IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 10-cv-02564-RBJ-KMT

MATTHEW MALLORY,

Plaintiff,

v.

SUSAN JONES, in her individual capacity as warden of Centennial Correctional Facility (CCF),

PAMELA J. PLOUGHE, in her individual capacity as warden of Colorado Territorial Correctional Facility (CTCF),

ARISTEDES W. ZAVARAS, in his individual capacity as Executive Director of Colorado Department of Corrections (CDOC),

CHERYL SMITH, in her individual capacity as Chief Medical Officer of CDOC,

JOANIE SHOEMAKER, in her individual capacity as the Director of Clinical Services for CDOC,

DAVID LADEAU, in his individual capacity as a correctional officer at CCF,

SERGEANT JOHNSTON, in his individual capacity as a sergeant at CCF,

LIEUTENANT CELLA, in his individual capacity as a supervising lieutenant at CCF,

SERGEANT PANEK, in his individual capacity as a sergeant officer at CCF,

JOSI EDWARDS in her individual capacity as a Licensed Practical Nurse (LPN) at CCF,

NEAL LOUSBERG, in his individual capacity as a physician's assistant working at CTCF's infirmary,

ASHLEY BENALLY, in her individual capacity as a RN at CCF,

Defendants.

SECOND AMENDED COMPLAINT

Plaintiff, Matthew Mallory, is currently on parole and submits this complaint for Defendants' failure to provide adequate medical care while he was confined in CCF and in the CTCF infirmary, resulting in violations of his rights under the Eighth and Fourteenth Amendments to the United States Constitution.

NATURE OF THE CASE

1. During Mr. Mallory's confinement in CCF, he vomited blood for several consecutive days, ultimately resulting in his collapse, transport to a hospital, and emergency surgery. Had Defendants provided proper medical treatment during the days prior, the surgery and the significant pain and suffering that Mr. Mallory experienced likely would have been prevented.
2. Defendants deprived Mr. Mallory of his constitutional right to proper medical treatment when they knew that he faced this life-threatening condition; yet medical and correctional staff alike consciously disregarded this risk, and failed to take basic and necessary action.
3. The failure to provide Mr. Mallory with adequate medical care did not rest with one person. Those individuals who were directly informed of his serious condition and deliberately disregarded his medical needs are responsible for his pain and near death. However, the relevant medical and custody supervisors also knew that conditions such as Mr. Mallory's were not being handled properly; yet, they continually failed to train staff appropriately and

ensure that policies were followed. By allowing such inadequate practices to persist—years after these failings were identified by a state audit—they are also responsible for consciously disregarding a risk to those, including Mr. Mallory, within their care.

4. After going to bed on October 7, 2009, the urge to vomit awoke Mr. Mallory in the middle of the night. Mr. Mallory rushed to the toilet and began to throw up profuse amounts of dark vomit. He repeatedly vomited blood over the next 72 hours. Although Mr. Mallory notified the appropriate correctional officers and members of the medical staff at CCF, the defendants failed to respond adequately or reasonably, disregarding the risk to his life.
5. At no point was Mr. Mallory even removed from his housing pod to be examined. Defendants also failed to send a doctor to examine Mr. Mallory, despite the fact he was clearly suffering from an emergency condition. Instead, they only had Defendant Edwards, an LPN—a position with even less medical training than a registered nurse—check on him through a steel door.
6. After four days of suffering, Mr. Mallory was finally taken to a hospital. However, due to the advanced state of his critical condition, the hospital where Defendants sent Mr. Mallory was not equipped to respond to his medical needs. Consequently, he had to be transported to a second hospital.
7. Mr. Mallory remained in the hospital for ten days after it was discovered that he had a massive gastrointestinal bleed. Mr. Mallory had to undergo an emergency procedure, which left him in pain and with an eight-inch scar running down his abdomen.

8. After his release from the hospital, Mr. Mallory was sent to the infirmary at CTCF. Even after the ordeal he was forced to endure, the medical staff at CTCF failed to provide Mr. Mallory with the ordered care that he required to recover properly from his surgery.
9. Both the hospital and the CDOC doctors ordered that Mr. Mallory be on a soft diet, which is a necessary treatment following gastrointestinal surgery. However, this diet was not provided; and the medical staff ignored Mr. Mallory's repeated requests for a soft diet to allow him to eat without pain.
10. Mr. Mallory seeks compensatory and punitive damages for Defendants' failure to provide adequate medical care, and for the resulting pain and suffering that he was forced to endure.

PARTIES

11. Plaintiff, MATTHEW MALLORY, is a citizen of the United States. Mr. Mallory was incarcerated in CDOC for non-violent property crimes from November 2005 to April 2010, when he was released on parole. He is successfully completing all parole requirements, including taking educational classes. He is employed at a full-time job, and works approximately ten hours a day, six days a week. On Sundays, he spends time with his family, including his eight-year old daughter, Ebony, and his grandmother, Mrs. Rebecca Bauer.
12. Defendant, SUSAN JONES, is the warden of CCF, and as such was responsible for the custody and care of Mr. Mallory, and all prisoners in CCF. She oversees all employees at CCF, including the medical staff, and has the authority for the establishment and implementation of all policies and procedures at that institution.

