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, et al.,
Defendants.

PLAINTIFF'S RESPONSE TO MOTION FOR SUMMARY JUDGMENT

By and through counsel, Matt Mallory responds to the Defendants' Motion for Summary Judgment (Doc. 98.)

INTRODUCTION

In October 2009, while confined in the Colorado Department of Correction (CDOC), Mr. Mallory was vomiting blood alone in his cell for more than three days. He continually asked correctional and medical staff for help during this time. In response, the prison staff refused to believe him, ignored his pleas, and failed to provide him adequate medical care. Their indifference to Mr. Mallory's suffering almost cost him his life. After more than three days, during which he lost 2/3 of his blood volume, he was taken to a hospital where he underwent an extensive surgery for a massive gastrointestinal bleed.

Defendants violated Mr. Mallory's right to be free from cruel and unusual punishment by failing to provide him with timely, adequate, and necessary medical care. This failure does not rest with one individual. Rahter, it was the Department-wide culture of indifference that led to Mr.

Mallory's harm and his inability to access medical care. This culture of indifference diffused through the entire Department including security officers, medical staff, and upper-management supervisors. The line staff medical and correctional Defendants knew that Mr. Mallory faced a life-threatening medical condition, yet they deliberately disregarded this risk by failing to take the basic actions to prevent his life-threatening condition. Managerial Defendants knew that prisoners, like Mr. Mallory, faced a serious risk of harm because of multiple failures of the CDOC's Quality Management Program. Additionally, the Department had inadequate policies concerning how prisoners accessed immediate medical help and Defendants failed to take reasonable measures to abate these problems.

As set forth below, there are numerous material factual disputes regarding the Defendants' knowledge and actions, thus rendering summary judgment inappropriate. Consequently, summary judgment for all Defendants should be denied.

FACTS

I. RESPONSE TO DEFENDANTS' STATEMENT OF FACTS

1-25. Undisputed.

26. Partially Disputed. Disputed that log entry refers to October 8, 2009. (Doc. 98, Ex. A, Att. 2, at 9 (AG 1516.))

27-31. Undisputed.

32. Partially Disputed. Disputed as to the time; the second Medline at Centennial Correctional Facility (CCF) on October 8th occurred at 2:46 p.m. (Doc. 98, Ex. C, Att. 1, AG2912.)

33-35. Undisputed.

36. Disputed. Mr. Mallory submitted his kite on the early morning of October 8th (Mallory Depo.

Tr., attached hereto as Ex. 1 83:7-18.) Kites are typically picked up on the morning rounds. (Edwards Depo. Tr., attached hereto as Ex. 2 at 8:21-9:4.)

37-42. Undisputed.

43. Partially Disputed. When asked at her deposition why she did not perceive the kite to be an emergency, she responded "I can't really answer that. I don't really remember any of that day." (Benally Depo., attached hereto as Ex. 3 at 64:25-65:4.) While RN Benally's affidavit implies that she remembers interacting with Mr. Mallory on October 8th, at her deposition she testified that she did not remember any such encounter. (Ex. 3 at 58:20-21.) Nor does Mr. Mallory recall speaking with RN Benally that day (Ex. 1. 95:13-19.)

44. Undisputed.

45. Partially Disputed. Dr. Frantz wavered regarding whether RN Benally's triage of Mr. Mallory's kite satisfied the appropriate standard of care (Frantz Expert Depo. Tr., attached hereto as Ex. 4 at 43:17-25, 89:14-90:2, 92:17-25.) Dr. Frantz first testified that RN Benally's decision regarding the kite was not reflective of the appropriate standard of care (Ex. 4 at 43:17-25) nor was it consistent with the Department's outlined policy (Ex. 4 at 89:14-90:2.) She later retracted these statements, testifying that RN Benally's care was acceptable. (Ex. 4 at 92:17-25.) Despite the Defendants' characterization of vomiting blood as a "general complaint of not feeling well," which "is not life threatening in young people," there is a difference between not feeling well and the symptoms stated in Mr. Mallory's kite. (Decl. of Joclynn Townsend, attached hereto as Ex. 5, Rebuttal Report of Dr. Greifinger, November 16, 2011 (Att. 6) ¶ 3.)

46. Undisputed.

47. Partially Disputed. Mr. Mallory told Licensed Practical Nurse (LPN) Edwards that he had been

throwing up *blood* for the last three days. (Mallory Dec., attached hereto as Ex. 6, ¶ 60; Doc. 98, Ex. A, Att. 2, at 12.)

48. Undisputed.

49-50. Disputed. Mr. Mallory does not recall LPN Edwards looking around his cell to verify his complaints. (Ex. 6 ¶ 60.)

51-56. Undisputed.

57. Partially Disputed. Undisputed that LPN Edwards asked the housing officer whether they had witnessed Mr. Mallory throwing up blood. Disputed as to whether she took any other steps to verify his report of vomiting blood for the last three days. (Ex. 2. 38:12-21.)

58. Undisputed.

59. Partially Disputed. Undisputed that LPN Edwards contacted the doctor. Disputed that LPN Edwards did not believe Mallory's complaint. LPN Edwards gave conflicting accounts of her belief in Mr. Mallory's report, first testifying she did not believe him (Ex. 2. 47:3-11), and later asserting that she told Mallory to stop taking nonsteroidal anti-inflammatory drugs (NSAIDs) as the precaution against increased internal bleeding. (Doc. 98, Ex. B, Edwards Aff. ¶ 22.)

60-62. Undisputed.

63. Partially Disputed. Undisputed that LPN Edwards failed to inform Dr. Wright that Mr. Mallory reported vomiting blood. (Ex. 2. 47:3-5.) Disputed as to whether she believed Mr. Mallory's complaint of vomiting blood and to the reasons why she failed to pass on this information because she stated in her deposition that "she works in a facility where 80 percent of our offenders don't tell the truth." (*Id.* at 29:22-30:9.)

64. Partially Disputed. Disputed that LPN Edwards observed Mr. Mallory playing basketball. Mr.

Mallory was not allowed access to a basketball court or a basketball and exercised alone. (Ex. 6 ¶ 12.)

65-71. Undisputed.

72. Partially Disputed. Disputed that Mr. Mallory was "alert" following his collapse, rather he was going in and out of consciousness. (Ex. 6 ¶ 80.)

73-80. Undisputed.

81. Partially Disputed. Undisputed as to what Dr. Ferguson put into the records. Disputed that there was no perforation; the perforation was extensive. (Dr. Lane Dep. Tr., attached hereto as Ex. 7 at 51:15-52:7.)

82-95. Undisputed.

96. Partially Disputed. In his deposition, Lieutenant Cella did not say that he asked the officer to "look again" to verify the presence of blood in Mr. Mallory's cell. (Lt. Eric Cella Dep. Tr., attached hereto as Ex. 8 at 57:15-61:6.) Further, Mr. Mallory only spoke to the officer twice: 1) initially to tell the officer he was vomiting blood and 2) later to be told no one was coming to help him. (Ex. 6 ¶¶ 26, 27, 32.) An officer did not come back and "look again" to see if there was blood in his cell.

97. Undisputed.

98. Partially Disputed. Undisputed that Lt. Cella claims the officer called him back; however, Mr. Mallory states that the officer did not return to verify whether there was blood and only returned to say that no one was coming see him. (Ex. 6 ¶ 32.)

99-101. Undisputed.

102-03. Partially Disputed. While Lt. Cella testified that he called Colorado Territorial Correctional Facility (CTCF), there is no documentation that this call occurred. Additionally, Lt. Cella cannot remember who he spoke with that night, so his call cannot be verified. (Ex. 8 at 59:7-12.)

104. Partially Disputed. Lt. Cella claims to have called Master Control, however, there is no evidence of this call other than his assertion.

105. Undisputed.

106. Disputed. Warden Jones stated that there is no reason for an officer to contact Master Control to pass medical information. (Warden Jones Depo. Tr., attached hereto as Ex. 9 at 28:11-17.) Master control is not for this type of information, but is only called if an officer is requesting either outside assistance or interfacility assistance. (Ex. 9 at 27:4-23.)

107-11. Undisputed.

112. Disputed. Correctional staff are not provided any training regarding when to pass on information to medical. (Ex. 9 at 40:8-21; Sgt. Johnston Depo. Tr., attached hereto as Ex. 10 at 58:9-59:1.) Whether to pass on the reported medical issues is based upon that officer's personal judgment. (Ex. 9 at 40:8-21; Sgt. Perdue Depo. Tr., attached hereto as Ex. 11 at 17:18-18:3.)

113. Disputed. Warden Jones is aware that there is no policy requiring correctional officers under her control to call medical every time a prisoner asks for medical help. (Ex. 9 at 42:15-43:5; Director Shoemaker Dep. Tr., attached hereto as Ex. 12 at 107:1-5.

114-18. Undisputed.

119. Disputed. Chief Smith had knowledge of deficient policies and procedures regarding the quality of care issues because these failures were obvious. *See* Pl.'s Facts ¶¶ 289, 298.

120-21. Undisputed.

122. Disputed. When Dir. Shoemaker started her job in 2007, some issues identified in the 2005 State Audit report had not been tracked or resolved. (Ex. 12 at 100:21-101:10, 102:11-23.)

123. Undisputed.

124. Disputed. Dir. Shoemaker had knowledge of deficient policies and procedures regarding the quality of care issues raised in the 2005 State Audit report because she read it and these failures were obvious. *See* Pl.'s Facts ¶¶ 265, 302.

II. PLAINTIFF'S STATEMENT OF ADDITIONAL UNDISPUTED FACTS

125. From 2005 to 2010, Matthew Mallory was incarcerated as the result of a non-violent crime. (Ex. 6 ¶ 5.) The CDOC released Mr. Mallory on parole in 2010. (Ex. 6 ¶ 4.)

126. He is in complete compliance with his parole obligations. (Ex. 6 ¶ 97.)

127. As a result of his near-death experience at CCF, Mr. Mallory still suffers complications that impair his ability to work, to be a husband, and to be a father. (Ex. 6 ¶¶ 103-111.)

128. While incarcerated at CCF, Mr. Mallory was held in segregation or close custody, where a prisoner is confined to a small concrete cell, alone for 23 hours a day. (Ex. 6 ¶¶ 7-8.)

129. Most of Mr. Mallory's contact with CDOC employees was through a large steel door with a small window, and usually lasted only a few seconds. (Ex. 6 ¶¶ 9, 63.)

130. When Mr. Mallory had medical emergencies, he could neither directly call medical staff, nor walk to the medical clinic (Ex. 6 ¶ 11.) Rather, he was dependent on the CDOC staff to provide him with access to emergency medical care (Ex. 6 ¶¶ 11, 41; Ex. 12 at 31:23-32:6.)

131. Mr. Mallory received an X-ray while incarcerated, which noted that he had a possible compression fracture in his back. (Radiology Report, attached hereto as Ex. 13.)

132. Despite repeatedly telling medical staff about his back pain, Mr. Mallory was not provided effective treatment, so he purchased medications from the canteen. (Ex. 6 ¶ 23.)

133. Mr. Mallory attempted to do the stretching exercises that were recommended by medical staff, but the exercises made his pain even worse. (Rebecca Bauer Dec., attached hereto as Ex. 14 at ¶ 7,

Letter dated 9/14/09 (Att. 1) & Letter dated 9/30/09 (Att. 2) at 2041; Ex. 6 ¶ 22.)

