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.

SECOND 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. Defendant Blake R. Davis was the Warden at ADX Florence from July 13, 2009-April 21, 2012. 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, at the times relevant to this action, Defendants provided no psychotropic medications and no meaningful mental health care to Control Unit prisoners.

Given their complete lack of access to mental health care, at the times relevant to this action seriously mentally ill prisoners confined in the Control Unit frequently had behavioral issues caused by their mental illness. Such conduct often resulted 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.

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19. 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.

20. 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.

21. The BOP has known since at least 1999 that extended periods of confinement in isolation can be psychologically damaging to any prisoner and can be particularly harmful to individuals with pre-existing mental illness. Specifically, a 1999 study conducted under the auspices of the DOJ and the National Institute of Corrections concluded:

> Insofar as possible, mentally ill inmates should be excluded from extended control facilities. Each inmate being considered for such a facility should have a mental health evaluation. Although some mentally ill offenders are assaultive and require control measures, much of the regime common to extended control facilities may be unnecessary, and even counterproductive, for this population.

22. In May 2013, the United States Government Accountability Office ("GAO") issued a detailed report entitled "Bureau Of Prisons: Improvements Needed in Bureau of Prisons' Monitoring and Evaluation of Impact of Segregated Housing." That report includes many troubling findings concerning the BOP's operation of ADX, including one making clear that the BOP's publication of policies does not even begin to address the problems at which the policies are aimed, because the BOP does not monitor compliance with its policies at ADX:

> While BOP has a mechanism to centrally monitor many of its segregated housing unit policies, BOP does not centrally monitor the policies specific to its most restrictive segregated prison, the

> ADX facility. As a result, BOP has less assurance that ADX staff consistently follows ADX-specific policies to the same degree that these requirements are followed for [Special Housing Units] and [Special Management Units].

23. The GAO also found:

> While most BOP officials told us there was little or no clear evidence of mental health impacts from long-term segregation, BOP's Psychology Services Manual explicitly acknowledges the potential mental health risks of inmates placed in long-term segregation. Specifically, it states that BOP "recognizes that extended periods of confinement in Administrative Detention or Disciplinary Segregation Status may have an adverse effect on the overall mental status of some individuals."

24. Following a June 2012 oversight hearing in the United States Senate during which the Director of the BOP admitted that the BOP has never evaluated the impact of solitary confinement on prisoners, the BOP commissioned an independent study on that issue. The study culminated with a 242 page report issued in December 2014. Among many other BOP failings, that report detailed, as follows, the mismanagement of mental illness in segregation units such as ADX:

> (a) A large number of prisoners in solitary confinement need mental health treatment, but are not receiving it;
>
> (b) No protocol exists to identify prisoners with mental illness who should be kept out of solitary confinement;
>
> (c) Inmates often receive a mental health diagnosis by medical students or interns who are not trained in psychiatry, and once diagnosed, they rarely receive follow-up reassessments or proper medication;
>
> (d) No reentry programs or means of tracking for prisoners coming out of segregation exist.

25. 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 21 years since ADX opened, 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.

26. Despite the foregoing and mountains of anecdotal and empirical data confirming the impact on mental health of extended isolated confinement, the BOP still assigns to ADX prisoners who suffer from serious mental illnesses, and still 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

27. 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.

28. 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.

29. 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.

30. BOP policies also require that all prisoners are to be given psychiatric screening upon arrival at ADX. For example, at the relevant times, BOP policies required 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 were to 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).

31. 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.

32. 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.*

33. 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.

34. 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).

35. 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 refused to administer such medication in violation of section 541.46(i). The BOP justified this in Orwellian fashion: it discontinued the prisoner's medication, thereby making the now non-medicated prisoner "eligible" for placement in the Control Unit. Then, when this newly "eligible" prisoner requested medication needed to treat his serious mental illness, he was told that BOP policy prohibited 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" were in actuality rarely performed on inmates in the Control Unit.

36. At the times relevant to this action, BOP policies required 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 were required to, at a minimum, conduct a monthly interview to assess the prisoner's treatment strategy. *Id*.

37. 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.

