UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF NEW YORK

J.M., as Administrator of the Estate of Her Son, C.B.,

Plaintiff,

-against-

ASHLEY SESSIONS; DOES 1-6,

Defendants.

Case No. _____

COMPLAINT &
JURY DEMAND

AN UNNECESSARY AND TRAGIC DEATH IN A NEW YORK STATE GROUP HOME

1. C.B. died on April 9, 2018 in his room in Valley Ridge CIT, a New York State group home for developmentally disabled individuals. C.B. was thirty-four years old.

2. This case involves, in the words of the New York State Justice Center for the Protection of People With Special Needs, "substantial systemic problems, including inadequate management, training, and supervision at the facility that exposed C.B. to harm or risk of harm."

3. C.B.'s tragic death should never have happened. With basic care, C.B.'s heart condition would have been discovered and treated, and he would be alive today. But the staff at Valley Ridge failed to help C.B. when, the day before his death, he complained of trouble breathing and his mother also called staff to say C.B. had trouble breathing. They failed to notice or treat C.B.'s substantial edema. They failed to inquire why C.B. had gained 50 pounds in a year, over 20 of those pounds in the last four months before his death—let alone address that alarming weight gain.

4. The night of C.B.'s death, staff including Defendant Ashley Sessions failed to conduct required bed checks that would have saved his life. Staff then tried to cover up that

failure to the police; Sessions pled guilty to the crime of filing a false statement and lying—twice—to the police.

5. As a result of these failures, C.B. was left helpless in his room, his heart failing. He died alone in his bed, slowly asphyxiating on fluid in his lungs.

6. Valley Ridge staff failed to do their most basic job: keeping a disabled resident in their custody safe. Now they must be held accountable.

PARTIES

7. Plaintiff J.M. is a United States citizen; she currently resides in Glens Falls, New York. Plaintiff is C.B.'s mother and the Administratrix of his estate.

8. At all relevant times, Defendant Ashley Sessions was an employee of the New York State Office for People with Developmental Disabilities ("OPWDD"), an agency of the State of New York, acting in the capacity of agent, servant, and employee of the State of New York, and within the scope of her employment as such, and under color of law. Sessions was working the overnight shift at the Valley Ridge Center for Intensive Treatment ("Valley Ridge CIT") on April 8-9, 2018. Sessions was required to check on C.B. every two hours during her overnight shift on April 8-9, 2018, which she failed to do. Sessions is sued in her individual capacity.

9. Defendant Doe 1 is the nurse who examined C.B. on April 8, 2018 at the Valley Ridge CIT, and who was interviewed by OPWDD's Office of Investigations and Internal Affairs ("OIIA") in connection with C.B.'s death on April 10, 2018. At all relevant times, Doe 1 was an employee of OPWDD, an agency of the State of New York, acting in the capacity of agent, servant, and employee of the State of New York, and within the scope of his/her employment as such, and under color of law. Doe 1 is sued in his/her individual capacity.

10. Defendant Doe 2 was the Valley Ridge CIT Head of Shift on April 8, 2018. Doe 2 was physically present when C.B. was examined by a nurse on April 8, 2018. Doe 2 was interviewed by OIIA in connection with C.B.'s death on April 10, 2018. At all relevant times, Doe 2 was an employee of OPWDD, an agency of the State of New York, acting in the capacity of agent, servant, and employee of the State of New York, and within the scope of his/her employment as such, and under color of law. Doe 2 is sued in his/her individual capacity.

11. Defendant Doe 3 was the Valley Ridge CIT Head of Shift on the overnight shift of April 8-9, 2018. Doe 3 was interviewed by OIIA in connection with C.B.'s death on April 9, 2018. At all relevant times, Doe 3 was an employee of OPWDD, an agency of the State of New York, acting in the capacity of agent, servant, and employee of the State of New York, and within the scope of his/her employment as such, and under color of law. Doe 3 is sued in his/her individual capacity.

