UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF FLORIDA
Ocala Division

ROBERT LEE HERNANDEZ,

Plaintiff,

vs. Case No. 5:11-cv-00370-EAK-TBS

UNITED STATES OF AMERICA,

Defendant.
_____/

FIRST AMENDED COMPLAINT

1. Plaintiff, Robert Lee Hernandez, pursuant to the Federal Tort Claims Act, 28 U.S.C. §§ 2671-2680, seeks compensatory damages arising from Defendant United States of America's (hereinafter "Defendant") negligence in failing to adhere to the prevailing professional standard of care which is generally recognized as acceptable and appropriate by reasonably prudent similar health care providers.

Jurisdiction and Venue

2. This Court has subject matter jurisdiction over this matter pursuant to 28 U.S.C. § 1331 in that this action arises under the laws of the United States of America and is premised on the acts and omissions of the Defendant acting under color of federal law. This Court further has subject matter jurisdiction over this matter pursuant to 28 U.S.C. § 1346(b) in that this is a claim against the Defendant United States of America, for money damages, accruing on or after January 1, 1945, for personal injury caused by the negligent and wrongful acts and omissions of employees of the Government while acting within the course and scope of their office or employ-

ment, under the circumstances where the Defendant, if a private person, would be liable to the Plaintiff.

3. Jurisdiction founded upon the federal law is proper in that this action is premised upon federal causes of action under the Federal Tort Claims Act (hereinafter "FTCA"), 28 U.S.C. § 2671, *et. seq*.

4. Pursuant to the FTCA, 28 U.S.C. § 2671, *et. seq*., the Plaintiff on or about July 6, 2010, Plaintiff presented his claim to the appropriate federal agency for administrative settlement under the FTCA requesting $1,000,000.00 or more. By letter dated December 21, 2010, Plaintiff's claim was finally denied in writing by the Southeast Regional Office of the Federal Bureau of Prisons and such denial was sent by certified or registered mail to the Plaintiff. (Claim #TRT-SER-2010-05587). This lawsuit was then timely filed.

5. This action is timely pursuant to 28 U.S.C. § 2401(b) in that it was presented to the appropriate federal agency within two years of accrual and this action was filed within six months of receipt of the certified letter sent by the federal agency denying the claim.

6. Venue is proper in this district pursuant to 28 U.S.C. §§ 1391(b) and 1391(c), as Defendant does business in this judicial district and the events or omissions giving rise to the claims occurred in this judicial district.

Parties

7. Plaintiff, Robert Lee Hernandez, is an inmate in the custody of the Federal Bureau of Prisons (hereinafter referred to as "BOP"), an agency of the Defendant, and currently resides at a BOP facility in Butner, North Carolina, a correctional facility owned and operated by Defendant.

8. At all times material to this action, Mr. Hernandez was an inmate in the custody of the BOP, and was assigned to the United States Penitentiary Coleman Low (hereinafter "Coleman"), located in Coleman, Sumter County, Florida, a correctional facility owned and operated by Defendant.

9. Defendant, United States of America, is subject to suit for personal injury caused by the negligent and wrongful acts and omissions of employees of the Government while acting within the course and scope of their office or employment, under the circumstances where the Defendant, if a private person, would be liable to the Plaintiff, pursuant to the FTCA.

10. At all times material to this action, Defendant was responsible for the correct and prompt response to the health care needs of inmates in its custody.

11. At all times material to this action, Mr. Hernandez was an inmate subject to the custody and control of the Defendant and subject to the care and treatment of the Defendant for any and all medical evaluation and treatment.

12. At all times material to this action, if Mr. Hernandez required medical evaluation or treatment, his only avenue was to rely on the medical evaluation and treatment provided by the Defendant.

Statement of Claim

13. Mr. Hernandez came into the custody of the BOP in January 2007. On or about June 17, 2008, Mr. Hernandez arrived at Coleman Low in the Special Housing Unit program.

14. On or about February 5, 2009, Mr. Hernandez began experiencing extreme and intense pain in his right leg. He had to be carried by two correctional officers to medical as he was unable to walk. Although later determined to be suffering from septic arthritis with osteomyelitis, when seen by a physicians' assistant, Plaintiff was not properly diagnosed.