38. 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.

39. 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.

40. 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

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

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

43. 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.

44. 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

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

46. Upon information and belief, on March 14, 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.

47. On the same day, March 14, 2003, Vega was transferred from USP Lewisburg to Allenwood United States Penitentiary ("USP Allenwood"), where he was immediately placed on suicide status.

48. On March 18, 2003, John R. Mitchell, BOP Psychologist, classified Vega as a high suicide risk and ordered that Vega remain on suicide watch pending a psychiatric referral to the United States Medical Center for Prisoners in Springfield, Missouri ("MCFP Springfield").

49. On March 25, 2003, Vega was transferred from USP Allenwood to MCFP Springfield, for mental health evaluation and treatment.

50. 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

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

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

53. On February 28, 2005, psychologist Marie Bailey of ADX wrote that Vega was previously diagnosed with Major Depressive Disorder and "willingly remained on [Celexa and hydroxyzine] until February 2004, in fact, records indicate ***he wished to remain on the medication*** but it was apparently discontinued in February 2004, which was less than two months prior to his arrival at the Control Unit." Dr. Bailey also noted that "[s]ince his arrival at ADX in April 2004, [Vega] has presented with rather odd behavior and has evidenced increasing paranoia . . . . Given this inmate's psychiatric history, his removal from medication shortly before his transfer to the Control Unit, his increasingly paranoid behavior," an "emergency transfer to USMCFP Springfield is being requested for diagnostic clarification and possible treatment."

54. On March 9, 2005, Vega was referred to MCFP Springfield.

55. 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.

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

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

58. On July 7, 2005, the BOP transferred Vega back to ADX Florence. This 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.

59. 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. Had this screening been performed properly, 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. Instead, Dr. Bailey wrote on an intake screening form that Vega "is currently not taking medication and has been

placed back in the Control Unit," despite her assertion that at "the time of the intake interview," it was her belief that Vega "remains psychotic (delusional)."

60. 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.

61. Vega's return to the Control Unit at ADX Florence meant he was unable to receive medication to treat or ameliorate the effects of his mental illness.

62. Indeed, by February 2006, Dr. Bailey wrote that Vega was becoming "significantly more agitated and paranoid," and that "[p]sychology staff believe this inmate is becoming increasingly more paranoid, delusional, and is probably hallucinating."

63. On March 7, 2006, Vega was transferred back to MCFP Springfield for mental health treatment.

64. On May 9, 2006, Dr. Bailey wrote to MCFP Springfield psychiatrist Dr. James Wolfson that it was her "opinion that inmate Vega's actions" while at ADX were "the result of mental disease, and his psychotic symptoms impaired his perception of reality[.]" Vega remained at Springfield for almost 18 months, again suggesting that BOP mental health professionals recognized the severity of his mental illness.

65. In November 2006, the BOP transferred Vega back to ADX Florence for the last time.

66. 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. Based on a review of records recently produced by the BOP in response to Plaintiff's FOIA request for all records relating to Vega -- which was incomplete including because, among other things, the BOP admits that it withheld some documents as unreleasable -- nothing indicates that a thorough assessment of Vega's mental health was conducted when he returned to ADX.

67. Defendants' apparent failure to conduct a thorough assessment of Vega's health upon his return to ADX was not only in violation of the BOP policies outlined above, but it contributed to Vega's demise.

68. In fact, upon Vega's return to ADX, Defendants again placed him back in the Control Unit, the most restrictive unit at ADX, where Vega remained isolated from other prisoners at all times, and where his only meaningful contact with other humans was with ADX Florence staff members.

69. Vega's return to the Control Unit at ADX Florence also meant he was unable to receive medication to treat or ameliorate the effects of his mental illness.