12. Defendant Doe 4 is the Valley Ridge CIT employee responsible for monitoring "acute and chronic medical problems," "medications," and seeing "individuals at the clinic for acute illnesses as well as admission history and complete annual physicals." Doe 4 was interviewed by OIIA in connection with C.B.'s death on April 20, 2018. At all relevant times, Doe 4 was an employee of OPWDD, an agency of the State of New York, acting in the capacity of agent, servant, and employee of the State of New York, and within the scope of his/her employment as such, and under color of law. Doe 4 is sued in his/her individual capacity.

13. Defendant Doe 5 is a Valley Ridge CIT staff member who heard C.B. state on April 4, 2018, "I don't feel good, I can't breathe." Doe 5 observed that C.B. could not finish vacuuming without taking a break on April 4, 2018. Doe 5 did not document any of C.B.'s behavior on April 4, 2018. Doe 5 was interviewed by OIIA in connection with C.B.'s death on

April 12, 2018. At all relevant times, Doe 5 was an employee of OPWDD, an agency of the State of New York, acting in the capacity of agent, servant, and employee of the State of New York, and within the scope of his/her employment as such. Doe 5 is sued in his/her individual capacity.

14. Defendant Doe 6 was the Approved Medication Administration Person working at the Valley Ridge CIT on April 8, 2018 and assigned to "E" house. On April 8, C.B.'s mother told Doe 6 that C.B. could not breathe and needed medical attention. Doe 6 did not report or memorialize his conversation with C.B.'s mother. Doe 6 was interviewed by OIIA in connection with C.B.'s death on April 12, 2018. At all relevant times, Doe 6 was an employee of OPWDD, an agency of the State of New York, acting in the capacity of agent, servant, and employee of the State of New York, and within the scope of his/her employment as such. Doe 6 is sued in his/her individual capacity.

JURISDICTION AND VENUE

15. This action arises under the Fourteenth Amendment to the United States Constitution, 42 U.S.C. §§ 1983 and 1988, and state common law.

16. The jurisdiction of this Court is predicated upon 28 U.S.C. §§ 1331, 1343(a)(3), 1367(a), and the doctrine of supplemental jurisdiction.

17. The acts complained of occurred in the Northern District of New York and venue is lodged in this Court pursuant to 28 U.S.C. § 1391(b).

JURY DEMAND

18. Plaintiff demands trial by jury in this action.

FACTUAL ALLEGATIONS

The Valley Ridge CIT

19. The Valley Ridge CIT is a 14-acre campus located in Norwich, NY operated by New York State through OPWDD.

20. The Valley Ridge CIT is a highly structured active treatment and facilitative residential program within a secure setting.

21. The Valley Ridge CIT provides services to approximately 43 individuals. Each individual has their own bedroom with key card access entry.

C.B.

22. C.B. was born on May 28, 1983.

23. C.B. was a disabled individual. He was diagnosed with mild mental retardation, among other disabilities.

24. When C.B. was 10 years old, he was hit by a car and suffered a head injury.

25. At age 18, C.B. was placed in the care of OPWDD at Broome Developmental Center.

26. In 2015, C.B. moved to Valley Ridge CIT.

27. Unlike many other residents at Valley Ridge CIT, C.B. was not sent there as part of a criminal conviction.

28. Staff at Valley Ridge CIT reported that C.B. was social and loved interacting with staff and peers.

29. C.B. worked a janitorial job at Valley Ridge CIT and was a punctual, diligent worker.

30. C.B. loved music and singing. He discussed his goal to live in a less restrictive setting than Valley Ridge CIT.

31. C.B. has a loving family, including his mother and siblings.

C.B.'s Premature Death

32. C.B. died on April 9, 2018 at approximately 5 a.m. at Valley Ridge CIT. He was thirty-four years old.

33. C.B.'s death was caused by either an idiopathic or viral cardiomyopathy.

34. C.B. was in heart failure at the time of his death.

35. On the night he died, C.B. was in pulmonary edema—*i.e.*, he had fluid in his lungs.

Defendants Ignore the Significant Health Concerns that Led to C.B.'s Death

36. Defendants' deliberate indifference to C.B.'s health proximately caused his premature death.

37. The heart failure that ultimately killed C.B. began 3-4 months before his death. During those months, Defendants ignored (i) C.B.'s extreme weight gain, (ii) significant swelling on C.B.'s arms and legs, (iii) C.B.'s fatigue, (iv) C.B.'s difficulties breathing, and (v) C.B.'s difficulties using the bathroom.