13. Defendant, ARISTEDES W. ZAVARAS, is the Executive Director of CDOC, and as such was responsible for the custody and care of Mr. Mallory and all prisoners in CDOC. He oversees all employees in CDOC, including the medical staff, and has the authority to establish, alter, and implement all policies and procedures within CDOC.
14. Defendant, CHERYL SMITH, is the Chief Medical Officer of CDOC, and as such is responsible for monitoring and directing the total process by which health care services are provided to prisoners. One of her duties is to ensure that the health care provided throughout CDOC is adequate.
15. Defendant, JOANIE SHOEMAKER, is the Director of Clinical Services for CDOC, and as such is responsible for the oversight and management of CDOC medical staff.
16. Defendant, DAVID LADEAU, is a correctional officer at CCF, and as such was responsible for the custody, care, and safety of Mr. Mallory at the times specified. As a correctional officer, he is also responsible for implementing crisis intervention.
17. Defendant, SERGEANT JOHNSTON, is a correctional officer with "sergeant" status at CCF, and as such was responsible for the custody, care, and safety of Mr. Mallory at the times specified. As a sergeant, he is also responsible for implementing crisis intervention, and for supervising other correctional officers assigned to his command.
18. Defendant, LIEUTENANT CELLA, is a supervising officer at CCF, and as such was responsible for the custody, care, and safety of Mr. Mallory at the times specified. As a supervising lieutenant, he is also responsible for implementing crisis intervention, and for supervising other officers assigned to his command.

19. Defendant, SERGEANT PANEK, is a correctional officer with "sergeant" status at CCF, and as such was responsible for the custody, care and safety of Mr. Mallory at the times specified. As a sergeant, he is also responsible for implementing crisis intervention, and for supervising other correctional officers assigned to his command.
20. Defendant, JOSI EDWARDS, is a licensed practical nurse (LPN) employed by CCF, and as such was responsible for providing Mr. Mallory with adequate medical care, including emergency health assessment and intervention.
21. Defendant, NEAL LOUSBERG, is a physician's assistant employed by Colorado State Penitentiary (CSP) who at all times specified was working in the infirmary at CTCF, and as such was responsible for providing inmates with adequate routine medical care and treatment.
22. Defendant, ASHLEY BENALLY, is an RN at CCF, and as such was responsible for providing Mr. Mallory with adequate medical care, including emergency health assessment and intervention.

JURISDICTION AND VENUE

23. This Court possesses subject matter jurisdiction over Plaintiff's claim pursuant to 28 U.S.C. § 1331 and 42 U.S.C. §1983.
24. Venue of this action is proper in this Court under 28 U.S.C. § 1391(b), as all of the events giving rise to the claims occurred in the District of Colorado.

FACTS

I. Defendants, including those in upper management, were aware that CDOC medical staff was continually failing to properly examine and care for prisoners, yet they failed to take action to ensure that adequate medical care was provided.

25. In 2005, the Office of the State Auditor conducted a performance audit of CDOC Internal Health Care. In that audit, 36% of the records reviewed revealed "quality-of-care concerns." More than a quarter of the records reviewed reflected that medical staff had "missed opportunities" to provide care. Additionally, 14% of the records demonstrated that clinical staff failed to perform comprehensive examinations, and 10% reflected a failure to provide proper medication and monitoring.

26. A remarkable 8% of the medical records indicated that patients were being inappropriately prescribed non-steroid anti-inflammatory drugs (NSAIDs).

27. Specifically, the audit revealed that CDOC medical staff was not properly monitoring the use of NSAID medicine, which can directly result in gastrointestinal (GI) bleeds. The report stated that NSAIDs were extremely overprescribed, such that ten inmates with histories of gastrointestinal bleeding, a counter-indication to NSAID prescription, were still prescribed such medications. The report further stated that, "failure to adjust drug therapy or to adequately monitor inmates' use of over-the-counter medications, increases the likelihood for adverse drug reactions and other quality-of-care concerns."

28. Members of CDOC's upper-management were present at the Legislative Audit Committee Meeting that presented the findings of the audit. Specifically, individuals from the offices at the highest levels including the Executive Director, Assistant Director of Clinical Services, and the Chief Medical Physician, were all present.

29. Accordingly, individuals in upper-management of CDOC had actual knowledge that the "department did not adequately monitor the medical functions of its Division of Clinical

Services." The report stated that, "we continue to have concerns about the adequacy of oversight."

30. Those who received the report and who are responsible for such oversight include: Wardens Susan Jones and Pamela Ploughe; the Executive Director of CDOC, Aristedes Zavaras; the Chief Medical Officer, Cheryl Smith; and the Director of Clinical Services, Joanie Shoemaker.