15. As a result of this misdiagnosis, between February 5, 2009 and March 2, 2009, medical staff at Coleman provided Mr. Hernandez with no treatment for his underlying medical condition, giving him only a number of different pain medications, none of which provided him relief. In fact, the pain medications given only served to mask the underlying medical condition which the Defendant failed to properly diagnose, much less treat.

16. On or about March 2, 2009, Mr. Hernandez began experiencing extreme pain in his chest and abdomen. He thought he was having a heart attack.

17. Shortly thereafter, Mr. Hernandez was seen by Dr. Davilla, a physician employed by the Defendant. Mr. Hernandez was crying given the intense pain in his chest and abdomen area, and he was having trouble breathing. Dr. Davilla stated there was nothing wrong with Mr. Hernandez, and that he was faking a medical emergency to receive relief for the pain in his leg.

18. Nonetheless, Mr. Hernandez was taken to an outside hospital on March 2, 2009, where he was diagnosed with urinary retention, a low potassium level, obstipation (severe constipation) due to the improperly administered medications by BOP medical staff, and pneumonia of the lower right lobe. He was released from the hospital on March 4, 2009.

19. Soon after his release from the hospital, Mr. Hernandez had an MRI of the lower spine on March 15, 2009. The MRI found Mr. Hernandez had multilevel lumbar spondylitis (arthritis of the spine due to aging) and degenerative disk and fact degenerative changes (arthritis). Because the Defendant focused the MRI on Mr. Hernandez's back, the MRI failed to properly identify the true nature of Mr. Hernandez's hip and lower extremities pain.

20. As early as June 16, 2009, Defendant's medical staff records note decreased strength in Mr. Hernandez's right leg and that his right leg was tender with passive range of mo-

tion and decreased muscle tone. The Defendant's records further note that the volume of Mr. Hernandez's right leg was 1.5 cm less than his left leg, which continues to this day.

21. Despite these findings, Defendant's BOP medical staff continued to treat Mr. Hernandez only with various pain medications such as Oxycodone and Ibuprofen for what Defendant continued to believe was an old back injury; Defendant continued to provide Mr. Hernandez with no treatment whatsoever for the pain in his right hip and right leg.

22. For the following eight months, Mr. Hernandez continued to complain to the Defendant of the extreme pain he was experiencing in his hip and lower extremities, all to no avail. During these months, BOP medical staff made over thirty (30) entries in Mr. Hernandez's medical file after seeing him in response to complaints of chronic, severe, and unremitting pain, but instead continued to prescribe only various pain medications while making little or no effort to diagnose the origin of Mr. Hernandez's severe and excruciating pain.

- On February 5, 2009, Plaintiff presents with severe pain in right groin area and right leg, and given pain medications.
- On February 8, 2009, Plaintiff's pain medication is not changed, and Tylenol#3 is continued despite no improvement.
- On February 9, 2009, Plaintiff's pain is managed with medication.
- On February 11, 2009, Plaintiff's pain in his right leg is managed by changing his medications.
- On February 15, 2009, Plaintiff's pain medications are changed.
- On February 18, 2009, Plaintiff's pain medications are changed.
- On February 21, 2009, Plaintiff's pain in the right leg results in pain shot and medications.
- On February 22, 2009, Plaintiff's pain medications are ordered.
- On February 23, 2009, Plaintiff appears in pain and distress, and given a pain injection and medications.

- On February 27, 2009, Plaintiff's pain medications are renewed.
- On March 4, 2009, Plaintiff's pain medications are renewed.
- On April 3, 2009, Plaintiff's pain medications are renewed.
- On April 18, 2009, Plaintiff's pain medications are renewed.
- On April 21, 2009, Plaintiff's pain medications are renewed.
- On April 27, 2009, Plaintiff's pain medications are cancelled.
- On April 29, 2009, Plaintiff is seen about abnormalities on MRI.
- On May 7, 2009, Plaintiff's pain medications are changed.
- On May 12, 2009, Plaintiff's chronic pain medications are changed.
- On May 22, 2009, Plaintiff's chronic pain medications are changed.
- On June 3, 2009, Plaintiff is seen in his cell complaining of chronic pain. Plaintiff was counseled about access to care.
- On June 19, 2009, Plaintiff presented with severe back and leg pain.
- On July 7, 2009, there was a change in Plaintiff's pain medication but no effort made to diagnose the reason for pain despite atrophy being noted in right leg.
- On July 13, 2009, Plaintiff saw medical because of "unremitting pain." He was given pain medication.
- On July 24, 2009, he saw medical in his cell because he could not walk for severe pain from the hip to the foot.
- On July 29, 2009, he complained of pain.
- On August 4, 2009, Plaintiff went to medical and told the EMT and Dr. Davilla of the pain in his leg and that it "feels like it is on fire." He was given a shot and pain medication.
- On August 5, 2009, he received a shot for the pain in his right leg.