38. Rapid weight gain, edema/swelling, difficulty breathing, and difficulty voiding (*i.e.*, going to the bathroom) are all telltale signs of pulmonary edema. C.B. displayed all of these symptoms over the final month of his life. Defendants ignored them.

Weight Gain

39. Defendants ignored C.B.'s significant weight gain during his time at the Valley Ridge CIT.

40. In June 2015, just after his arrival at the Valley Ridge CIT, C.B. weighed 238 pounds. Less than three years later, when he died in April 2018, he weighed 294 pounds. C.B. gained ten pounds in just the final month of his life.

41. OPWDD's Justice Center noted that "there was little in the record to explain or rectify [C.B.'s] significant weight gain over the course of several years prior to his death at the [Valley Ridge] CIT." The Justice Center explained that "further evaluation of his weight gain and whether [C.B.] demonstrated symptoms consistent with Metabolic Syndrome or some other medical condition should have been identified and addressed by [Valley Ridge] CIT medical staff." *Id.* But OPWDD staff, including Defendants, ignored C.B.'s alarming weight gain and took no action.

42. Doe 4 in particular was responsible for monitoring C.B.'s "acute and chronic medical problems." But she/he recklessly ignored C.B.'s chronic weight gain and the significant heart issues that it portended.

Swelling

43. The medical examiner reported that C.B.'s arms and legs showed "2+ pitting edema bilaterally" at the time of his death. Pitting edema means that, when a finger is pressed into the skin, an indentation remains. On the edema scale of 0 to 2+, 2+ reflects serious edema.

44. Pitting edema is a clear sign of heart failure.

45. The enormous amount of fluid in C.B.'s extremities was obvious to the naked eye.

46. For days and even weeks prior to his death, OPWDD staff, including Defendants, failed to treat or even note the significant swelling in C.B.'s arms and legs.

47. On April 8, 2018, the day before his death, C.B. was seen by Doe 1, a Valley Ridge CIT nurse. Doe 2, the Head of Shift at Valley Ridge CIT on April 8, 2018, was also present for the exam.

48. Upon information and belief, Doe 1 and Doe 2 saw the significant swelling in C.B.'s arms and legs.

49. Neither Doe 1 nor Doe 2 recorded or addressed the massive swelling in C.B.'s arms and legs.

"I Can't Breathe"

50. On April 4, 2018, just four days before C.B.'s death, Doe 5 observed that C.B. "could not complete vacuuming" without stopping to rest. C.B. told Doe 5: "I don't feel good. I can't breathe."

51. This was a serious cry for help, and strong evidence of a serious—even potentially life-threatening—medical issue.

52. Doe 5 did not document C.B.'s breathing troubles on April 4, 2018.

53. Upon information and belief, properly documenting medical complaints of Valley Ridge CIT residents is critical to ensuring the residents receive necessary medical care.

54. Upon information and belief, Doe 5 did not take sufficient action to address or report the medical issue that was causing C.B.'s breathing problems.

55. Another Valley Ridge CIT staff member noticed that C.B.'s "breathing had been a little erratic" in the "last few weeks" before he died.

56. On April 8, 2018, C.B. again complained to Valley Ridge CIT staff that he could not breathe.

57. On April 8, Doe 1 noticed that when C.B. arrived at the clinic, "he was breathing fairly heavily."

58. Doe 2 was present at the clinic with C.B. on April 8 and, upon information and belief, noticed that he was breathing fairly heavily.