31. Despite knowledge of these medical care issues, adequate remedial action was not taken within CCF.

32. During the fall of 2008, Mr. Mallory's back was injured while he was held in CSP. Defendants provided Mr. Mallory with copious amounts of NSAIDs, including Naprosyn and Ibuprofen, for approximately six months to treat his back pain.

33. The development of ulcers and upper GI bleeds are known to be common possible side-effects of prolonged ingestion of NSAIDs.

34. The medical staff demonstrated its awareness of the possible negative side-effects of taking NSAIDs for a prolonged period of time. For example, on August 24, 2009, Nurse Boyd recorded that she advised Mr. Mallory that there are potential adverse effects of NSAIDs and instructed him that "bleeding [is] to be reported."

35. Despite the medical staff's demonstrated knowledge of the commonly known risks of prolonged intake of NSAIDs, the medical staff nevertheless continued giving Mr. Mallory Ibuprofen and Naprosyn without adequately monitoring him for signs that he was suffering from potential side effects.

36. Although Defendants Jones, Ploughe, Zavaras, Smith, and Shoemaker had been warned that the Department's health care was not being adequately managed and that multiple inmates had suffered from GI bleeds after taking NSAIDs, they failed to properly monitor the health care providers under their management to ensure they were appropriately prescribing these medications and monitoring recipients of these medications for adverse side effects.

II. Defendants provided inadequate care and were deliberately indifferent to Mr. Mallory when he was suffering from a serious medical condition.

37. After going to bed on October 7, 2009, the urgent need to vomit awoke Mr. Mallory in the middle of the night. Mr. Mallory, feeling a "painful burn in [his] stomach area," began to vomit large amounts of dark, seemingly undiluted blood.

38. According to the Mayo Clinic, ulcers cause burning pain and may cause, "severe signs or symptoms such as: the vomiting of blood. . .dark blood in stools or stools that are black or tarry, nausea or vomiting, unexplained weight loss, [and] appetite changes."

39. It is widely known, even among non-medical laypersons, that vomiting blood is a sign of a serious medical condition and always requires immediate emergency response.

40. Identifying the cause of vomiting blood is essential because it can indicate a life-threatening condition and requires immediate medical attention. The Mayo Clinic website states that, "Bleeding in [the] upper gastrointestinal tract…from peptic ulcers or torn blood vessels is a common cause of vomiting blood."

41. Under CDOC policies, all heath care employees and contract workers are to be trained to respond to health-related situations within a four-minute response time. This training includes, but is not limited to: "recognition of signs and symptoms, and knowledge of action required in potential emergency situations…and methods of obtaining assistance…."

42. CDOC's policy regarding emergency medical care states that each facility is to provide access to 24-hour emergency medical care, which includes on-site emergency treatment and intervention; and, when necessary, emergency evacuation of offenders from the facility.

43. Additionally, CDOC's policies state that, "medical services shall be provided in a manner that ensures the maintenance of basic health and prevention of health deterioration." This policy states that the medical services are to include emergency care, which is, "medical cases that, without treatment, would result in further deterioration of an essential nature of an offender's condition . . . ."

44. As previously instructed by CDOC medical staff, Mr. Mallory promptly notified Lieutenant Cella when he realized that his vomit was full of blood.

45. Under CDOC's policies, timely communication of reportable incidents to appropriate CDOC employees is required. All incidents in which a CDOC offender becomes seriously ill are considered reportable incidents.

46. CCF policies require that in the event that an offender becomes serious ill, the on-duty or on-call provider is to be notified, and 24-hour emergency health care services are to be provided.

47. However, there was no provider available to treat any inmates at CCF at that time.

48. Lieutenant Cella told Mr. Mallory that he had contacted the "on call" infirmary nurse at Colorado Territorial Correctional Facility, but that no one would be coming.

49. Mr. Mallory was informed that the only advice for him to follow that night was just to put a washcloth on his head.

50. CCF policy 4-4351 requires that, "if an emergency requires clinical intervention which the clinical unit is not able to provide on-site, the offender will be transported to an outside facility."

51. Mr. Mallory should have been examined immediately for his symptom of vomiting blood, even if it required being transported to an outside facility.

52. The next day, October 8, 2009, Mr. Mallory continued to vomit blood numerous times. Mr. Mallory asked to see someone from medical and was told that he would have to go through the prison formalities and submit a kite in order to receive any medical attention.

53. Accordingly, Mr. Mallory submitted a kite requesting medical assistance for this concern.

54. At this time, Mr. Mallory was confined in the segregation unit.

55. According to CCF policy 4-436, "offenders in segregation units will have access to Clinical Services on a daily basis."

56. Upon information and belief, each CDOC employee in the unit had a responsibility to triage the incoming medical requests or kites and to identify and treat those with urgent conditions.

57. Despite that there were three nurses and a doctor at the facility on the 8th, and that Mr. Mallory had submitted a kite asking for immediate treatment, he was never examined that day.

58. On October 8, Dr. Wright was at CCF treating inmates from 8:20 A.M. until 2:05 P.M. However, Dr. Wright did not even check on Mr. Mallory.