134. Mr. Mallory's medical complaints led some of the CCF staff—including lower level staff and at least one shift commander—to refer to him as "the crybaby." (Off. LaDeau Dep. Tr., attached hereto as Ex. 15 at 66:20-67:5.)

Early Morning October 8th – Mr. Mallory Begins Vomiting Blood

135. Early morning on October 8, 2009, Mr. Mallory awoke with a sudden urge to vomit. (Ex. 6 ¶ 25.) Mr. Mallory vomited a large quantity of thick red blood into his toilet. (Ex. 6 ¶ 25.)

136. Gregory Morris, the prisoner in the cell next to Mr. Mallory, heard Mr. Mallory vomit, pounded on the cell wall, and asked if he was okay (Gregory Morris Decl., attached hereto as Ex. 16 ¶ 12.)

137. Mr. Mallory informed Mr. Morris that he was throwing up blood (Ex. 16 ¶ 17.)

138. Mr. Mallory had to wait for the correctional officer to come by his cell during rounds to alert him of his urgent condition (Ex. 6 ¶ 26.) Once the officer arrived, Mr. Mallory told him he was vomiting blood and pointed at the blood in the toilet. (Ex. 6 ¶ 27.)

139. Upon seeing the blood, the officer exclaimed, "Wow, that's a lot of blood." (Ex. 6 ¶ 28.)

140. Mr. Mallory declared a medical emergency to the officer, asking to see someone immediately. (Ex. 6 ¶ 29; Ex. 16 ¶¶ 13-14.)

141. While there is confusion regarding what constitutes "declaring a medical emergency," generally this is the name for when a prisoner tells correctional staff he wants to see a medical professional immediately. (Ex. 9 at 30:20-31:10.)

142. The officer told Mr. Mallory that he would report the incident after he completed rounds. (Ex. 6 ¶ 30.)

143. If a prisoner declared a medical emergency during the third shift, there should be an

incident report detailing the situation. (Ex. 9 at 61:12-16.) In two prior situations where Mr. Mallory declared a medical emergency, there was a note from CTCF and an incident report. (Defs.' Facts 6, 8.)

144. There is no incident report from the morning of October 8, 2009.

145. Had there been a report, Mr. Mallory's condition would have been discussed at the morning roll call and he likely would have been seen promptly by medical staff. (Ex. 9 at 52:25-53:14.)

146. Lt. Cella claims to have called Master Control to tell them Mr. Mallory needed to be seen by medical (Defs.' Fact 104.)

147. Both Warden Jones and RN Supervisor Moore testified that Master Control is not the appropriate location to call to ensure medical sees a prisoner with a concern. (Ex. 9 at 27:24-28:17; Nurse Moore Depo. Tr., attached hereto as Ex. 17 at. 52:8-16.)

148. Approximately thirty minutes passed from the time Mr. Mallory reported vomiting blood to when the officer returned. (Ex. 6 ¶¶ 31-32.) During that wait, he suffered extreme stress, not knowing whether someone would come to help him and worrying that he was dying. (Ex. 6 ¶ 36.)

149. When he did return, the officer told Mr. Mallory that he would not be seen at that time and that no one was available until morning. (Ex. 6 ¶¶ 32-33; Ex. 16 ¶ 13.) He told Mr. Mallory to fill out a medical kite and to put a washcloth on his head. (Ex. 6 ¶¶ 33-35.)

150. After the officer left, Mr. Mallory suffered terrible mental anguish. (Ex. 6 ¶¶ 36-41) Afraid he was going to die because he was still vomiting blood, he worried that he would never be able to see his grandmother or his young daughter again. (Ex. 6 ¶¶ 36-38.)

151. Lt. Cella did not check again on Mr. Mallory that night nor did he have any other officer check on him. (Ex. 8 at 62:13-17.)

152. As a shift commander, Lt. Cella had the ability to call an ambulance. (Ex. 9 at 19:13-15), but he did not do so.

October 8th – The First Day of Vomiting Blood

153. On the morning of October 8th, Mr. Mallory did as he was told by the correctional officer and filled out a kite about vomiting blood, requesting medical attention. Ex. 6 ¶ 42.)

154. It is normal for a prisoner in segregation to fill out a kite and leave it outside of his door (Ex. 3 at 25:15-20.)

155. Throughout the day, Mr. Mallory continued to vomit blood (Ex. 6 ¶ 51.)

156. Mr. Mallory told a nurse on the morning of October 8th that he had been throwing up blood and showed her the blood (Ex. 1. 83:23-84:7.)

157. Mr. Mallory was also telling officers that he was vomiting blood and needed help (Ex. 6 ¶ 47), and prisoners can request medical care for other prisoners. (Ex. 9 at 75:18-20.)

158. Mr. Morris remembers hearing Mr. Mallory tell multiple officers that he was throwing up blood and that he needed medical attention, and Mr. Morris was also was telling officers that Mr. Mallory was sick. (Ex. 16 ¶¶ 17, 20-21.)

159. Mr. Mallory is unable to recall the names of most of the correctional officers that he complained to because he was very sick at the time (Ex. 6 ¶ 47.)

160. Despite this, no officer opened Mr. Mallory's door in order to look and see if there was blood inside. (Ex. 6 ¶ 77.)

161. Mr. Mallory spoke to Sergeant Johnston, who was on shift on October 8th. (Ex. 10 at 128:23-129:1.) Mr. Mallory told him that he was throwing up blood (Ex. 6 ¶ 50.)

162. Mr. Morris also told Sgt. Johnston that Mr. Mallory was throwing up blood and that he needed

help right away. (Ex. 16 ¶ 21.)

163. Sgt. Johnston claims that he calls medical anytime that a prisoner reports a medical problem that is not "minor." (Ex. 10 at 57:12-21.) He considers it part of his job responsibility to contact medical even if the prisoner has not asked for help. (Ex. 10 at 67: 16-19.)

164. Despite this practice, he testified that he would not contact medical for a complaint of "swine flu" because that is a "minor complaint." However, he testified that a headache requires a call to medical. (Ex. 10 at 57:18-21.)

165. Though Sgt. Johnston does not remember his conversation with Mr. Mallory, he testified that every day he interacts with each prisoner, asking them how they are doing, sometimes a few times a day. (Ex. 10 at 11:21-12:2.)

166. His failure to remember the interaction with Mr. Mallory is consistent with the fact that his memory of the events of that week is faulty. (Ex. 10, *compare* 83:6-11 *with* 118:14-25; and *compare* 83:14-15 *with* 87-16:88-1.)

167. Sgt. Johnston did not call clinical services when Mr. Mallory complained to him of throwing up blood on October 8th. (Ex. 10 at 129:2-8.)

168. At some point on October 8th, RN Benally obtained Mr. Mallory's kite, though she does not remember the exact circumstances of how she received it. (Ex. 3 at 56:12-14.)

169. A Registered Nurse is required to triage medical kites to identify emergent or urgent medical conditions (Sick Call Clinical Standard, attached hereto as Ex. 18 at AG 1512) for referral to primary care medical providers and other health care professionals. (RN Job Description, attached hereto as Ex. 19 at AG 1345.)

170. Any kite that holds the possibility of an emergent health care need warrants having the

prisoner brought to the clinic to be assessed more thoroughly. (Ex. 18 at AG 1512.)

171. RN Benally knew that vomiting blood is a condition that may be urgent or emergent because it may lead to serious harm or debilitating pain (Ex. 3 at 31:23-32:6; Benally Admissions, attached hereto as Ex. 20 ¶ 1-2.)

172. RN Benally testified that she read kites at the door, and if the complaint was for vomiting blood she would have the prisoner come up to the door so she could examine him. (Benally dep. 38:13-25.)

173. She would then determine if he needed to come out of his cell. (Benally dep. 39:3-7.)

174. If RN Benally had taken either of these steps—if she *discussed* anything with Mr. Mallory—she would have documented the encounter. Benally affidavit ¶ 20; Ex. 3 at 68:4-9

175. RN Benally did not bring Mr. Mallory to the clinic for evaluation. (Ex. 6 ¶ 54.)

176. She noted that the only way to determine whether a prisoner's complaint of throwing up blood is urgent or emergent was to assess the patient, including asking about the amount and the color of the blood (Ex. 3 at 16:15-19.) RN Benally did not speak to Mr. Mallory to verify the amount or the color of his vomit.

177. Nurse Moore, RN Benally's supervisor, testified that Mr. Mallory's kite would require seeing him (Ex. 17 at 26:21-24) or at least asking him more questions about his condition (Ex. 12 at 114:7-115:8.)

178. Instead of examining Mr. Mallory, RN Benally entered his kite at 6:45 pm (Doc. 98, Ex. A, Att. 2, at 10 (AG 59)) and then went home at 7:12 pm (Payroll Records, attached hereto as Ex. 21 at AG 88), knowing she would not be at CCF tomorrow and that there was no nurse that night at CCF either. (Ex. 3 at 7:13-15 (rarely worked at CCF); 48:7-13.)

179. When a nurse triages a prisoner's medical kite, there are three different options for the acuity field–routine, urgent, and emergent---which allow the nurse the ability to identify those prisoners who need to be seen first. (Ex. 17 at 17:24-18:1.)

180. When a prisoner scheduled as "routine", it is typical for a prisoner to wait seven days or longer to be seen (Ex. 3 at 67:24-68:6.)

181. RN Benally entered Mr. Mallory's kite as routine. (Doc. 98, Ex. A, Att. 2, at 10 (AG 59).)

182. RN Benally's care fell far below the standard of correctional care because she knew of Mr. Mallory's complaint of throwing up blood yet failed to examine him or arrange for prompt medical evaluation (Ex. 5, Expert Report of Dr. Greifinger, November 5, 2011 (Att. 1) at ¶ 68.)

183. On October 8th, despite submitting a kite and repeatedly asking for help, no medical provider came to talk to Mr. Mallory. (Ex. 6 ¶¶ 42, 44-45, 52, 54.) Mr. Mallory was terrified that he would never receive medical help. (Mallory's Dec. ¶ 55.)

October 9th – The Second Day of Vomiting Blood

184. Through the night Mr. Mallory continued to vomit blood and to ask correctional officers for help. (Doc. 98, Ex. A, Att 2, at 9 (AG 1516.)) At 5:00 a.m. on October 9th, the officers noted that Mr. Mallory was asking to see medical (*Id.*)

185. There is no documentation that the correctional staff called medical or followed up with Mr. Mallory on his request.

186. In the morning on October 9th, Mr. Mallory vomited blood again (Ex. 6 ¶ 56.)

187. When LPN Edwards was doing medical rounds this morning, he again asked for help and told her that he had been vomiting blood. (Ex. 1. 109:14-12, Ex. 6 ¶ 60.)

188. LPN Edwards knows that vomiting blood is a serious medical condition, which places a person

at risk of further deterioration, including serious, debilitating pain (Edwards Admissions, attached hereto as Ex. 22 at ¶ 1.)

189. While LPN Edwards could have pulled Mr. Mallory out of his cell to examine him, she failed to do so, examining him only through a slot in a steel door. (Ex. 2. 42:8-12; Ex. 6 ¶ 63.) She could only see him in a small window, and her only physical contact with Mr. Mallory was through the food port (Ex. 2. 39:23- 40:9.)

