UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TEXAS
EL PASO DIVISION

GRACIELA GALINDO; JESUS GALINDO, Sr.; EDITH GALINDO, individually and as Next Friend of MARGARITA GALINDO, and as Representative of the ESTATE OF JESUS MANUEL GALINDO; ERICA LOZANO, as Next Friend of JOHNATHAN GALINDO and JACOB GALINDO; and JANNETTE FLORES ESTRADA, as Next Friend of LESLIE ESTRADA, Plaintiffs, v. REEVES COUNTY, TEXAS; THE GEO GROUP, INC.; PHYSICIANS NETWORK ASSOCIATION; and in their individual capacities: VERNON FARTHING, M.D.; WALTER BRADY, D.O.; RICHARD FEARS, P.A.; JAMES FITCH; LOU ANN MILLSAP, R.N.; FNU BULLOCK; Warden DWIGHT SIMS; Capt. CHAD DEVIVO; Lt. KENNETH MARTIN; JAMES BURRELL, Federal Bureau of Prisons (BOP) Privatization Management Branch Administrator; MATTHEW NACE, Chief, BOP Acquisitions Branch; EDUARDO DE JESUS, M.D., BOP Medical Auditor; and DONNA GRUBE, BOP Contracting Officer, Defendants.	Cause No. 10-CV-454

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INTRODUCTION

1. Jesus Manuel Galindo was 32 years old when he died on December 12, 2008, after suffering an epileptic seizure in an isolation cell at Reeves County Detention Center ("RCDC"). Epilepsy is a manageable condition and is not life-threatening as long as appropriate, or therapeutic, levels of medication are maintained in the blood. The medical examiner's report documented sub-therapeutic levels of antiepileptic drugs in Galindo's blood at the time of his death.

2. A long-time epileptic, Galindo had been held in solitary confinement for one month before he died as punishment for complaining that his seizure medication was not working. He suffered at least two seizures while in isolation during that month, and repeatedly asked medical and prison staff to adjust his medication and move him out of solitary so that he would not be alone when he seized. Galindo ultimately suffered a fatal seizure during the night and died alone, unattended and undermedicated—exactly as he feared he would in the anguished days and weeks preceding his death. RCDC prison and medical staff discovered his body the following morning in *rigor mortis*.

3. Mr. Galindo is survived by four minor children, three of whom are American citizens, and by his parents and two siblings, all legal permanent residents living in Anthony, New Mexico. A Mexican national from Juarez, Galindo was serving a 30-month sentence for illegal reentry, a non-violent crime that until a few years ago was not aggressively prosecuted. From December 20, 2007 until his death almost one year later, Galindo was housed at RCDC in the custody of the Federal Bureau of Prisons ("BOP").

4. In May 2006 and January 2007, BOP awarded Reeves County two "Criminal Alien Requirement" ("CAR") contracts, CAR 5 and CAR 6, to house exclusively low-security,

noncitizen, primarily Mexican men at RCDC, a prison complex owned and operated by the County. RCDC consists of three units—RCDC I & II (operated jointly) and RCDC III—with a combined capacity of 3,760 beds. Galindo was incarcerated in RCDC III, operated pursuant to CAR 5. The RCDC complex is located in Pecos, a remote West Texas town whose economy has become almost wholly dependent on the industry of housing federal prisoners.

5. Reeves County in turn subcontracted the management of RCDC to The GEO Group, Inc. ("GEO"), a publicly traded prison company reporting over $1 billion in revenue in 2008. The County also subcontracted the provision of health care at RCDC to Physicians Network Association ("PNA"), a privately held correctional medical company based in Lubbock that promised significant cost cuts. BOP was fully aware of and approved these subcontracting arrangements prior to awarding CAR 5 to Reeves County in May 2006. Galindo arrived at RCDC III a year and a half later.

6. All four entities involved in Mr. Galindo's custody and care—PNA, GEO, Reeves County, and BOP—bear legal and moral responsibility for his utterly preventable death.

7. Galindo's epileptic disorder was known to BOP officials prior to his sentencing and assignment to RCDC III and was documented by medical staff at his intake exam at RCDC. Galindo's seizures had long been controlled by the drug Topamax, which was listed on the BOP formulary. PNA staff changed Galindo's medication to Dilantin, a less expensive drug.

8. Medical records show that Galindo began experiencing headaches within a week of his arrival at RCDC and seized at the prison on January 29, 2008. His records from just the month of January show 14 missed doses of Dilantin. Things did not improve. In the twelve months that Galindo's medical care was managed by PNA medical staff, his records indicate almost 90 documented omissions of Dilantin, meaning medical staff simply failed to give him

his medication that many times. There is not one notation indicating that Galindo ever refused his medication.

9. As a result, Galindo's blood level of Dilantin vacillated wildly. Of the scant 16 serum Dilantin levels taken during his year at RCDC, 10 were either above or below PNA's internally designated therapeutic range. Galindo reported swollen and bleeding gums to medical staff at least five times between February and November 2008. Swollen and bleeding gums are a classic and known side effect of Dilantin and a signal to discontinue use. Galindo was never taken off Dilantin.

10. Most distressingly, for month after month after month throughout his time at RCDC, Galindo continued to suffer seizures—at least one or two per month. No fewer than nine seizures were documented by medical staff. Several times Galindo fell and injured his face and body while seizing. While in general population, he relied on his fellow prisoners to call for medical help and protect him during the sometimes violent episodes, which could strike at any time. He lived always in fear.

11. On November 11, 2008, Galindo suffered a grand mal seizure and was transported to Reeves County Hospital. His medication administration records shows that he had missed 4 doses of Dilantin with no refusals prior to his ER visit. When he returned to RCDC the next day, prison and medical staff placed Galindo in an isolation cell in the Special Housing Unit ("SHU") for "compliance of meds"—where he died a month later.

12. SHU cells are designed for punitive purposes not medical observation. There is absolutely no record that Galindo was charged with or found guilty of any kind of disciplinary infraction, let alone one that would merit placement in solitary confinement for one month. On

information and belief, RCDC prison and medical staff at that time frequently used the SHU to punish and isolate prisoners who complained about deficient medical care.

13. During his time in the SHU, Galindo told anyone he came into contact with—medical staff, prison guards, the warden—that his seizures were not controlled and he should not be isolated. Someone from the federal public defender's office, as well as his mother, called RCDC to express concern about his medical treatment and his placement in the SHU. And yet, from November 13 until his death four weeks later, he was never removed from isolation and his medication level was not monitored. The utter disregard shown by RCDC prison and medical staff to Galindo's repeated, beseeching, well-founded expressions of fear for his own personal safety bordered on sadistic.

14. Galindo's tragic experience at RCDC bears a striking resemblance to the experiences of prisoners in PNA's care at other facilities. In 2003, the U.S. Department of Justice Civil Rights Division ("DOJ") issued a Findings Letter documenting numerous constitutional deficiencies in PNA's provision of health services under contract at the Santa Fe County Adult Detention Center. Specifically, DOJ found that PNA's system of medication administration led to frequent missed doses; PNA staff failed to check blood levels of antiepileptic and other critical medications at regular intervals to ensure proper dosage; and PNA staff failed to respond to indications that dosage was inappropriate. After the DOJ issued its findings, PNA pulled out of the Santa Fe contract. Despite this documented history, which should have raised critical doubts about PNA's ability to safely treat prisoners with chronic medical needs, BOP contracted with Reeves County with full knowledge that PNA would be the medical subcontractor.

15. This lawsuit brings federal constitutional and/or state tort claims against PNA, GEO, and the County, and a number of individual employees of each these entities, for their actions, policies and practices related to Galindo's disastrously incompetent and deliberately indifferent medical treatment, and his prolonged, perilous and entirely unjustified placement in isolation. In addition, this lawsuit brings federal constitutional claims against BOP officials and employees for knowingly and with deliberate indifference: (1) placing Galindo's health and safety in the hands of subcontractor PNA, whose past performance should have raised critical doubts about its ability to safely treat prisoners like Galindo with chronic medication needs; and (2) failing to remedy PNA's constitutionally deficient medication administration practices, or GEO's, PNA's, and the County's intentional practice of isolating seriously ill prisoners, despite the obvious risks associated with these practices.

16. After receiving the news that Galindo had suffered a seizure and died alone in the SHU on December 12, 2008, prisoners at RCDC rioted, causing over $1 million in damages. A delegation of prisoners demanded a meeting with the Mexican consulate, the FBI, and the Warden. They explained that the uprising was a response to poor medical care at RCDC and the use of solitary confinement to isolate sick prisoners.

17. Galindo's mother, Graciela Galindo, keeps the letters her son sent from his isolation cell in plastic covers to preserve them from repeated readings. His last letter to her states:

> Mom today is already Wednesday [December 10, 2008] and the warden and the doctor already came and I spoke with them and I told them that they have not checked my blood and that they need to do this so they can release me from here. I already told them that I have been here for one month alone and I have gotten sick twice. Let's see if they move me or do something soon. Oh, they only tell me yes, yes and they don't do anything. . . . I've already asked if they can place me with someone else so I won't be by myself anymore. . . . All of a sudden, I am very sad but I think of you and my father and my children and that's when I ask

> God and I put more will-power to get out ahead and not look back. . . . Well, Mom, I'm ok I love you and well, if something happens I will let you know right away. Kisses from your "Blackie" that loves you.
>
> Oh, write to me every day, ok?

18. Galindo mailed the letter on December 11, 2008. By the next morning, he was dead.

JURISDICTION AND VENUE

19. This Court has subject matter jurisdiction over the federal claims in this action pursuant to 28 U.S.C. § 1331 because they arise under the Constitution and laws of the United States; and pursuant to 28 U.S.C. §§ 1343(a)(3) and (4) because they seek to redress the deprivation, under color of state law, of Plaintiffs' civil rights and to recover damages for the violation of those rights. This Court has supplemental jurisdiction to consider state causes of action under 28 U.S.C. § 1367, as the state claims "form part of the same case or controversy" as the federal claims over which the Court has jurisdiction.

20. In addition, this Court has subject matter jurisdiction over *all* claims in this action pursuant to 28 U.S.C. § 1332 because diversity of citizenship exists between the parties and the amount in controversy exceeds the jurisdictional threshold.

21. All administrative prerequisites for suing Defendant Reeves County under the Texas Tort Claims Act have been satisfied and, alternatively, Reeves County had full knowledge of the facts giving rise to this claim and the possibility of the claim itself.

22. Venue is proper in this judicial district pursuant to 28 U.S.C. § 1391(b)(2) because a substantial part of the events or omissions giving rise to Plaintiffs' claims occurred in this district.

PARTIES

I. Plaintiffs

23. Plaintiffs **Graciela Galindo** and **Jesus Galindo, Sr.,** are the surviving parents of Jesus Manuel Galindo ("Galindo") and his wrongful death beneficiaries pursuant to Tex. Civ. Prac. & Rem. Code § 71.004. They are Legal Permanent Residents who reside in Anthony, New Mexico.

24. Plaintiff **Edith Galindo** is the surviving spouse of Galindo and the mother and next friend of Galindo's surviving minor daughter, **Margarita Galindo**. Edith Galindo and Margarita Galindo are both U.S. citizens and residents of Anthony, New Mexico, and are Galindo's wrongful death beneficiaries pursuant to Tex. Civ. Prac. & Rem. Code § 71.004. Edith Galindo is also the Representative of the Estate of Jesus Manuel Galindo.

25. **Erica Lozano** is the mother and next friend of Galindo's surviving minor sons, **Johnathan Galindo** and **Jacob Galindo,** both of whom are U.S. citizens and New Mexico residents. Johnathan and Jacob Galindo are Galindo's wrongful death beneficiaries pursuant to Tex. Civ. Prac. & Rem. Code § 71.004

26. **Jannette Flores Estrada** is a citizen of Mexico and a resident of the state of Chiapas, Mexico. She is the mother and next friend of **Leslie Estrada**, Galindo's surviving minor daughter. Leslie Estrada is Galindo's wrongful death beneficiary pursuant to Tex. Civ. Prac. & Rem. Code § 71.004.

II. Defendants

27. All BOP Defendants acted under color of federal law with respect to all matters alleged herein. All other Defendants acted under color of state law with respect to all matters alleged herein.

28. Defendants GEO and PNA are not in contractual privity with the federal government in connection with the services they provide at RCDC. Both companies contract directly with Reeves County. For all relevant purposes, GEO and PNA and their employees are state actors and derive their authority from Reeves County, a creature of the State of Texas.

29. All individual Defendants are sued only in their individual capacities.

A. BOP Defendants

30. Defendant **James Burrell** is an official and employee of the BOP. At all relevant times, Defendant Burrell was Administrator of BOP's Privatization Management Branch and in that capacity monitored and oversaw the contract performance of Reeves County and subcontractors GEO and PNA and their employees at RCDC III. Defendant Burrell was also the Source Selection Official who evaluated and authorized the award of the BOP's CAR 5 contract to Reeves County for RCDC III.

31. Defendant **Matthew Nace** is an official and employee of the BOP. At all relevant times, Defendant Nace held the position of Contracting Officer or higher within BOP's Acquisitions Branch, which he currently heads. Defendant Nace reviewed, recommended, and awarded the RCDC III CAR 5 contract and approved subsequent renewals to Reeves County. In his capacity as Contracting Officer, Defendant Nace also oversaw and/or participated in monitoring and evaluation of contractor and subcontractor performance at RCDC III.

32. Defendant **Donna Grube** is a Texas resident and BOP employee who worked on-site at RCDC. At all relevant times, Defendant Grube was BOP's on-site Contracting Officer in Pecos, and in that capacity oversaw and/or participated in monitoring and evaluation of contractor and subcontractor performance at RCDC III.

33. On information and belief, Defendant **Eduardo De Jesus, M.D.,** is a physician and BOP employee. On information and belief, Defendant De Jesus was at all relevant times a medical auditor for BOP who performed semi-annual, on-site medical audits at RCDC.

B. Reeves County

34. Defendant **Reeves County** is a political subdivision of the State of Texas located within the Western District of Texas. At all relevant times, Reeves County owned and operated RCDC III and contracted directly with BOP for the housing of federal prisoners within that facility. Reeves County is a "person" for the purposes of 42 U.S.C. § 1983.

C. GEO Defendants

35. Defendant **GEO Group, Inc. ("GEO")** is a for-profit Florida corporation, which at all relevant times contracted to and did manage the RCDC III facility in Pecos, Texas.

36. Defendant **Dwight Sims** ("Warden Sims") is a Texas resident and was at all relevant times employed by GEO as the Warden of RCDC III. In that capacity, Defendant Sims was responsible for operational policies and procedures at RCDC III; the placement of inmates in segregated housing; the performance of audits and internal reviews; and the supervision, training, staffing, screening, hiring, and disciplining of subordinate employees.

D. County/GEO Defendants

37. Defendant **Chad Devivo** ("Capt. Devivo") is a Texas resident and was at all relevant times jointly employed by Reeves County and GEO as a correctional officer at RCDC III. At all relevant times, Capt. Devivo was the correctional official responsible for staffing, cell-assignment, and operations in the Special Housing Unit ("SHU") at RCDC III.

38. Defendant **Kenneth Martin** ("Lt. Martin") is a Texas resident and was at all relevant times jointly employed by Reeves County and GEO as a correctional officer at RCDC III. At all relevant times, Lt. Martin was the lieutenant who oversaw the SHU at RCDC III.

E. PNA Defendants

39. Defendant **Physicians Network Association ("PNA")** is a privately held for-profit correctional medical services corporation founded in 1991 by Defendant **Vernon Farthing** and headquartered in Lubbock, Texas. At all relevant times, PNA contracted to and did plan, implement, direct, and control the clinical and administrative functions of the health services system at RCDC III. At all relevant times, PNA was the employer of Defendants Vernon Farthing, Walter Brady, Richard Fears, James Fitch, Lou Ann Millsap, and FNU Bullock.

40. Defendant **Vernon Farthing, M.D.,** is a Texas resident, physician, employee, agent, and/or borrowed servant of PNA. At all relevant times, Farthing was President and Medical Director of PNA and in that capacity supervised all healthcare providers and oversaw all patient care at RCDC III. Farthing also provided services as Galindo's physician at RCDC III.

41. Defendant **Walter Brady, D.O.,** is a Texas resident, physician, and employee, agent, and/or borrowed servant of PNA. At all relevant times, Brady was Galindo's physician at RCDC III.

42. Defendant **Richard Fears, P.A.**, is Texas resident, physician assistant, and employee, agent, and/or borrowed servant of PNA. At all relevant times, Defendant Fears was Galindo's physician assistant at RCDC III.

43. Defendant **James Fitch** is a Texas resident and employee, agent, and/or borrowed servant of PNA. Defendant Fitch was Health Services Administrator at RCDC III during the time that Galindo was incarcerated there and in that capacity had supervisory authority over

health services and made determinations regarding medical staffing schedules, medication administration practices, and inmate medical grievances/requests to staff.

44. Defendant **Lou Ann Millsap, R.N.,** is a Texas resident, registered nurse and employee, agent, and/or borrowed servant of PNA. Defendant Millsap was Health Services Administrator at RCDC III at the time of Galindo's death and in that capacity had supervisory authority over health services and made determinations regarding medical staffing schedules, medication administration practices, and inmate medical grievances/requests to staff. Defendant Millsap was also Galindo's attending nurse at RCDC III the night of his death.

45. Defendant **First Name Unknown ("FNU") Bullock** is a Texas resident and employee, agent, and/or borrowed servant of PNA. Defendant Bullock was a medical administrator at RCDC III in the month prior to Galindo's death.