70. Inevitably, Vega's mental health rapidly deteriorated. For example, by April 2007, Vega was throwing feces on officers at ADX and was subsequently placed in ambulatory restraints for ten days, an extraordinary amount of time. Ambulatory restraints are an extreme measure of punishment that involve tightly shackling an inmate's legs, cuffing his hands and

attaching the cuffs to a chain around his torso. Ambulatory restraints are a form of discipline so severe, BOP policies (discussed further below) mandate that, when using these restraints, staff are to submit reviews to the Warden ***every fifteen minutes*** to assess the continued need for restraint. Moreover, the Warden is required to notify the Regional Director or Regional Duty Officer whenever a prisoner is placed in ambulatory restraints for more than eight hours. Here, Defendants kept Vega physically restrained for ten days.

Jose Martin Vega's Allegations of Abuse

71. 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.

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

73. 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.

74. 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.

75. 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.

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

77. 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.

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

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

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

81. 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.

82. 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.

83. 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.

84. 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.

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

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

87. 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.

88. 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.

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

90. 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.

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

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

93. 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.

94. 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.

95. 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

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

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

98. Upon information and belief, between 2006 and 2010, following his final 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.

99. Upon information and belief, Vega weighed at least 200 pounds when he arrived at ADX in 2004. Upon information and belief, between 2006 and 2010 Vega experienced dramatic weight loss.

100. Upon information and belief, between 2006 and 2010, Vega began mutilating himself.

Defendant Davis's Knowledge of or Deliberate Indifference to Vega's Serious Mental Needs

101. As noted above, Vega died on May 1, 2010. Defendant Blake R. Davis was the Warden at ADX Florence from July 13, 2009-April 21, 2012. Thus, the period of time during which Davis was Warden overlapped with the period of time when Vega was assaulting staff and he had deteriorated and continued to deteriorate both physically and mentally in an obvious fashion.

102. According to the Transcript of Record in *United States v. Richardson*, No. 1:08-CR-139-CC (D. Ga. Apr. 18-19, 2012) (Ex. B, attached hereto), Vega was well-known at ADX Florence for having committed most of the assaults on staff members from 2008-2010. While referring to a graph on assaults on staff members by inmates at ADX Florence, Thomas J. Reidy, Ph.D., testified that Vega's "typical MO seems to be either spitting or throwing urine and feces." Tr. at 76-77.

103. As Warden, Defendant Davis was responsible for knowing who was located in the Control Unit, which housed a relatively small number of prisoners compared with the overall

population at ADX Florence.[1] As described in more detail below, Warden Davis was also responsible for knowing whether the inmates in the Control Unit were being disciplined in certain ways and reviewing those incidents. He was also responsible for periodically determining, on a case-by-case basis, whether a specific inmate should be released from the Control Unit and, if not, Warden Davis would have to approve the inmates' continued confinement in the Control Unit. This specific review of each prisoner is because of the extreme conditions within the Control Unit and the mental and physical repercussions generally associated with confinement there. In performing these individual reviews, Warden Davis obtained specific knowledge of Vega's presence in the Control Unit, and specifically evaluated his behavior and condition, and gave specific approval for Vega's continued confinement in that unit, as detailed below.

104. As Warden, Defendant Davis was required to be aware of every incident in which an inmate was placed in restraints. According to a Program Statement number P5566.06, entitled "Use of Force and Application of Restraints," the purpose of the Program Statement is to ensure that "[e]ach use of force incident" for disciplinary purposes "will be documented, reported, and reviewed." *Id*. at 2. The Program Statement details several reviews that must be performed by the Warden after any use of force. *See id*. at 18-19. Among other things, following any use of restraints, staff are to submit the following reviews to the Warden: "(a)

[1] For example, according to a Special Housing Unit Review and Assessment, conducted by the BOP, the facility census at the time of review (2014) was 410 inmates. Of those, only 75 were assigned to the Control Unit. *See* Federal Bureau of Prisons: Special Housing Unit Review and Assessment, available at: http://www.bop.gov/resources/news/pdfs/CNA-SHUReportFinal_123014_2.pdf (last visited July 14, 2015).