190. LPN Edwards's visit with Mr. Mallory had severe limitations since she took all his vital signs through the food port (Ex. 2. 39:23-40:9.)

191. Mr. Mallory and LPN Edwards both had to kneel down and have Mr. Mallory stick his arm through the food port, in order for LPN Edwards to take his blood pressure. (Ex. 2. 39:23-40:9.)

192. LPN Edwards did not take a full set of vitals, which would have included palpating his stomach for abnormalities, which is critical when trying to determine whether a patient has a GI bleed. (Dr. Greifinger Expert Depo. Tr., attached hereto as Ex. 23 at 68:7-69:20.) Additionally, she never took Mr. Mallory's respiratory rate (Ex. 23 at 69:10-11), which is a critical vital sign for someone complaining of symptoms indicative of a GI bleeding.

193. LPN Edwards also failed to use the mandatory nursing protocols (Ex. 5, Att. 1 at ¶ 37; *see also* Doc. 98, Ex. A, Att. 2 at 12.) CDOC has a Gastrointestinal (GI) Protocol that would be applicable to Mr. Mallory's complaint of vomiting blood. (GI Protocol, attached hereto as Ex. 24; *see also* Ex. 17 at 47:11; Ex. 22 ¶ 4.)

194. Proper use of the GI Protocol would have resulted in a more thorough examination of Mr. Mallory outside of his cell (Ex. 5, Supplemental Report of Dr. Greifinger (Att. 2) at ¶ 12); Ex. 24.)

195. LPN Edwards's cell-side examination was incomplete and inappropriate for a prisoner that

complains of throwing up blood. (Ex. 23 at 180:8-24.)

196. Even with these limitations there were indicators of the severity of Mr. Mallory's illness LPN Edwards noted his pulse was abnormally high (Ex. 2 at 41:16-24), Mr. Mallory's blood pressure was 127/50, which was also abnormal. (Ex. 23 at 68:7-69:20.)

197. These vital signs placed Mr. Mallory at risk of several acute illnesses, including severe anemia, severe dehydration, and shock. (Ex. 23 at 191:14-21.) These vitals are also indicative of a gastrointestinal bleed. (*See* Ex. 24 at AG 1501.)

198. Following her cell-side examination, LPN Edwards told Mr. Mallory that he had the swine flu (Doc. 98, Ex. B, Edwards Aff. ¶ 23), even though throwing up blood is not a symptom of the swine flu (Ex. 3 at 54: 6-8.)

199. It is outside the scope of LPN Edwards's license to diagnose. (Ex. 4 at 137:5-12; Greifinger Depo. 85:6-14.) It is also outside of an LPN licensure to tell a patient to discontinue taking a medicine. (Dr. Wright Depo. Tr., attached hereto as Ex. 25 at 37:3-5.)

200. After the examination, LPN Edwards failed to inform the provider, Dr. Wright, that Mr. Mallory reported vomiting blood and that she had told him to stop taking his NSAID medications. (Ex. 2. 47:3-5, 48:21-49:2.)

201. A Licensed Practical Nurse is required to accurately report to a supervising nurse or a medical provider the physical condition of a prisoner during sickline and emergencies. (LPN Job Description, attached hereto as Ex. 26.)

202. It is fundamental that a LPN, who is not authorized under her license to make a full assessment or diagnose, passes on a patient report of a potentially life-threatening symptom to a medical provider. (Ex. 5, Att. 1 at ¶ 40.)

203. Dr. Wright testified that if LPN Edwards had told him that Mr. Mallory had complained of throwing up blood, he would have had Mr. Mallory examined. (Ex. 25 at 22:5-7.)

204. Dr. Wright ordered that Mr. Mallory was followed up with on the same day. (Doc. 98, Ex. A, Att. 2, at 12.) There is no documentation that LPN Edwards followed up with Mr. Mallory that day.

205. LPN Edwards's failure to communicate and pass along Mr. Mallory's report of vomiting blood fell far below the standard of correctional health care. (Ex. 5, Att. 1 at ¶ 66.)

October 10th – Day Three of Vomiting Blood

206. Over the next day, Mr. Mallory became weaker and weaker. (Ex. 6 ¶ 73.)

207. Seemingly remedial tasks became difficult for Mr. Mallory. (Ex. 6 ¶ 58.) When walking to the showers and retrieving his meals he had to move at a much slower pace as he struggled to keep his balance. (Ex. 6 ¶ 5.)

208. Mr. Mallory's physical appearance began to change (Ex. 16 ¶ 23.) He was very pale and Mr. Morris thought he looked as though he was embalmed. (*Id.*)

209. To anyone who saw Mr. Mallory, it was obvious that there was something seriously wrong with him. (Ex. 16 ¶ 24.)

October 11th – Day Four of Vomiting Blood

210. On the morning of October 11th, Mr. Mallory continued vomiting blood. He felt so weak, he could barely stand up. (Ex. 6 ¶ 75.)

211. Mr. Morris talked to Sgt. Johnston, again, about Mr. Mallory's condition that morning. Johnston did not call medical or ask any additional questions regarding Mr. Mallory's health. (Ex. 16 ¶ 28.)

212. When Mr. Mallory's door was opened for him to get his lunch, he was so weak that he was

unable to walk out of the cell. (Ex. 6 ¶ 76.)

213. When Officer LaDeau came to figure out why Mr. Mallory had not left his cell, Mr. Mallory told him that he was sick with swine flu and could not get his lunch tray. Mr. Mallory asked if he or Mr. Morris could get his tray for him. (Ex. 6 ¶ 76; Ex. 16 ¶¶ 29-30; Ex. 14 ¶ 17, Letter dated 10/26/09 (Att. 3) at 2043.)

214. Rather than assist him, Officer Ladeau replied, "This isn't Burger King where you can have it your way." (Ex. 6 ¶ 76; Ex. 16 ¶ 32; Ex. 14, Att. 3 at 2043.)

215. Mr. Mallory summoned the little strength that he had to slowly walk out of his cell to get his tray. As he walked he struggled to retain his balance, so he had to lean against the wall to avoid falling. (Ex. 6 ¶ 79; Ex. 16 ¶ 33.)

216. Before getting his food, Mr. Mallory collapsed, hitting his head on the table as he fell to the cement floor. (Ex. 6 ¶ 79; Ex. 16 Ex. X, ¶ 34; Ex. 14, Att. 3 at 2043; Marmolejo Incident Report, attached hereto as Ex. 27 at AG 36.)

217. When LPN Edwards arrived to assist the officers with Mr. Mallory, she asked Mr. Mallory, "Are you still throwing up blood?" Mr. Mallory replied affirmatively. (Video of October 11, 2009 Incident, submitted under separate cover to court as Ex. 28, at 1 min. 30 sec.)

218. Rather than take Mr. Mallory to the infirmary, LPN Edwards decided Mr. Mallory needed to be returned to his cell. (Ex. 10 at 76:19-77:10.) There was no medical reason for this move. (*Id.*)

219. Unable to walk on his own, Mr. Mallory was taken back to his cell by LPN Edwards and an officer. (Johnston Incident Reports, attached hereto as Ex. 29 at AG 26.)

220. Moments after the staff let go of Mr. Mallory, he collapsed again to the floor. (Ex. 29 at AG 26; Ex. 28 at 2 min. 20 sec.)

221. The blood on the floor of Mr. Mallory's cell was obvious and was noted by Sergeant Johnston and other officers. (Ex. 28 at 2 min. 50 sec.; Ex. 10 at 119:15-22.)

222. Nearly an hour after his collapse, Mr. Mallory was taken via ambulance to St. Thomas Moore hospital emergency room. (Ex. 14, Att. 3 at 2043-44; Padilla Incident Report, attached hereto as Ex. 30 at AG 28.)

223. There was enough blood in Mr. Mallory's cell that it had to be cleaned up via a biohazard process. (Ex. 29 at AG 40.)

Mr. Mallory's Hospitalization and Emergency Surgery

224. Because St. Thomas Moore hospital was not equipped to handle Mr. Mallory's emergency, he was then transferred to St. Mary Corwin Hospital (SMCH.) (Ex. 7 at 18:1-3.)

225. Before arriving to the hospital, Mr. Mallory lost two-thirds of his blood. (Ex. 7 at 16:4-10.)

226. Dr. Lane, the treating physician at St. Mary Corwin, told Mr. Mallory that if he had gone to sleep on the day he collapsed without being taken to the hospital, he would have died. (Ex. 6 ¶ 89; Ex. 14, Att. 3 at 2047; Ex. 7 at 55:6-13, 56:15-18.)

227. The procedure of inserting the tube through his nasal cavity was painful and resulted in breaking Mr. Mallory's nose cartilage. (Ex. 6 ¶ 83; Ex. 14, Att. 3 at 2044.)

228. Mr. Mallory was diagnosed with massive gastrointestinal bleed as the result of peptic ulcer disease developed due to taking nonsteroidal anti-inflammatory medications. (Ex. 5, St. Mary Corwin Hospital History and Physical Report (Att. 3) at 0043; Ex. 7 at 29:11-14.

229. Mr. Mallory had a duodenal ulcer of 2.5 centimeter, which is approximately the size of a quarter. This is classified as a "large" ulcer. Ex. 7 at 36:24-37:9; (Ex. 5, St. Mary Corwin Hospital GI Lab Procedure Report (Att. 4) at 0101.)

230. This ulcer, which had perforated the gastrointestinal tract, had to be corrected through surgery. Lane Depo. 49:22-52:11.

231. Dr. Lane testified that most people with this type of ulcer would go into surgery immediately, but surgery was not possible at this time due to Mr. Mallory's severe loss of blood and the high probability of death. (Ex. 7 at 32:23-33:3.)

232. As a result of the severe blood loss, Mr. Mallory had a seizure, during which he stopped breathing and did not have a palpable pulse. Following the seizure, Mr. Mallory vomited more blood and more blood was suctioned out of his stomach. (Ex. 7 at 43:15-20; Ex. 5, St. Mary Corwin Hospital Consultation Report (Att. 5) at 0049.)

233. When he was finally resuscitated, Mr. Mallory was taken into emergency surgery. (Ex. 5, Att. 5 at 0049.)

234. Dr. Lane, the treating physician, testified that Mr. Mallory's most significant damage—the erosion of the ulcer into the gastroduodenal artery—most likely occurred 24 to 48 hours prior to Mr. Mallory starting to throw up massive amounts of blood. (Ex. 7 at 74:20-75:5.)

235. Mr. Mallory's scar from this procedure is large and required fifty staples to close. (Ex. 14 ¶ 17, Letter dated 10/30/09 (Att. 5) at 2052.)

236. Further, as a result of this surgery, Mr. Mallory has to take Prilosec, which reduces production of stomach acid, likely for the rest of his life. (Ex. 6 ¶ 107.)

237. During his entire hospital stay—and despite CDOC's own policy (AR 850-10)-- Mr. Mallory's family was never notified of his transport to the hospital. Mr. Mallory's grandmother only learned of his condition after repeated calls to the prison, trying to find out where he was. (Ex. 14 ¶¶ 11-16.)