FACTS

I. "Crimmigration" – the Increase in Federal Criminal Immigration Enforcement

A. The Federal Outsourcing of Immigrant Incarceration

46. Entering the United States without inspection is a misdemeanor crime punishable by a fine and imprisonment of up to six months, pursuant to 8 U.S.C. § 1325. Re-entering the United States without inspection after having been denied admission, excluded, deported, or removed is a felony punishable by a fine and up to two years of imprisonment. 8 U.S.C. § 1326.

47. The United States had a policy of "catch[ing] and release[ing]" (via deportation) the majority of immigration offenders until approximately 2005, when then-Secretary of the Department of Homeland Security (DHS) Michael Chertoff announced that the government would shift to a policy of "catch and detain." Accordingly, the government began aggressively enforcing 8 U.S.C. §§ 1325 and 1326.

48. Immigration prosecutions are up 139% compared to five years ago, 459% compared to 1999, and 973% compared to 1989. Immigration accounts for roughly 55% of all federal prosecutions nationwide.

49. In the Southern District of Texas, prosecutions of these two crimes alone accounted for 84% of *all* prosecutions in 2009.

50. Despite the nonviolent nature of the crime of illegal entry or illegal re-entry, 96% of immigration offenders receive a prison sentence—a higher rate of imprisonment than federal firearms or violent offenses. The average length of a prison sentence for an immigration offense is 25 months.

51. This criminalization of immigration law, particularly in the border regions of the country, is causing significant shifts in the demographic makeup of the federal prison population. Latinos now represent the largest single racial-ethnic group among sentenced federal offenders. According to a recent study by the Pew Center, the number of Latinos sentenced in federal courts nearly quadrupled between 1991 and 2007, accounting for 54% of the growth in the total number of offenders.[1]

52. This explosive growth in the federal prison population has created a need for additional prison beds to house individuals convicted of immigration crimes.

53. The Federal Bureau of Prisons (BOP) was established in 1930 "to provide more progressive and humane care for Federal inmates, to professionalize the prison service, and to ensure consistent and centralized administration of the 11 Federal prisons in operation at that time." Within a year of its creation, BOP was operating 14 facilities housing 13,000 inmates. Over the course of the next ten years, from 1930 to 1940, the inmate population increased to a

[1] Mark Lopez, Pew Hispanic Center, *A Rising Share: Hispanics and Federal Crime*, at 8 (Nov. 18, 2009), http://pewhispanic.org/files/reports/104.pdf (last visited Dec. 4, 2010).

little over 24,000 inmates housed in 24 facilities. The number of inmates in the custody and control of BOP remained static for the next 40 years.

54. A series of changes in federal criminal law beginning in the 1980s dramatically increased the BOP inmate population, which more than doubled during the 1980s from 24,000 to 58,000, and more than doubled again in the 1990s, reaching 136,000 total inmates in the care and custody of BOP by the end of 1999.

55. During the present decade, due in part to the federal government's shift in policy towards undocumented immigrants from "catch and release" to "catch and detain," the number of inmates in federal custody has continued to grow rapidly.

56. As of September 25, 2010, BOP reported its total inmate population as 209,714. Of these, 173,012 inmates were housed in BOP-operated facilities and 22,378 inmates were housed in privately-managed secure facilities.

57. Although BOP generally owns and operates the long-term incarceration facilities that house U.S. citizens, it began outsourcing the long-term imprisonment of noncitizens a little over ten years ago.

58. In 1999 BOP issued the first "request for proposals" (RFP) to fulfill a so-called "Criminal Alien Requirement" (CAR) contract to house up to 7,500 low-security, non-violent criminal aliens.

59. CAR contracts are firm-fixed priced, performance based contracts, with incentives, for the management and operation of correctional facilities housing a low-security non-US male inmate population.

60. The most recent CAR RFP, CAR 12, was issued on January 8, 2010. On information and belief, approximately 20,000 criminal aliens in the custody of BOP are currently

housed in CAR contract facilities under the operation of private companies and state and local governments.

B. Cashing in on Crimmigration

i. Reeves County and the Reeves County Detention Center

61. Reeves County covers 2600 square miles of West Texas and is home to approximately 13,000 people. Of those, 9,000 live in Pecos, which is the county seat. Reeves County is governed by an elected county judge and four elected county commissioners.

62. The Reeves County Detention Center (RCDC) was built by Reeves County in 1985 at the urging of County Commissioner Jimmy Galindo (no known relation to the deceased), who advocated the construction of a prison facility on speculation that the County could recruit federal inmates ensnared in the burgeoning "War on Drugs."

63. The federal government has long been a sought-after source of inmates for state, county and municipal facilities with extra prison bed space to sell, because the federal per diem for inmates is significantly higher than most state and county rates.

64. Two immigration reform acts, Immigration Reforms and Control Act (IRCA) in 1986 and Illegal Immigration Reform and Immigrant Responsibility Act (IIRIRA) in 1996, dramatically increased the number of crimes for which immigrants could be detained, deported and permanently barred from re-entering the United States.

65. In 2004, Judge Galindo contracted the services of Public-Private Strategies Consulting to represent Reeves County in negotiating a contract for federal inmates at RCDC, despite the County auditor's objection to the $120,000-per-year-plus-expenses fee of the firm's president Randy DeLay, whose brother Tom DeLay was the Majority Leader of the U.S. House

of Representatives at the time. Judge Galindo reportedly told the County Commissioners, "I think it is vital we have someone with a direct line into the inner workings."[2]

66. On June 21, 2005, BOP published an RFP for CAR 5, for "services to house approximately 1,200 low security non United States citizen sentenced males [sic] in one or more existing secure correctional institution(s) procured from private sources or state and local governments."

67. Reeves County applied for the CAR 5 contract and proposed subcontracting with GEO to manage the facility and PNA to provide medical services at the facility. On information and belief, both private companies had been providing services on behalf of the County related to the incarceration of both state and federal prisoners at the RCDC complex since at least 2003.

68. On May 24, 2006, BOP issued a Contract Award Notice that Reeves County received the CAR 5 contract to house federal criminal aliens at RCDC III. The contract fee award was for $76,000,608 guaranteed minimum for a four-year base period, with three two-year option years. The contract was estimated to generate approximately $218 million in operating revenues for the County over a ten-year period. RCDC has been touted as the largest detention/correctional facility under private management in the world.

69. Beyond the required publication of the total CAR contract fee, BOP, Reeves County, and the private subcontractors that operate RCDC (GEO) and provide medical care (PNA) have, on information and belief, resisted every effort by advocacy groups and private individuals to bring any transparency to the government's contracting process generally, or the profits, revenue, and fees associated with CAR 5 specifically. BOP is currently engaged in litigation brought under the federal Freedom of Information Act (FOIA) for refusal to disclose

[2] Tom Barry, *A Death in Texas: Profits, Poverty, and Immigration Converge*, THE BOSTON REVIEW, Nov.-Dec. 2009, at 3, http://bostonreview.net/BR34.6/barry.php (last visited Dec. 4, 2010).

responsive records concerning CAR contracts, including CAR 5. *See, e.g.*, *Raher v. Federal Bureau of Prisons*, 09-CV-536-ST (D. Ore., filed May 13, 2009). Reeves County has filed suit in Travis County Court to contest a ruling by the Texas Attorney General requiring it to disclose information relating to the RCDC contracts under the state's Public Information Act, Tex. Gov't Code § 552 *et seq.* *See Reeves County v. Greg Abbott*, No. D-1-GN-10-000800, District Court, 261st Judicial District, Travis County, Texas (2010).

ii. The GEO Group

70. The GEO Group, Inc. (GEO) was founded in 1984 as Wackenhut Corrections Corporation, Inc. It has corporate headquarters in Florida and regional headquarters in New Braunfels, Texas.

71. INS, ICE's predecessor agency, awarded Wackenhut the company's first contract in 1987, to house 150 "illegal detainees" at the Aurora Processing Center in Aurora, Colorado.

72. The Bureau of Prisons awarded Wackenhut the agency's very first private contract, in 1997, to operate a 2,048-bed facility for low-security inmates in Taft, California.

73. Wackenhut is notorious for civil rights violations and other kinds of misconduct.[3] Most recently, the survivors of Gregoria de la Rosa, an inmate who was beaten to death at a Willacy, Texas facility by other inmates as "Wackenhut's officers stood by and watched and Wackenhut's wardens smirked and laughed," brought suit alleging that Wackenhut and Warden David Forrest negligently caused De La Rosa's death and acted with malice and gross negligence. *See Gregorio de la Rosa Sr. v. Wackenhut*, No. 13-06-00692-CV (Tex. Ct. App. Apr. 2, 2009). The company was found to have destroyed evidence to the beating leading up to

[3] *See, e.g.*, Project on Government Oversight ("POGO"), *POGO's Federal Contractor Misconduct Database*, http://www.contractormisconduct.org/index.cfm/1,73,221,html?ContractorID=88&ranking=122 (last visited Dec. 4, 2010); *Wackenhut/G4S Security Firm Faces Debarment From City Contracts*, PR Newswire, June 26, 2010, http://www.prnewswire.co.uk/cgi/news/release?id=201647 (last visited Dec. 4, 2010).

the trial, including a videotape of the incident. The original award was for $47.5 million, but was reduced to $42.5 million on appeal because one of de la Rosa's family members had passed away. After the death of de la Rosa, both Wackenhut and Forrest were charged with murder. *See also Tapia v. GEO*, No. SA-06-CA-0147 (W.D. Tex., Dec. 27, 2006) (wrongful death suit brought by survivors of female inmate who committed suicide after being raped in Val Verde County Detention facility); *Toon v. Wackenhut*, 250 F.3d 950 (5th Cir. 2001) (appeal of attorney sanctions for disclosing terms of confidential $1.5 million settlement with Wackenhut for sexual, physical, and mental abuse of girls at Coke County Juvenile Justice Center).

74. Wackenhut changed its name to The GEO Group, Inc. in 2003. GEO currently operates approximately 14 facilities in the state of Texas.

75. Pursuant to its contract with Reeves County, GEO operates RCDC for a fee of over $400,000 a month, resulting in revenue of approximately $5 million annually for the company. RCDC's Warden is a GEO employee, and the prison is staffed by Reeves County employees managed by GEO.

76. GEO's business has expanded exponentially as a result of the boom in immigration enforcement and private prison contracting by both ICE and BOP. In its 2009 Annual Report, GEO noted that the private correctional industry has grown by more than 47% since 2000 and cited government "initiatives focused on border enforcement and illegal immigration detention with an emphasis on criminal alien populations" as the basis for its profitable partnership with the federal government. GEO's revenue has increased 80% since 2005.

77. GEO posted profits of $17.7 million for the first quarter of 2010. In 2009, GEO's annual revenue was $1.14 billion, amounting to profits of $69 million for 2009. On August 10,

2010, GEO announced its successful merger with Cornell Industries, another private prison provider. As a result of the merger, GEO manages and/or owns 119 correctional, detention, and residential treatment facilities, with a total capacity of approximately 81,000 beds. GEO anticipates an increase in annual revenue of $400 million, for a total of approximately $1.5 billion.

iii. Physicians Network Association

78. Physicians Network Association (PNA) is a privately held correctional medical services corporation, founded in 1991 by Dr. Vernon Farthing and headquartered in Lubbock, Texas. PNA has 450 employees in three states (TX, AZ, NM) with 24 medical service contracts and annual revenue of $17 million.

79. PNA and Dr. Farthing have been sued in numerous cases alleging deliberate indifference and medical malpractice. *See, e.g., Ortiz v. PNA*, No. 5:07-cv-00645, 2008 WL 219564 (W.D. Tex. Jan. 25, 2008) (inadequate monitoring of prisoner who died from untreated alcohol withdrawal); *Heron v. RCDC*, No. 4:08-cv-00003 (W.D. Tex. Sep. 13, 2008) (failure to provide necessary blood pressure medication); *Morrisey v. MTC*, No. 1:07-cv-00040 (D.N.M. Jan. 10, 2007) (failure to provide follow-up care after tooth extraction such that inmate died of sepsis); *Mata v. MTC*, No. 1:09-cv-00015 (D.N.M. Apr. 3, 2006) (failure to provide or refer to vital neurological care); *Romero v. MTC*, No. 6:05-cv-00822 (D.N.M. Nov. 15, 2005) (neglect of metastatic cancer); *Sanchez v. MTC*, No. 1:05-cv-00784 (D.N.M. Aug. 19, 2005) (inadequate monitoring and treatment of suicidal prisoner undergoing heroin withdrawal); *Jenner v. PNA*, No. 1:03-cv-00930 (D.N.M. Aug. 8, 2003) (failure to medicate, monitor, and appropriately house suicidal inmate).

80. In 2002, the U.S. Department of Justice Civil Rights Division investigated the Santa Fe County Detention Center for reported Eighth Amendment violations. At the time, the County had contracted with Management Training Corporation (MTC) to operate the Detention Center, and MTC subcontracted with PNA to provide medical care. The DOJ's Findings Letter documented a number of serious concerns regarding the provision of health care at the Santa Fe facility. Specifically with regard to epileptics, DOJ identified several instances in which PNA failed to monitor inmates' medication levels in their blood, even when the inmates complained of side effects. Even when they did monitor the medication levels, PNA employees failed to respond to indications that the patient's dosage was inappropriate. In the case of one inmate, the laboratory results showed that his medication levels were too low to achieve the therapeutic effect, though there was no reference to this finding anywhere else in his medical record. Seven days later he attempted suicide and then had a seizure. Even receiving additional medical care after his suicide attempt, his medication level was not attended to, and he remained below the therapeutic level.[4]

81. Pursuant to its contract with PNA, Reeves County pays $6.09 per inmate per day for health care, resulting in annual fees of up to $8 million when the prison is at full capacity.

II. The Preventable Death of Jesus Manuel Galindo

A. Galindo and his Family

82. Jesus Manuel Galindo was born on November 29, 1976, 80 miles south of El Paso, Texas, in Villa Ahumada, Mexico. He was the eldest of Graciela and Jesus Galindo's three children. With the exception of one daughter in Mexico, Galindo's family has resided in Anthony, New Mexico since about 1990, including:

[4] Ralph Boyd, Assistant Attorney General, U.S. Dep't of Justice Civil Rights Division, *Findings Letter Re: Santa Fe County Adult Detention Center* at 13-14 (Mar. 6, 2002) http://www.justice.gov/crt/split/documents/santa_fe_findings.pdf (last visited Dec. 4, 2010).

- His parents, Jesus and Graciela Galindo; his brother, David Galindo; and his sister, Sandra Galindo, all of whom are Legal Permanent Residents of the United States;
- His wife, Edith Galindo, a U.S. citizen;
- His six-year-old daughter, Margarita Yahaira Galindo, a U.S. citizen;
- His ten-year-old son, Jacob Alexander Galindo, a U.S. citizen; and
- His thirteen-year-old son, Johnathan Galindo, a U.S. citizen.

83. Galindo, however, was a Mexican national and resident of Juarez, Mexico. On May 29, 2007, U.S. Customs and Border Patrol officers arrested Galindo after he waded across the Rio Grande to see his family.

B. History of Epilepsy

84. Galindo began experiencing seizures and headaches in 2004. A neurological specialist in Juarez diagnosed Galindo with epilepsy and prescribed him Topamax ("topiramate")—an anticonvulsant medication used to treat epilepsy and migraines. Galindo's physician in Juarez instructed him to take 25 mg of Topamax every 8 hours. Galindo was able to successfully control his epilepsy and prevent seizures on this medical regimen.

85. Galindo's history of epileptic seizures was known to BOP officials since he entered federal custody in May 2007. He received some treatment for epilepsy while awaiting sentencing, and the condition was recorded in his October 2007 Pre-Sentence Investigation Report.

86. Prior to being sentenced, Galindo was held at the Otero County Prison Facility in Chaparral, New Mexico. The medical provider at the Otero County Prison is PNA, the same private contractor that later denied Galindo adequate treatment for his epilepsy at RCDC III.

87. While at Otero, PNA prescribed Galindo the anti-convulsive medication Dilantin. This medication did not work, and Galindo reported to his mother that he was feeling dizzy and ill.

88. On November 26, 2007, Judge David Briones sentenced Galindo to a 30-month term of incarceration for illegal reentry.

89. At Galindo's sentencing, Graciela Galindo presented Judge Briones with a letter asking the Judge to consider her son's serious epileptic condition in sentencing her son and recommending an assignment.

90. Judge Briones recommended to BOP that Galindo serve his sentence at the BOP facility FCI La Tuna, which is located in Anthony, Texas—a town just across the state line from Anthony, New Mexico, where the Galindo family resides. FCI La Tuna is classified as a CARE Level 2 facility , indicating that BOP has designated it as an appropriate place to incarcerate inmates with chronic medical conditions like epilepsy.

91. Rather than placing Galindo at FCI La Tuna, BOP officials assigned him to RCDC III, the contract facility where he died twelve months later.

C. Deliberate Indifference to Galindo's Serious Medical Needs at RCDC

92. For the entire duration of his incarceration at RCDC III, Galindo and his family feared for his life. Their fears stemmed from the continuous failure to adequately treat Galindo's chronic epilepsy, and from his placement in isolated confinement without medical observation for weeks at a time.

93. As an epileptic whose seizures were not controlled, Galindo needed to be housed at all times in an environment with 24-hour nurse monitors or some kind of medical observation. During the time of Galindo's incarceration, RCDC III did not have an infirmary or medical

observation unit. The very last place that he should have been placed was in solitary confinement, where he ultimately died. Defendants Brady, Fears, Millsap, Bullock, Sims, Devivo, and Martin were all either actively involved in segregating Galindo despite knowledge of his medical condition, or were aware of his dangerous isolation and did nothing to remedy it.