- On August 6, 2009, he saw Dr. Davilla and was again given pain medications. He went to see Dr. Davilla again on August 7, 2009, and again all that was done was to provide more pain medications.
- On September 3, 2009, Plaintiff is put on different pain medication.
- On September 5, 2009, Plaintiff is put on different pain medication.
- On September 11, 2009, Plaintiff is put on different pain medication.
- On September 15, 2009, Plaintiff is put on different pain medication.

23. In an attempt to get the attention of someone outside Coleman for the medical treatment he so desperately needed, Mr. Hernandez even went so far as to file a Federal Tort Claim Act request with the Southeast Regional Office of the BOP regarding the undiagnosed pain in his right hip and leg (Claim #TRT-SER-2009-04139). Unsurprisingly, this request was denied by BOP Regional General Counsel on November 10, 2009.

24. After over six (6) months of continuing complaints regarding the extreme pain and discomfort in Mr. Hernandez's right hip and right leg, on August 12, 2009, an outside neurosurgeon noticed that Mr. Hernandez's back MRI did not account for his hip and leg pain, and ordered a CT scan of his abdomen and pelvis. The neurosurgeon additionally noted: "About seven months ago, he [Mr. Hernandez] had the acute onset of excruciating pain down his right leg. He has no left leg pain. His pain is so severe, it wakes him every 20 minutes. His leg is wasted from disuse because of pain. He has lost weight because he is in too much pain to eat." A C-reactive protein and Sed Rate were also ordered by this same neurosurgeon to determine whether there was an infection in the retro peritoneal area which was later determined to be abnormal.

25. Even after the outside neurosurgeon noted that Mr. Hernandez's pain could not be accounted for by his prior MRI, that infection was suspected, and that a CT scan of his abdomen

and pelvis was required, Defendant's treating physician, Dr. Davilla, did not counter-sign this entry until months later on October 1, 2009. As a result, the Defendant's health care staff continued to misdiagnose and mistreat Mr. Hernandez throughout the next two months, even after the neurosurgeon's consult report of August 12, 2009.

26. More importantly, the outside neurosurgeon's recommended CT scan was delayed for six (6) weeks for no apparent reason. The delayed CT scan, finally taken on September 27, 2009, showed an abnormality to Mr. Hernandez's right femoral head and neck. The radiologist reviewing the CT scan diagnosed the result as possible acute osteomyelitis and an MRI was ordered of the right femoral head and neck.

27. Two weeks later on October 10, 2009, the ordered MRI was finally performed, and, as a result, Mr. Hernandez was sent to the hospital for treatment.

28. On October 16, 2009, Dr. Mark Tidwell, another physician employed by the Defendant, read the MRI and admitted that Defendant had failed to properly diagnose Mr. Hernandez. He noted the following:

> Inmate developed pain in the back and down the right leg about 9 months ago, was thought to be low back pain with a radicular component. He was treated for this without improvement. Had MRI of IS spine and was seen by neurosurgery and told this was not the source of his pain. Further work up found a moth eaten apparenc [sic] to the right hip. MRI was done which confirmed septic arthritis

29. As a result of the MRI, Mr. Hernandez was finally properly diagnosed – over eight and a half (8½) months after he first presented – with right hip septic arthritis with corresponding osteomyelitis (infection of the bone).

30. As a result of the Defendant's failure to properly diagnose and timely treat his osteomyelitis with antibiotics for over eight and a half months, Mr. Hernandez underwent surgery and a cement bone with antibiotics was placed in him at Munroe Regional Medical Center in

Ocala on November 10, 2009, followed by physical therapy and a protracted period of IV antibiotics for 6-8 weeks. Largely as a result of the antibiotics, Mr. Hernandez developed *Clostridium difficile* (referred to as "C. Diff") which caused him to be violently ill due to severe diarrhea and other intestinal diseases because competing bacteria in the gut flora have been wiped out by antibiotics. Mr. Hernandez was continuously hospitalized during this time.