59. On the same day, Nurse Josie Edwards worked from 5:30 A.M. to 1:30 P.M.; Roger Cissel, an RN at CCF, worked from 6:00 A.M. to 7:20 P.M.; however, neither nurse checked on

Mr. Mallory or did anything to follow up on the kite he had submitted to determine whether his condition was serious.

60. Also, on October 8, 2009, Ashley Benally, an RN, worked at CCF from 1:49 p.m. to 7:12 p.m.

61. At 6:45 p.m., Ms. Benally read and entered Mr. Mallory's written request for medical help, which indicated that he had been throwing up blood on the night of the 7th and that ever since then he had been weak, lightheaded, and nauseated.

62. Ms. Benally knew that throwing up blood could be potentially a life threatening medical condition.

63. Ms. Benally was aware that the only way to verify the seriousness of the condition when someone was throwing up blood was to conduct a physical examination.

64. Ms. Benally indicated that in the event that an inmate was potentially experiencing a medical emergency, she normally goes to the inmate's cell door to examine the inmate or requests that the inmate be removed from his cell and brought to the exam room for examination. Yet, Ms. Benally failed to visit Mr. Mallory after she received his request for immediate medical help.

65. The CDOC Clinical Standards for Sick Calls states that "any request that holds the possibility of an emergent health care need warrants having the offender brought to the clinic to be assessed more thoroughly to evaluate the significance of the complaint."

66. Had Ms. Benally followed the CDOC Sick Call standard and taken Mr. Mallory to the clinic for a physical assessment, she would have been able to verify that Mr. Mallory, in fact, was seriously sick and needed immediate medical attention.

67. Despite her awareness that Mr. Mallory was experiencing a potentially life-threatening condition, Ms. Benally deliberately failed to provide the care necessary to determine if he needed immediate treatment.

68. Ms. Benally stated that if the inmate had a history of inaccurately self-reporting his medical condition, she would use her personal judgment and discretion to determine whether she would respond to the inmate's potentially life-threatening medical emergency.

69. Ms. Benally stated that she would verify the veracity of an inmate's allegations by referring to the inmate's medical records, which could indicate a history of the medical condition that the inmate was complaining about, or she would confirm that the inmate's medical condition with the correctional officers.

70. There is no evidence that Ms. Benally checked Mr. Mallory's medical records or verified his symptoms with the correctional officers.

71. Instead, Ms. Benally stated that in her experience a lot of the inmates exaggerate their medical symptoms and conditions.

72. Had Ms. Benally believed the Plaintiff was in fact throwing up blood, she would have conducted a medical examination.

73. Rather, she entered the request for care into the system, marked the acuity field "routine" and went home thirty minutes later.

74. When she entered "routine" in the acuity field of the medical request, Ms. Benally knew that it might take days, or potentially weeks, for an inmate to be seen.

75. Ms. Benally deliberately refused to provide Mr. Mallory with adequate medical care when she did not take any action to assist or examine Mr. Mallory upon receiving his request that required immediate medical help.

76. Because Ms. Benally took no action to help him, Mr. Mallory continued to throw up blood for three more days resulting in his near death experience.

77. While Mr. Mallory was forced to wait, he continued to repeatedly vomit blood. Unable to keep food down, he had very little to eat and stayed in his cell instead of going to the recreational yard.

78. That night, Mr. Mallory continued to vomit blood and request help.

79. Unfortunately, Mr. Mallory was again told that no one from the medical staff was at the facility at that time, and thus he would not be seen until the next day.

80. On the morning of October 9, 2009, LPN Edwards refused to believe Mr. Mallory when he told her that he had been throwing up blood continuously for three days. LPN Edwards did not believe Mr. Mallory simply because he is a prison inmate when he complained to her of throwing up blood because LPN Edwards stated that 80 percent of all offenders are liars.

81. On October 9, 2009, LPN Edwards observed Mr. Mallory in his cell through the glass in the cell door window and noted in her report that he looked pale. Through the small opening in the steel cell door, LPN Edwards checked his pulse rate, which was recorded at 114. LPN Edwards knew that a pulse rate of 114 was abnormally high and, thus, medically concerning.

82. LPN Edwards also checked Mr. Mallory's turgor and noted in her report that his turgor was poor. Skin turgor is commonly used by health care workers to assess the degree of fluid loss or dehydration. Poor skin turgor is a late sign of moderate to severe dehydration.

83. LPN Edwards knows that vomiting blood is a medical emergency.

84. Typically, if LPN Edwards were to see an inmate during her routine medical rounds and the inmate stated that he was vomiting blood, she would respond by having that inmate brought to the medical clinic for further examination.

85. Despite knowing that vomiting blood is a sign of medical emergency and that his turgor indicated that he was suffering from dehydration, LPN Edwards did not take Mr. Mallory to the emergency unit at the facility, nor did she even have him examined in the pod's medical room.