59. And Doe 3 was aware that C.B. "usually gets up a lot at night complaining of heart burn."

60. None of these Defendants (Doe 1, Doe 2, or Doe 3) took any action to address C.B.'s breathing difficulties. None sought medical intervention. Had these Defendants taken even minimal action, they would have uncovered the significant health problems of which C.B.'s breathing difficulties were a symptom.

Fatigue

61. C.B. had been exhibiting signs of fatigue for nearly a month before he died.

62. Nursing notes from March 15, 2018 indicate that C.B. "seem[ed] tired, 'not with it.'"

63. Doe 4, who was responsible for monitoring "acute and chronic medical problems," was aware that C.B. had made "some complaints" to his psychiatrist about being tired.

64. Doe 4 did nothing to address C.B.'s fatigue or diagnose the serious health issues of which his fatigue was a clear symptom.

65. Doe 4's failure to address C.B.'s repeated complaints of fatigue was a proximate cause of C.B.'s death.

Difficulty Voiding

66. On April 8, 2019, C.B. complained to Doe 1 that he was having "difficulty voiding."

67. Upon information and belief, Doe 2, who was present at the clinic with C.B. on April 8, heard C.B.'s complaint about having difficulty voiding.

68. Doe 1 examined C.B. but did nothing to provide C.B. relief and ignored the obvious likelihood that his voiding problems—coupled with his breathing troubles, his fatigue, his swelling, and his weight gain—were symptomatic of more serious health concerns.

Defendants Exacerbate the Health Issues that Led to C.B.'s Death

69. On at least three occasions, Defendants responded to C.B.'s health complaints by telling him to drink more fluids.

70. Drinking fluids increases the likelihood of death in people suffering from pulmonary edema.

71. On March 15, 2018, a Valley Ridge CIT nurse "encouraged . . . [C.B.] to drink plenty of fluids."

72. This was disastrous advice, and it contributed to C.B.' death.

73. On April 4, 2018, after C.B. complained about not feeling well and could not finish vacuuming the floor without taking a rest, a Valley Ridge CIT staff member told him to drink plenty of fluids.

74. On April 8, 2018, after she/he finished examining C.B., Doe 1 instructed him to "drink plenty of water."

75. Again, this was disastrous medical advice for someone with pulmonary edema.

76. Staff's repeated instruction to C.B. to drink plenty of fluids was a proximate cause of C.B.'s death.

C.B.'s Mother's Call for Help Is Ignored

77. On the morning of April 8, 2018 C.B. called his mother, J.M., and complained that he was having trouble breathing and could not urinate. During the call, C.B. was in obvious distress, crying on the phone. His mom was afraid.

78. Shortly after that call, J.M. called Valley Ridge CIT.

79. J.M. told a staff member, Doe 6, that her son could not breathe.

80. J.M. also told Doe 6 that C.B. could not urinate.

81. J.M. told Doe 6 that her son needed immediate medical attention.

82. In response, Doe 6 apparently did nothing.

83. Doe 6 did not note the alarming report from J.M. that C.B. could not breathe.

84. Doe 6 did not note that J.M. called at all.

85. The nursing notes from April 8, 2018 do not mention J.M.'s call.

86. The nursing notes from April 8, 2018 do not mention C.B.'s complaints about trouble breathing.

87. No one at Valley Ridge CIT, including Doe 6, did anything in response to Plaintiff's report about her son.

88. No one even called J.M. back to follow-up with her.

89. J.M. never had the chance to speak with her son again.

Ashley Sessions and Doe 3 Leave C.B. Alone to Die, then Sessions Lies About It

90. On the night of April 8-9, 2018, Ashley Sessions was responsible for checking on C.B. every two hours, starting at 11:00 p.m.