31. Thereafter, on December 27, 2009, as a result of the Defendant's failure to properly diagnose and timely treat his osteomyelitis with antibiotics for over eight and a half (8½) months, Mr. Hernandez had to undergo a second surgical procedure at Florida Hospital in Orlando, which included a total right hip replacement and a replacement of a large portion of his right femur due to avascular necrosis. Mr. Hernandez continued to be hospitalized during this time.

32. As a further complication of the Defendant's failure to properly diagnose and treat his osteomyelitis, Mr. Hernandez was in the hospital for an additional six (6) months after hip and femur replacement surgery. While in the hospital, Mr. Hernandez developed an acute septic mega colon (acute dilatation of the large bowel) and underwent a subtotal colectomy and ileostomy. Mr. Hernandez also lost his gall bladder, had pancreatitis, suffered a hernia and a pinched nerve, and had gout. As a result, he was in the intensive care unit (ICU) on a ventilator, in critical condition, and nearly died.

33. Mr. Hernandez's condition became so dire as a result of Defendant's negligence, that Defendant called Mr. Hernandez's daughters in California to tell them that they had better come to Florida to visit their father as it was anticipated he would soon die.

34. As a further result of Defendant's negligence, Mr. Hernandez's right leg has atrophied and is two to three (2-3) inches shorter than his left leg, thereby requiring Mr. Hernandez

to wear special shoes for the remainder of his life. Mr. Hernandez also has an artificial hip which will periodically need replacement at a substantial cost, an artificial right femur, and as a result of Defendant's negligence, his back pain is now far worse than before and he often becomes unstable and falls.

35. As a further result of Defendant's negligence, Mr. Hernandez is now disabled for the remainder of his life, and unable to be employed in his past occupation as a roofer.

36. Defendant has in its employ and/or agency doctors, nurses, and other medical care providers, over which it exercises control and supervision. At all times material to this action, Defendant authorized these agents and employees to act for Defendant when they committed the negligent acts alleged herein. Defendant's agents and employees accepted the undertaking of acting on behalf of Defendant when they committed the negligent acts alleged herein. Defendant had control over its agents and employees when they committed the negligent acts alleged herein.

37. The negligent acts of Defendant's agents and employees were committed while acting within the course and scope of their employ and/or agency with Defendant. Thus, Defendant is vicariously liable for the actions of its agents and employees when they committed the negligent acts alleged herein.

38. At all times material to this action, Defendant had a non-delegable duty to provide Plaintiff, Mr. Hernandez, with reasonable medical care. Accordingly, Defendant is also vicariously liable for the actions of contracted-with medical providers.

39. At all times material to this action, Defendant, by and through its staff, physicians, employees and/or agents, acting within the course and scope of their employment and/or agency, undertook a duty to render medical care to Plaintiff, Mr. Hernandez, in a skillful and

careful manner and in accordance with the accepted standards of medical care and treatment rendered in such cases by physicians in Sumter County, Florida or in any similar medical community.

40. At all times material to this action, Defendant, by and through its staff, physicians, employees and/or agents, acting within the course and scope of their employment and/or agency, negligently breached the duty of care owed to Plaintiff, Mr. Hernandez, by failing to examine, diagnose, care for, and treat Mr. Hernandez in accordance with the accepted standards of care.

41. The care and treatment of the Plaintiff, Mr. Hernandez, by the medical staff of the Defendant at Coleman, fell below the prevailing standard of professional care for a primary care physician in one or more of the following ways:

a. Failure to fully and properly document the symptoms experienced by the Plaintiff in the eight and a half (8½) months leading to the eventual diagnosis of septic arthritis and osteomyelitis.

b. Failure to properly consider and/or diagnose the Plaintiff's excruciating and severe pain in his hip area and lower extremities during those eight and a half (8½) months, despite repeated visits to the Defendant's health care providers.

c. Failure to properly consider and/or diagnose the Plaintiff's leg atrophy and deterioration of his right leg by two to three (2-3) inches, nearly 100 pounds of weight loss and inability to walk, despite repeated visits to the Defendant's health care providers.

d. Failure and/or refusal to perform an MRI of the very area where the Plaintiff was experiencing pain so it could be determined that the cause of Plaintiff's pain was septic arthritis and osteomyelitis, not back pain.

e. Failure to consider the possibility that the more acute and life-threatening diagnosis of septic arthritis and osteomyelitis was causing the severe and excruciating pain in the Plaintiff's hip area and lower extremities, not back pain from a preexisting condition, resulting in the complete deterioration of Plaintiff's right hip and femur.

f. Failure to move past a misdiagnosis of back pain for over eight and a half (8½) months, despite the absence of a positive result for the treatment and pain medications provided for same.

g. Failure to make an immediate referral to an orthopedist and radiologist to determine the cause of Plaintiff's severe and excruciating pain when the initial diagnosis and treatment was unsuccessful.