86. CCF policy 4-4346 states that if assessment of a sick offender "requires a more direct hands-on [examination] by the health care provider, the offender will be escorted to the unit/pod exam room and/or clinic unit." Because Mr. Mallory was losing massive amounts of blood, his condition was very serious and required more advanced medical knowledge than an LPN alone would be able to provide.

87. Despite Mr. Mallory's statement that he had been vomiting blood and despite LPN Edwards' own observations that he was pale, dehydrated, and had an abnormally high pulse rate, LPN Edwards deliberately took no further actions to treat Mr. Mallory for vomiting blood, and deliberately withheld from Dr. Joseph Wright, the doctor on-call, that Mr. Mallory was reporting that he was vomiting blood.

88. Instead, LPN Edwards only told Dr. Wright that Mr. Mallory was pale, had poor skin turgor, had a high pulse rate, and was vomiting.

89. LPN Edwards deliberately did not tell Dr. Wright about Mr. Mallory's most critical symptom – that Mr. Mallory had been vomiting blood – because she did not believe Mr. Mallory when he stated that he was vomiting blood.

90. During the morning encounter with LPN Edwards on October 9, 2009, Mr. Mallory told LPN Edwards that he had notified security staff earlier that he had been throwing up blood.

91. To verify the veracity of his statement, LPN Edwards asked the housing officer in the pod whether he had personally witnessed Mr. Mallory throwing up blood. The housing officer replied that he had not witnessed Mr. Mallory vomiting blood, but he also stated that he does not go inside the individual cells. LPN Edwards did not ask anyone else to confirm Mr. Mallory's statement about vomiting blood and assumed that Mr. Mallory was lying.

92. Had LPN Edwards taken a few moments to verify Mr. Mallory's statements, by having correctional officers open the door to his cell, she would have seen traces of blood in his cell.

93. LPN Edwards failed to properly verify his statements that he had been vomiting blood with security because she did not believe Mr. Mallory when he said that he was throwing up blood.

94. Because LPN Edwards refused to believe Mr. Mallory, she deliberately did not take Mr. Mallory to the medical clinic for closer examination and withheld critical information from Dr. Wright.

95. As a direct result of LPN Edward's deliberate withholding of the information to Dr. Wright, the doctor misdiagnosed Mr. Mallory as having a stomach flu and, as a result, he merely prescribed an anti-nausea medication (Phenergen) and instructed that the patient increase his fluid intake and be on a clear liquid diet.

96. The symptoms of flu include: fever, body aches, cough, sore throat, headaches, diarrhea, and vomiting. However, vomiting blood is not a symptom of the flu. Mr. Mallory never complained about having a fever, body aches, cough, or a sore throat. Nor did he complain that he was suffering from a headache or diarrhea. Rather, he complained that he had been repeatedly vomiting blood.

97. Prescribing Phenergen is not appropriate for someone who is vomiting blood.

98. Had LPN Wright told Dr. Wright that Mr. Mallory was vomiting blood, Dr. Wright would have personally evaluated Mr. Mallory.

99. After this initial visit, LPN Edwards failed to follow up on Mr. Mallory's condition to determine whether he was improving. Had LPN Edwards checked on Mr. Mallory or had another nurse check on him, she would have realized that his condition was not improving, and that he was in fact continuing to vomit blood. Throughout the day of October 9th, after LPN Edwards' visit, Mr. Mallory continued to vomit blood multiple times.

100. On Friday, October 9th, Roger Cissel and Kathy Abel worked from 1:30 to 7:20 P.M.; yet, despite that Nurse Edwards had noted that follow-up care was to be provided, neither RN ever followed up on Nurse Edwards' diagnosis or on Mr. Mallory's condition.

101. During this time, another prisoner in a cell near to Mr. Mallory's notified Sergeant Johnston, Sergeant Panek, and Officer Ladeau that Mr. Mallory was very sick and needed

help. In response, he was told that the situation was not his problem, and that his complaining was creating a facility disruption.

102. The prisoner repeatedly informed the officers that Mr. Mallory was vomiting blood, pale, and unable to eat. He asked why no one would help, but he received no response.

103. Defendants Johnston, Panek, and Ladeau made no effort at that time to ascertain Mr. Mallory's condition or retrieve a medical staff member.

104. On October 10th, Mr. Mallory continued to vomit blood throughout the day. Despite his quickly deteriorating condition, Defendants made no attempt to reassess his diagnosis or to provide further treatment.

105. Kathleen Abel, an employee of CCF, was doing a standard medication pass on October 10th and noted in Mr. Mallory's file that he appeared to be pale. When Mr. Mallory approached his cell door to receive his medication, he was silent. Ms. Abel asked him how he was doing. Mr. Mallory, believing that it "really wouldn't make a difference if I complained any further," answered that he was, "ok."

106. Roger Cissel never checked on Mr. Mallory on October 10th even though he worked that day from 6:00 A.M. to 7:20 P.M.

107. During this time, Mr. Mallory was very weak to the point of being nearly immobile.

108. On October 11th, LPN Edwards was at the facility starting at 5:30 A.M., and RN Buffy Stotler was at the facility starting at 6:00 A.M.