Fifteen-minute check - fifteen-Minute Restraints Check Form (24 Hours) (BP-S0717.055); (b) Two-hour Lieutenant check - Two-Hour Lieutenant Restraints Check Form (24 Hours) (BP-S0718.055); (c) Health Services Staff Review - Health Services Restraint Review Form (24 Hours) (BP-S0719.055); and (d) Psychology Staff Check - Psychology Services Restraint Review Form (24 Hours) (BP-S0720.055)." *Id*. at 18. And the directive states that:

> Staff must complete all forms until the inmate is released from restraints. ***The forms will be submitted to the Warden as required for periodic reviews of an inmate's placement in restraints***. After release from restraints, these forms must be compiled and maintained in the Inmate's Central File and Special Investigative Supervisor's file.

Id. at 19 (emphasis added).

105. The Program Statement also includes a requirement that the Warden review videotaped evidence of any use of force incident:

> c. Videotape of Use of Force Incidents. Staff must obtain a video camera immediately and record any use of force incident, unless it is determined that a delay in resolving the situation would endanger the inmate, staff, or others, or would result in a major disturbance or serious property damage.
>
> The video recording will also include any medical examination conducted after:
>
> - the application of restraints,
> - use of chemical agents,
> - use of pepper mace, and/or
> - use of non-lethal weapons.
>
> Calculated use of force shall be videotaped following the sequential guidelines presented in the Correctional Services Manual. The original videotape must be maintained and secured as evidence in the SIS Office. ***A copy of every videotape, after review by the Warden (within four work days of the incident), unless requested sooner by the Regional Director, will be provided immediately to the Regional Director for review.***

Id. at 19 (emphasis added).

106. Further, the Program Statement required Warden Davis to conduct a review of use of force and application of restraint incidents.

107. The Program Statement also requires the Warden and the rest of the After-Action Review Team to review videotape of the incident and to complete a report on it. Thus, Defendant Davis was required to conduct a review of the use of force and restraints that were applied to Vega during Defendant Davis's tenure.

108. The Program Statement also provides that,"[w]hen it is necessary to restrain an inmate for longer than eight hours, ***the Warden (or designee) or institution administrative duty officer shall notify the Regional Director or Regional Duty Officer by telephone***." (emphasis added).

109. As discussed in more detail below, Vega had numerous incidents with Staff that required discipline. Moreover, just ***two weeks prior to Vega's death***, Warden Davis wrote a memorandum to the Regional Director detailing the circumstances surrounding Vega being placed in ambulatory restraints for 24 hours. According to the memo, the reason why Vega was subjected to this extraordinary discipline is because he threw feces and urine at BOP staff.

110. According to BOP policies, Defendant Davis, as Warden, also had ultimate control over whether inmates could be recommended for release from the Control Unit. *See* BOP Control Unit Programs, No. FLM 5212.07I (Apr. 22, 2013) at 4 ("Inmates can only be released from the Control Unit by the Executive Panel . . . . Prior to each Executive Panel Review, the Unit Team will prepare an Executive Panel Review Sheet . . . on each inmate and

submit a list of recommended releases to the Executive Panel for consideration. All release recommendations must be approved by the Warden.")

111. According to BOP policies, the Executive Panel (composed of the Regional Director, North Central Region, and Assistant Director, Correctional Programs Division, or their designees) reviews each case in the Control Unit every 60 to 90 days to determine the inmate's readiness for release from the Control Unit.

112. As set forth below, Defendant Davis participated in these Control Unit Executive Panel Hearings, and signed off on all approvals or denials for Control Unit release recommendations. In so doing, Defendant Davis repeatedly and specifically considered and approved Vega's placement in the Control Unit.

113. According to a newly-produced September 2009 ADX Control Unit Executive Panel Review ("September 2009 Review") (Exhibit C, attached hereto), "Vega received *numerous* incident reports during the review period and was on Disciplinary Segregation status. His interactions with staff are deemed poor. The Unit Team recommends continuation in the Control Unit until further review." (emphasis added). In the "Overall Adjustment" section of the September 2009 Review, of the options "Good," "Satisfactory," "Poor," or "Not Rated," the "Poor" box is marked. *Id.*

114. The September 2009 Review states the reason for Vega's placement in the Control Unit. It says, *inter alia*, that:

> Vega was approved for Control Unit placement on March 11, 2004, after the Discipline Hearing Officer found he had committed the prohibited acts of Assault on Staff and two counts of Possession Of a Sharpened Instrument. Specifically, on March 14, 3003, in the dining room at USP Lewisburg, Vega assaulted a staff member with a sharpened instrument. He approached the staff member from behind

> and placed his right hand on the victim's shoulder. Vega then reached around the victim and slashed the left side of his face with a single edged razor blade. Vega then utilized the weapon to hold responding staff members at bay and threatened to cut anyone who approached. Eventually, staff were able to subdue and disarm him.