42. As the direct and proximate result of the failure of Defendant's medical staff at Coleman to properly diagnose and treat Plaintiff's severe and excruciating pain between approximately February 5, 2009, and October 16, 2009, Plaintiff:

a. suffered severe and excruciating pain for approximately eight and a half (8½) months;

b. was on IV antibiotics for 6 weeks;

c. lost approximately one hundred (100) pounds due to the severe and excruciating pain he was in and inability to eat;

d. was unable to ambulate for months thereby causing his right leg to atrophy four (4) inches and causing him to be permanently disabled and in need of special shoes for life;

e. had to have extensive surgery and to have an artificial hip and metal femur installed;

f. lost his gall bladder;

g. had pancreatitis;

h. had a hernia;

i. suffered gout;

j. suffered a pinched nerve;

k. had complications from the surgery on December 27, 2009, which caused him to nearly die and be placed in a hospital for six (6) months, a portion of which was spent in intensive care (ICU);

l. developed an acute septic mega colon (acute dilatation of the large bowel) and underwent a subtotal colectomy and ileostomy, and was in an intensive care unit (ICU) on a ventilator and in critical condition;

m. is in need of having a reverse colectomy, otherwise he has to have colostomy bags for the remainder of his life; and

n. has become totally disabled and unable to work.

43. It is more likely than not that if Plaintiff had been referred to an orthopedist and radiologist in a timely fashion after the Defendant's initial diagnosis and treatment proved unsuccessful, the need for surgery for an artificial hip and femur and all the other subsequent problems which resulted could have been avoided with the timely administration of antibiotics for septic arthritis and osteomyelitis.

44. As the further direct and proximate result of the failure of medical staff at Coleman to properly diagnose and treat Plaintiff's severe and excruciating pain in his right hip and right leg between February 5, 2009, and October 16, 2009, Plaintiff has been permanently disabled and has lost the enjoyment of being physically active.

45. As the direct and proximate result of the negligence, carelessness, and medical malpractice of the Defendant's employees and contractors, Plaintiff has suffered pain, mental anguish, bodily injury, and permanent disability, and will continue to suffer pain, mental anguish, bodily injury, and permanent disability in the future.

46. As the further direct and proximate result of the failure of medical staff at Coleman to properly diagnose and treat Plaintiff's severe and excruciating pain in his right hip and right leg between February 5, 2009, and October 16, 2009, Plaintiff now has to defecate using a colostomy bag which has to be periodically emptied, causes his stoma and the area around it to become infected, is embarrassing as it often smells, and has caused the Plaintiff to be permanently disabled and has lost the enjoyment of being physically active.

47. As the direct and proximate result of the negligence, carelessness, and medical malpractice of the Defendant's employees, Plaintiff now requires, and will require in the future, periodic hip replacements, special shoes for the shortened right leg, pain medication, extensive treatment for back pain, and physical rehabilitation.

48. As the direct and proximate result of the negligence, carelessness, and medical malpractice of the Defendant's employees and contractors, Plaintiff is permanently disabled and unable to work in his former occupation when released from the care and custody of the Defendant.

WHEREFORE Plaintiff, Robert Lee Hernandez, demands judgment against the Defendant, United States of America, as follows:

a. The sum of $1,000,000.00 or more;

b. Costs of suit;

c. Post-judgment interest; and

d. Such other relief as the court may deem just and proper.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on December 15, 2011, I electronically filed the foregoing document with the Clerk of the Court using CM/ECF. I also certify that the foregoing document is being served this day on all counsel of record or *pro se* parties identified on the attached Service List in the manner specified, either via transmission of Notices of Electronic Filing generated by CM/ECF or in some other authorized manner for those counsel or parties who are not authorized to receive electronically Notices of Electronic Filing.

s/Randall C. Berg, Jr.
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SERVICE LIST
Hernandez v. USA
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United States District Court, Middle District of Florida

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