109. On the morning of October 11th, Mr. Mallory asked a prisoner in the neighboring cell to tell the correctional officer that he could not get up without passing out and so he requested that a neighboring prisoner be allowed to bring Mr. Mallory his food tray.

110. Officer Ladeau approached Mr. Mallory's cell and declined to assist Mr. Mallory, stating, "This place isn't like Burger King where you can have it your way." Defendant Ladeau told Mr. Mallory that if he wanted to eat, he would have to get up and go get the food himself.

111. At 10:59 A.M., Mr. Mallory attempted to get up to retrieve his lunch, at which time he collapsed.

112. When Mr. Mallory awoke after collapsing and losing consciousness, LPN Edwards and RN Stotler were attempting to check his vitals. LPN Edwards reported that he was "very pale" and that his pulse was "weak and thready."

113. It was only after Mr. Mallory collapsed that anyone from medical came to check on him. When LPN Edwards and RN Stotler finally checked on him after his collapse, they were unable to obtain his blood pressure, likely because it was dangerously low.

114. Nurse Edwards also noted that the oxygen saturation of Mr. Mallory's blood was at 86%.

115. Oxygen saturation below 90% signifies that the brain and other organs are not receiving enough oxygen to properly function.

116. Despite the severity of Mr. Mallory's condition, the staff at CCF still did not even want to take him to the prison medical center to wait for an ambulance. Instead, they wanted him to wait in his cell.

117. However, while trying to get Mr. Mallory back to his cell, he again collapsed. Only at this time was CCF staff willing to transport him to the prison's medical center.

118. Mr. Mallory was transported to the prison's medical center, where a normal saline IV was started.

119. While waiting for an ambulance to arrive, Mr. Mallory continued to go in and out of consciousness. Mr. Mallory's inability to remain conscious necessitated that he be placed on a stretcher and wheeled to the ambulance.

120. Defendants Zavaras, Jones, Smith, and Shoemaker, are each responsible for overseeing CDOC medical staff, and for establishing and implementing all CDOC policies. Each of these Defendants has a responsibility to ensure that CDOC's policies regarding medical care were properly followed and that adequate medical care is being provided to the prisoners within their care.

121. If any one of defendants Zavaras, Jones, Smith, or Shoemaker had ensured that responsibilities for responding to health care concerns had been properly allocated and that CCF employees were following protocol, someone would have arrived to examine Mr. Mallory before 72 hours had passed since he first reported vomiting blood, and before he collapsed. Each Defendant's failure to enforce the existing medical care policies, and to ensure they were being followed demonstrates deliberate indifference to Mr. Mallory's condition.

III. Defendants' failure to adequately diagnose and treat Mr. Mallory's massive gastrointestinal bleed necessitated that he receive extensive emergency medical treatment at a hospital.

122. Intake records from St. Thomas Moore Hospital (STMH) indicate that Mr. Mallory had vomited blood and passed dark, tarry stools for four days, and that those symptoms were still present.

123. When Mr. Mallory arrived at STMH, his temperature was taken and blood work was performed.

124. The average human body temperature is 98.6 degrees Fahrenheit.

125. Mr. Mallory's temperature was only 95.6 degrees Fahrenheit when he arrived at St. Thomas Moore.

126. A low hemoglobin count is generally defined for men as less than 13.5 grams of hemoglobin per deciliter (135 grams per liter) of blood.

127. Upon admission to the hospital, Mr. Mallory's hemoglobin level was only 4.7.

128. Additionally, the average Hematocrit Blood (Hct) level of an adult male is 42-54%, which is about *four times* that of Mr. Mallory's mere 13.6%. Low Hct levels signify that a patient is anemic, and one of the most common causes of anemia is blood loss.

129. The emergency staff at the hospital performed a scope on Mr. Mallory, which required that they break the cartilage in his nose to allow them to thread a tube down his nasal cavity.

130. Mr. Mallory also immediately received a blood transfusion.

131. The severity of Mr. Mallory's condition required that he be transported to St. Mary Corwin Hospital because it was determined that, "STMH does not have the capability of providing appropriate care for [Mr. Mallory]."

132. In the ambulance on the way to St. Mary Corwin, Mr. Mallory was transfused with a second unit of blood. The nurse in the ambulance noted that he was "still very pale."

133. Upon examining Mr. Mallory, Dr. Lane, a surgeon at St. Mary Corwin, noted that, "The patient underwent an esophagogastroduodenoscopy (EGD) in the ER by Dr. Vahil which [showed] a large clot in the posterior duodenal bulb with a large ulcer. The clot was not disturbed according to Dr. Vahil because he was afraid that if it was a gastroduodenal artery bleed, he would not be able to control it."

134. Mr. Mallory was transfused with two more units of blood and four more units were ordered.

135. In St. Mary Corwin's Intensive Care Unit (ICU), Mr. Mallory was "completely unrescusitated" due to his extremely low fluid levels; thus, he was "unable to go to the operating room for any kind of definitive surgery."