94. RCDC medical staff employed by PNA—including Defendants Brady, Galindo's attending physician; Farthing, PNA's Medical Director; and Fears, Galindo's attending physician assistant—also knew that Galindo was a long-time epileptic but refused to provide him with the necessary type or dosage of anti-seizure medication. They denied him the specific medication that successfully controlled his seizures, instead providing a less expensive and less effective substitute – Dilantin – that never worked to control his epilepsy. Moreover, when Dilantin proved to be dangerously ineffective, Defendants repeatedly declined to refer Galindo for an off-site neurology consult, where an expert could have addressed his specific medication needs. This callous disregard for Galindo's health caused him to experience repeated epileptic seizures, physical injuries, painful side effects, extreme emotional distress, and, ultimately, death.

95. Galindo repeatedly informed both medical and correctional staff, in person and on BOP medical request forms, that the medication PNA physicians administered to him failed to control his epilepsy; that PNA employees were not checking the levels of medication in his blood; and that he was afraid of suffering seizures unattended.

96. Galindo's mother, Graciela Galindo, also informed RCDC medical staff that her son's medication was failing to control his epilepsy. The staff member with whom she spoke erroneously advised Mrs. Galindo that the drug that controlled Galindo's epilepsy prior to his incarceration – Topamax – was not available in the United States. That staff member then told

Mrs. Galindo that she needed to remember that her son was in a prison. At the time of Graciela Galindo's phone call to RCDC, BOP included Topamax in its National Formulary.

97. Topamax, however, is more expensive than Dilantin, one of the cheapest anti-convulsive drugs available.

98. Graciela Galindo attempted to send her son's pre-incarceration medical files to the prison so her son could present them to medical staff and obtain the medication that had previously worked for him. RCDC employees refused to accept the package and returned it to Mrs. Galindo.

99. PNA Defendants Brady, Farthing, Fears, Fitch, Millsap, and Bullock (PNA's medical records administrator at RCDC) violated the community standard of care when they uniformly disregarded the need to obtain Galindo's medical history or past medical records and repeatedly ignored evidence that the medication they provided to Galindo failed to control his epilepsy.

100. Indeed, PNA Defendants Brady, Farthing, and Fears failed to maintain stable levels of any antiepilepsy medication in Galindo's system for the duration of his time at RCDC. According to PNA, the therapeutic range for Dilantin is between 6.0 and 14.0. The following are Galindo's recorded Dilantin levels at RCDC III:

1/3/08	11.4
1/29/08	9.4
2/15/08:	20.5
3/19/08:	10.1
5/16/08:	14.3
6/15/08	7.3
6/23/08:	28.3
6/30/08:	17.8
8/20/08	8.1
10/06/08:	27.5
10/14/08	21.9
10/22/08:	30.7

11/03/08: 13.2
12/13/08: 5.1 (autopsy)

PNA Defendants were deliberately indifferent to the fluctuations in Galindo's medication levels above and below their internally designated range and failed to take or recommend any corrective action with regards to his treatment.

101. Galindo presented to PNA medical staff with swollen and bleeding gums at least five times—on February 19, 2008; May 8, 2008; June 23, 2008; September 2, 2008; and October 10, 2008. Although abnormal enlargement, overgrowth, and bleeding of the gingival tissues is a known side effect and contraindication for continued Dilantin usage, Galindo was never taken off Dilantin.

102. Finally, Galindo experienced repeated seizures throughout his incarceration at RCDC III. PNA Defendants acted with callous disregard for Galindo's condition when it became clear that his seizures were increasing. They did not change his medication, increase the monitoring of his blood levels, or refer him to a neurological specialist even though his epilepsy was never controlled at RCDC. Instead, Defendants knowingly and with deliberate indifference to Galindo's serious medical needs allowed his condition to deteriorate over the course of a year until his death.

i. Winter 2007

103. Galindo arrived at RCDC III on December 20, 2007. He was accompanied by a BOP transit document that identified him as an epileptic and noted the Dilantin prescription PNA medical staff had administered him during his pre-sentencing detention at Otero County Prison Facility.

104. Defendant Fears processed Galindo's intake on his arrival. PNA Licensed Vocational Nurse R. Benitez also filled out an intake report for Galindo at this time. There is no

indication that Fears or Benitez discussed either the efficacy of Galindo's Dilantin prescription or Galindo's pre-incarceration medical history during the intake process. Indeed, the intake forms do not even mention Topamax; only Dilantin. Although the intake form included a checkbox for referral to the pharmacy to order medication, as well as a checkbox for health services referral to a physician, Benitez placed Galindo into general population with no referral to care. Although both Fears and Benitez noted on their intake forms that Galindo had a history of seizure disorder, Galindo was not seen in the Chronic Clinic for nearly two weeks.

105. There are no records indicating that Galindo received either his morning or evening dose of anti-seizure medication on December 20, the day of his arrival. Rather, Galindo's medical file indicates that PNA continued to miss 14 more doses of anti-seizure medication during just his first month at RCDC.

106. On December 27, 2007, one week after he was first admitted to RCDC III, Galindo informed PNA physician Dr. Adel Nafrawi that he was experiencing stabbing headaches and that he felt ill. Nafrawi deliberately disregarded these warning signs, prescribed Tylenol for Galindo's headache, and continued him on the same dosage of Dilantin.

107. One month later, on January 29, 2008, Galindo suffered a seizure. He was carried to the medical area on a stretcher. RCDC staff did not arrive to attend to him until the seizure was over. Although a blood test showed that Galindo's Dilantin levels were within the therapeutic range designated by PNA, Nafrawi inexplicably attributed the seizure to Galindo's "noncompliance" with his medication rather than the drug's ineffectiveness for Galindo. Nafrawi ordered that the Dilantin be continued.

108. On at least two occasions, Galindo asked that medical staff permit him to carry antiepilepsy medication on his person because he was worried that he was continuing to suffer

seizures—once on December 27, 2007 in a request to L. Ackerstrom, R.N., and once on January 2, 2008 in a request to Defendant Fears. Both Fears and Ackerstrom refused to allow him to do so, stating that Dilantin was not a "keep on person" medication according to RCDC policies.

109. On February 2, 2008, Galindo submitted a health services request reporting that he had problems with his gums: "real bad bleeding" for a number of months. PNA nursing staff did not refer Galindo to a physician to assess his Dilantin prescription and its side effects.

110. On February 19, 2008, Galindo presented to PNA dentist Dr. Grewal, DDS with bleeding gums. Swollen and bleeding gums are a known side effect of Dilantin, indicating that the medication should be discontinued and the patient switched to an alternative. However, Grewal made no note that Galindo's Dilantin prescription should be reconsidered and only recommended prophylaxis (routine cleaning).

ii. Spring 2008

111. On March 2, 2008, Galindo was brought to the clinic after he reported feeling like he was about to seize. He was experiencing nausea, dizziness, and shaking.

112. On May 5, 2008, Galindo reported to PNA President, Medical Director, and attending physician Dr. Vernon Farthing that he had experienced 3 seizures in the past month. Farthing did not reevaluate whether Dilantin was appropriate, nor did he prescribe Galindo Topamax, the medication that had been successful in controlling his seizures in the past. Instead, he recommended that Galindo's Dilantin dosage be increased to from 400 mg to 500 mg and ordered that his blood levels be checked in 10 days.

113. On May 8, 2008, Galindo presented to Grewal with swollen and bleeding gums for the third time. Again, Grewal made no recommendation regarding reconsideration of Galindo's Dilantin prescription.

114. On May 11, 2008 Galindo had a seizure while in the recreation yard. Staff members failed to respond to other inmates' calls for help until after Galindo's seizure had ended.

115. On May 12, Galindo filled out a BOP form entitled "Inmate Request to Staff" addressed to Defendant Fitch, in which he wrote:

> I am epeletic [sic] and for some reason the medication I am given doesn't help me. Actually I have been having more seizures at least two a week sometimes more, and the left side of my head has been hurting me like an ongoing migraine headache. I need medical attention, my whole body aches from head to toes, due to the frequent seizures that I have been getting. Please check the meds …

Defendant Fitch deliberately disregarded the serious medical issues Galindo brought to his attention, and no PNA medical staff made changes to Galindo's medical regime following this request. Given the clear indications that Dilantin was not working to control his seizures, Galindo should have been evaluated by a neurological specialist who could propose a more effective treatment. This never happened.

iii. Summer 2008

116. On June 15, 2008, Galindo suffered two seizures, one of which caused him to fall and injure his face. PNA medical staff noted that his face was swollen from his injury, but did not provide Galindo with a mouth guard when he requested one for protection during seizures.

117. Following Galindo's June 15 seizure, Defendant Brady prescribed him another medication – Tegretol ("carbamazepine") – to be taken in conjunction with Dilantin. PNA staff discontinued his Tegretol prescription shortly thereafter with no record as to why—no physician recorded an order to discontinue the drug, and no nursing staff recorded either the distribution of Tegretol or the termination of it. Brady's failure to assess the efficacy of the Tegretol prescription, note contraindications, and/or ensure its consistent delivery and continuation

constituted deliberate indifference to Galindo's medical needs. The PNA nursing staff's failure to keep current and accurate records regarding the administration of Tegretol also constituted deliberate indifference to Galindo's health.

118. On June 23, 2008, Galindo reported bleeding gums for the fourth time. Despite noting that Galindo suffered from Dilantin hyperplasia that caused swelling, bleeding, and overgrowth of his gums over his anterior teeth, PNA dentist M. Nethery did nothing but recommend prophylaxis (routine cleaning) "when we get a dental hygienist." He made no indication that Galindo's Dilantin prescription should be reconsidered.

119. On July 3, 2008, Galindo informed Brady that he was experiencing dizziness. Brady did not re-evaluate whether Dilantin was the appropriate treatment for him, and did not mention Tegretol at all.

120. Upon learning of her son's injuries and untreated seizures at this point, Graciela Galindo feared for her son's life and became very upset. On or around June 16, 2008, she called the Federal Defender's Office ("FDO") in an agitated state and told Galindo's appellate counsel, attorney Judy Madewell, that her son was having seizures and was not being medicated properly.

121. In response, Ray Herrera—then an investigator in the El Paso office of the FDO—called RCDC and spoke to Defendant Fitch about Galindo's condition. Fitch informed Herrera that PNA was treating Galindo for the seizures he'd recently experienced. He also told Herrera that Galindo's condition was not life-threatening.

122. On July 14, 2008 Galindo again filled out the BOP form entitled "Inmate Request to Staff Member," reporting to the Medical Department that since the time of his arrival he had suffered numerous epileptic seizures. He again requested that his medication be reviewed because it was not working, stating:

> I have been here for aprx. 7 months and during this period I have been experiencing numerous epileptics seizure. I have requested to medical dept. for better medication . . . the medication I am getting is not working. My mouth and [tongue] hurt from falling on my face and when things like this happen the people around me don't know whats going on and they get scared. Please help me before something really bad happens . . .

Galindo also requested again that he be given a mouth guard to protect himself during seizures. Fears saw Galindo on July 22, 2008 and noted that his condition was "controlled." He made no change to Galindo's medication regime and did not provide him with a mouth guard.

123. On August 20, 2008, Galindo suffered another seizure. Defendant Fears blamed Galindo for being "noncompliant" with his medication. Galindo's medication was not changed or adjusted, and he was not referred off-site for a specialist consult. Instead, Fears and Defendant Devivo removed Galindo from general population and isolated him in the SHU for ten days, maliciously and with deliberate disregard for his precarious post-seizure medical state.

iv. Autumn 2008

124. On September 2, 2008, Galindo reported bleeding for at least the fifth time, writing in a sick call request: "I have real bad gum's infecsion. [sic] I need your help please, this is the 2 or 3 time that I ask for help. Gracias."

125. On September 23, 2008, Galindo reported to Defendant Fears that he felt sick and dizzy. Fears continued him on 500 mg of Dilantin with no further review.

126. On October 8, 2008, over a month after Galindo requested help for his teeth, Defendant Fears examined Galindo and noted that he had gingival hyperplasia, a painful, visually distressing, and extremely unpleasant condition. Galindo informed Fears that he had experienced gum pain for several months, and that the pain was getting worse. On information and belief, Fears ignored this well-known contraindication for Dilantin and was deliberately

indifferent to Galindo's pain, distress, and serious medical need when he nonetheless continued Galindo on Dilantin.

127. On October 10, 2008, Galindo reported bleeding gums for the seventh time on record. Despite noting that Galindo's "Dilantin hyperplasia" was causing inflammatory overgrowth of his gums over his anterior teeth, Physicians Assistant Fears and PNA dentist M. Nethery simply decided to reduce Galindo's Dilantin dosage back to 400 mg rather than consider that medication's discontinuation in favor of another, more appropriate anticonvulsant medication.

128. On October 14, 2008, Galindo reported feeling sick and dizzy to Fears, who raised him back up to 500 mg of Dilantin with no further review.

129. On November 2, 2008, Galindo suffered a seizure, causing him to injure his shoulder when he collapsed and hit his bunk bed.

130. On November 3, 2008, Defendant Brady examined Galindo, noting a blood draw indicated a Dilantin level of 13.2. Despite clear evidence that Dilantin was not controlling Galindo's seizures even at a therapeutic level, neither Defendants Fears nor Brady—the medical staff primarily responsible for overseeing his care—changed his medication or apparently thought to refer him to a specialist.

131. The seizures and gum bleeding never subsided. On November 11, 2008, Galindo suffered a grand mal seizure and had to be transported to Reeves County Hospital for emergency treatment.

132. The hospital's instructions called for the RCDC to return Galindo to the hospital if his condition worsened and indicated that he should receive follow-up monitoring. Defendants Fears and Brady failed to act in accordance with these instructions.

133. Upon his return from the hospital on November 12, Defendant Fears confirmed that Galindo had sub-therapeutic levels of Dilantin in his blood. Galindo informed Defendant Fears that he had been given his medicine the day of the seizure, but the dosage had been incorrect.

134. Instead of evaluating his pharmacological protocol and changing the ineffective Dilantin medication, Defendants Fears and Brady blamed Galindo for his November 11 seizure, accusing him of being noncompliant with his medication, and ordered that he be placed in an isolation cell designed to be used for punitive disciplinary purposes in the Special Housing Unit (SHU).

v. Isolation in the SHU

135. Galindo needed close monitoring and observation because he was epileptic, especially because he was inadequately medicated. The decision to place Galindo in the SHU deprived him of the care and observation of his fellow inmates in general population, upon which he relied. Instead, he was placed in a disciplinary cell with a broken intercom and ignored.

136. Galindo begged not to be placed in the SHU and to be returned to general population because he feared being alone and without help if another seizure occurred. In desperation, he threatened to harm himself, but promised to cease his suicide threat if he was returned to general population. After less than 24 hours without incident, Galindo was taken off suicide watch and placed unmonitored into the SHU.

137. On November 13, 2008, FDO Investigator Ray Herrera called RCDC III responding to concerns regarding Galindo's recent seizures and placement in the SHU, but medical staff would not tell him anything about Galindo's condition—instead they referred him to PNA Area Director Luis Gonzalez, who was unavailable.

138. Defendant Fears knew and was deliberately indifferent to the fact that Galindo's sub-therapeutic levels made him especially vulnerable to seizure. Knowing this, he nonetheless signed a form stating that Galindo was medically "clear for SHU."

139. RCDC correctional staff—including Defendants Devivo and Martin, the officers in charge of the SHU—placed Galindo in the SHU even though they knew he was epileptic.

140. The intercom in Galindo's segregation cell was broken and he was unable to call for help. RCDC prison and medical staff—including, on information and belief, Defendants Sims, Devivo, Martin, and Dr. Brady—knew that the intercom was broken but did nothing to fix it or move Galindo to a different cell. There was no video observation of Galindo in the SHU.

141. Defendants Sims, Devivo, and Martin failed to ensure that correctional officers assigned to the SHU performed regular checks on Galindo; they also failed to ensure the staffing levels and shift assignments necessary for such monitoring within the SHU.

142. PNA Defendants Farthing, Brady, Fears, Bullock, Fitch, and Millsap failed to perform regular checks on Galindo's condition or ensure that other staff at RCDC were performing such monitoring. Brady, Fears, Millsap, and certified nurse assistant Stephanie Camacho derogated from their responsibilities to monitor Galindo. Defendant Fears failed to visit Galindo on a daily basis and to document each visit, as required by BOP policy.

143. While in the SHU, Galindo suffered at least two seizures. Galindo suffered these seizures alone in his cell, without medical staff, correctional employees, or even other inmates being present. Galindo wrote to his mother that his body was bruised from suffering seizures alone in the isolation cell.

144. On November 20, 2008, Galindo informed Defendant Brady that he was still experiencing seizures. He suggested to Brady again that his Dilantin prescription might need to

be increased. Brady did not evaluate his pharmacological protocol, change the ineffective Dilantin medication, or recommend that Galindo be returned to the hospital as recommended by the ER He simply ordered that Galindo's blood be drawn in 30 days.

145. On December 2, 2008, Galindo woke from an unattended seizure alone and bleeding. He reported this to RCDC correctional officers and PNA medical staff, who were indifferent to his suffering and to the danger posed to his life. Defendants Sims, Devivo, and Martin refused to release him from the SHU, and Defendants Brady and Fears did not recommend that he be released.

146. Graciela Galindo, Galindo's mother, called RCDC to notify prison officials of her son's deteriorating health in the SHU. Her concerns were disregarded.