91. On the night of April 8-9, 2018, Doe 3 was assigned to be the Head of Shift.

92. Sessions was supposed to check on C.B. at 11:00 p.m., 1:00 a.m., 3:00 a.m., and 5:00 a.m.

93. Sessions did not check on C.B. at 3:00 a.m. on April 9.

94. Sessions did not check on C.B. at 5:00 a.m. on April 9.

95. Doe 3 was in Valley Ridge CIT's "E" house, where C.B. lived, from 3:00 a.m. to 5:30 a.m. on April 9.

96. Doe 3 did not check on C.B. between 3:00 a.m. and 5:30 a.m. on April 9 to ensure he was safe.

97. As the Head of Shift, Doe 3 was responsible for ensuring that Valley Ridge CIT staff working on April 8-9, 2018 did their jobs.

98. Doe 3 did not ensure that Sessions or anyone else checked on C.B. every two hours on April 9.

99. Doe 3 did not ensure that Sessions or anyone else protected C.B. on the night of April 8-9, 2018.

100. After C.B. died, Sessions falsified Valley Ridge CIT documents, writing that she had checked on C.B. at 3:00 a.m. and 5:00 a.m.

101. On the morning of April 9, 2018, Sessions signed a sworn supporting deposition, claiming (i) she saw C.B. walking to the bathroom at 1:00 a.m. and (ii) "I do nightly checks every two hours, and check to make sure that each consumer is responsive and breathing. I checked on C.B. at 3AM and again at 5AM."

102. These statements were lies.

103. Later on April 9, 2018, Sessions admitted to police that she had lied.

104. She stated, "I did not [check] C.B.'s door at 3 and 5 as I had stated," though she "was supposed to do bed checks at 11, 1, 3, and 5."

105. In another police interview on April 11, 2018, Sessions admitted: "I falsified a document for work that said I saw C.B. up at around 1 AM."

106. She also admitted that she *never* saw C.B. awake during her shift.

107. Though Sessions still claimed she did bed checks at 11:00 p.m. and 1:00 a.m., she couldn't even "tell if C.B. was alive when [she] performed these checks."

108. Sessions also admitted that her supervisor, OPWDD employee Jen Smith, had told her to lie to police and claim she had seen C.B. that night, when in fact she had not.

109. Sessions eventually pleaded guilty to providing false statements.

110. Had Sessions completed the bed checks she was required to complete on the night of April 8-9, 2018, she would have seen C.B. in increasing distress and called for assistance to save his life.

111. Had Doe 3 ensured that Sessions was completing the bed checks she was required to complete on the night of April 8-9, 2018, Sessions would have seen C.B. in increasing distress and called for assistance to save his life.

112. Sessions' failure check on C.B. on the night of April 8-9, 2018, as she was required do, proximately caused C.B.'s death.

113. Doe 3's failure to ensure that Sessions did her job by checking on C.B. on the night of April 8-9, 2018 proximately caused C.B.'s death.

OPWDD Substantiates Three Charges of Abuse and Neglect

114. The New York State Justice Center for the Protection of People with Special Needs ("Justice Center") investigated C.B.'s death.

115. "[T]he investigation revealed substantial systemic problems, including inadequate management, training, and supervision at the facility that exposed [C.B.] to harm or risk of harm."

116. "This includes the facility's failures: (1) to implement a procedure to require all communications from the house to nursing be documented in the individual resident record as well as house communication log; (2) to require shift notices [to] include any signs and symptoms of individual medical complaints."

117. The Justice Center also substantiated charges of abuse and neglect due to Sessions's failure to conduct required bed checks and the State's falsification of documents to cover up those incomplete bed checks.

C.B. Suffered Before as He Died

118. The pulmonary edema that C.B. experienced leading up this death was immensely painful.

119. For a significant period of time prior to his death, C.B. was drowning in his own fluids and struggling to catch his breath.

120. As a result, C.B. suffered severe physical and emotional injury, pre-death terror, pain and suffering, and was deprived of his life, and the lost enjoyment of life.