238. Mr. Mallory continues to struggle with physiological and psychological issues related to his

ulcer surgery. (Ex. 6 ¶¶ 104-123; Sheena Mallory Decl., attached hereto as Ex. 31 at ¶¶ 2-11; Ex. 14 ¶¶ 19-22).

Supervisory Defendants

Defendant Shoemaker, Deputy Director of Prisons for Clinical Services

239. Since 2007, Dir. Shoemaker was Deputy Director of Prisons for Clinical Staff and ultimately supervised all of the CDOC clinical staff. She is responsible for the quality of healthcare provided by the entire Department. (Ex. 12 at 7:22-24; 32:12-20.)

240. She reviews, updates, and approves CDOC clinical policies and standards. (Ex. 12 at 11:10-16.)

241. In 2009, Dir. Shoemaker was responsible for ensuring the adequacy of the Quality Management Program's ("QMP") procedures and its effective implementation by the clinical staff. (Ex. 12 at 46: 8-15.)

Defendant Smith, Chief of Operations for Clinical Services

242. In 2009, Defendant Smith was the Chief of Operations for Clinical Services. (Chief Smith Depo Tr., attached hereto as Ex. 32 at 15:12-16:4.)

243. In 2009, Chief Smith was also acting in the capacity of a Regional Health Services Administrator ("RHSA".) (Ex. 32 at 15:12-16:4.) In that position she supervised both Provider Services and Nursing Services. (Ex. 32 at 16:18-24.) She was responsible for supervising processes, service delivery, and filling of positions. (Ex. 32 at 16:25-17:4.) Chief Smith was responsible for looking at system processes and policies and relaying identified problems to upper-management (Ex. 32 at 69:19-70:3.)

244. In 2009, she directly supervised the administrator of the QMP (Renae Jordan Depo. Tr., attached hereto as Ex. 33 at 9:1-3.) If operational issues were identified through the QMP, Chief

Smith was responsible for fixing such issues (Dr. Frantz 30(b)(6) Depo. Tr., attached hereto as Ex. 34 at 77:22-78:4.)

Defendant Jones, Warden of CCF

245. Warden Jones is responsible for ensuring her correctional staff can effectively perform their jobs as described in their job descriptions. (Warden Job Description, attached hereto as Ex. 35 at AG 002892.)

246. She is also responsible for developing and implementing Operational Memorandum, Implementation Adjustments, and Post Orders. (*Id.*.)

247. It is her duty to ensure facility policies and procedures are consistent with Department's goals and that policies are adhered to and followed. (*Id.*) She is to monitor these policies and make any recommendations that are necessary. (*Id.*.)

248. In conjunction with such implementation and monitoring, Defendant Jones is to improve training for staff assigned to CCF. (*Id.*)

Access to Medical Care & Declaring a Medical Emergency Policy

249. CDOC is required to provide 24-hour emergency services to the prisoners at the CCF. (Letter of Agreement, attached hereto as Ex. 36 at AG 1490.)

250. For a prisoner to request immediate medical care, he must "declare a medical emergency." (Ex. 12 at 107:21-108:7.)

251. No written policy exists that details how a prisoner should "declare a medical emergency" or the required response from correctional staff. (Ex. 12 at 108:8-12; Ex. 32 at 69:5-11; Michael Bergondo Dep. Tr., attached hereto as Ex. 37 at 51:23-52:3, 52:15-22; Ex. 9 at 33:4-10.)

252. CDOC provides no training to correctional staff on how to handle a prisoner's declaration of

a medical emergency. (Ex. 11 at 29:2-6.)

253. The only way prisoners are formally informed about the declaring a medical emergency policy is via the CDOC Offender Handbook, which states only that emergency services are available 24/7 and that prisoners are to notify a CDOC employee if they are experiencing an emergency. (Offender Handbook, attached hereto as Ex. 38 at AG 2749.) No other details or direction is given.

254. In practice, CDOC employees may withhold immediate medical care for patients who do not state explicitly and exactly that they are "declaring a medical emergency." (Ex. 5, Att. 1 ¶ 74.)

255. Some staff members testified that if a prisoner does not say that he is "declaring a medical emergency," but rather asks for "immediate" medical care, he has failed to declare an emergency (Ex. 37 at 56:3-58:1; Ex. 17 at 37:22-24.)

256. Correctional officers are not trained to clarify with a prisoner whether he is declaring a medical emergency, and there is no policy requiring officers to ask that question of prisoners. (Ex. 9 at 33:11-34:3.)

257. Neither are correctional staff provided training on when to document a prisoner's request for an emergency (Ex. 9 at 49:20-50:4), beyond a general directive of "anything you think you need to write a report on, write a report on." (Ex. 10 at 52:22-53:10.)

258. There is neither a mechanism to track how many prisoners are declaring a medical emergency nor a system to monitor whether prisoners who declared an emergency received immediate medical care. (Ex. 12 at 105:18-23; Ex. 37 at 50:25-51:7, 54:12-21.)

259. The policy of declaring a medical emergency is a "play with words" and is punitive and dangerous, resulting in the policy falling far below the standard of correctional care. (Greifinger Report, Nov. 5, 2011, ¶ 74.)

260. This policy is unconscionable because it fails to provide timely access to an appropriate level of care. (Ex. 23 at 78:5-24; 154:18-155:18.)

Access To Medical Care – Correctional Officers Screen Medical Complaints

261. For both emergency and non-emergency situation, the policy regarding when an officer should contact medical on behalf of a prisoner is unclear and therefore inadequate. (Ex. 5, Att. 2 at ¶ 3.)

262. Correctional officers have the responsibility to "[decide] whether or not to refer an inmate to . . . medical staff depending on the behavior being exhibited or the particular problem." (Sgt. Job Description, attached hereto as Ex. 39 at AG 001287.)

263. However, correctional officers receive no official training on how to decide when to refer a prisoner to medical. (Ex. 9 at 12:8-21; *see also* Ex. 10 at 58:22-59:1.)

264. The only training correctional staff receive regarding medical issues is a First Aid training that covers CPR and Basic Life Support. (Ex. 9 at 12:8-21, 15:12-14; Ex. 37 at 50:19-21.) There is no training on how to identify medical urgencies. (Ex. 5, Att. 2 at ¶ 5.)

265. There is no policy requiring correctional officers to call medical every time prisoners asks for medical help. (Ex. 12 at 107:1-5.)

266. As a result, the officers are unsure when to call medical. (*See generally* Pl.'s Facts ¶¶ 267-68.) They call medical whenever they feel it is appropriate; for example, at least one officer testified that he calls medical based on his personal judgment of the situation. (Ex. 11 at 18:1-3.)

267. Some officers assess the prisoner's "overall physical" health to verify his symptoms before contacting medical staff. (Ex. 10 at 64:10-21.)

268. Other staff consider it is a part of their job to verify whether a prisoner tells truth when they complain of medical issues. (Ex. 11 at 35:1-9.)

269. There is no mechanism to ensure that correctional staff adequately respond to prisoners' medical requests. (Ex. 37 at 51:4-7; Ex. 9 at 22:1-4.)

270. Expecting officers to utilize their judgment regarding medical issues without sufficient training is a failure of policy. (Ex. 23 at 157:7-10.)

Gastrointestinal Bleeds Were a Common Problem in CDOC

271. The Department uses a third party administrator or consultant, Correctional Health Partners (CHP) to monitor its health care program. (Ex. 32 at 76:12-77:17.)

272. CHP provides monthly reports to CDOC regarding hospital admissions and other data regarding health care services. (*Id.*; *see also* CHP Reports, attached as Ex. 40.)

273. These reports are discussed in monthly "UM JOC" meetings, which, in 2008 and 2009 were regularly attended by Dir. Shoemaker and Chief Smith. (Portion of CHP Report and Meeting Minutes, attached hereto as Ex. 40.)

274. One topic reviewed in these meetings is the "top admitting diagnosis," which is a tabulation of the most frequent diagnoses causing prisoners to be admitted to the hospital. (*See, e.g.,* Ex. 40 at AG 3519.)

275. On several occasions in 2008 and 2009, GI hemorrhages were listed as one of the most frequent reasons for hospital admissions. (*See, e.g.,* Ex. 40, at AG 2982, AG 3372, GI bleeds are listed among two codes: "Unspecified Hemorrhage of GI Tract" and as "GI Hemorrhage".)

276. In August 2009, or a few months prior to Mr. Mallory's incident, GI hemorrhages were listed as the number one cause of hospital admissions. (Ex. 40 at AG 3519.)

277. Indeed, between 2007-2010, there were approximately 200 GI bleeds in CDOC that resulted in hospitalization or inpatient care. (Ex. 33 at 55:18-58:4; Shoemaker Interrogatory Response and

Chart, attached hereto as Ex. 41.)

278. Despite being aware of this significant problem, neither Dir. Shoemaker nor Chief Smith took steps to assess whether CDOC staff was identifying and treating GI bleeds as needed.

279. Rather, Dir. Shoemaker and Chief Smith unreasonably relied on the Quality Management Program (QMP) to address such problems, without taking basic steps to ensure that the QMP was fulfilling this role.

The Quality Management Program

280. The Quality Management Program (QMP) is a department-wide policy and program, designed to identify, monitor, and improve the quality of clinical health care. (Administrative Regulation on QMP, attached hereto as Ex. 42 at AG 259.)

281. CDOC uses the QMP as the mechanism in which management supervises lower-level clinical staff (Ex. 32 at 100; 6-16.)

282. The QMP reviews significant events, called "quality occurrences" or "sentinel events," to identify areas where additional training or adjusted policies are necessary. (*See generally* Quality Occurrence Reporting Clinical Standard, attached hereto as Ex. 43.)

283. A sentinel event is "any unexpected clinical occurrence involving death, potential for death, or serious injury." (Ex. 42 at AG 261.)

284. While there are a few sentinel events that automatically are submitted for QMP review, the majority of events are supposed to be identified and reported by staff members. (Ex. 43 at AG 1581.)

285. In practice, staff members are supposed to self-report quality occurrences they participated in or report those occurrences that they observe regarding their co-workers. (Ex. 32 at 103: 5-19.)

286. Despite this requirement, clinical staff is not trained on when to report GI bleeds, (Ex. 33 at 20:3-18), nor required to read the QMP policy on this topic (*id.* at 46:12-47:6).

287. There is no formal tracking mechanism to ensure that the clinical staff is reporting any sentinel events, including GI bleeds. (Ex. 34 at 68:22-24.)

288. As a result, there is underreporting of sentinel events in the Department, a fact that the QMP administrator was aware of. (Ex. 33 at 32:1-5.)

289. Dir. Shoemaker and Chief Smith admit that when incidents go unreported, problems could be going unaddressed at the CDOC. (Ex. 32 at 96:9-12; Ex. 12 at 50:1-5.)

290. Underreporting is a problem because it inhibits the QMP Committee from identifying and remedying systemic problems (Ex. 23 at 201:21-202:11.)

Clinical Staff Failed to Report GI Bleeds Through the QMP System

291. The policy lists "GI Catastrophe" as a "sentinel event" requiring report for QMP review. (Ex. 43 at AG 1581.)

292. A serious GI bleed—one that requires hospitalization or inpatient care — is required to be reported for QMP review. (Ex. 43 at AG 1580-1581; Ex. 34 at 73:14-17; Ex. 37 at 90:4-10.)