147. On Tuesday, December 3, 2008, an investigator from the Alpine office of the FDO – Octavio Vasquez – visited Galindo at RCDC. Along with Vasquez, Galindo spoke to PNA medical records administrator FNU Bullock regarding his inappropriate placement in the SHU. Galindo showed Vasquez and Defendant Bullock the injuries that he had received from falling during seizures, including a bruised shoulder, scars on his tongue, and a contusion on his face.

148. Galindo expressed to Vasquez and Bullock that he was fearful of being completely alone when he had a seizure. He stressed that he would feel safer in the general population of the facility because other inmates could care for him when he had an attack and could call for immediate medical assistance. Galindo also expressed his concern that no medical staff had conducted his regular blood draw to check for Dilantin levels.

149. Bullock assured Vasquez and Galindo that Galindo would be released from the SHU into general population shortly.

150. After Vasquez left RCDC, he called Bullock at RCDC to confirm that Galindo was being moved back to general population. Bullock did not return Vasquez's calls nor respond to his messages. Galindo was never moved back into general population. On information and belief, Bullock never informed other RCDC medical and correctional staff about his conversation with Vasquez or did anything to facilitate Galindo's removal from the SHU.

151. On Thursday, December 5, 2008, Galindo wrote a letter to his mother. He wrote that he was getting sick in the SHU alone, that staff did not check on him, and that the doctor did not even know that he was getting sick in his cell. He reported that the medical treatment at the facility was bad and that he was afraid.

152. Also in his December 5 letter to his mother, Galindo expressed concern that he would be kept in the SHU for another month alone. Galindo told his mother to ask why he was in a punishment cell without telephone access and with restricted visits. He requested that his mother tell someone that the cell where he was housed did not allow him to alert the guards in case of a medical emergency.

153. Also in his December 5 letter to his mother, Galindo wrote that an RCDC staff member had informed him that the doctor would attend to him by the following Monday or Tuesday. Galindo then wrote that his mother should call Octavio Vasquez to inform the Federal Defender's Office that RCDC staff were not planning on attending to his medical needs until the following week. Galindo gave his mother Vasquez's name and contact information so she could call to ask what was happening and request that the FDO petition for his transfer to another prison.

154. Epileptic patients require regular blood monitoring to ensure that they are maintained at a stable, medicated level. PNA nurses and physicians were deliberately indifferent to their duties to monitor Galindo's blood.

155. Between November 13 and December 11, 2008, the month directly preceding Galindo's death, PNA staff failed to monitor his blood even one time to check the level of medication in his system, deliberately disregarding his medical needs.

156. During that time, Galindo submitted a BOP request form to RCDC's medical services department pleading for staff to draw his blood and check his levels.

157. On December 10, two days before he died with sub-therapeutic levels of Dilantin in his system, Galindo informed Brady that he had not had his blood drawn to check his medication levels in the past four weeks. Brady did not draw Galindo's blood to test his levels despite this request—nor did he ensure that someone else would do it.

158. Galindo also told Brady that he was concerned about his placement in solitary confinement because of the danger of undergoing seizures alone. Galindo informed Brady that he had suffered two seizures while in the SHU, and that he had been in the SHU for a month.

159. Despite being told that Galindo had already fallen and suffered seizures alone in the SHU, Brady did not recommend that Galindo be moved from the SHU. Brady also did not issue or recommend any medical orders providing that Galindo be regularly monitored in the event of another seizure. Instead, Brady's response was to indicate in his medical notes that Galindo had an "attitude problem" because he "[didn't] like being in the SHU for medical reasons."

160. On information and belief, Warden Sims was aware of Galindo's medical situation and his placement in the SHU for some time before his death, and was aware of and

sanctioned the routine practice at RCDC of placing prisoners who complained about their medical care into the SHU. On information and belief, Warden Sims also spoke directly to Galindo on December 10, 2008, two days before his death. At that time, Galindo informed Sims that he suffered from epilepsy and that medical staff were not checking his blood at required intervals. He informed Sims that he had been in the SHU for a month and that he had suffered two seizures alone in his cell.

161. Defendant Sims disregarded this information. Although he retained the authority to control inmate placement in the SHU, he failed to order that Galindo be reassigned out of the SHU and placed into a more appropriate medical setting. He also failed to order correctional and medical staff to perform regular checks on Galindo in the event of another seizure.

162. After Galindo's discussions with Sims and Brady, a nurse came to his cell and informed him that someone would be coming to draw his blood. This never happened.

163. On the evening of December 10, Galindo wrote a letter addressed to his mother, telling her that the day was over, but still no one had stopped by to draw his blood to check his medication levels.

164. Galindo's increasing desperation regarding his medical treatment and isolation at RCDC was evident in letters he wrote in the month leading up to his death. Galindo wrote to his mother: "I get sick here locked up all by myself …They don't even know and I am all bruised up … Mama the whole day passed and where I am, no one even stopped."

165. Galindo also wrote to his federal defender, Judy Madewell: "I'm afraid I will choke to death on my tongue or hit my head and nobody will realize."

vi. Death in Isolation

166. True to his fears, Galindo died alone in his isolation cell, unattended, sometime between the evening of December 11, 2008 and the early morning of December 12, 2008.

167. At 7:00 am on December 12, Correctional Officer ("C/O") Raymundo Cantu found Galindo's body while making rounds to deliver breakfast. When Galindo did not respond to Defendant Cantu's knocking, Cantu yelled through the food slot of the cell door. When Galindo still did not respond, Cantu called for the doors to Galindo's isolation cell to be opened. He went to shake Galindo and felt that his body was cold.

168. Galindo was blue and purple in color. He had blood dried around his mouth and nose and there was a bloodstain on his pillow. His body had been ignored for so long that it was already stiff with *rigor mortis*.

169. Cantu called a Code Blue. Millsap and Camacho—the medical staff on-call at that time—arrived at Galindo's cell and confirmed that he had no pulse or respiration.

170. At 7:35 am—approximately a half hour after Galindo's body was discovered—Reeves County emergency medical technicians arrived.

171. At 9:35 am, Justice of the Peace Jim Riley officially pronounced Galindo deceased.

172. A death report by the Texas Rangers concluded that Galindo likely died from suffocation during his seizure.

173. In a conversation with Sergeant Don Williams, the author of the Texas Rangers report, Defendant Farthing asserted that Galindo had died as the result of a seizure.

174. Farthing informed Sgt. Williams that Galindo had been treated for grand mal epilepsy with Dilantin, and that his Dilantin levels were within the therapeutic levels. However,

there is no record of Galindo's blood being monitored in the weeks directly preceding his death. Rather, Galindo was actively pleading for his medication levels to be monitored up until the time of his death.

175. Farthing also told Sims that he believed Galindo had suffocated in his pillow during a seizure.

176. A PNA 24-hour mortality review report completed by Health Services Administrator Millsap on December 12 identified the cause of death as "unknown" but suspected to be "respiratory failure due to seizure."

177. Millsap, Camacho, and County/GEO joint employee C/O Cantu were on duty in Galindo's unit on December 11 and 12 and each of them knew that Galindo had uncontrolled seizures. Their failure to monitor Galindo while on duty left him alone and without medical assistance in the hours directly preceding his death.

178. In the 24-hour mortality review, Defendant Millsap identified herself as the healthcare staff providing care at the time of death.

179. Graciela Galindo called RCDC on December 12 to inquire about her son's health. Prison officials repeatedly refused to respond to her inquiries and told her that they would have to wait for the doctors to provide her with a response to her questions. Graciela begged prison officials to do something to help her son, unaware that he had died the night before. After about an hour of pleading with prison officials on the phone, someone at RCDC finally informed Graciela that her son was dead, telling her that they were "unable to do anything to help Jesus."

180. On December 22, 2008, Warden Sims completed a Custodial Death Report regarding Galindo. That report identified the cause of death as "suffocation during seizure."

181. An independent autopsy report ordered by the County and conducted by medical examiner Juan Contin, M.D., identified the cause of death as epileptiform seizure disorder and noted that Galindo had sub-therapeutic levels of anti-seizure medication in his bloodstream at the time of his death. A December 23, 2008 toxicology report conducted by NMS Labs confirmed this result.

D. Riots at RCDC

182. After other RCDC inmates observed the funeral home removing Galindo's body from the prison in a body bag, they became upset and began to ask prison officials about Galindo. Inmates then refused to "lock down" as instructed, in protest of the policy of confining seriously ill inmates like Galindo in the SHU. This series of events is documented in the FBI, Odessa Police Department, and Texas Rangers reports on the December 2008 riots at RCDC. The reports also recorded the demands of the prisoners, which were: "better treatment, better food, and better medical care."

183. The Odessa Police report documented statements made by inmates to police negotiators regarding what had happened to Galindo. They told police that Galindo was sick, that he had been in the SHU, and that someone should have been there with him—that "special housing was not the place for him."

184. On information and belief, the treatment of chronically ill prisoners at RCDC continues to be dangerously deficient. A number of rioters were prosecuted.

III. Policies and Customs of Deliberately Indifferent Medical Care

185. PNA Defendants, County/GEO Defendants, and Warden Sims jointly and willfully participated and conspired with Reeves County officials and employees to provide constitutionally deficient medical care to Galindo. Moreover, the entities PNA, GEO, and

Reeves County each maintained official customs and policies of deliberately indifferent medical care that resulted in Galindo's death.

A. PNA

186. On information and belief, PNA maintained official policies and customs of withholding necessary medications, services, and care from inmates in its care. These policies and customs served the goal of cutting costs and increasing profits for PNA, and they resulted in deliberate indifference to the serious medical needs of Galindo and other chronically ill inmates at RCDC.

187. These policies and customs originated at the highest corporate level of the organization, with PNA Medical Director Farthing and the "Corporate Utilization Management" office, which retained final control over all referrals for outside treatment and specialist consultation at RCDC III. Health care priorities and policies were also set on a regional level by PNA policymakers like Regional Area Director Luis Gonzalez. On information and belief, Gonzalez had specific knowledge of Galindo's placement and seizures in the SHU.

188. PNA policies and customs of deliberately indifferent medical care were promulgated and implemented on a facility-level at RCDC III by PNA supervisory and administrative staff. Health Services Administrator Fitch, Health Services Administrator Millsap, the Director of Nursing, and the Facility Physician (on information and belief, Defendant Brady) were responsible for making determinations related to redesignation of inmates whose medical needs could not be met at the facility; for referral to outpatient specialist consultation; and for approval of outpatient emergency care.

i. Inadequate Formulary and Limiting Access to Medication

189. On information and belief, PNA maintains a policy and custom of relying on a company formulary which includes a limited selection of less expensive and/or outdated medications as compared to the BOP National Formulary. On information and belief, PNA adopted a limited formulary in order to reduce costs and increase profits, resulting in the denial of a medically necessary anti-convulsant – Topamax – to Galindo.

190. PNA contractually assumes the cost of all medications that its employees prescribe to inmates housed at RCDC. On information and belief, PNA promoted a custom or policy of making determinations regarding individual medication regimens based on cost-cutting prerogatives rather than the health of the patient, and on this basis did not provide Galindo with any anti-convulsive medication other than Dilantin.

ii. Denial of Access to Specialized, Intensive, and Emergency Care

191. On information and belief, PNA has a custom or policy of unreasonably delaying and/or refusing the referral of prisoners to outside medical providers—even when prisoners' medical conditions far exceed the capabilities of staff and facilities available at RCDC, and even in situations dangerously close to medical emergencies. On information and belief, PNA adopted this custom or policy to reduce costs associated with off-site medical visits.

192. On information and belief, Defendants Brady, Farthing, Fears, Fitch, and Millsap acted in accordance with PNA custom or policy when they deliberately disregarded Galindo's need to see a neurological specialist for reconsideration of his medical regimen during the time his condition was rapidly deteriorating at RCDC.

193. On information and belief, Defendants Brady, Farthing, and Fears acted in accordance with PNA custom or policy when they deliberately disregarded Reeves County

Hospital's November 11 recommendation to return Galindo to the hospital in the event that his condition worsened—choosing instead to keep him isolated in the SHU until his death on December 12, 2008.

iii. Failure to Maintain Medical Records & Provide Follow-up Care

194. On information and belief, PNA's customs and policies for record-keeping and follow-up care significantly deviate from generally accepted medical standards and community standards of care, and as a result PNA's employees improperly diagnose sick inmates and fail to note medical warning signs. Alone and in combination, these customs and policies caused Galindo to deteriorate over the course of a year until his death.

195. PNA's custom or policy of substandard record-keeping is evidenced by Galindo's incomplete medical record. Galindo's medical file did not contain his pre-sentencing medical records from other institutions or from his doctor in Juarez. Galindo's medical file also contains no indication of when and why PNA stopped administering Tegretol and contains a number of missing or incomprehensible notes regarding the distribution of his medication.

196. PNA's insufficient and inaccurate record-keeping exacerbated the problems caused by its custom or policy of inadequate follow-up care. PNA physicians neglected to review the provision of new medications to inmates in order to screen for efficacy and side effects; PNA medical staff also failed to monitor inmates previously confirmed to require medical attention. In accordance with this custom or policy, Bullock, Brady, Farthing, Fears, Millsap, and nurse assistant Camacho failed to provide Galindo with appropriate follow-up care regarding his medication regimen and failed to monitor his condition while they isolated him in the SHU.

iv. Paucity of Staffing, Supervision, and Review

197. PNA maintained a deliberately indifferent policy of inadequate medical staffing at RCDC III, both by shift and on an institutional level. PNA failed to consistently staff RCDC with enough adequately credentialed medical staff to meet inmate needs. PNA's policy of inadequate staffing is evidenced by the Proposed Minimum Staffing Pattern attached to the company's Medical Services Agreement with Reeves County. For the entire inmate population of approximately 1300 men, the staffing plan provided for the following full-time credentialed staff: one registered nurse to also serve as the Director of Nursing; one physician assistant; and three licensed vocational nurses (LVNs). The staffing plan provides for no full-time physicians and only one part-time physician.

198. As a result of understaffing, PNA physicians and nurses did not have adequate time to diagnose and treat chronically ill inmates like Galindo. On information and belief, some PNA medical staff performed functions they were not trained or qualified to perform. For example, the staffing plan assigned one of the three LVNs at RCDC III to administer the Chronic Clinic—a role that an LVN is not qualified to perform under Texas Nursing Standards. PNA's policies of inadequate staffing were deliberately indifferent to the medical needs of the inmates at RCDC III, particularly those like Galindo, who had chronic conditions requiring a more-than-cursory level of care.

199. PNA contractually assumed the responsibility to provide 24-hour medical care "at all times," then derogated from this duty, leaving RCDC III inmates without care at crucial times. For example, on information and belief, no on-site medical attention, even from an LVN, was available at RCDC III on the weekends.

200. PNA maintained a custom or policy of inadequate supervision, internal review and quality control. Although Galindo experienced several seizures and his condition steadily deteriorated over the course of a year, on information and belief, no oversight or internal audit ever addressed the continuing denial of care to seizure patients or other prisoners with chronic conditions.

201. Defendants Farthing, Fitch, and Millsap had the ability and the duty to provide oversight and remedial action with regard to medical care at RCDC III. As Medical Director, Defendant Farthing had principal responsibility for the supervision of medical services provided by PNA. As Health Services Administrators, Defendants Fitch and Millsap made determinations regarding staffing schedules and had supervisory authority over health services at RCDC III. The Director of Nursing at the facility was responsible for the oversight and allocation of nursing staff and for medication administration practices. On information and belief, these individuals largely abandoned their supervisory roles and failed to enact policies and procedures to ensure internal quality control.

B. Reeves County and GEO

i. Denial of Medical Services and Medical Understaffing

202. On information and belief, Reeves County officials and GEO policymakers adopted, encouraged, facilitated, and ratified PNA's policies and customs of medical understaffing and denying access to medications, services, and care for the purpose of cutting costs.

203. In 2002, it was reported that then-Warden Franco announced at a County Commissioners' meeting that in just four months PNA had drastically reduced surgeries (from 15 to 2); X-rays (from 101 to 4); off-site medical visits (from 59 to 4); and all outside medical

services (from 3148 to 222). He also stated that PNA had changed the formulary at RCDC and that subcontracting to PNA would save the County $400,000 annually. In light of this information, the County Commissioners approved a medical services contract with PNA, which it renewed again in 2004, and then in 2006.

204. The Medical Services Agreement with PNA for RCDC III, signed by County Judge Jimmy Galindo, ratifies PNA's policy of dramatic understaffing, reflected in the proposed staffing plan attached to the contract. The County also contractually retained joint authority with PNA over the redesignation and referral of inmates whose medical needs could not be met at RCDC to other facilities or outside medical providers. PNA's failure to redesignate or refer Galindo to a better-equipped facility or an outside specialist occurred pursuant to the County's and PNA's jointly authorized practice of disfavoring off-site medical referrals for cost-savings reasons.

205. As the chief administrator at RCDC III and a GEO policymaker, Warden Sims was aware of staffing levels throughout the facility, including correctional and medical staff charged with monitoring prisoners with medical needs who were placed in segregated confinement. Warden Sims is also known for his practice of regularly walking the cell blocks at RCDC, including the SHU, which gives him regular exposure to inmate concerns and on-the-ground conditions related to medical care and staffing. On information and belief, Sims was aware, or should have been aware, that inadequate correctional and medical staffing in the SHU created an unreasonable risk to prisoners in need of round-the-clock medical monitoring.

ii. Failure to Monitor and Protect from Deficient Medical Care

206. Reeves County and GEO adopted a custom or policy of deliberate indifference to PNA's practice of withholding adequate medical care at RCDC during the CAR contract periods.