FIRST CLAIM
42 U.S.C. § 1983, Substantive Due Process

121. Plaintiff repeats and realleges the foregoing as if the same were fully set forth at length herein.

122. As C.B.'s custodians, responsible for his safety and well-being, the Defendants had an affirmative duty to care for and protect C.B. under the Due Process Clause of the Fourteenth Amendment to the United States Constitution.

123. The Defendants breached that duty. The Defendants' actions and omissions were a substantial departure from the exercise of reasonable professional judgment, practice and standards, were grossly negligent, and amounted to deliberate indifference to C.B.'s health and welfare.

124. The Defendants acted with deliberate indifference to, and callous disregard for, the significant health problems that led to C.B.'s death, about which he and others complained to Defendants repeatedly.

125. The Defendants' complete failure to respond to C.B.'s evident and excessive weight gain; their disregard for the substantial swelling in his arms and legs in the days before his death; their failure to respond to his repeated complaints of fatigue and difficulty breathing; their instructions to C.B. that he keep drinking fluids despite the fact that drinking fluids increases the risk of death in people suffering from pulmonary edema; their failure to check on C.B. on the night of April 8-9, 2018, as required; and all their other conduct set forth above exhibited deliberate indifference to, and callous disregard for, the safety, well-being and civil rights of C.B., proximately causing him substantial and unnecessary physical and emotional harm, and proximately causing his death.

126. By virtue of the foregoing, the Defendants deprived C.B. of clearly-established rights protected by the Due Process Clause of the Fourteenth Amendment to the United States Constitution, and C.B. sustained the damages hereinbefore alleged.

SECOND CLAIM
Negligence

127. Plaintiff repeats and realleges the foregoing as if the same were fully set forth at length herein.

128. Defendants had a duty to care for C.B., diagnose his health problems, check on him during the night, prevent him from suffering, and protect his life.

129. Defendants breached those duties by the conduct set forth above, and by failing to respond to C.B.'s evident and excessive weight gain; disregarding the substantial swelling in his arms and legs in the days before his death; failing to respond to his repeated complaints of fatigue and difficulty breathing; instructing C.B. to keep drinking fluids despite the fact that drinking fluids increases the risk of death in people suffering from pulmonary edema; and failing to check on C.B. on the night of April 8-9, 2018, as they were required to do.

130. As a direct and proximate result of Defendants' breaches of their duties, C.B. sustained the damages hereinbefore alleged.

THIRD CLAIM
Medical Malpractice (against Does 1, 4 and 6 only)

131. Plaintiff repeats and realleges the foregoing as if the same were fully set forth at length herein.

132. Upon information and belief, and subject to further discovery, at all relevant times, Does 1, 4, and 6 (the "Medical Defendants") undertook to provide medical care to residents of the Valley Ridge CIT, including C.B., and were legally obligated and had a special duty to do so effectively.

133. Upon information and belief, and subject to further discovery, the Medical Defendants held themselves out as possessing the proper degree of learning and skill necessary to render medical care, treatment, and services in accordance with good and accepted medical practice, and held themselves out as using reasonable care and diligence in the care and treatment of the residents of Valley Ridge CIT, including C.B.

134. By their misconduct detailed above, the Medical Defendants acted contrary to sounds medical practice and committed acts of medical malpractice against C.B.

135. As a direct and proximate result of the Medical Defendants' negligence, C.B. endured the damages hereinbefore alleged.

136. A certificate of merit pursuant to Section 3012-a of the New York Civil Practice Law and Rules is annexed to Plaintiff's Complaint.

WHEREFORE, Plaintiff requests that the Court grant the following relief jointly and severally against Defendants:

A. Compensatory damages in an amount to be determined at trial.

B. Punitive damages against each Defendant in an amount to be determined at trial.

C. An order awarding Plaintiff reasonable attorneys' fees, together with the costs of this action.

D. Such other and further relief as the Court may deem appropriate.

Dated: January 27, 2020
New York, New York

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/s

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**Application to Northern District of New York pending*