293. When the QMP Committee reviews GI bleeds, it identifies quality of care issues, along with recommending ways in which staff can improve their care (Ex. 33 at 112:12-113:8.)

294. Of the approximately 200 GI bleeds that would require report (from 2007-2010), (Ex. 33 at 55:18- 58:4; Shoemaker Interrogatory Response and Chart, attached hereto as Ex. 41), only seven were reported (AG 2105 - 2160.)

295. Of those seven reports, five GI bleeds resulted in the death of the prisoners (QMP Reviews, attached hereto (under seal) as Ex. 44, at AG 2105-AG 2111, AG 2117-AG2128, AG2139-AG2146,

AG2147-AG2155, AG 2156-AG2160.) Deaths are reviewed automatically and do not require quality of care reporting. (Ex. 33 at 116:9-17.)

296. Therefore, CDOC staff voluntarily reported only two of the 200 sentinel GI bleeds.

297. This severe underreporting of GI bleeds concerns the QMP Administrator. (Ex. 33 at 58:13-59:1.)

298. Despite knowledge of the monthly numbers of individuals with hospital admissions resulting from GI bleeds, neither Dir. Shoemaker nor Chief Smith reported these sentinel events to the QMP, or checked to make sure these serious incidents were already reported.

299. Those few sentinel GI bleeds that were reported through the QMP waited an average of nine months to be reviewed by the QMP Committee. (*See* Ex. 44, calculated by averaging time among all reviews.) Some reviews were delayed as long as two years after the bleed occurred. (Ex. 33 at 117:17-118:15.)

300. These excessive delays substantially hinder the Department's ability to flag quality of care issues, and administer appropriate remedies (Ex. 23 at 201: 21-202:11; *see also* Ex. 4 at 117:10-118:2.)

301. During the delays, unnecessary and preventable harm may have befallen other prisoners (Ex. 23 at 201:15-20.)

302. Dir. Shoemaker knew that the QMP posed a significant risk to prisoners because she read the 2005 State Audit Report ("the Audit"). (Ex. 12 at 94:22-25.) The Audit identified that QMP Committee failed to meet with appropriate frequency (Doc. 98, Ex. K, Att. 1 at 32), and that the current reviews were occurring informally and sporadically. (*Id.*)

303. Chief Smith was aware that the QMP posed a substantial risk because she was a listed member of the QMP Committee and she was notified every time a prisoner was transported to a hospital

(Smith Depo. P. 39:1-40:14; Ex. 42 at AG 263-64.)

304. When the QMP Committee finds quality of care issue with a reported incident, it can recommend further training for lower-level staff to prevent the problem in the future. (Ex. 33 at 112:12-113:8.)

305. Prior to Mr. Mallory's incident, the QMP Committee identified over-prescription of NSAIDs as a problem, and recommended both that clinical staff "avoid, as much as possible, long term use of NSAIDS," and that "physicians need[ed] more options for pain management." (2092-2097; 2112-2116; 2139-2146.)

306. The QMP Committee also found that clinical staff had failed to identify a prisoner's GI bleed symptoms as urgent. For example, two prisoners (not Mr. Mallory) reported GI bleed symptoms for four days prior to being examined. (2083-2084; 2085-2086)

307. These identified but unaddressed issues "served to deny Mr. Mallory timely access to appropriate level of care" (Ex. 23 at 107:5-18.)

308. To this day, there has been neither report nor review on Mr. Mallory's sentinel event.

ARGUMENT

I. SUMMARY JUDGMENT STANDARD OF REVIEW.

A motion for summary judgment must be denied if there is sufficient evidence that a reasonable jury could return a verdict for the non-moving party. *Allen v. Muskogee*, 119 F.3d 837, 839 (10th Cir. 1997) (citing *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). If the determination of a material fact requires a credibility assessment, this is to be left for the factfinder. Fed. R. Civ. P. 56; *Anderson*, 477 U.S. at 255 ("credibility" determinations, the weighing of the evidence, and the drawing of legitimate inferences from the facts are jury functions . . .."); *Fogarty v. Gallegos*, 523 F.3d

1147, 1165 (10th Cir. 2008) ("On summary judgment a district court may not weigh the credibility of the witnesses.").

II. LIABILITY FOR LINE STAFF DEFENDANTS - EDWARDS, BENALLY, JOHNSTON, AND CELLA.

A. The Eighth Amendment Standard

To demonstrate an Eighth Amendment claim, a prisoner must show 1) that his medical need is objectively serious; and 2) that the defendants "knew of and disregarded an excessive risk to inmate health and safety." *Farmer v. Brennan*, 511 U.S. 825, 834 (1994); *Perkins v. Kansas Dep't. of Corr.*, 165 F.3d 803, 809-10 (10th Cir. 1999.)

1. Delay in treating vomiting blood satisfies the objective prong.

The Tenth Circuit has held that a medical need is sufficiently serious "if it is one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention." *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980) (internal quotation omitted.) Delay in providing medical care may constitute a violation of the Eighth Amendment, in particular in life-threatening situations and instances in which it is apparent that delay would exacerbate the prisoner's medical problems. *Grant v. Bernalillo Cty. Detention Center*, 173 F.3d 863, *2 (10th Cir. 1999) (unpublished.) "Considerable pain" caused by delay in care will be sufficient to satisfy the objective prong of the Eighth Amendment. *Garrett v. Stratman,* 254 F.3d 946, 950 (10th Cir. 2001).

In their Motion, Defendants appear to concede for the purposes of summary judgment that vomiting blood is a serious condition that satisfies the objective prong of the Eighth Amendment. (Doc. 98 at 22.) Courts have determined that vomiting blood can be an indication of a serious

medical need that satisfies the objective prong. *See, e.g., Gillard v. Rosati*, No. 9:08-cv-1104(LEK/DEP), 2011 WL 4402131, *16 (N.D.N.Y. August 22, 2011); *Hale v. Rao*, No. 9:08-cv-612, 2009 WL 3698420, at *5 (N.D.N.Y. Nov. 3, 2009) (citing *Morgan v. Maass*, No. 94-35834, 1995 WL759203, at *2 (9th Cir. Dec. 26, 1995)).

2. The subjective prong requires a showing of deliberate indifference.

Prison officials are deliberately indifferent if they know of a serious condition of a prisoner in their custody, but fail to take reasonable measures to abate that condition. *Farmer*, 511 U.S. at 847; *Hunt v. Uphoff*, 199 F.3d 1220, 1224 (10th Cir. 1999). Adequate or reasonable medical care requires provision of services by *qualified* medical personnel "capable of evaluating the need for treatment." *Sealock v. Colorado*, 218 F.3d 1205, 1211 (10th Cir. 2000); *Ramos*, 639 F.2d at 575. The medical care provided must be acceptable when measured by professional standards in the community. *See Hill v. Corr. Corp. of America,* No. 07-cv-0571, 2009 WL 2475134, at *7 (D. Colo. Aug. 11, 2009) (citing *Barrett v. Coplan*, 292 F.Supp.2d 281, 285 (D.N.H.2003). While "matters for medical judgment . . . are beyond the Eighth Amendment's purview," *Callahan v. Poppell*, 471 F.3d 1155, 1160 (10th Cir. 2006), prison officials cannot knowingly deny a prisoner effective care or fail to meet accepted standards for health care. *See Ramos*, 639 F.2d at 575.

B. A Reasonable Factfinder Could Conclude that LPN Edwards and RN Benally were Deliberately Indifferent to Mr. Mallory's Serious Condition of Vomiting Blood.

Neither of the two medical Defendants who were aware of Mr. Mallory's complaint responded reasonably, thus, both exhibited deliberate indifference.

1. A reasonable factfinder could conclude that LPN Edwards acted with deliberate indifference.

To find an Eighth Amendment violation, a defendant must have had knowledge of a

substantial risk of serious harm. *Farmer,* 511 U.S. at 834. Here, there is no dispute that LPN Edwards knew that Mr. Mallory was at substantial risk harm from a serious, life threatening condition; she recorded that Mr. Mallory was self-reporting vomiting blood. (Pl.'s Fact ¶ 187.) Further, she admitted that vomiting blood is a serious medical condition that could result in patient deterioration or serious pain. (Pl.'s Fact ¶ 188.) Thus, there is sufficient evidence of a serious condition and of LPN Edwards's knowledge.

A factfinder could find that LPN Edwards did not take the necessary steps to provide Mr. Mallory adequate medical care resulting in her being deliberately indifferent. Once a prison official has personal knowledge, the question becomes whether that person responded reasonably to that serious condition. *Farmer*, 511 U.S. at 847. First, LPN Edwards was unreasonable when she failed to perform a thorough examination of Mr. Mallory. She examined Mr. Mallory only through a solid steel cell door, failing even to take a complete set of vital signs. (Pl.'s Facts ¶¶ 189, 190, 192.) She failed to palpate his stomach, which could have been performed in an exam room at the prison. (Pl.'s Fact ¶ 192.) Even the limited information LPN Edwards obtained (abnormal pulse and blood pressure) indicated the need for a more thorough examination, yet failed to take him to the clinic for a hands-on assessment. (Pl.'s Facts ¶¶ 189, 196.) A factfinder could conclude that she has no reasonable explanation for this failure.

Further, LPN Edwards was unreasonable in her actions following Mr. Mallory's cell-side examination. Informing Mr. Mallory that he had the diagnosis of swine flu was outside the scope of her LPN license and was inconsistent with his symptoms. (Pl.'s Facts ¶¶ 198, 199.) Additionally, her license *required* that she report Mr. Mallory's symptoms to the provider. (Pl.'s Facts ¶¶ 201, 202.) Yet she failed to pass along Mr. Mallory's complaint of vomiting blood to the doctor. (Pl.'s Fact ¶

200.) Had she conveyed this information to the doctor, he would have diagnosed and treated Mr. Mallory's symptoms differently, and likely would have identified and treated his GI bleed more quickly. (Pl.'s Fact ¶ 203.)

Defendants argue that LPN Edwards's actions were reasonable. First, they claim that no action was required because she was unable to verify that Mr. Mallory was throwing up blood. (*See* Doc. 98 at 25.) As an initial matter, LPN Edwards's attempts to verify the blood are in dispute, Mr. Mallory does not recall her looking into his cell. (Defendants' & Pl.'s Facts ¶¶ 49, 50.) What is not in dispute is that she did not examine Mr. Mallory, nor did she have his door opened to verify whether there was blood. A factfinder is necessary when there is a material dispute of fact.

Defendants also argue that LPN Edwards did not act with deliberate indifference because she relied upon her professional judgment. (Doc. 98 at 25.) However, a factfinder could find that LPN Edwards's bias against prisoners caused her to act with deliberate indifference to Mr. Mallory's needs. LPN Edwards testified in her deposition that she believes eighty percent of all prisoners lie. (Pl.'s Fact ¶ 68.) Based on this statement, a factfinder could conclude that her bias, as opposed to professional judgment, was the reason why she ignored Mr. Mallory's life-threatening condition.

Denying summary judgment for LPN Edwards is appropriate, because there are material facts still in dispute as to whether she acted with deliberate indifference.