As the prime contractor, Reeves County, via the County Judge and Commissioners, retained the ability to set medical care priorities and policies and to take corrective action vis-à-vis its subcontractor's failures; but it failed to do so despite warning signs of inadequate and/or unreasonably delayed care at RCDC .

207. On information and belief, BOP's, GEO's, and/or the County's own audits of PNA's performance identified significant and repeated deficiencies in the provision of medical care at RCDC on multiple occasions. County policymakers had notice of at least four deaths at RCDC prior to Galindo's death. On January 3, 2006, RCDC inmate Jose Ramirez Gonzalez died at the age of 28 of bleeding in the brain. Two days later, RCDC inmate Luis Susayta-Villa died of internal bleeding in his liver. On December 2007, yet another RCDC inmate died of sepsis. County officials nonetheless continued to entrust the health care of inmates at RCDC to PNA, deliberately disregarding their medical needs.

208. Prior to Galindo's death, County officials had specific knowledge of the failures of care at RCDC but did not remedy them. According to the terms of its contract with PNA, Reeves County received copies of the following policies and documents sufficient to give notice to the County as to the state of medical care, staffing, and record-keeping at RCDC:

- Copies of written policies, procedures, and protocol for PNA health services staff;
- Quality Improvement data and peer review information compiled by PNA;
- Materials related to PNA's Health Services Unit training and orientation;
- A copy of the pharmacist facility inspection of PNA's medical distribution areas;
- Documents associated with PNA's participation in the facility Contractor Quality Control Program;
- Credentials for all PNA personnel providing health services; and

- Staffing records, including those documenting shift assignment, overtime, and vacancies.

Furthermore, Reeves County Commissioners received invoices, financial records, Contract Facility Management reports, and other documents from PNA and GEO sufficient to give notice to the County as to the state of medical care and medical staffing at RCDC III.

209. Reeves County Monitor Bill Weinacht was employed by the County for the express purpose of providing regular, on-site monitoring of RCDC under the terms of the County's contract with GEO. Weinacht had access at all times to all documents and records relating to BOP inmates housed pursuant to CAR 5. However, Weinacht maintained a custom or policy of total indifference towards the gravely and obviously deficient medical practices at RCDC. On information and belief, actual work performed by Weinacht in his monitoring role was at best negligible and certainly not worth his $50,000 annual salary—to Reeves County taxpayers or to the prisoners at RCDC.

210. On information and belief, Reeves County policymakers had knowledge of PNA failures of care at other prisons, making the County's deliberate indifference towards PNA's performance at RCDC especially reckless. Reeves County Commissioners met with PNA representatives to discuss their performance on other contracts, and DOJ's findings regarding the Santa Fe facility were publicly available as of March 6, 2003. In October 2007, an inmate at another GEO- and PNA-operated facility in Frio County, Texas suffered a seizure alone in his cell and died after PNA reportedly failed to monitor and treat his alcohol withdrawal symptoms. Galindo's suffering and death was foreseeable in light of PNA's past failures to treat and monitor inmates susceptible to seizures; yet Reeves County and County Monitor Weinacht declined to take prophylactic measures to ensure the delivery of adequate services to such inmates at RCDC.

IV. Policies and Customs of Deliberately Indifferent Medical Isolation in the SHU

211. PNA Defendants, County/GEO Defendants, and Warden Sims jointly and willfully participated and conspired with Reeves County officials and employees to isolate sick prisoners like Galindo, thus depriving him of constitutionally adequate medical care and reasonable safety. Moreover, the entities PNA, GEO, and Reeves County each maintained official customs and policies of deliberately indifferent medical isolation that resulted in Galindo's death.

A. GEO and Reeves County

212. GEO and Reeves County jointly employ prison staff and correctional officers at RCDC III. While Reeves County issues the paychecks for correctional officers from County funds and authorizes hiring and salary-related determinations, GEO by contract with the County has final authority over employment screening, hiring, discipline, and firing decisions. Both GEO and Reeves County jointly retain the duty to train and supervise prison staff and correctional officers at RCDC III.

213. On information and belief, Defendants GEO and Reeves County failed to enact, implement, and monitor policies governing appropriate uses and maintenance of the SHU and failed to supervise and train their employees on the implementation of existing facility, state, and BOP policies governing use of the SHU. As a result of these failures, Warden Sims and County/GEO joint employees Devivo, Martin, and Cantu condoned, enabled, and participated in a policy or custom of abusively and dangerously isolating sick inmates at RCDC III.

i. Placing Sick Inmates in Disciplinary Segregation

214. GEO and the County endorsed a policy or custom of using disciplinary segregation as punishment for inmates with serious unmet medical needs. GEO, through

Warden Sims, knowingly and recklessly permitted PNA employees to use the SHU to punish sick inmates, even though BOP policies provide that restrictive confinement in what purports to be "medical observation" must never be used "for reasons that may be deemed punitive."

215. As GEO's highest ranking on-site employee, Warden Sims retained the ultimate authority to place inmates in segregated housing. On information and belief, Defendant Sims delegated this authority to County/GEO correctional employees—including Defendants Devivo and Martin—without first ensuring that they had received training or supervision on proper management of the SHU. In ignoring BOP policy with respect to isolated confinement, Defendant Sims also enabled PNA medical staff to refer inmates to the SHU without the proper training, supervision, or authority to do so.

216. GEO employed on-site Quality Control Specialists at RCDC III to implement GEO's correctional policies. At all relevant times herein, GEO employee Ramona McDaniels was a Quality Control Specialist operating on-site at RCDC III. On the day that Galindo's body was found, Defendant Sims wrote an e-mail addressed to BOP contract monitor Donna Grube and GEO Quality Control Specialist Ramona McDaniels stating that Galindo had been housed in the SHU for a month "per medical."

217. By maintaining a policy or custom of facilitating punitive or spurious use of the SHU by medical staff, GEO and County employees deliberately abandoned their duty to provide due process prior to the imposition of disciplinary segregation. On December 9, 2008, FNU Michaels, LPC visited Galindo in the SHU and filled out a BOP Detention /Segregation 30-Day Review form. That form recorded Galindo's cell assignment as "administrative detention." No GEO or County employee ever presented Galindo with a copy of an administrative detention order detailing the reasons for his isolated confinement. On information and belief, no such

order was ever issued. On information and belief, this was consistent with GEO's routine practice in placing prisoners in the SHU for invalid reasons.

218. Before Galindo's final confinement in isolation, GEO, County, and PNA employees had subjected him to their deliberately indifferent SHU practices once before, during the period of August 22 to September 10, 2008. After Galindo suffered a serious seizure and had to be taken to the trauma unit, Defendant Devivo placed Galindo in the SHU for "noncompliance" at the direction of PNA nurse Pam McKay. Devivo released Galindo from the SHU only when PNA staff authorized his transfer to general population.

219. GEO and the County maintained a policy or custom of keeping inmates in impermissibly prolonged isolation in the SHU. BOP policies provide that the Warden may place an inmate in segregation for medical reasons only when the institution hospital does not have adequate security provisions to house that inmate, and only for a maximum of five days. With the Warden's sanction, GEO and County employees kept Galindo alone in the SHU for thirty continuous days before he died in isolation on December 12, 2008.

ii. Failure to Provide and Maintain Adequate Facilities

220. On information and belief, there were no medical observation or infirmary beds in RCDC III during Galindo's incarceration there. Furthermore, the disciplinary cells in the SHU—which did not have functional electronic monitoring equipment or appropriate doors for visual observation—could not have been used for medical observation purposes without violating BOP rules regarding "sight and sound requirements."

221. Although County policymakers were aware of the range of illnesses within the RCDC inmate population, and in fact represented to BOP that RCDC III had an infirmary when bidding for the CAR 5 award, County officials failed to maintain essential medical facilities or

medical observation beds within the prison during the time of Galindo's incarceration. Instead, the County contracted and accepted payment to house chronically ill BOP inmates like Galindo, deliberately disregarding those inmates' medical needs.

222. RCDC's isolation cells had broken intercom systems and no video monitoring. These conditions resulted from Reeves County's policy or custom of deliberate indifference towards the basic maintenance of its facility, as well as GEO's managerial failure to detect and/or address these defects in the course of its facility audits.

iii. Inadequate Staffing, Supervision, and Medical Monitoring in the SHU

223. GEO and Reeves County maintained a custom or policy of inadequate staffing and monitoring in the SHU, with deliberate indifference to the medical needs of the inmates housed therein. GEO and Reeves County failed to ensure minimum levels of observation and monitoring of inmates in the SHU by correctional officers. As a result, there were no correctional officers that Galindo could call for help in the hours preceding his death; nor were there any correctional officers present in the SHU to find him in time for an effective emergency medical intervention. As C/O Cantu recounted, by the time he found Galindo's body, it was in *rigor mortis*.

224. County officials, who approve RCDC budgetary items and salaries, and GEO management were fully aware of inadequate staffing levels and the ongoing difficulty of recruiting and hiring correctional and medical staff in the remote town of Pecos, Texas. Reeves County, GEO, and PNA regularly recruit and hire in the El Paso area, although essential and non-essential staff vacancies remain a perennial problem at RCDC.

iv. Failure to Monitor and Protect from Dangerous Isolation

225. Reeves County maintained a custom or policy of deliberate indifference towards the dangerous segregation practices at RCDC that ultimately caused Galindo's death. The County Commissioners and County Monitor Weinacht indifferently discharged their policymaking and monitoring duties and failed to take measures within their power to correct RCDC's SHU practices, even when the dangers of these practices became apparent.

226. On August 2, 2008, more than four months before Galindo died in isolation, prisoner Reyes Garcia Rangel committed suicide in RCDC's SHU. RCDC officials had removed Rangel from general population and placed him in the SHU after he complained that he was not receiving medical attention. While Rangel was in the SHU, PNA staff failed to provide him with anti-depressant medications he had been prescribed at a previous institution, despite noting his vulnerable mental health state and his recorded history of depression. Even after Rangel threatened to kill himself, RCDC medical and correctional staff failed to adequately monitor him while he was isolated, such that he was able to take his own life by cutting into his neck until he bled to death. Despite the obvious warning signs that Rangel's suicide raised regarding the punitive isolation of inmates with serious medical needs at RCDC, neither GEO nor Reeves County took corrective actions to prevent Galindo from suffering a similar fate.

227. In its CAR 5 agreement with BOP, Reeves County contractually assumed the duty to "establish and maintain a complete quality control program"—*i.e.*, to perform inspections, identify deficiencies in the quality of services, and implement corrective action. The County performed (or failed to perform) these internal review functions with deliberate indifference to the well-being of inmates at RCDC III, such that it failed to identify and remedy:

- Abusive segregation practices carried out in the SHU by PNA, GEO, and the County's own employees;
- Deficiencies in the physical facilities RCDC used to house sick inmates; and
- PNA's failures to provide adequate medical care and monitoring in the SHU.

B. PNA

i. Referring Patients to Disciplinary Segregation

228. PNA maintained a policy or custom of referring seriously ill patients to disciplinary segregation without due process and with deliberate disregard for the danger of isolating inmates with serious medical needs. County officials discussed PNA's policy at a September 2009 Commissioner's meeting after Galindo's death, when County Judge Sam Contreras noted that RCDC inmates "were being placed in the SHU when they didn't do nothing wrong. They were just sick." On information and belief, PNA nurses and physicians assigned their patients to the SHU for impermissibly punitive purposes and/or to retaliate against inmates demanding better medical care.

229. PNA also maintained a policy or custom of keeping inmates in prolonged isolation by refusing and/or failing to "medically clear" those individuals for release from the SHU in a timely manner. PNA employees acted in accordance with this policy when they failed to clear Galindo for release from the SHU for nearly a month before he died, despite his repeated pleas.

ii. Inadequate Staffing and Medical Monitoring in the SHU

230. PNA contractually assumed the responsibility to provide medical monitoring of inmates in segregated housing. Disregarding this duty, PNA maintained a policy or custom of inadequate medical monitoring in general, and failed to sufficiently plan, implement, direct, or

control the medical monitoring of inmates its employees improperly placed in the SHU. Pursuant to this custom or policy, Defendants Brady, Fears, Millsap and nurse assistant Camacho failed to medically monitor or ensure monitoring for Galindo in the days – and hours – preceding his death.

V. BOP Defendants' Failure to Protect Galindo From Obvious Risk

A. Segregation of Noncitizen Inmates in CAR Contract Facilities

231. Throughout his incarceration at RCDC, Galindo was a federal prisoner in BOP custody, and BOP retained ultimate responsibility for his welfare pursuant to its statutory mandate to "provide suitable quarters for the safekeeping, care, and subsistence of all persons charged with or convicted of offenses against the United States…." 18 U.S.C. § 4042(a).

232. BOP began contracting for the placement of lower security inmates in private facilities in the early 1980s, although for many years this practice was mostly limited to pre-release housing in residential community facilities. As the number of federal prisoners began to rise dramatically in the 1980s and 1990s, BOP increasingly turned to private prisons to confine even long-term inmates.

233. Although BOP generally owns and operates the prison facilities that house U.S. citizens, the agency began outsourcing the imprisonment of noncitizens a little over ten years ago. Today approximately 20,000 criminal aliens—virtually all the noncitizens in BOP custody—are incarcerated in privately owned or operated facilities, pursuant to CAR contracts like the one with Reeves County.

234. Accordingly, criminal aliens in BOP custody disproportionately bear the brunt of profit-preserving, cost-cutting measures by private prisons and private medical providers that may compromise their access to baseline health care and humane conditions of confinement.

235. On information and belief, criminal aliens in BOP custody are more likely to be denied or delayed medical treatment than other federal prisoners because most are serving relatively short sentences for non-violent immigration crimes and all face deportation after serving their sentences—creating a financial incentive for private contractors to shunt their medical care to their home countries.

236. Most criminal aliens in BOP custody, and at RCDC, are Limited English Proficient ("LEP"), which impedes their access to prison grievance procedures and the court system.

237. Finally, the remote location of RCDC in Pecos, over 200 miles from the closest metropolitan area in El Paso, poses an additional challenge for prisoners at RCDC who need assistance from lawyers or family members in advocating for better medical care or improved conditions of confinement.

238. All of the above factors relating to the vulnerability of criminal aliens in CAR facilities, and at RCDC in particular, applied to Galindo. And all were obvious and known to all BOP Defendants, who evaluated and awarded the CAR 5 contract to Reeves County in May 2006; and/or provided on-site monitoring or contract oversight for the next two-and-a-half years—during which time Galindo was assigned to RCDC, suffered horribly in the care of private medical and prison staff, and then died.

B. Failure to Adequately Oversee Private Prisons and Medical Providers

239. BOP has historically failed to provide effective oversight of its private prison contractors and subcontractors, particularly its medical care providers.

240. As early as 1991, when privatization at BOP was still relatively new, the U.S. General Accounting Office ("GAO") issued a report to Congress recommending legislation to

"specifically address the need for adequate controls in contracts to preserve the rights of federal offenders in private facilities, ensure contractor accountability, and provide for effective government oversight."[5] Such legislation was never enacted.

241. Sixteen years later in October 2007, well after BOP privatization was firmly entrenched, the GAO reviewed comparable BOP facilities and privately operated facilities housing low-security federal offenders over a four-year period from 2002-2006 and issued another report, finding that BOP does not require or maintain sufficient data from private facilities to enable the agency to evaluate quality of service. BOP subsequently rejected the GAO's recommendation that the agency require private prison contractors to collect and report the same data that it requires of its own facilities, noting that it would drive up contract costs.[6]

242. In February 2008, the Audit Division of the U.S. Department of Justice Office of the Inspector General ("OIG") initiated an audit to determine, *inter alia*, whether BOP effectively administered its medical services contracts and monitored its medical services providers. With respect to contract administration, the OIG concluded:

> This audit, along with prior OIG audits of individual BOP medical contracts, found that BOP institutions lacked adequate management controls to ensure the effective administration of critical medical service contract functions. The absence of such controls appears to stem from BOP headquarters not identifying systemic weaknesses and implementing the necessary policies and internal control procedures to remedy the issues.[7]

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[5] U.S. General Accounting Office, *Private Prisons: Cost Savings and BOP's Statutory Authority Need To Be Resolved*, Report to the Chairman, Subcommittee on Regulation, Business Opportunities and Energy, Committee on Small Business, U.S. House of Representatives at 5 (Feb. 1991), http://archive.gao.gov/d21t9/143337.pdf (last visited Dec. 4, 2010).

[6] U.S. Government Accountability Office, *Cost of Prisons: Bureau of Prisons Needs Better Data to Assess Alternatives for Acquiring Low and Medium Security Facilities*, Report to the Subcommittees on Commerce, Justice, and Science, Senate and House Appropriations Committees at 12, 30 (Oct. 2007), http://www.gao.gov/new.items/d086.pdf (last visited Dec. 4, 2010).

[7] U.S. Dep't of Justice Office of the Inspector General, Audit Division, *The Federal Bureau of Prison's Efforts to Manage Inmate Health Care*, Audit Report at 42 (Feb. 2008), http://www.justice.gov/oig/reports/BOP/a0808/final.pdf (last visited Dec. 4, 2010).

243. Similarly, with respect to the monitoring of private health services providers, the OIG found that BOP does not generally develop and issue guidance to correct systemic health care deficiencies found during its monitoring reviews. The OIG also found that BOP had allowed some private health care providers to practice medicine without valid authorizations, or without having their medical practices peer-evaluated per BOP policy. The OIG audit report concluded that BOP could be "subjected to liability claims by inmates if improper medical services are provided by these practitioners."[8]

244. In spite of and without addressing two federal agencies' significant, documented concerns regarding BOP's inadequate data collection and inability to address systemic problems in contractor health care delivery, BOP issued the CAR 5 solicitation, selected Reeves County and its subcontractors to provide services under the contract, and then began to monitor the provision of those services.