Id.

115. As noted above, according to BOP policies, prior to each Executive Panel Review a review sheet is prepared on each inmate documenting his behavior, and a list of recommended releases is provided to the Executive Panel for consideration. All release recommendations must be approved by the Warden. Demonstrating Warden Davis' specific awareness of Vega, his poor condition, and the background and history of his placement in the Control Unit, this Executive Panel Review was signed by Defendant Davis.[2] By signing the document, Warden Davis specifically authorized the continued confinement of Vega in the Control Unit notwithstanding that Davis had knowledge of, or was deliberately indifferent to, Vega's deteriorated and problematic state.

116. According to a newly-discovered December 2009 ADX Control Unit Executive Panel Review ("December 2009 Review") (Exhibit D, attached hereto), which was again signed by Defendant Davis, Vega had "one incident reports *[sic]* during the review period and was on Disciplinary Segregation status. His interactions with staff are deemed poor. The Unit Team recommends continuation in the Control Unit until further review."

117. In the "Overall Adjustment" section of the December 2009 Review, of the options "Good," "Satisfactory," "Poor," or "Not Rated," the "Poor" box is marked.

118. The December 2009 Review contains the same statement regarding Vega's history/reason for placement in the Control Unit as in the September 2009 Review.

[2] The BOP has confirmed that Davis' signature appears on the Warden signature block.

119. According to a newly-discovered March 2010 ADX Control Unit Executive Panel Review ("March 2010 Review) (Exhibit E, attached hereto) -- signed by Defendant Davis ***one month before Vega's death*** -- "Vega received numerous incident reports during the review period and was on Disciplinary Segregation status. His interactions with staff are deemed poor. The Unit Team recommends continuation in the Control Unit until further review."

120. In the "Overall Adjustment" section of the March 2010 Review, of the options "Good," "Satisfactory," "Poor," or "Not Rated," the "Poor" box is marked.

121. The March 2010 Review contains the same statement regarding Vega's history/reason for placement in the Control Unit as in the September 2009 and December 2009 Reviews.

122. Warden Davis' review and sign off on these ADX Control Unit Executive Panel Reviews demonstrates knowledge and specific approval of Vega's continued confinement in the Control Unit notwithstanding obvious signs of serious mental illness.

123. In addition to the Control Unit Executive Panel Reviews discussed above, Plaintiff recently obtained nine ADX Monthly Control Unit Review Forms for Vega, from August 2009-April 2010. (Collectively, Exhibit F, attached hereto) ("Monthly Forms"). BOP Policies require these Monthly Forms to be completed for each review, outlining the inmates behavior and progress and remaining months to be served in the Control Unit. This form is signed by each member of the Control Unit Team with the Warden serving as the reviewing authority.

124. The purpose of these Monthly Reviews is to assess whether an inmate will receive "credit" for time spent in the Control Unit. A review committee consisting of five individuals

provides a committee recommendation, and the Warden reviews and signs off on the recommendation.

125. Defendant Davis's signature appears on seven out of the nine Monthly Reviews for Vega. This demonstrates that Defendant Davis received routine updates on Vega's status in the nine months leading up to Vega's death and had specific knowledge of his distress.

126. In each of the nine Monthly Reviews, Vega's "adjustment since last review" was deemed "Poor."

127. In each of the nine Monthly Reviews, Vega's "release readiness" factors are the same, including:

- Quarters Sanitation: Poor
- Personal Grooming & Cleanliness: Poor
- Personal Relationship With Other Inmates and Staff: Poor

128. These factors clearly describe Vega's physical deterioration, and demonstrate that others were aware of Vega and took notice of his poor appearance and lack of cleanliness.