2. A reasonable factfinder could conclude that RN Benally acted with deliberate indifference.

There is no dispute that RN Benally was aware of Mr. Mallory's report of vomiting blood. (Defs.' fact ¶ 38.) It is not disputed that RN Benally triaged Mr. Mallory's kite that expressly stated that he had vomited blood. (Defs' fact ¶ 37, 38.) She also admitted that vomiting blood is a serious

medical condition that could result in serious pain and deterioration. (Pl.'s Fact ¶ 171.)

A factfinder could conclude that RN Benally acted with deliberate indifference because she failed to assess Mr. Mallory's urgent condition or take any reasonable steps to ensure that he received medical care. Her basic job responsibilities required her to triage medical kites to identify emergent or urgent medical conditions. (Pl.'s Fact ¶ 169.) Any kite that holds the *possibility* of an emergent health care warrants having the prisoner brought to the clinic to be assessed. (Pl.'s Fact ¶ 170.) However, after reading Mr. Mallory's report of vomiting blood, RN Benally never saw Mr. Mallory cell-side nor did she take him to the clinic to be assessed. (Pl.'s Facts ¶¶ 175, 182.) Rather, knowing there was no medical staff to follow up in the evenings, she simply entered the kite and went home shortly thereafter. (Pl.'s Fact ¶ 178.) She passed Mr. Mallory's kite onto scheduling as "routine," knowing that it could take up to seven days for Mr. Mallory to be scheduled for an appointment. (Pl.'s Fact ¶ 180.) Several Department supervisors noted that assessment would be necessary, (Pl.'s Fact ¶ 177), and even the Defendants' expert, Dr. Frantz, at first testified that her actions fell below the standard of care and were neither guided by prison policy nor reasonable under the circumstances. (Pl.'s Fact ¶ 45.)

Defendants characterized RN Benally's actions and inactions regarding Mr. Mallory's kite as a negligent mistake, having failed to perceive the kite to require immediate attention. (Doc. 98 at 24.) In her declaration for Defendants' motion, RN Benally now states that she both saw Mr. Mallory when she collected his kite, and that she was unable to verify that he was throwing up blood. (Doc. 98, Ex. C, affidavit of Ashley Benally, ¶ 21, 27.) However, these alleged facts are a substantial departure from what she said in her deposition, at which she did not remember the circumstances of receiving Mr. Mallory's kite nor did she speak with Mr. Mallory on October 8th.

(Pl.'s Fact ¶ 43.) A reasonable factfinder could determine her recent statements to be not credible. Further, even *if* the events RN Benally now claims to remember actually did take place, she still acted unreasonably when she failed to take basic steps, such as asking Mr. Mallory about his symptoms, or examining him. (Pl.'s Facts ¶¶ 175, 176.)

Since there are still material facts left in dispute, denial of summary judgment is appropriate because a factfinder must determine whether RN Benally acted with deliberate indifference to Mr. Mallory's medical needs.

C. A Reasonable Factfinder Could Find That Sergeant Johnston, LPN Edwards, and RN Benally Failed to Fulfill Their Duty as Gatekeepers.

A prison official may be held liable for violation of a prisoner's Eighth Amendment rights if, in his role as a "gatekeeper," he delays or prevents a prisoner's access to medical care. *Sealock v. Colorado*, 218 F.3d 1205, 1209-1211 (10th Cir. 2000.) A "gatekeeper" is a staff member who does not provide actual medical treatment but has the duty to provide access to medical care to the prisoner. *See Id.* "Gatekeeper" liability could be found if the prison official (1) knows of his role as a "gatekeeper" for medical professionals qualified to evaluate or treat a condition, (2) knows of the substantial risk of serious harm to the prisoner's health; and (3) delays or refuses to fulfill his "gatekeeper" role. *Mata v. Saiz*, 427 F.3d 745, 751-52 (10th Cir. 2005.) A factfinder may conclude that the "gatekeeper" knew of a substantial risk of serious harm by drawing inferences from circumstantial evidence or from the fact that the risk was obvious. *Id.* at 752 (citing *Farmer*, 511 U.S. at 842.) The Tenth Circuit has denied summary judgment under a "gatekeeper" theory where a defendant knew about the plaintiff's symptom, knew that the symptom could indicate a serious medical condition, and failed to contact a medical provider. *Id.* at 758-59. Summary judgment has

been granted to defendants who fulfilled their "gatekeeper" roles by passing on *all* relevant information to the appropriate medical personnel. *Id.* at 759-60.

Under this type of claim, it is irrelevant that another "gatekeeper" or medical staff provided assistance to the prisoner after the defendant denied such assistance. *Id.* at 756. The "gatekeeper" defendant is deliberately indifferent *at the time* he delays or prevents a prisoner's access to medical care. *Id.* (emphasis in original).

A reasonable factfinder could find that Sgt. Johnston, LPN Edwards, and RN Benally were deliberately indifferent to Mr. Mallory's medical needs because they failed to fulfill their duty as "gatekeepers."

1. Sgt. Johnston failed to fulfill his gatekeeper role.

A reasonable factfinder could conclude that Sgt. Johnston failed to act as a "gatekeeper" and allow access to medical. Although Sgt. Johnston is not a medical personnel, his job duties require him to refer prisoners to medical staff for evaluation. (Pl.'s Fact ¶ 262.) He acknowledges this responsibility and states that he contacts medical even if a prisoner has not asked for help, and will do so anytime that a prisoner has a medical problem that is not "minor." (Pl.'s Facts ¶¶ 163-64.)

There is sufficient evidence to conclude that Sgt. Johnston was aware that Mr. Mallory had a serious medical condition. On October 8th, both Mr. Mallory and Mr. Morris alerted him that Mr. Mallory was vomiting blood. (Pl.'s Facts ¶¶ 161-62.) On the morning of October 11th, Mr. Morris told Sgt. Johnston again about Mr. Mallory's condition. (Pl.'s Fact ¶ 211.) While Sgt. Johnston cannot remember these conversations, a reasonable jury member could find that he was aware of Mr. Mallory's condition based on testimony from Mr. Mallory and Mr. Morris, as well as the fact that Sgt. Johnston's memories from the relevant week are extremely faulty. (Pl.'s Fact ¶ 166.)

It is undisputed that Sgt. Johnston did not inform medical staff of Mr. Mallory's symptoms. Even though it is his job as a "gatekeeper" to refer prisoners for medical care when necessary, he failed to ensure Mr. Mallory received care. Since a reasonable factfinder could find that Sgt. Johnston was deliberately indifferent because he failed to fulfill his duty as "gatekeeper," summary judgment is inappropriate.

2. LPN Edwards failed to fulfill her gatekeeper role.

A reasonable factfinder could find that LPN Edwards also failed to fulfill her role as a medical "gatekeeper." As a Licensed Practical Nurse, Defendant Edwards is required to accurately report to a supervising nurse or a medical provider the physical condition of a prisoner during emergencies. (Pl.'s Fact ¶ 200.) It is fundamental that a LPN, who is not authorized under her license to make a full assessment or diagnose, passes on a patient report of a potentially life-threatening symptom to a medical provider. (Pl.'s Fact ¶ 202.)

As discussed above, it is undisputed that LPN Edwards had knowledge of Mr. Mallory's serious condition. (Pl.'s Fact ¶ 188.) LPN Edwards recorded Mr. Mallory's report that he had been vomiting blood for three days and was aware of the seriousness of this condition. (Doc. 98, Exh. B, att. 1, ¶ 188.) Because LPN Edwards recognized the seriousness of Mr. Mallory's condition, she advised him to stop taking Motrin and naprosyn, the medications that can increase bleeding. (Doc. 98, Ex. B, affidavit of Josi Edwards, ¶ 22.) In addition, there are credibility issues with LPN Edwards's testimony that could only be resolved by a factfinder. LPN Edwards asserts both that she did not believe Mr. Mallory's complaint of vomiting blood (Pl.'s Fact ¶ 63), and that she gave credence to his complaint and recognized that Mr. Mallory was facing a life-threatening condition. (Doc. 98, Exh. B, affidavit of Josi Edwards, ¶ 22.) Based on this discrepancy, summary judgment is

inappropriate.

A reasonable factfinder could find that LPN Edwards failed to fulfill her gatekeeper responsibilities. While she did call Dr. Wright about Mr. Mallory's symptoms, she failed to tell him the most significant piece of information—that Mr. Mallory reported throwing up blood for days. (Pl.'s Fact ¶ 200.) LPN Edwards also did not tell Dr. Wright that she had instructed Mr. Mallory to stop taking Motrin and naprosyn to avoid further internal bleeding. (*Id.*) Dr. Wright indicated that had LPN Edwards told him that Mr. Mallory had complained of throwing up blood, he would have arranged for Mr. Mallory to be examined in the clinic. (Pl.'s Fact ¶ 203.) Accordingly, a factfinder could conclude that her failure to report this significant information prevented Mr. Mallory from receiving necessary care.

3. RN Benally failed to fulfill her gatekeeper role.

A reasonable factfinder could find that RN Benally also failed to fulfill her role as Mr. Mallory's "gatekeeper." As a Registered Nurse, Defendant Benally is required to triage medical kites to identify emergent or urgent medical conditions for referral to primary care medical providers and other health care professionals (Pl.'s Fact ¶ 169.) Despite reading and entering Mr. Mallory's kite stating that he was vomiting blood (Doc. 98, Exh. C, affidavit of Ashley Benally, ¶ 21, Doc. 98, Exh. C, att. 2), she did not contact any providers and scheduled him for a "routine" appointment to take place in several days. (Pl.'s Fact ¶ 180.) A reasonable factfinder could find that RN Benally failed to fulfill her role as a medical "gatekeeper"; rather than call a provider or even another nurse; she simply chose to go home for the night. For these reasons, summary judgment is inappropriate.

D. A Reasonable Factfinder Court Determine that Lt. Cella Acted With Deliberate Indifference to Mr. Mallory's Report of Vomiting Blood.

Summary judgment is properly denied to a correctional officer that unreasonably relies on obviously improper medical judgments of medical staff. *Weatherford ex rel. Thompson v. Taylor*, 347 Fed.Appx. 400, 404 (10th Cir. 2009) ("[I]t has been clearly established for over a decade that unreasonable reliance on the advice of a medical professional will not excuse deliberate indifference to a prisoner's serious medical needs.") (unpublished); *see also Iko v. Shreve*, 535 F.3d 225, 242 (4th Cir. 2008) *Johnson v. Doughty*, 433 F.3d 1001, 1010-11 (7th Cir. 2006) (holding that prison officials may rely on a medical professionals judgment unless the prisoner is obviously receiving inadequate care). In such a case, the officer faces "liablility for *their own* decisions." *Iko*, 535 F.3d at 243 (emphasis in original). For example, in *Iko* a prisoner collapsed after having been pepper-sprayed. *Id.* The court held that the officer could not avoid liability by relying on a medical staff member's decision not to treat. *Id.*

1. A factfinder could conclude that Lt. Cella acted with deliberate indifference because his reliance on medical staff was unreasonable.

It is undisputed that Lt. Cella was aware that Mr. Mallory was at risk of harm, as he admits that he received a call that Mr. Mallory reported vomiting blood. (Defs.' fact ¶ 94.) After receiving this information, Lt. Cella stated that he called Colorado Territorial Correctional Facility (CTCF) about Mr. Mallory's condition. (Defs.' facts ¶¶ 17, 99, 101.) Lt. Cella told a CTCF nurse that Mr. Mallory reported vomiting blood. (Defs.' fact ¶ 101.) Despite this, the nurse stated that the situation was non-emergent and that no one would come to see Mr. Mallory that night. (Defs.' and Pl.'s Fact ¶ 102.)