C. Failure to Ensure Actual Competition in CAR 5 Award Process

245. BOP's Acquisition Branch is responsible for acquiring the goods and services required for BOP to execute its mission. Within the Acquisitions Branch, Privatized Corrections Contracting ("PCC") is responsible for establishing contracts with providers to manage and operate private prison facilities pursuant to CAR contracts. BOP's Acquisition Branch is currently headed by Defendant Matthew Nace.

246. BOP issued the CAR 5 solicitation on June 21, 2005, seeking an RFP "for services to house approximately 1,200 low security non United States citizen sentenced males in one or more existing secure correctional institution(s) procured from private sources or state and local governments located in the continental United States."

[8] *Id.* at 54.

247. BOP ultimately awarded the CAR 5 contract to Reeves County to house federal criminal alien prisoners at RCDC III for a four-year base period with three two-year option periods. The BOP award letter and official offer to County Judge Jimmy Galindo, dated May 24, 2006, is signed by Nace, who was then a Contracting Officer in PCC.

248. Two days later, on May 26, 2006, BOP issued the CAR 6 solicitation, which was virtually identical to CAR 5 except that it sought services to house approximately 7000 criminal alien prisoners. Reeves County eventually received, for RCDC I & II, one of five contracts that were awarded under the CAR 6 solicitation.

249. Both the CAR 5 and the CAR 6 solicitations expressly reserved BOP's right to make multiple awards based on that solicitation.

250. On information and belief, all potential contractors that made an offer on either CAR 5 or CAR 6 were awarded a CAR contract by BOP.

251. A Magistrate Judge in the U.S. District Court for the District of Oregon recently found, in ruling on summary judgment motions in a federal FOIA enforcement action filed against BOP, that the agency had failed to show that the CAR 5/CAR 6 procurement process involved actual competition:

> [I]t appears that the BOP may have simply divided the number of prison beds needed among the bids it received, such that each submitter having the capacity to provide the required detention facilities and services was awarded a contract, regardless of the differences, if any, in such competitive factors as price, operations plans, staffing formulas, and so forth.

Raher v. Federal Bureau of Prisons, No. 3:09cv526-ST, 2010 WL 3488975 at *7 (D. Or. Sept. 2, 2010).

252. Federal procurement regulations require "full and open competition" in contracting for good and services. On information and belief, the BOP evaluation and selection

process resulting in the CAR 5/CAR 6 awards to Reeves County did not involve meaningful competition.

253. In the absence of meaningful competition, BOP Defendants had an even greater obligation to thoroughly evaluate and examine Reeves County's initial proposal to house criminal alien prisoners at RCDC, using the subcontracted services of PNA and GEO. They failed to do so.

D. Constitutional Claims Against BOP Defendants

i. Deliberately Indifferent Contracting/Failure to Protect from Obvious Risk

a. Nature of Claim

254. BOP officials Matthew Nace and James Burrell ("Contracting Defendants") knowingly and with deliberate indifference deprived Galindo of reasonable safety and adequate medical care when they subjected him, and all RCDC prisoners with chronic illnesses, to the obvious risk posed by PNA's documented medical incompetence and outright indifference to medical needs. Contracting Defendants' selection of PNA to provide medical care at RCDC, via the awarding of CAR 5 to Reeves County, was a moving force behind the violation of Galindo's constitutional rights that led to his death.

255. Adequate scrutiny of the performance history of subcontractor PNA—required by federal acquisition regulations—should have led Contracting Defendants to conclude that an obvious consequence of PNA's provision of medical services at RCDC would be the deprivation of the constitutional rights of seriously ill prisoners like Galindo. In particular, adequate scrutiny of PNA's history of systemic failures in chronic medication delivery and monitoring of epileptic

prisoners would have revealed the significant and unreasonable risk PNA posed to prisoners with epilepsy like Galindo.

256. On information and belief, Contracting Defendants either did not conduct a thorough or meaningful past performance evaluation of PNA, Reeves County's proposed medical services subcontractor, prior to awarding CAR 5 to the County; or they did, but ignored critical evidence that should have led BOP to reject PNA as potential subcontractor. This failure to act to avert obvious risk constitutes deliberate indifference and is causally linked to Galindo's death.

b. Specific Facts Related to Claim

257. Federal acquisitions regulations required BOP, prior to awarding CAR 5 to Reeves County in May 2006, to take into account relevant past performance information regarding subcontractors who would be providing critical services required under the contract—such as PNA and GEO. 48 C.F.R. § 15. 305 (a)(2)(iii).

258. The attachment to the CAR 5 solicitation setting forth BOP's own evaluation factors for the award identifies "Past Performance/Experience" as the most important non-price evaluation criteria. According to the attachment:

> The evaluation will focus on information which demonstrates quality of performance relative to the size and complexity of the procurement under consideration. References other than those identified by the offeror may be contacted.
>
> Information utilized may be obtained from the references listed in the proposal, other customers known to the Government or of whom it becomes aware, consumer protection organizations, and any others who may have useful and relevant information. Information may also be considered regarding significant subcontractors, corporate personnel and essential personnel.

259. An Office of Federal Procurement Policy ("OFPP") guide from May 2000, *Best Practices for Collecting and Using Current and Past Performance Information*, advises that past

performance evaluations should consider the severity of past performance problems and the demonstrated effectiveness of any corrective actions, and should treat subcontractor past performance information the same as information about the prime contractor.

260. On information and belief, Contracting Defendants did not adequately or reasonably consider recent, directly relevant past performance information regarding subcontractors PNA and GEO when making the decision to award CAR 5 to Reeves County in May 2006.

1. PNA

261. Until September 30, 2004, PNA was the subcontracted medical provider at Santa Fe County Adult Detention Center. During the three years that PNA provided medical services at the Santa Fe facility, the U.S. Department of Justice Civil Rights Division began an investigation of reported Eighth Amendment violations there, including grossly deficient medical care. At the time, Santa Fe County had contracted with Management Training Corporation (MTC) to operate the facility, and MTC had subcontracted with PNA to provide medical care.

262. On March 6, 2003, DOJ issued a Findings Letter that documented a number of serious concerns regarding the provision of health care at the Santa Fe facility. Specifically, DOJ identified systemic problems in the administration of medications including:

- a pattern of frequently missed doses that was attributed, without basis, to inmate non-compliance;
- failure to identify adverse side effects and adjust prescription levels;
- failure to monitor blood levels to ensure proper dosage; and
- exclusive reliance on PNA's formulary, which did not contain effective medications for certain inmates.

263. The Findings Letter also included a description about the dangers such practices caused for epileptic prisoners:

> When certain medications are prescribed, such as anti-epileptic medications, it is necessary to check blood levels of these medications at regular intervals to ensure the inmate's health is not at risk from either too high or too low a dosage. We found several instances in which PNA failed to monitor inmates on these types of medications, even when inmates reported experiencing side effects.
>
> Even when staff did monitor medication levels, they failed to respond to indications that an inmate's dosage was inappropriate. For example, an inmate had been prescribed a medication for his seizure disorder, in addition to several other medications, and his blood levels of the seizure medication had been measured. Although the laboratory results showed that the amount of drug in his system was not enough to achieve the intended therapeutic effect, there was no reference to this finding anywhere else in his medical record. Moreover, staff failed to respond appropriately, such as adjusting his medication. Seven days later, the inmate attempted suicide by cutting his wrists, then suffered a seizure. Even with all the attention from medical staff due to his suicide attempt, his seizure medication blood level was not measured until four days after his suicide attempt, at which point it was still well below the therapeutic range.[9]

264. The above description of PNA's medication administration practices depicts organizational incompetence and indifference—a complete absence of effective policies, practices and protocols to achieve safe medication delivery in the prison setting. The same description almost precisely describes PNA practices with respect to Galindo several years later, when BOP knowingly placed his care in the hands of the same medical provider.

265. One month after PNA's contract to provide medical care at the Santa Fe facility ended, DOJ entered into an agreement with Santa Fe County that includes numerous provisions related to medication management. On information and belief, PNA withdrew from its contract rather than reform its practices to comply with constitutionally mandated minimum standards of care. There is no evidence that PNA reformed its medication administration practices before leaving Santa Fe.

[9] *See supra* note 4.

266. The DOJ Civil Rights Division, which investigated the Santa Fe facility, is an agency within the DOJ, as is BOP. The findings of DOJ Civil Rights Division attorneys and investigators were readily available to Contracting Defendants.

267. On information and belief, Contracting Defendants did not reasonably inquire into PNA's serious performance problems in Santa Fe, and did little if anything to ensure that those performance problems—particularly with respect to medication administration—had been fixed and would not create a risk for prisoners like Galindo at RCDC.

2. GEO

268. BOP also had access to recent, relevant information with respect to GEO, the other subcontractor at RCDC. GEO owns and operates Rivers Correctional Institution in Winton, North Carolina. The Rivers facility houses D.C. prisoners and foreign nationals in BOP custody. BOP contracts directly with GEO for the use of Rivers, a low-security prison housing approximately 1300 men.

269. The D.C. Prisoners' Project, a section of the Washington Lawyers' Committee for Civil Rights & Urban Affairs, has advocated for the rights of D.C. prisoners since 1989. The Project's Director, Philip Fornaci, testified before Congress about medical care at Rivers since the facility opened in 2002:

> In contrast to treatment provided at FMCs, or even at comparably-sized BOP-run prisons, medical care at Rivers is abysmal.
>
> . . . From the moment of its opening, our organization has received a steady stream of complaints from prisoners housed there, from the failure to provide basic primary medical care to an unwillingness to send prisoners off-site for specialty care to abrupt changes in medication regimens in the interests of saving money.[10]

[10] Testimony of Philip Fornaci, Director, D.C. Prisoners' Project, Washington Lawyers' Committee for Civil Rights & Urban Affairs, at Federal Bureau of Prisons Oversight Hearing, Subcommittee on Crime, Terrorism, and Homeland Security, House of Representatives Committee on the Judiciary at 2-3 (July 21, 2009), http://judiciary.house.gov/hearings/pdf/Fornaci090721.pdf (last visited Dec. 4, 2010).

270. GEO is the prime contractor at the Rivers facility and the quality of its performance there has been known to Contracting Defendants, or easily available to them, since 2002.

271. On information and belief, Contracting Defendants did not reasonably inquire into GEO's past performance at Rivers, and did little if anything to ensure that any performance problems would not create a risk for prisoners like Galindo at RCDC.

3. Source Selection Decision

272. Reeves County's "Offer and Other Documents" in response to the CAR 5 solicitation was released in heavily redacted form by BOP in response to a FOIA request. The County's offer appears to include a large amount of corporate and financial information on GEO, and marketing materials for secure detention facilities run by GEO. On information and belief, there is no discussion in Reeves County's submission to BOP of the many lawsuits filed against GEO (formerly named Wackenhut) for civil rights violations.

273. In the unredacted parts of Reeves County's submission, there is just one mention of PNA, the proposed medical subcontractor, and it includes a critical inaccuracy. A GEO marketing sheet for RCDC states that RCDC III includes an infirmary: "Our inmate Infirmary service is fully staffed by Physician's Network Associates [sic] (PNA) employees, who maintain a commitment to appropriate medical care and health services 24 hours per day, seven days per week."

274. There was no infirmary at RCDC III in August 2005, when Reeves County submitted its CAR 5 offer, or in December 2008 when Galindo died.

275. Defendant James Burrell was the Source Selection Official for the CAR 5 award. Burrell attended the pre-proposal conference with potential offerors on August 2, 2005 and

reviewed all offers that were subsequently submitted. Defendant Nace, then a Contracting Officer within PCC, signed the documents awarding CAR 5 to Reeves County on May 24, 2006 and is designated as an ongoing point of contact within the agency for CAR 5. According to a declaration Nace submitted recently in the *Raher* FOIA litigation in Oregon, contracting staff at PCC in Washington perform all pre-award functions for new private-prison procurement, including reviewing and analyzing past performance information and contacting references.

276. On information and belief, both Burrell and Nace participated in the evaluation and selection of Reeves County for the CAR 5 solicitation, and both participated in or became familiar with the past performance evaluations of the County and its subcontractors PNA and GEO.

277. BOP's Source Selection Decision awarding CAR 5 to Reeves County is signed by Burrell. It was released by the agency in the *Raher* litigation with all content redacted.

278. On information and belief, in selecting Reeves County for the CAR 5 award, Contracting Defendants failed to adequately scrutinize the performance history of subcontractors PNA and GEO. Adequate scrutiny of PNA's recent performance history at the Santa Fe facility, in particular, would have led reasonable contracting officials to conclude that the plain and obvious consequence of approving PNA as the subcontracted medical provider at RCDC would be the deprivation of the constitutional rights of seriously ill prisoners, including epileptics like Galindo.

279. Contracting Defendants exhibited deliberate indifference and deprived Galindo of reasonable safety and adequate medical care when they placed his health and safety in the hands of subcontractors whose relevant past performance they either ignored or failed to adequately

scrutinize. Such failures were a moving force in the constitutional violations that ultimately led to Galindo's death.

ii. Deliberately Indifferent Monitoring/Failure to Remedy Obvious Risk

a. Nature of Claim

280. BOP officials James Burrell, Donna Grube and Eduardo de Jesus, M.D. ("Monitoring Defendants") knowingly and with deliberate indifference deprived Galindo of reasonable safety and adequate medical care when they failed to force improvements in the provision of medical services or the way segregated housing was used by PNA, GEO and Reeves County and their employees prior to Galindo's death.

281. On information and belief, for several years prior to Galindo's death, GEO, County, and PNA employees openly and notoriously misused segregated housing to punish sick inmates and conspired to deprive them of access to necessary medical care. These practices constituted serious, obvious, and long-standing risks to prisoners with chronic illnesses like Galindo. The failure of Monitoring Defendants to reasonably act to remedy these obvious risks was a direct cause of the constitutional violations that led to Galindo's death.

282. Monitoring Defendants had the authority, opportunity, ability, and obligation to compel Reeves County and its subcontractors to improve contract performance in the provision of medical services and the use of segregated housing. Defendants Nace and Burrell, as senior BOP contracting and management officials, had the authority, opportunity, ability, and obligation to impose sanctions for egregiously deficient contract performance under CAR 5, to terminate BOP's contractual relationship with the Reeves County, or to force the County to do the same with its subcontractors. The failure of Monitoring Defendants to take any of these

actions in the face of obvious risk to prisoners at RCDC constitutes deliberate indifference and is causally linked to Galindo's death.

b. Specific Facts Related to Claim

283. Federal acquisitions regulations require agencies to ensure that the services tendered by contractors meet contract requirements. 48 C.F.R. § 46.102(b). Contracting officers are obligated to reject services that do not conform "in all respects" to contract requirements. 48 C.F.R. § 46.407(a). And contracting officers must discourage repeated, even minor nonconformance "by appropriate action, such as rejection and documenting the contractor's performance record." 48 C.F.R. § 46.407(e).

284. Health services is a key contract requirement under CAR 5, accounting for fifteen percent of the total value of the contract, according to BOP's solicitation.

285. Among other things, CAR 5 requires the contractor to comply with all applicable American Correctional Association ("ACA") and Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") standards and levels of quality, and adhere to all applicable federal, state, and local laws and regulations governing the delivery of health services. Medical services provided under the contract are required to be "commensurate to the level of care available in the community." CAR 5 references BOP Program Statements and other agency materials as guides to the expected standard of health care delivery under the contract. The contractor is required to follow the BOP National Formulary.

1. BOP's monitoring role

286. In addition to his role as Source Selection Official for the CAR 5 award, Defendant Burrell is the Administrator of BOP's Privatization Management Branch ("PMB"), which oversees and monitors for contract compliance all privately run facilities housing BOP

inmates. On information and belief, he held this position and/or another senior position within PMB prior to and at the time of Galindo's death.

287. BOP utilizes a multi-tiered monitoring approach at RCDC that includes on-site BOP staff who perform daily monitoring activities, and semi-annual comprehensive institutional audits by an outside team of BOP subject matter experts.

288. Defendant Donna Grube was the on-site BOP Contracting Officer at the Reeves Privatization Field Office in Pecos prior to and at the time of Galindo's death. On information and belief, Defendant Eduardo De Jesus, M.D., was BOP's on-site medical auditor and medical subject matter expert prior to and during the year Galindo was incarcerated at RCDC III. On information and belief, both Grube and De Jesus worked within PMB and reported to Burrell.

289. The terms of CAR 5 establish BOP's authority, ability and intent to monitor for contract compliance. The contract reserves BOP's right to have various staff on-site to monitor contract performance and to conduct announced and unannounced inspections "of any part of the institution at any time and by any method to assess contract compliance." The contract reserves 2500 sq. ft. of office space for on-site BOP staff, and no less than 10 BOP parking spaces at the front entrance of the facility. CAR 5 also provides for regular performance evaluation meetings between the contractor's representative and various BOP contracting officials.

2. Obvious risk

290. Notwithstanding this significant, anticipated, and regular on-site BOP presence at RCDC III, and the availability of enforcement tools to compel improved contract performance if not full compliance, Monitoring Defendants failed to address egregious deficiencies in the provision of health care and use of isolated confinement that were linked to Galindo's death.

291. From May 2006, when CAR 5 was awarded to Reeves County, until December 2008, when Galindo died, Defendant De Jesus audited the medical program at RCDC III twice a year. On information and belief, De Jesus found repeated deficiencies in chronic infectious disease screening at during multiple, successive semi-annual audits. However, BOP's medical audits at RCDC remained limited in scope.