129. Vega was on Disciplinary Segregation during each of the review periods, except one *(see* Jan. 6, 2010 Report).

130. Each of the nine Monthly Reviews states that Vega did not receive credit for satisfactory conduct during the 30-day period under review.

131. In five of the Monthly Reviews, including one from April 2010 -- ***one month before Vega's death*** -- Vega was not credited due to misconduct. Defendant Davis's signature appears on every single one of these documents.

132. Vega received "numerous incident reports""during the Monthly Reviews period, including during the March 3, 2010-April 7, 2010 review period, just weeks before Vega took

his life. Defendant Davis's signature appears on this Monthly Review, demonstrating Davis' knowledge of Vega's condition and knowledge or willful blindness of his serious mental illness.

133. Additionally, on April 28, 2010, consistent with the BOP policies described above, Defendant Davis wrote a Memorandum to BOP Regional Director Michael K. Nalley regarding Vega. Warden Davis wrote this memo to inform the Regional Director that Vega had been placed in Hard Ambulatory Restraints for 24 hours on April 27, 2010. According to the Memorandum, Vega was placed in restraints because he had been throwing urine and feces at ADX officers. While Defendant Davis noted in the Memorandum that Vega "has no current mental health issues," the circumstances above demonstrate the fact that Defendant Davis considered and was deliberately indifferent to Vega's serious mental illness. (Exhibit G, attached hereto). Warden Davis drafted and sent this memorandum ***a mere two weeks before Vega's death***,

Vega's Final Days and Death

134. Upon information and belief, by May 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.

135. Upon information and belief, in early April, 2010, Vega was in ambulatory restraints for three to four days, yelling and throwing feces.

136. 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.

137. On April 28, 2010, ***three days before Vega killed himself***, he requested a transfer to MCFP Springfield, and was denied.

138. 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.

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

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

141. 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 H.

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

143. 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

144. 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.

145. 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.

146. 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."

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

148. 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

149. As Warden of ADX during certain periods relevant to this action, Defendant Davis was responsible for the care and safety of ADX inmates, and in particular, those housed in the Control Unit, including Vega.

150. The ADX Control Unit Executive Panel Reviews and monthly ADX Control Unit Reviews demonstrate that Defendant Davis had specific knowledge of the events occurring in the Control Unit that concerned Vega, and further had knowledge of the facts and circumstances demonstrating Vega's obvious serious mental illness.

151. According to interviews Plaintiff conducted with current ADX prisoners, 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.

152. Based on the ADX Control Unit Executive Panel Reviews, monthly ADX Control Unit Reviews, and Plaintiff's interviews with ADX prisoners, 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.

153. Based on the BOP policies outlined above, Warden Davis would have had specific knowledge of every incident in which Vega was placed in disciplinary restraints. As detailed above, this was true of a serious incident that occurred only weeks before Vega's death. It also would have been true of every instance that occurred during Warden Davis's tenure.

154. Indeed, based on the Program Statement outlined above, Defendant Davis would have reviewed videotape of every application of use of force on Vega.

155. 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. As noted above, on April 28, 2010 -- ***three days before Vega killed himself*** -- Vega requested a transfer to MCFP Springfield. This request was denied.

156. Based on the ADX Control Unit Executive Panel Reviews, monthly ADX Control Unit Reviews, Plaintiff's interviews with ADX prisoners, and BOP policies outlined above,

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.

157. 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 his obligations relating to Vega was a legal cause of Vega's death.

158. 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)

159. Plaintiff incorporates the preceding paragraphs of this pleading.

160. 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.

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

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

163. 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)

164. Plaintiff incorporates the preceding paragraphs of this pleading.

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

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

167. 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.

168. 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: July 15, 2015

Respectfully submitted,

ARNOLD & PORTER LLP

By s/ Veronica E. Callahan

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CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 15th day of July, 2015, the foregoing **SECOND AMENDED COMPLAINT** was filed with the Clerk of the Court using the CM/ECF system which will send notification of such filing to all counsel of record as follows:

Amy L. Padden
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/s/ Linda J. Teater