A reasonable factfinder could determine that, even though Lt. Cella called medical staff, his following inaction was unreasonable in response to this emergency. After being told that Mr.

Mallory would not receive care for an obvious emergency—vomiting blood—Lt. Cella failed to take many steps that were available to him. He did not call CTCF again or make any attempt to contact other medical staff. He did not check on Mr. Mallory, nor did he have another officer do so. He did not even ask to have Mr. Mallory's door opened to verify his symptoms. He did not pass on Mr. Mallory's condition to the oncoming correctional or medical shift. He did not call 911 or have Mr. Mallory transported to an outside hospital, though it was within his discretion to do so. Just as in *Iko*, summary judgment should be denied Lt. Cella, because a factfinder can reasonably infer that Lt. Cella's lack of action was deliberate indifference.

2. A reasonable factfinder could conclude that Lt. Cella's testimony that he called medical is not credible.

It is Mr. Mallory's alternative position that Lt. Cella did not actually call CTCF that night and report his symptoms. The only evidence that he did call is his own testimony; however, his testimony is inconsistent with other evidence. Determinations of credibility are to be in the realm of the jury. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986.)

First, a reasonable factfinder could conclude that Lt. Cella did *not* actually call CTCF as he claims because there is no evidence of his call besides his own testimony. He cannot remember who he spoke with that night, so his call cannot be verified. (Pl.'s Facts ¶¶ 102, 103.) There is neither an incident report of the call, nor a CTCF notation of the call, both of which are standard for after hours medical contacts. (Pl.'s Facts ¶¶ 102,103,104.) In the past such incident reports were done for complaints of back pain, (Defs.' facts ¶¶ 6,8), so the failure to do one for a report of vomiting blood is notable. Indeed, Lt. Cella made not one single notation of his encounter with Mr. Mallory; it is not entered in the shift log, a control log, a pass on log, or even in Mr. Mallory's chron log. A

factfinder could conclude the total lack of documentation means that Lt. Cella did not call CTCF as he claims.

Finally, a factfinder could determine that Lt. Cella did *not* call because he was biased against Mr. Mallory. Officer LaDeau testified that the staff thought of Mr. Mallory as a "crybaby." (Pl.'s Fact ¶ 134.) This epithet was not used only among lower ranks, as another Lieutenant had used the term with regard to Mr. Mallory. (*Id.*.) A factfinder could reasonably conclude that Lt. Cella knew of Mr. Mallory's reputation and was deliberately indifferent, inline with this belief.

Overall, there is strong circumstantial evidence that could persuade a jury that Lt. Cella's testimony is not credible. If Lt. Cella did not call that night, his actions would place him directly in line with *Sealock*. Accordingly, denial of summary judgment for Lt. Cella is appropriate, because a jury is necessary to determine the credibility of his statements.

III. LIABILITY FOR SUPERVISOR DEFENDANTS - SHOEMAKER, SMITH, AND JONES.

A. Legal Standard for Supervisory Liability

While traditional *respondent superior* liability is unavailable under § 1983, supervisors will be responsible when liability is "'based [up]on personal involvement in the alleged constitutional violation.'" *Fogarty v. Gallegos*, 523 F.3d 1147, 1162 (10th Cir. 2008) (quoting *Foote v. Spiegel*, 118 F.3d 1416, 1423 (10th Cir. 1997)). While personal involvement is required, it is "not limited solely to situations where a defendant violates a plaintiff's rights by physically placing hands on him." *Id.* A supervisor may be held liable for a violation of the plaintiff's Eighth Amendment rights if: (1) the supervisor promulgated, created, implemented or possessed responsibility for the continued operation of a policy, (2) the policy denied the plaintiff access to medical care, and (3) the

supervisor acted with deliberate indifference. *Dodds v. Richardson*, 614 F.3d 1185, 1199-1200 (10th Cir. 2010). Supervisory liability is extended to the failure to train, ultimately implicating failures regarding the supervisor's implementation of a policy. *Dodds,* 614 F.3d at 1209 (Tymkovich, J., concurring); *Myers v. Koopman*, No. 09-cv-02802-REB-MEH, 2011 WL 650328, *6 (D. Colo. Feb. 11, 2011).

To satisfy the "causation" prong, a plaintiff must show an affirmative link between the supervisor's actions and the deprivation of the plaintiff's rights. *Dodds,* 614 F.3d at 1202. This necessary connection is satisfied when the supervisor "set[s] in motion a series of events that he knew or reasonably should have known would cause his [subordinates] to violate [plaintiffs'] constitutional rights... ." *Buck v. City of Albuquerque,* 549 F.3d 1269, 1291 (10th Cir. 2008.) Additionally, "deficiencies that result in a jail atmosphere in which… supervision is entirely lacking may be sufficiently related to a particular instance… that a jury is permitted to conclude that the conditions proximately caused the [harm]." *Tafoya v. Salazar*, 516 F.3d 912, 922 (10th Cir. 2008.)

The supervisor must also have acted with deliberate indifference. *Tafoya,* 516 F.3d at 916. Deliberate indifference means that a supervisor is "aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference." *Farmer,* 511 U.S. at 837. The risk of harm need not relate to a particular prisoner and could be applicable to a whole class of prisoners in his situation. *Tafoya*, 516 F.3d at 916. A factfinder could infer actual knowledge of a substantial risk of serious harm to a plaintiff based solely on circumstantial evidence, such as the obviousness of the condition. *Id.* at 916-17 (citing *Farmer*, 511 U.S. at 842.) However, a supervisor who actually knew of the risk may avoid liability if he responded reasonably to the risk, even if the harm ultimately was not averted. *Farmer,* 511 U.S. at 844.

B. ACCESS TO CARE
A Factfinder Could Conclude that Director Shoemaker and Warden Jones Failed to Ensure Adequate Access to Medical Care.

Dir. Shoemaker and Warden Jones have maintained a dangerous practice of allowing correctional officers to make decisions regarding prisoner access to medical care. While correctional officers are required by their job descriptions to refer prisoners to medical (Pl.'s Fact ¶ 262), the officers are not trained to perform this job function. (Pl.'s Fact ¶ 263.) As a result, when Mr. Mallory repeatedly asked for medical attention from officers, his requests did not result in the necessary care or were ignored.

The policy regarding when an officer should contact medical is unclear and therefore inadequate. (Pl.'s Fact ¶ 261.) There is neither a written policy nor training to guide the officers in making the determination of when to refer a prisoner to medical. (Pl.'s Facts ¶¶ 264-65.) As a result, correctional officers at CCF do not have a consistent idea of when to contact medical and are independently making assessments on when to contact medical. (Pl.'s Facts ¶¶ 266-68.) Expecting officers to employ medical judgment without sufficient training is a failure of policy. (Pl.'s Fact ¶ 270.)

Further, the lack of a coherent policy on declaring a medical emergency can lead to either delay or denial of urgent medical care for inmates. In order for a prisoner to obtain immediate medical care, he is required to "declare a medical emergency" to an officer or a nurse. (Pl.'s Fact ¶ 250.) Yet none of the CDOC's policies explain the "declaring a medical emergency" requirement, nor is there a written policy explaining how correctional staff should handle the prisoners' requests for emergent medical help. (Pl.'s Fact ¶ 251.) In addition to not having a policy, there is no training

of correctional staff on how to handle a prisoner's declaration of a medical emergency. (Pl.'s Fact ¶ 252.) As a result, many of these requests are simply ignored by staff unless the "magic words" are used. (Pl.'s Facts ¶¶ 254-55.) Dr. Greifinger, an expert in correctional health care, found the policy to be punitive and dangerous and concluded that it falls far below the standard of correctional care. (Pl.'s Facts ¶¶ 259-60.)

1. A reasonable factfinder could find that Director Shoemaker and Warden Jones were responsible for the access to care policies.

The law requires that in order to hold a supervisor liable under a theory of supervisory liability, she must have promulgated, created, implemented or possessed responsibility for the continued operation of a policy. *Dodds*, 614 F.3d at 1199.

As the Deputy Director for the Clinical Services, Dir. Shoemaker was responsible for the quality of healthcare provided to prisoners. (Pl.'s Fact ¶ 239.) Dir. Shoemaker approves the Department's Clinical Standards and updates Administrative Regulations for the Clinical Services. (Pl.'s Fact ¶ 240.) A reasonable factfinder could conclude that Dir. Shoemaker possessed responsibility for the promulgation and implementation of the access to care policies.

Warden Jones possessed responsibility to establish written policy and training to ensure correctional officers were appropriately contacting medical on prisoners' behalf. (Pl.'s Facts ¶¶ 245-47.) Further, Warden Jones is responsible to ensure her correctional staff fulfill their job responsibility of appropriately referring individuals to medical. (Pl.'s Fact ¶ 248.) A factfinder could conclude both that Warden Jones possessed responsibility to establish a written policy regarding when officers need to contact medical, and that she needed to correctional staff on how to fulfill this job function.

2. A reasonable factfinder could find that the inadequate policies caused delay, prohibiting Mr. Mallory from receiving the necessary care.

A plaintiff must show an affirmative link between the supervisor's actions and the deprivation of the plaintiff's rights. *Dodds,* 614 F.3d at 1202. In this case, a reasonable factfinder could find that the lack of a clear policy regarding prisoner access to medical care led to Mr. Mallory's substantial delay in receiving necessary medical care. During his ordeal, Mr. Mallory wanted to receive emergency care, and repeatedly asked for help from correctional officers. (Pl.'s Facts ¶¶ 158, 161, 213.) Despite Mr. Mallory's requests, numerous correctional staff failed to contact medical services on Mr. Mallory's behalf before his collapse. (Pl.'s Facts ¶¶ 167, 184, 185, 211, 214.) A reasonable factfinder could conclude that—had Warden Jones or Dir. Shoemaker created a policy requiring officers to consistently contact medical and had trained them on that policy—Mr. Mallory would likely have been treated sooner.

3. Director Shoemaker and Warden Jones acted with deliberate indifference to the serious risk of harm faced by not having adequate access to care.

A supervisor will be liable if she acts with deliberate indifference, meaning that the supervisor was aware of a risk, yet disregarded it. *Farmer,* 511 U.S. at 837. Here, a factfinder could determine that the risk of denial of care is obvious—officers are forced to determine when to contact medical simply did not know how to act when they heard medical complaints or requests for emergency care. (Pl.'s Fact ¶ 266.) Without clear written policy on how to obtain emergent medical care, future harm to prisoners in need of immediate medical attention is inevitable and foreseeable. These problems with having no policy, no guidance to prisoners, and no training to correctional staff create an obvious risk of harm (Pl.'s Facts ¶¶ 263-65), and a reasonable factfinder could

determine that Dir. Shoemaker and Warden Jones were aware of this risk.

Despite Dir. Shoemaker's knowledge that there are no clear guidelines on how to declare a medical emergency, she failed to take reasonable steps to fix the policy. She failed to create and implement a clear written policy outlining how prisoners could request immediate medical help and how staff should respond. (Pl.'s Fact ¶ 251.) In addition, she did not implement a mechanism to monitor whether prisoners who declared a medical emergency actually received immediate medical care. (Pl.'s Fact ¶ 258.) A reasonable factfinder may find that Dir. Shoemaker was deliberately indifferent for failing to establish a clear access to care policy.