292. Standard baseline medical audits in a prison setting typically include a review of chronic care clinics and protocols, medical staffing levels, and medication administration practices to ensure consistency with applicable standards. On information and belief, Dr. De Jesus did not audit these areas at RCDC III. In particular, Dr. De Jesus never reviewed PNA's medication administration records ("MARs"), which were so famously deficient at the Santa Fe facility; he never observed the medical treatment of prisoners housed in segregation; and he never audited the seizure clinic or checked its protocols. In light of what was known about PNA's past performance history, BOP's failure to directly audit such practices was unreasonable and reckless.

293. Monitoring Defendants had access to PNA's proposed staffing pattern for the Health Services Unit at RCDC III, which was attached to PNA's contract with the County. As noted above (*see* ¶¶ 197-99), the physician and nurse staffing levels proposed and implemented by PNA were notably deficient. Notwithstanding this obvious fact, Monitoring Defendants did not review the sufficiency of medical staffing levels at RCDC III.

294. From May 2006 to December 2008, there was also growing evidence that GEO-run facilities shared a pattern of using solitary confinement to punish and deter prisoners who complained about deficient medical care.

295. For example, in June 2007, the Washington Lawyers' Committee filed a class action complaint against BOP and GEO alleging systemic denial of medical care at the Rivers facility in North Carolina. The original complaint alleged that

> [p]risoners who complain frequently about the deficiencies in health care have been punished with "administrative segregation"—solitary confinement—which is punitive to the prisoner. By erecting obstacles to filing a grievance, and through threats and acts of retribution, Rivers staff have effectively discouraged or foreclosed meaningful access to the grievance process for many prisoners.

The *Mathis* case remains active. The U.S. District Court for the Eastern District of North Carolina recently denied BOP's motion to dismiss Eighth Amendment claims against the agency, noting that the plaintiffs had alleged systemic failures and deficiencies in health care delivery that were "open and notorious." *See Mathis v. GEO*, No. 2:08-CT-21-D, 2010 WL 3835141, at *7 (E.D.N.C. Sept. 29, 2010).

296. In August 2008, just four months before Galindo died, BOP inmate Reyes Garcia Rangel committed suicide at RCDC while confined in the SHU. The wrongful death and survival action that was later filed against Reeves County, GEO, and PNA in connection with Rangel's death alleged that the defendants had maintained "a standard operating procedure and policy of placing inmates who continually sought medical attention and/or filed grievances in SHU in order to quash the inmate's efforts to obtain medical care and/or file grievances." *See Favila v. Reeves County*, No.10-07-19702-CVR, District Court, 143rd Judicial District, Reeves County, Texas (2010).

297. On information and belief, from the start of the CAR 5 contract period until Galindo's death, Monitoring Defendants did not reasonably modify the scope of their review to address known and dangerous practices associated with either PNA or GEO, the subcontractors running the facility. While at RCDC III, Galindo experienced serious problems related to such

practices—*e.g.*, error-riddled medication administration records, inadequate treatment of his chronic condition, and retaliatory confinement in segregated housing for complaining about his medical care. These problems caused his health to deteriorate and ultimately led to his death. These problems also reflected systemic health care deficiencies and routine confinement practices at RCDC III that should have been obvious to the BOP monitors and auditors who were on-site at the facility in 2008.

3. Failure to act

298. The deficient medical practices and abusive use of segregated confinement at RCDC III not only violated numerous contract requirements under CAR 5, but also constituted significant, ongoing, and obvious risks to prisoners with chronic illnesses like Galindo. On information and belief, Monitoring Defendants were aware of these systemic problems and the obvious risks they posed, or through the reasonable performance of their BOP jobs, they should have been aware of them.

299. As officials and employees charged with monitoring and administering BOP's contract with Reeves County, Monitoring Defendants had the authority, opportunity, ability, and obligation to demand improvements in contract performance that would have remedied these obvious risks for prisoners like Galindo—and could have averted his death.

300. For example, mandatory ACA standards require that prisoners in segregation be visited on a daily basis by a health care provider, and that the visit be announced and recorded. On information and belief, RCDC III prison and medical staff routinely disregarded this requirement. No records exist showing daily visits from medical staff during Galindo's four weeks in segregation.

301. Similarly, BOP regulations on inmate discipline and special housing units—which expressly apply to "all persons committed to the care, custody, and control (direct or constructive) of the Bureau of Prisons"— prohibit the placement of an inmate in disciplinary segregation without a hearing and an order by the hearing officer, and limit such placements to circumstances "when other available dispositions are inadequate to achieve the purpose of punishment and deterrence necessary to regulate an inmate's behavior within acceptable limits." 28 C.F.R. § 541.10, § 541. 20. On information and belief, RCDC III prison and medical staff routinely disregarded this regulation and placed prisoners in the SHU for spurious and retaliatory reasons. No disciplinary record exists justifying Galindo's four-week placement in segregation.

302. CAR 5 requires adherence to the BOP National Formulary in dispensing medications at RCDC III, and ACA standards require prison medical staff to follow a formalized process for obtaining nonformulary medications, if necessary. On information and belief, in 2008 the BOP National Formulary included Topamax, the antiepileptic medication Galindo had used successfully to control his seizures prior to entering BOP custody. PNA, as was its practice at the Santa Fe facility, relied exclusively on its own inferior formulary at RCDC III. PNA did not offer and refused to obtain Topamax for Galindo.

303. Had Monitoring Defendants made adequate efforts to enforce contract requirements with respect to any of the above examples—something they are required to do by applicable federal acquisition regulations—an obvious and serious risk would have been remedied for prisoners with chronic medication needs, or for those who were particularly at medical risk in segregated housing. Adequate monitoring and prompt corrective actions would have improved flagrantly poor medication administration practices at RCDC III, and curtailed the abusive use of segregated confinement at the facility, which was open and notorious.

Monitoring Defendants' failure to take such steps in the face of obvious risk to prisoners like Galindo constituted deliberate indifference and led to his death.

E. BOP Defendants' Awareness of Galindo's Serious Medical Need

i. Knowledge Prior to Placement at RCDC

304. BOP officials were aware that Galindo had epilepsy from the time he came into federal custody in May 2007. Galindo's Pre-Sentence Investigation Report noted his medical condition, and his "Alien In Transit" documentation also identified him as an epileptic. Finally, Galindo was documented as needing treatment for epilepsy while he was housed at Otero County Prison awaiting his federal sentencing.

305. As an epileptic, Galindo should have been considered an inmate with a chronic care requirement, according to BOP's internal definitions. As such, BOP policies called for the Central Office Medical Designator to make his initial designation to a BOP facility "having resources to meet the inmate's needs." BOP Program Statement P5100.08 at 7.

306. BOP regulations require the Medical Designator to consider five factors in making an initial medical designation: (1) the inmate's medical needs; (2) the inmate's security needs; (3) proximity to the inmate's home; (4) transportation requirements; and (5) recommendations made by the sentencing judge.

307. In Galindo's case, all five factors indicated that he should have been assigned to FCI La Tuna. Judge David Briones of U.S. District Court for the Western District of Texas, who sentenced Galindo, recommended that he be incarcerated at FCI La Tuna, a low-security facility in Anthony, Texas, just twelve miles north of El Paso. BOP has rated FCI La Tuna "CARE Level 2." This internal rating means that agency has deemed the facility adequate to meet chronic care needs like Galindo's epilepsy.

308. Notwithstanding BOP's medical designation system, which appears to apply to all federal prisoners except criminal aliens, BOP officials rejected Judge Briones' recommendation and assigned Galindo to RCDC III.

309. On information and belief, like all CAR-contracted private facilities housing noncitizens in BOP custody, RCDC did not have a CARE Level rating indicating that it was appropriate for Galindo's chronic medical needs. Indeed, throughout the time that Galindo was at RCDC III, the facility did not even have an infirmary.

ii. Knowledge During Incarceration at RCDC

310. On information and belief, BOP's on-site or regional staff at RCDC, including Defendants De Jesus and Grube, became aware of Galindo and his medical difficulties during his time at the prison.

311. Galindo's medical problems were not isolated or subtle. Over the course of a year, Galindo seized repeatedly in different parts of the prison, often in full view of other prisoners and staff, always creating a stir and usually prompting some kind of response from prison and medical staff. In November 2008, Galindo was hospitalized after a seizure and various staff were involved in the logistics of transporting him to the hospital and back. Galindo's seizure condition was so well-known and discussed by prisoners and staff at RCDC III that when he died in the SHU a riot broke out in general population the same day.

312. For almost one year, Galindo consistently complained of deficient medical care and submitted numerous medical "cop-outs" and Inmate Requests on BOP forms. Medical staff also completed many other BOP forms for Galindo during his year at RCDC, including: a Psychology Services Inmate Questionnaire, a Detention/Segregation 30-Day Review, and the Special Housing/Psychiatric Pre-Crisis Management Health Evaluation (twice). All these BOP

forms and Galindo's medical requests were retained in his federal Sentry medical file, where they were available to BOP's medical auditor, Dr. De Jesus, and other BOP staff who were involved in conducting medical audits and other oversight at RCDC.

313. Generally accepted auditing practices should have caused Dr. De Jesus to review the medical files of prisoners with persistent chronic care issues and daily medication needs, to assess the performance of medical staff in those key areas.

iii. BOP's Willfully Blind Grievance Policies

314. Galindo in fact submitted two highly specific, heart-rending Inmate Requests on BOP forms, dated May 12, 2008 and July 14, 2008, about his recurring seizures, his medication problems, and his gnawing fear of serious injury or worse. (*See supra* ¶ 115 and ¶ 122.) The requests were simply referred to medical to be kept in Section 6 of Galindo's Sentry file.

315. If Galindo's Inmate Requests were never seen beyond the RCDC medical department, it was because of pervasive ignorance and confusion among prisoners and staff about the grievance procedure at the facility, and because of BOP policies that intentionally impede noncitizens like Galindo from bringing their problems to the attention of BOP officials.

316. The BOP Inmate Request form submitted twice by Galindo is used as an informal resolution form at RCDC. Prisoners are required to file a request for informal resolution before they file a grievance. RCDC III grievance procedure states that if the prisoner is not satisfied with the informal resolution, he will be given a formal grievance form. On information and belief, Galindo was never provided with a formal grievance form or made aware that he could officially grieve the issue of his uncontrolled seizures or placement in isolation. If he had been, he surely would have done so, given his persistent efforts to seek improved medical treatment throughout his incarceration at RCDC III.

317. In addition to the opaque and inaccessible grievance procedures at RCDC, Galindo faced other obstacles in drawing BOP's attention to his plight. First, administrative remedy appeals to BOP must be written in English. Under the direction of Burrell, PMB has hewed to this BOP policy for grievances submitted by RCDC prisoners, disregarding the fact that most prisoners at RCDC are limited in English proficiency.

318. Second, complaints about medical issues are not appealable to BOP from CAR facilities. BOP's administrative remedy program ordinarily provides that a grievance may be appealed to the Regional Director if the prisoner is not satisfied with the response at the facility level, and then to BOP's General Counsel for further review. However, CAR facilities are not governed by the same policies that govern all BOP facilities nationwide, but are instead governed by policies promulgated by PMB. Defendant Burrell has adopted a policy precluding any formal or management-level review of grievances on medical care issues at private facilities housing criminal aliens. According to Burrell, the medical care of noncitizens at RCDC is a "non-BOP issue."

319. On information and belief, numerous prisoners at RCDC have submitted administrative remedy appeals to BOP officials on medical issues, which have been returned with the remark: "Medical concerns are not appealable to the BOP." On information and belief, many more RCDC prisoners would have appealed medical issues to BOP officials if they had been permitted to do so in Spanish, or if such appeals were accepted by the agency.

320. The non-appealability policy effectively means that only criminal aliens—and no other group—in BOP custody are deprived of an administrative remedy appeal to BOP on medical and other institution-based issues. This policy constitutes a kind of willful blindness on the part of the agency with respect to the treatment of noncitizens in its custody. If Galindo had

been provided the means to directly address his medical concerns to BOP officials, it is clear they would not have listened.

CAUSES OF ACTION

FIRST CAUSE OF ACTION
Medical Malpractice
Tex. Civ. Prac. & Rem. Code ch. 74 *et seq.*
Against Defendants: PNA, Farthing, Brady, Fears, Fitch, Millsap
(Wrongful Death and Survival Claim)

321. Plaintiffs incorporate paragraphs 1 through 320 as set forth above.

322. Defendants PNA, Farthing, Brady, Fears, Fitch, and Millsap had a duty to exercise ordinary care to protect the health and safety of persons housed in RCDC III and to take reasonable steps to provide them with medical care. Each of these individual defendants had a duty to Galindo to exercise the degree of care, skill and learning expected of a reasonably qualified healthcare provider in the same or similar circumstances. Defendants breached these duties in numerous ways that caused Galindo's death.

323. Defendants Farthing, Brady, and Fears had a duty to refer Galindo to a neurological specialist who could properly diagnose and treat his condition; a duty to change his medication to one that worked; a duty to ensure that his medication levels remained reasonably consistent; a duty to ensure that he was constantly monitored in the event of a seizure; and a duty to ensure that he was not placed in isolation as punishment for seeking medical help. Defendants breached these duties, leading directly and proximately to Galindo's death.

324. Defendants Fitch and Millsap, as Health Services Administrators at RCDC III, had a duty to ensure that PNA nursing staff consistently administered Galindo's medications; regularly monitored his serum blood levels; and recorded these actions appropriately in his

medical records. Defendants failure to meet these duties caused Galindo to be inadequately medicated and prone to seizures for prolonged periods and ultimately caused his death.

325. Defendants Millsap and nurse assistant Camacho were on duty the night Galindo died and knew that he had uncontrolled seizures. These medical professionals had a duty to constantly monitor Galindo and/or assign others to constantly monitor him. Their failure to do so left Galindo alone and isolated when his fatal seizure occurred, precluding the possibility of medical assistance and directly causing his death.

326. Defendants PNA and Farthing had a duty to supervise the provision of medical care at RCDC III in such a way that inmates' safety was not unreasonably compromised. Defendants breached this duty by failing to adopt and inculcate adequate policies, procedures, protocols and post orders relating to medical care; by failing to provide adequate staffing, training, facilities, and equipment for medical care; and in otherwise failing to provide adequate supervision. This breach of the standard of care for medical supervision directly and proximately caused Galindo's death.

327. PNA is liable for the tortious acts and omissions of Farthing and other PNA employees, joint employees, agents, and contractors under the doctrines of *respondeat superior* and borrowed servant.

328. As a direct and proximate result of the medically negligent acts, omissions and conduct of Defendants PNA, Farthing, Brady, Fears, Fitch, and Millsap, as set forth above, Galindo suffered numerous avoidable seizures; physical bruising; facial contusions; bleeding gums; extreme physical, mental and emotional pain and distress; and death.

SECOND CAUSE OF ACTION
Negligence and Gross Negligence
Against Defendants: GEO, Sims, PNA, Farthing, Brady, Fears, Fitch, Millsap, Bullock
(Wrongful Death and Survival Claim)

329. Plaintiffs incorporate paragraphs 1 through 320 as set forth above.

330. Defendant GEO had a duty to establish policies and properly train its agents, servants, and employees in the appropriate and safe operation of segregated housing units. GEO had a duty to hire and retain sufficient competent personnel to insure the safety and well-being of persons incarcerated in the SHU at RCDC III. GEO breached these duties of reasonable supervisory care, leading directly and proximately to Galindo's death.

331. Defendant Sims, as Warden of RCDC III and supervisor of GEO and Reeves County employees, had a duty to exercise reasonable care to ensure that inmates' safety and medical care were not unreasonably compromised. Sims had a duty to ensure adequate staffing; to adopt, inculcate and implement appropriate policies, procedures, protocols and post orders; and to properly screen, monitor, supervise, and discipline RCDC III employees. Sims breached these duties in ways that directly and proximately caused Galindo's death.

332. For example, Sims had a specific duty to appropriately administer and manage the placement of inmates in the SHU. Sims failed to meet this duty in that he knew that Galindo and other chronically ill inmates were being isolated in the SHU for unjustified and spurious reasons, contrary to BOP policy and at obvious risk to their health, but he failed to remedy the situation.

333. GEO employees, joint employees, agents, and borrowed servants—including Defendants Devivo and Martin—had a duty to properly assess, diagnose, and report Galindo's ailments to medical providers; and a duty to ensure that inmates needing constant medical observation, like Galindo, were not isolated or were appropriately monitored while in isolation. GEO employees failed to meet these duties, and this failure was a direct and proximate cause of Galindo's death.

334. Defendants Farthing, Brady, Fears, Fitch, Millsap, and Bullock had a duty to exercise reasonable care in referring and approving inmates for placement in isolation; in reviewing the medical consequences of their continued isolation and removing them if necessary; and in appropriately monitoring isolated inmates with serious medical needs. Defendants breached all these duties with respect to Galindo, and these failures directly caused his death.

335. In deliberately and repeatedly ignoring Galindo's medical condition and holding him in solitary confinement—alone, scared, and isolated from any help—solely for the offense of requesting better medical care, Defendants Sims, Farthing, Brady, Fears, Fitch, Millsap, and Bullock acted with reckless disregard and intent to cause Galindo pain, suffering, and emotional distress.

336. GEO is liable for the tortious acts and omissions of Sims, Devivo, Martin, and other GEO employees, joint employees, agents, and contractors under the doctrines of *respondeat superior* and borrowed servant.