136. Consequently, he was fluid resuscitated, given blood, and a central line was started.

137. Mr. Mallory's final diagnosis was a massive upper gastrointestinal bleed secondary to a duodenal ulcer, profound anemia, and hypovolemic seizures.

138. Ulcers are defined by the Mayo Clinic as, "open sores that develop on the inside lining of your stomach, upper small intestine or esophagus." Mr. Mallory's ulcer had grown to be 2½ cm, which means that the hole in his intestines was approximately the size of a quarter.

139. Mr. Mallory was temporarily stabilized in the ICU; however, the following morning, on October 12th, he "acutely bled again, became unstable and had a seizure."

140. On October 12th, Dr. McClung noted that Mr. Mallory was, ". . . retching and retched out a large volume of bright red blood. I would estimate there was probably 200 cc in the bed, on the patient and on the floor. The patient subsequently had a seizure. . . vomited probably another 100 cc of what looked like undiluted blood. The patient was. . . intubated and then a nasogastric tube was carefully placed orally and a total of what appeared to be about 700 cc of blood was suctioned out of his stomach. . . ." In this one-hour time period, Mr. Mallory lost approximately 1,000 ccs of blood, requiring that he continue receiving transfusions.

141. Subsequently, Mr. Mallory was "taken to the operating room [where an] exploratory laparotomy, vagotomy, pyloroplasty, [and an] oversewing of the posterior duodenal artery were performed."

142. The surgeon's notes state, "The patient's stomach was markedly distended…his gallbladder is stuck over the top of the duodenum. We peeled the gallbladder off the inflammation of the duodenal ulcer…the ulcer was probably perforated into the wall of the gallbladder."

143. Typically, surgical intervention is not required to treat ulcers because they can usually be treated with only antibiotics and antacids.

144. However, because Defendants failed to properly diagnosis or treat Mr. Mallory's ulcer, it had advanced to such a critical stage that emergency surgery was required.

145. After his surgery, Mr. Mallory was transferred to the ICU and placed on a ventilator to assist him with breathing.

146. Mr. Mallory's doctors placed him on a liquid diet, which was slowly advanced to a soft diet.

147. Shortly before this incident, because of on-going concerns about the medical care he was receiving from Defendants, Mr. Mallory signed a consent form, allowing the prison to release information regarding his health to his next of kin, his grandmother, Rebecca Bauer.

148. It is the policy of CDOC to, "make timely notification to individuals designated as emergency notification/next of kin by an offender in the event of an offender's death, serious bodily injury, or serious illness." A serious illness is defined by the Department's policies as, "any illness requiring hospitalization which could possibly result in death."

149. Despite the established policy to contact family members in the event of a medical emergency, Defendants failed to contact Mrs. Bauer to inform her that Mr. Mallory had gone to the hospital for his serious illness and emergency surgery.

150. Instead, Mrs. Bauer happened to call to schedule a visit with her grandson. It was only then that she was informed by an employee of CDOC that Mr. Mallory was "not in the facility."

Still, no one from CDOC informed Mr. Mallory's grandmother that he was in the ICU and undergoing emergency surgery.

151. Concerned when no one at CDOC would not tell her where her grandson was, Mrs. Bauer tried contacting the prison's Chaplain. When he also would not provide her with any helpful information, she then called Mr. Mallory's case manager.

152. Only then was Mrs. Bauer able to obtain any information regarding Mr. Mallory's whereabouts and condition.

153. Mrs. Bauer asked why she had not been contacted when Mr. Mallory went to the hospital and underwent emergency surgery; the response she received was that she would have been called if "something drastic had happened."

154. The CDOC violated its own policies by not contacting Mrs. Bauer when Mr. Mallory was suffering from a serious illness.

155. At no time was Mr. Mallory told that his grandmother was trying to ascertain his condition, nor was he given the opportunity to call home.

156. When released from St. Mary Corwin on October 21st, Mr. Mallory was transferred to CDOC's infirmary at CTCF.

IV. The staff at CTCF failed to provide Mr. Mallory with the follow-up care that his condition required.

157. Upon his release, the hospital ordered that Mr. Mallory receive a soft diet. At intake, the prison acknowledged this was necessary and ordered that Mr. Mallory receive a soft diet.

158. Doctors recommend that patients recovering from the type of procedure Mr. Mallory endured be on a soft diet in order to prevent the occurrence of a bowel obstruction or perforation, which could require additional surgery or even cause death.

159. On October 21st, a contracting physician, Dr. Ferguson, ordered that Mr. Mallory receive the soft diet that was ordered by the doctors at St. Mary Corwin. After that order was not followed by the infirmary staff, Dr. Ferguson put in another order for a soft diet on October 22nd, and entered that order onto the computer.

160. However, Mr. Mallory still did not receive food that he could easily digest.

161. The food provided to Mr. Mallory did not meet the medically accepted definition of the tangibly soft diet that is required after gastrointestinal surgery in order to allow for painless digestion.