Additionally, a factfinder could conclude that Warden Jones recklessly disregarded the risk of harm to prisoners like Mr. Mallory. She failed to implement a policy on medical referrals (Pl.'s Fact ¶ 251), failed to train her staff about this topic (Pl.'s Fact ¶ 257), and failed to monitor whether referrals were actually being made appropriately. (Pl.'s Fact ¶ 258.) A reasonable factfinder may conclude that Warden Jones was deliberately indifferent to the substantial risk of serious harm faced by prisoners by failing to establish and train her officers on access to medical care for prisoners.

C. GI BLEEDS & QUALITY MANAGEMENT PROGRAM
A reasonable factfinder could find that Director Shoemaker and Chief Smith are liable for failing to address a known GI bleed problem through the QMP.

Between 2007 and 2010, there were approximately 200 GI bleeds at CDOC, often ranking as one of the top reasons for prisoner hospitalizations. (Pl.'s Facts ¶¶ 275-77.) Dir. Shoemaker and Chief Smith were aware of the prevalence of GI bleeds and the fact that it was one of the leading diagnoses resulting in hospital admissions of prisoners. (Pl.'s Facts ¶¶ 273-75.) Despite having awareness of the significant number of GI bleeds and the significant risk they pose to prisoners' health, the only method they used for assessing the quality of treatment on this issue was the QMP.

(Pl.'s Facts ¶¶ 278-79.) However, their reliance upon this system was unreasonable.

The QMP utterly failed to effectively identify and remedy the causes of the numerous GI bleeds due to underreporting and delayed reviews. Of the approximately 200 GI bleed incidents that would require a quality of care review, only seven incidents were reported through the QMP system. (Pl.'s Fact ¶ 294.) The reported number was fewer than 5% of the total number of the GI bleed incidents. (Pl.'s Facts ¶¶ 295-96.) Of those GI bleeds that were reviewed, the QMP Committee identified two issues: over-prescription of NSAIDS and the failure to identify GI bleed symptoms as urgent medical conditions. (Pl.'s Fact ¶ 305.) Dir. Shoemaker was knowledgeable about the failings of the QMP, both because they were obvious and because she had been specifically informed about them through the audit. (Pl.'s Fact ¶ 302.) Likewise, Chief Smith was aware of these obvious QMP deficiencies. (Pl.'s Fact ¶ 303.) Despite knowing of the high number of GI bleeds, and the failure of the QMP to address this issue, neither supervisor took reasonable action to ensure that the quality of care was appropriate. Had they addressed *either* the treatment of GI bleeds directly, *or* the failing QMP, the harm suffered by Mr. Mallory likely would have been prevented.

1. A factfinder could conclude that Dir. Shoemaker and Chief Smith were responsible for assuring that GI bleeds were being appropriately treated through the QMP.

The law requires that in order to hold a supervisor liable under a theory of supervisory liability, she must have been responsible for the continued operation of the policy that caused the plaintiff's constitutional violation. *Dodds*, 614 F.3d at 1199.

Both Dir. Shoemaker and Chief Smith were responsible for the QMP policies and practices. Dir. Shoemaker was responsible, as Deputy Director of the Prisons, to ensure adequate QMP policies and practices. (Pl.'s Fact ¶ 241.) Chief Smith was responsible for identifying and relaying

system problems to upper-management. (Pl.'s Fact ¶ 243.) Chief Smith was specifically responsible for fixing problems identified by the QMP, along with supervising the program's administrator. (Pl.'s Fact ¶ 244.) For these reasons, a reasonable factfinder could conclude that both Dir. Shoemaker and Chief Smith possessed responsibility for the continued operation of the QMP.

2. A factfinder could conclude that Dir. Shoemaker's and Chief Smith's failure to fix the QMP system caused Mr. Mallory's harm because it failed to address and remedy the known GI bleed problem.

The causal connection required for supervisor liability is satisfied if the defendant set in motion a series of events that the defendant knew, or reasonably should have known, would cause others to deprive a plaintiff of his constitutional rights. *Snell v. Tunnell*, 920 F.2d 673, 700 (10th Cir. 1990).

A factfinder could conclude that Dir. Shoemaker's and Chief Smith's failure to ensure that numerous GI bleeds were reported and reviewed through the QMP process likely resulted in the harm to Mr. Mallory. Had all 200 GI bleeds been reported, the QMP Committee likely would have identified and recommended additional training for lower-level staff regarding NSAID use and the identification of GI bleed symptoms as urgent conditions. (Pl.'s Facts ¶¶ 293, 304.) Severe underreporting and delayed review of GI bleeds incidents prohibited these quality of care issues from being identified as a systematic problem. (Pl.'s Facts ¶¶ 290, 300, 307.) Had the lower-level defendants received this additional training, Mr. Mallory likely would have received timely access to medical care. (Pl.'s Fact ¶ 304.) For these reasons, a factfinder could conclude that Dir. Shoemaker's and Chief Smith's failures caused Mr. Mallory's constitutional violation.

3. A factfinder could conclude that Dir. Shoemaker and Chief Smith acted with deliberate indifference to the substantial risk caused by the QMP failure to identify and remedy the known GI bleed problem.

A supervisor will be liable under a theory of supervisory liability if she knew of a substantial risk, yet disregarded it. *Dodds*, 614 F.3d at 1205-06.

A factfinder could find that Dir. Shoemaker had knowledge of the substantial risk caused by the QMP because she read the 2005 State Audit report, which flagged several QMP deficiencies, including that the QMP Committees met only infrequently and that the QMP failed to regularly conduct reviews regarding the quality of care on a systemic level. (Pl.'s Fact ¶ 302.) A reasonable factfinder could determine that Dir. Shoemaker had knowledge of the substantial risks that the QMP posed since she read the Audit.

Defendants argue that even though Ms. Shoemaker read the Audit, she thought those problems identified in the Audit were resolved, negating her knowledge. The Tenth Circuit has denied this exact type of argument. In *Tafoya v. Salazar*, three years prior to when Ms. Tafoya filed her lawsuit against the Sheriff Salazar, two similar lawsuits were brought against him, as a supervisor, for the rape of two other female prisoners -- the exact same risk alleged by Ms. Tafoya. *Tafoya*, 516 F.3d at 914. After the first two lawsuits, but prior to Ms. Tafoya's allegations, Sheriff Salazar took some measures to remedy the risk; however, the Tenth Circuit held that a reasonable factfinder could find that he had the requisite knowledge to impose liability even after he took some remedial action, because he failed to implement all reasonable alternatives available to him and the risk persisted. *Id.* at 918. Here, a reasonable factfinder could find that Dir. Shoemaker had knowledge of the substantial risk of the QMP, although she unreasonably claims that all problems identified in the Audit were resolved by 2008, which was not confirmed by the evidence in the case.

In the alternative, a factfinder could conclude that the substantial risk created by the deficient QMP was obvious to Dir. Shoemaker based upon the fact that clinical staff were not required to familiarize themselves with the QMP policy, they were not trained on the QMP policy, and the Department was not tracking compliance with the QMP policy. (Pl.'s Facts ¶¶ 286-87.) A reasonable factfinder could conclude that the QMP lacked adequate supervision and training such as to give Dir. Shoemaker knowledge.

A factfinder could conclude that the substantial risk that the QMP created was obvious to Chief Smith. She was listed as a member of the QMP Committee that was responsible for reviewing reported GI bleeds. (Pl.'s Fact ¶ 303.) Additionally, in 2009, as acting RHSA, she received notification of every prisoner who was transported out of a facility to a hospital, likely qualifying as a reportable event. (Pl.'s Facts ¶¶ 243, 303.) Due to Chief Smith's role in the QMP, and the fact that she received this hospitalization notification, she was aware that the clinical staff was not reporting all qualifying sentinel events. (Pl.'s Fact ¶ 303.) A reasonable factfinder could conclude that the QMP lacked such adequate supervision and training as to infer that Chief Smith had knowledge of the risk, as it was obvious.

A factfinder could find that Dir. Shoemaker and Chief Smith failed to take any reasonable steps to eliminate the substantial risk created by the QMP. First, Defendants could have required that the clinical staff read the QMP policy and follow its requirements. (Pl.'s Fact ¶ 286.) Second, they could have required clinical staff to be trained on when to report GI bleeds. (*Id.*.) Last, they could have developed tracking mechanisms to ensure that clinical staff was complying with the QMP policy. (Pl.'s Fact ¶ 287.) With this array of reasonable alternatives, a factfinder could find that Dir. Shoemaker and Chief Smith failed to take the necessary steps to eliminate the QMP's

substantial risk to prisoners.

The denial of summary judgment is appropriate for Dir. Shoemaker and Chief Smith because a reasonable factfinder could conclude that they are liable for Mr. Mallory's harm under the theory of supervisory liability.

QUALIFIED IMMUNITY

Defendants should be denied qualified immunity. To overcome a defense of qualified immunity a plaintiff must show that 1) the official violated the plaintiff's constitutional or statutory right, and 2) this right was clearly established when the alleged violation occurred. *Olsen v. Layton Hills Mall*, 312 F.3d 1304, 1312 (10th Cir. 2002.) A right is clearly established when a reasonable person in the official's position would have known of the right. *See Murrell v. School Dist. No. 1, Denver, Colo.,* 186 F.3d 1238, 1251 (10th Cir. 1999) (citing *Harlow v. Fitzgerald*, 457 U.S. 800, 818 (1982).) "A plaintiff need not present an identical case to show the law was clearly established; instead, a plaintiff must show only that the contours of the right [are] sufficiently clear that a reasonable official would understand that what he is doing violates that right." *Sutton v. Utah State Sch. for Deaf & Blind*, 173 F.3d 1226, 1241 (10th Cir. 1999) (internal quotations omitted.)

"[T]he law [is] clearly established that a prison official's deliberate indifference to a prisoner's serious medical needs violates the Eight Amendment." *Estelle v. Gamble*, 429 U.S. 97, 104-05 (1976.) Mr. Mallory's complaint against these Defendants is that each one was deliberately indifferent to his serious medical need. Defendants Cella, Johnston, Benally, and Edwards were aware of Mr. Mallory's condition but did not get him adequate medical care. Defendants Shoemaker, Smith, and Jones were responsible for creating, implementing, and monitoring policies to ensure prisoners were receiving adequate medical care.

Defendants assert that the law is not clearly established in regard to liability for Lt. Cella and Sgt. Johnston. However, in *Weatherford*, the Tenth Circuit set a strong precedent stating that "it has been clearly established for over a decade that unreasonable reliance on the advice of a medical professional will not excuse deliberate indifference to a prisoner's serious medical needs." 347 Fed.Appx. 400, 404 (10th Cir. 2009) (unpublished).

CONCLUSION

For the foregoing reasons, summary judgment for all Defendants should be denied.

Dated: April 21, 2012

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 21st day of April, 2012, I electronically filed the foregoing Plaintiff's Response to Defendants' Motion for Summary Judgment with the clerk of Court using the CM/ECF system, which will send notification of such filing to the following email addresses:

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