallowing in his own waste.

76. Upon information and belief, the behavior claimed by the BOP to justify the abuse alleged in the complaint and Vega's other filings 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.

Jose Martin Vega's Deteriorating Mental Health

77. Upon information and belief, upon his return to ADX Florence from MCFP Springfield, Vega had grown a beard down to his waist.

78. Upon information and belief, upon his return to ADX Florence, Vega's fellow inmates did not recognize him and described him as appearing "totally shot out."

79. Upon information and belief, between 2006 and 2008, after his return from MCFP Springfield, Vega spiraled "downhill" from a "normal" guy who wrote poems for his fellow inmates and helped them with their legal work, to an isolated, "weird," "bat shit" crazy man who talked to himself and grew increasingly concerned about people spraying poison gas into his cell and poisoning his food.

80. Upon information and belief, Vega weighed at least 200 pounds when he arrived at ADX in 2004. Upon information and belief, between 2006 and 2008, Vega experienced dramatic weight loss.

81. Upon information and belief, between 2006 and 2008, Vega began mutilating himself.

Vega's Final Days and Death

82. Upon information and belief, by 2010 Vega had lost as much as 50 pounds, customarily wore grossly ill-fitting clothes and shoes, was no longer maintaining physical hygiene, and was largely incoherent.

83. In early April, 2010, upon information and belief, Vega was in ambulatory restraints for three to four days, *yelling and throwing feces.*

84. On April 20, 2010, upon information and belief, Vega was heard screaming that he was tired of the treatment he was receiving, and was going to do something about it.

85. Upon information and belief, on or about April 30, 2010, Vega was placed in ambulatory restraints in his cell by presently unknown members of the ADX staff. Upon information and belief, at that time Vegas was in profound and obvious psychological distress. Nevertheless, ADX staff failed to seek necessary mental health care for Vega and instead left him in his cell chained hand and feet, and utterly alone.

86. On May 1, 2010, upon information and belief, the duress light went on in Vega's cell.

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

88. The coroner's report that evaluated Vega after his death noted that Vega died as a result of hanging. The Coroner's Report is attached as Exhibit B.

89. The investigation and autopsy indicated that his injuries were intentional and self-inflicted.

90. The coroner's report indicated that information received from the ADX health administrator indicated that Vega "had a long psychiatric history."

The Treatment of Vega's Body And Possessions After His Death

91. After Vega was found hanging lifeless in his cell, currently unknown members of the ADX staff cut him down, and then placed his dead body in handcuffs and shackles. Only then was any effort to resuscitate Vega made. Hours later, Vega's body was delivered to the medical examiner, still chained hand and feet.

92. Upon information and belief, following Vega's death, and despite repeated requests by Plaintiff and Vega's other family members, the BOP failed to return Vega's body to his family in New York for a service and burial in a prompt manner. Plaintiff and his family entered into a dispute with the BOP regarding the shipment and burial of Vega's body. The body was not returned to New York until many days after Vega's death.

93. Upon information and belief, when ADX finally shipped Vega's body to his family, he arrived in a small pine coffin, wearing a prison uniform. Vega's body was emaciated, and according to his family members he looked like he had been "starved to death."

94. Upon information and belief, the government would not permit Vega's family to bury his body, but insisted that it be cremated.

95. Upon information and belief, the BOP withheld Vega's personal belongings, including but not limited to, drawings, writings and photographs from his family following Vega's death. Despite several telephone requests from Vega's family members, the BOP has not, to this day, returned a single piece of Vega's personal property to Plaintiff or any other member of Vega's family.

Defendants' Responsibility

96. 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.

97. Upon information and belief, during relevant periods Defendant Davis visited the ADX Control Unit and spoke with inmates confined there, and through those interactions and through other means became familiar with events occurring in the Control Unit and the condition of the prisoners confined there.

98. Upon information and belief, Defendant Davis 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.

99. Upon information and belief, during relevant periods Defendant Davis had the discretionary authority to authorize the transfer of ADX inmates, including Vega, to medical facilities such as MCFP Springfield, where they could be treated for mental health problems more serious than could effectively be treated at ADX.

100. Upon information and belief, Defendant 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 MCFP Springfield, and the means of accessing other mental health services required by Vega. Nevertheless, Defendant Davis failed and refused to make any of those resources and medical services available to Vega.

101. Upon information and belief, Defendant Davis also failed to prevent the abuse of Vega by ADX staff, failed to ensure that Vega was adequately 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's failure to discharge their obligations relating to Vega was a legal cause of Vega's death.

102. Upon information and belief, Defendant Davis 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)

103. Plaintiff incorporates the preceding paragraphs of this pleading.

104. Pursuant to the Eighth Amendment to the United States Constitution, 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.

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

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

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

SECOND CAUSE OF ACTION
(Deprivation of Right of Familial Association)

108. Plaintiff incorporates the preceding paragraphs of this pleading.

109. Plaintiff has an interest in his relationship with his brother protected by the First and Fourteenth Amendment of the United States Constitution.

110. These interests survived the death of Plaintiff's brother.

111. Defendants intentionally interfered with this interest by, among other things, deliberately disregarding Vega's serious medical needs, disregarding Plaintiff's right to the prompt return of the body of his brother following his death, and refusing to return Vega's personal possessions to Plaintiff.

112. The actions of the Defendants were thus in violation of the First and Fourteenth Amendment of the United States Constitution.

PRAYER FOR RELIEF

WHEREFORE Plaintiff prays for judgment against Defendants for:

(a) a sum to compensate the Estate for the suffering and death of Vega 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, and Defendants' intentional mistreatment of Vega's body and personal items following his death;

(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: August 30, 2012

Respectfully submitted,

ARNOLD & PORTER LLP

By s/ Edwin P. Aro

Edwin P. Aro
370 Seventeenth Street, Suite 4400
Denver, CO 80202
(303) 863-1000
ed.aro@aporter.com

Attorneys for Plaintiff Raymond Vega