162. On October 22nd, Mr. Mallory reported that he was still receiving food that was painful to digest. He requested a softer diet in accordance with the hospital's and Dr. Ferguson's orders.

163. Still not receiving food he could digest, he requested the soft diet again on October 24th.

164. On October 25th, after still not receiving softer foods, Mr. Mallory complained to Defendant Neal Lousberg that he was still not being provided with the diet that had been ordered. After Mr. Mallory told him that he was only able to eat a small amount of each of his meals, Defendant Lousberg confirmed that Mr. Mallory was supposed to be receiving a soft diet.

165. Nevertheless, Defendant Lousberg did not ensure that Mr. Mallory was actually provided with softer foods.

166. On October 26th, Mr. Mallory told Nurse Shock that he was not getting the right diet. He voiced concern about his inability to tolerate the foods that were being provided to him and he explained to her that he was only able to eat pieces of what was being given to him.

167. Another prisoner witnessed the unsympathetic treatment that Mr. Mallory received at CTCF. He observed Mr. Mallory repeatedly notifying medical staff that the food they were giving him was painful to eat. According to that individual, the nurse told Mr. Mallory that the reason he was not receiving a soft diet was because there was nothing written about it in his file. This statement was clearly contrary to what is evinced in Mr. Mallory's medical records, which document at least two separate orders for Mr. Mallory to be on a soft diet.

168. The next day, after receiving eighteen meals of foods that were difficult for him to eat, an order was put in for Mr. Mallory to receive a regular diet.

169. The defendants' failure to provide Mr. Mallory with an adequately soft diet as had been prescribed by doctors at both, St. Mary Corwin and the prison, put him at a significant risk for developing further complications, which could have potentially been fatal.

170. Mr. Mallory continues to suffer effects from these incidents, including that he has an eight-inch scar down his abdomen. This scar serves as a permanent, daily reminder of the surgery that was made necessary by the defendants' failure to provide him with timely, adequate medical care.

CAUSE OF ACTION

Against all Defendants.
Failure to provide adequate medical treatment violated Mr. Mallory's right to be free of cruel and unusual punishment under the Eighth Amendment.

(42 U.S.C. §1983 – Eighth Amendment Violation of Plaintiff's Right to be Free of Cruel and Unusual Punishment)

171. The Eighth Amendment to the United States Constitution forbids cruel and unusual punishment. The Eighth Amendment prohibits deliberate indifference to serious medical needs of prisoners.

172. 42 U.S.C. § 1983 provides a remedy for constitutional violations where the violations are committed under color of State law.

173. The defendants violated Mr. Mallory's right to be free from cruel and unusual punishment by failing to provide him with adequate medical treatment, and by failing to properly test, diagnosis, and treat Mr. Mallory when he experienced a serious and obvious medical emergency.

174. Defendants' refusal to properly treat Mr. Mallory's medical needs by providing an adequate diagnosis and treatment, which is specifically required by CCF's policies, constitutes cruel and unusual punishment.

175. Defendants' deliberate indifference to Mr. Mallory's serious medical condition is documented in his medical records at CCF and CTCF. Vomiting blood is a sign of a serious medical condition and is severe enough that the need for immediate medical care is obvious even to non-medical laypersons.

176. As a result of Defendants' failure to provide Mr. Mallory with proper medical treatment Mr. Mallory has suffered damages, injuries, pain and suffering, inconvenience, emotional distress, impairment of quality of life, past and future economic losses, and reasonable and necessary medical, hospital, and other expenses.

177. Defendants were personally involved in the alleged constitutional violation in that each of them: (1) directly participated in the infraction; (2) failed to remedy the wrong after learning of a violation through a report or appeal; (3) created a policy or custom under which unconstitutional and unlawful practices occurred; (4) allowed such a policy or

custom to continue; and/or (5) was deliberately and recklessly indifferent in managing subordinates who caused the unlawful conditions and events.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully requests:

A. A declaration that Mr. Mallory has been deprived by Defendants of his right to be free form cruel and unusual punishment in violation and contravention of the Eighth Amendment to the United States Constitution;

B. An award of attorneys' fees and costs of this action, including expert witness fees, on all claims allowed by law;

C. An award of punitive damages for violation of the Eighth Amendment of the United States Constitution, 42 U.S.C. §1983;

D. An award of all damages allowed by law, including compensatory damages for violation of the Eighth Amendment of the United States Constitution, 42 U.S.C. §1983; and that this Court award pre-judgment and post-judgment interest at the lawful rate; and

E. Any additional or alternative relief as may be just, proper, and equitable.

Dated: October 7, 2011

Respectfully submitted,

/s/ Brittany Glidden
Student Law Office
Brittany Glidden
Joclynn Townsend, Student Attorney
Anna Alman, Student Attorney
James Swinhart, Student Attorney
University of Denver Sturm College of Law
2255 E. Evans Ave.
Denver, CO, 80208
Ph: 303-871-6140
Fax: 303-871-6847

Email: bglidden@law.du.edu