337. PNA is liable for the tortious acts and omissions of Farthing, Brady, Fears, Fitch, Millsap, and Bullock, and other PNA employees, joint employees, agents, and contractors, under the doctrines of *respondeat superior* and borrowed servant.

338. As a direct and proximate result of the negligent acts, omissions, and conduct of Defendants GEO, Sims, PNA, Farthing, Brady, Fears, Fitch, Millsap, and Bullock, as set forth above, Galindo suffered physical injuries; extreme physical, mental and emotional pain, anguish, and distress; and death.

339. Defendants conduct placed Galindo at extreme risk of serious injury or death and exhibited a conscious indifference to his safety. Defendants actions in this regard were extreme, outrageous, malicious and grossly negligent.

THIRD CAUSE OF ACTION
Negligence – Texas Tort Claims Act
Tex. Civ. Prac. & Rem. Code ann. § 101.001 *et seq.*
Against Defendant: Reeves County
(Wrongful Death and Survival Claim)

340. Plaintiffs incorporate paragraphs 1 through 320 as set forth above.

341. At all relevant times herein, Reeves County employed or jointly employed Defendants Devivo and Martin, C/O Cantu, and numerous other RCDC correctional staff who, in the course and scope of their employment: assigned Galindo to the SHU in November 2008 for unjustified and spurious reasons and without necessary due process; physically placed him in the SHU; maintained his placement in the SHU until he died; operated and staffed the SHU throughout the time that Galindo was housed there; brought Galindo his meals, interacted with him, and were aware of his continued and dangerous isolation; failed to remove Galindo from the SHU before he died despite knowledge of his uncontrolled seizures; failed to adequately monitor Galindo while in the SHU or to assign others to monitor him; and failed to repair a broken intercom in Galindo's isolation cell that might have provided him with a means of summoning help in a medical emergency.

342. Galindo's injuries and death were caused by the condition and use of tangible personal and real property by Reeves County employees or joint employees, including the condition and use of the Special Housing Unit itself and of Galindo's isolation cell in the SHU, which had numerous features making it inappropriate and dangerous for use in housing epileptic prisoners with uncontrolled seizures—such as the broken intercom buzzer, the lack of video observation equipment, and the limited-visibility door.

343. In addition, to the extent that County employees or joint employees participated in the use of medication monitoring equipment on Galindo or assisted in administering anti-seizure

medication to Galindo, these items also constitute tangible personal or real property, the condition and use of which caused Galindo's injuries and death.

344. Galindo's placement and retention in the SHU, given the physical features of this housing unit and the accepted practice of indifferent and inadequate monitoring of SHU prisoners by RCDC III correctional and medical staff, created an unreasonable risk to his safety. Reeves County, via its employees or joint employees, County Monitor Weinacht, and other County officials, had actual and constructive knowledge of the unreasonable risk that SHU placement posed to prisoners like Galindo. The County failed to exercise ordinary care to remedy that risk. Galindo's injuries and death were a foreseeable result of that failure.

345. As a direct and proximate result of the negligent acts, omissions, and conduct of Defendant Reeves County and its employees or joint employees, as set forth above, Galindo suffered physical injuries; extreme physical, mental and emotional pain, anguish, and distress; and death.

FOURTH CAUSE OF ACTION
Intentional Infliction of Emotional Distress
Against Defendants: GEO, Sims, PNA, Farthing, Brady, Fears, Fitch, Millsap
(Survival Claim and Claim on Behalf of Graciela Galindo and Jesus Galindo, Sr.)

346. Plaintiffs incorporate paragraphs 1 through 320 as set forth above.

347. By deliberately placing Galindo in solitary confinement for a month, alone, scared, and isolated from any help as he suffered unattended seizures; by deliberately failing to adequately treat Galindo's epilepsy such that he suffered numerous terrifying seizures and gradually worsening gum disease over many months; and/or by deliberately ignoring Galindo's repeated pleas for medical attention to his deteriorating health such that they caused him to fear for his life over the course of an entire year until his death, Defendants GEO, Sims, PNA,

Farthing, Brady, Fears, Fitch, and Millsap engaged in intentional and/or reckless conduct that proximately caused Galindo severe and prolonged mental and emotional distress.

348. Defendants' conduct in this regard was extreme and outrageous.

349. By responding to the repeated pleas of Graciela Galindo and Jesus Galindo, Sr., to save their son's life with disregard and scorn; by refusing Graciela Galindo's offer of her son's pre-incarceration medical records to help them identify the correct medication to control his seizures; by notifying Graciela Galindo of her son's death in a cruel and unfeeling manner; and/or by causing Graciela Galindo and Jesus Galindo, Sr., to witness their son's mounting fear and slow deterioration over the course of an entire year until his death, Defendants engaged in intentional and/or reckless conduct that proximately caused Graciela Galindo and Jesus Galindo, Sr., severe and prolonged mental and emotional distress.

350. Defendants' conduct in this regard was extreme and outrageous.

FIFTH CAUSE OF ACTION
Deliberately Indifferent Denial of Medical Care
Eighth Amendment – U.S. Constitution
(42 U.S.C. § 1983)
Against Defendants: Farthing, Brady, Fears, Fitch, Millsap
(Wrongful Death and Survival Claim)

351. Plaintiffs incorporate paragraphs 1 through 320 as set forth above.

352. Galindo's epileptic condition was a serious medical need. Defendants Farthing, Brady, Fears, Fitch, and Millsap had actual knowledge of Galindo's epilepsy and actual knowledge that his seizures were not being adequately controlled during his time at RCDC III and in the month before he died.

353. By failing to provide Galindo with appropriate antiepileptic medication to control his condition; by refusing to adjust his medication or refer him to an off-site specialist when his condition worsened; by repeatedly failing to ensure that his medication was administered

consistently and at appropriate levels; and/or by blocking his access to essential medical and emergency care during his time in the SHU; Defendants Farthing, Brady, Fears, Fitch, and Millsap deprived Galindo of an essential human need—adequate medical care.

354. Defendants' acts and omissions constitute deliberate indifference to Galindo's serious medical needs. Defendants' conduct was an unreasonable response to obvious medical risk and did not in any way reflect legitimate medical judgment. Defendants acted willfully, deliberately, maliciously, and with reckless disregard for Galindo's health and safety.

355. As a direct result of the deliberately indifferent acts and omissions of Defendants Farthing, Brady, Fears, Fitch, and Millsap, as set forth above, Galindo suffered extreme physical, mental and emotional pain, anguish and distress; and death.

SIXTH CAUSE OF ACTION
Deliberately Indifferent Medical Isolation in the SHU
Eighth Amendment – U.S. Constitution
(42 U.S.C. § 1983)
Against Defendants: Sims, Devivo, Martin, Farthing, Brady, Fears, Fitch, Millsap
(Wrongful Death and Survival Claim)

356. Plaintiffs incorporate paragraphs 1 through 320 as set forth above.

357. Galindo's epileptic condition was a serious medical need. Defendants Sims, Devivo, Martin, Farthing, Brady, Fears, Fitch, and Millsap had actual knowledge of Galindo's epilepsy, and actual knowledge that Galindo had suffered and could continue to suffer seizures while isolated in the SHU.

358. By removing Galindo from general population and placing him in the SHU for unjustified and spurious reasons; by failing to adequately monitor or observe him while he was in the SHU; and/or by refusing to take action to move him out of isolation despite the obvious risk to his health and safety; Defendants Sims, Devivo, Martin, Farthing, Brady, Fears, Fitch, and Millsap deprived Galindo of reasonable safety and adequate medical care.

359. Defendants' acts and omissions constitute deliberate indifference to Galindo's serious medical needs and to his right to reasonable safety. Defendants' conduct was an unreasonable response to obvious risk and did not in any way reflect legitimate medical or correctional judgment. Defendants acted willfully, deliberately, maliciously, and with reckless disregard for Galindo's health and safety.

360. As a direct result of the deliberately indifferent acts and omissions of Defendants Sims, Devivo, Martin, Farthing, Brady, Fears, Fitch, and Millsap, as set forth above, Galindo suffered extreme physical, mental and emotional pain, anguish and distress; and death.

SEVENTH CAUSE OF ACTION
Policies and Customs of Deliberately Indifferent Medical Care
Eighth Amendment – U.S. Constitution
(42 U.S.C. § 1983 – Municipal Liability)
Against Defendants: PNA, Reeves County, GEO
(Wrongful Death and Survival Claim)

361. Plaintiffs incorporate paragraphs 1 through 320 as set forth above.

362. At all relevant times, Defendant PNA has maintained or sanctioned official policies and customs of providing deliberately indifferent medical care to prisoners at RCDC III, including: an inadequate formulary and limiting access to necessary medications; routine denial of access to specialized off-site care and consultations; failure to properly maintain medical and medication administration records; delayed, denied or inaccurate diagnosis and follow-up care; a paucity of medical staffing; inadequate medical supervision, training, and quality control; and a lack of medical observation beds.

363. PNA policymakers during the relevant time period—including but not limited to Defendant Farthing, Regional Area Director Gonzalez, Defendant Brady (the ranking physician at RCDC III); Defendants Fitch and Millsap (Health Services Administrators at RCDC III); and the RCDC III Director of Nursing—had actual and constructive knowledge of PNA's official

policies and customs with respect to medical care, and the ability to modify and remedy those practices.

364. PNA's official policies and customs of deliberately indifferent medical care were a moving force behind the deprivation of adequate medical care that caused Galindo's injuries and death.

365. At all relevant times, Defendants Reeves County and GEO have maintained or sanctioned official policies and customs leading to the provision of deliberately indifferent medical care to prisoners at RCDC III, including: insufficient correctional and medical staffing and failure to appropriately assign staff to monitor prisoners with serious medical needs; lack of medical observation beds; routine denial of access to specialized off-site care and consultations; and a failure to adequately audit the provision of medical care and impose corrective actions for medical deficiencies.

366. Reeves County and GEO policymakers during the relevant time period—including but not limited to Defendant Sims, the County Judge, County Commissioners, and County Monitor Weinacht—had actual and constructive knowledge of the County's and GEO's official policies and customs with respect to medical care, and the ability to modify and remedy those practices.

367. Reeves County's and GEO's official policies and customs leading to deliberately indifferent medical care were a moving force behind the deprivation of adequate medical care that caused Galindo's injuries and death.

368. As a direct and proximate result of the intentional and/or deliberately indifferent official policies and customs of Defendants PNA, Reeves County, and GEO, as set forth above, Galindo suffered extreme physical, mental and emotional pain, anguish and distress; and death.

EIGHTH CAUSE OF ACTION
Policies and Customs of Deliberately Indifferent Medical Isolation in the SHU
Eighth Amendment – U.S. Constitution
(42 U.S.C. § 1983 – Municipal Liability)
Against Defendants: GEO, Reeves County, PNA
(Wrongful Death and Survival Claim)

369. Plaintiffs incorporate paragraphs 1 through 320 as set forth above.

370. At all relevant times, Defendants Reeves County and GEO have maintained or sanctioned official policies and customs of deliberately indifferent medical isolation in the SHU, including: a routine practice of placing prisoners in the SHU as punishment for seeking improved medical care or filing medical complaints; a routine practice of improper, insufficiently documented and retaliatory use of the segregated housing unit; insufficient correctional and medical staffing and failure to appropriately assign staff to monitor prisoners with serious medical needs in the SHU; lack of appropriate medical observation beds; and failure to properly repair and maintain SHU facilities such as the intercom buzzer in Galindo's isolation cell.

371. Reeves County and GEO policymakers during the relevant time period—including but not limited to Defendant Sims, the County Judge and County Commissioners, and County Monitor Weinacht—had actual and constructive knowledge of the County's and GEO's official policies and customs with respect to medical isolation in the SHU, and the ability to modify and remedy those practices.

372. Reeves County's and GEO's official policies and customs leading to deliberately indifferent medical isolation were a moving force behind the deprivation of adequate medical care and reasonably safety that caused Galindo's injuries and death.

373. At all relevant times, Defendant PNA has maintained or sanctioned official policies and customs of deliberately indifferent medical isolation in the SHU, including: the referral of prisoners to isolation in the SHU as retaliation for demanding better medical care, as

punishment for purported non-compliance with medical instructions, and for "medical observation" in lieu of actual observation beds; the refusal to "medically clear" prisoners for release from the SHU in a timely and safe manner; and failure to adequately staff and implement necessary medical monitoring of prisoners in the SHU.

374. PNA policymakers during the relevant time period—including but not limited to Defendant Farthing, Regional Area Director Gonzalez, Defendant Brady (the ranking physician at RCDC III); Defendants Fitch and Millsap (Health Services Administrators at RCDC III); and the RCDC III Director of Nursing—had actual and constructive knowledge of PNA's official policies and customs with respect to medical isolation, and the ability to modify and remedy those practices.

375. PNA's official policies and customs of deliberately indifferent medical isolation were a moving force behind the deprivation of adequate medical care that caused Galindo's injuries and death.

376. As a direct and proximate result of the intentional and/or deliberately indifferent official policies and customs of Defendants GEO, Reeves County, and PNA, as set forth above, Galindo suffered extreme physical, mental and emotional pain, anguish and distress; and death.

NINTH CAUSE OF ACTION
Deliberately Indifferent Contracting/Failure to Protect from Obvious Risk
Eighth Amendment – U.S. Constitution
(*Bivens* Claim)
Against Defendants: Nace and Burrell
(Wrongful Death and Survival Claim)

377. Plaintiffs incorporate paragraphs 1 through 320 as set forth above.

378. By failing to adequately scrutinize the performance history of subcontractors PNA and GEO; by ignoring clear evidence that should have led them to reject PNA and GEO as potential subcontractors; and by approving PNA and GEO as subcontractors via the awarding of

CAR 5 to Reeves County; Defendants Nace and Burrell subjected Galindo and other chronically ill prisoners at RCDC III to the serious and unreasonable risks posed by PNA's documented medical incompetence and outright indifference and GEO's well-established practice of retaliatory medical isolation.

379. Adequate scrutiny of PNA's history of systemic failures in chronic medication delivery and monitoring of epileptic prisoners would have revealed the significant and unreasonable risk PNA posed to prisoners with epilepsy like Galindo. Nace and Burrell awarded the CAR 5 contract to Reeves County with deliberate indifference to the known and obvious consequence of that contracting decision—*i.e.*, the deprivation of the constitutional rights of epileptic prisoners to be placed in PNA's care at RCDC III. In doing so, Defendants failed to protect Galindo from an obvious risk.

380. Defendants Nace and Burrell knowingly and with deliberate indifference deprived Galindo of reasonable safety and adequate medical care by placing his health and safety in the hands of subcontractors PNA and GEO. Defendants' contracting decision was a moving force behind the violation of Galindo's constitutional rights that led to his death.

381. As a direct and proximate result of the acts and omissions of Defendants Nace and Burrell, as set forth above, Galindo suffered extreme physical, mental and emotional pain, anguish and distress; and death.

TENTH CAUSE OF ACTION
Deliberately Indifferent Monitoring/Failure to Remedy Obvious Risk
Eighth Amendment – U.S. Constitution
(*Bivens* Claim)
Against Defendants: Burrell, Grube and De Jesus
(Wrongful Death and Survival Claim)

382. Plaintiffs incorporate paragraphs 1 through 320 as set forth above.

383. The policies, practices, acts, and omissions of Reeves County, PNA, GEO, and their employees, as detailed throughout this Complaint, created serious, obvious, and long-standing risks to prisoners with chronic illnesses, daily medication needs, or conditions requiring regular medical observation. These risks were open and apparent.

384. Defendants Burrell, Grube, and De Jesus had the authority, opportunity, ability, and obligation to compel Reeves County and its subcontractors to remedy these risks by improving contract performance in the provision of medical services and the use of segregated housing. Defendants failed to do so despite obvious, ongoing risk to prisoners like Galindo. This failure constitutes deliberate indifference.

385. Defendants Burrell, Grube, and De Jesus knowingly and with deliberate indifference deprived Galindo of reasonable safety and adequate medical care by failing to remedy serious deficiencies in the provision of medical care at RCDC III that are linked to Galindo's death, and by failing to halt the open and notorious use of segregated housing to isolate and punish prisoners with serious medical needs at RCDC III.

386. As a direct and proximate result of the acts and omissions of Defendants Burrell, Grube, and De Jesus, as set forth above, Galindo suffered extreme physical, mental and emotional pain, anguish and distress; and death.

DEMAND FOR JURY TRIAL

387. Plaintiffs respectfully demand a jury trial on all claims.

PRAYER FOR RELIEF

388. Wherefore, Plaintiffs respectfully request that, after due proceedings, judgment be entered in favor of Plaintiffs and against all Defendants, jointly and severally, and that the Court award the following relief to Plaintiffs:

- All compensatory damages reasonable under the circumstances pursuant to the Texas Survival Statute and the Texas Wrongful Death Statute, including but not limited to: damages for physical pain and suffering, mental anguish and emotional distress, loss of enjoyment of life, loss of companionship and society, loss of financial support and maintenance, medical expenses, and funeral and burial expenses;
- Punitive damages against GEO, PNA, and all individual Defendants sued under 42 U.S.C. § 1983;
- Exemplary damages against GEO, PNA, and all individual Defendants sued for gross negligence and/or intentional infliction of emotional distress;
- Reasonable attorneys' fees and court costs under 42 U.S.C. § 1988, 28 U.S.C. § 2412, and other applicable law;
- Legal interest on all damages awarded from the date of judicial demand until paid; and
- Such other and further relief as this Court deems just and proper.

Dated: December 7, 2010

Respectfully Submitted,

/s/ Lisa Graybill

Attorneys for Plaintiffs

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