IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO

TRINI ENCINIAS, as personal representative of the ESTATE OF ADONUS R. ENCINIAS, deceased,

Plaintiff,

- against -

CENTRAL NEW MEXICO CORRECTIONAL FACILITY, STATE OF NEW MEXICO, NEW MEXICO CORRECTIONS DEPARTMENT, MHM HEALTH PROFESSIONALS, INC., CENTURION CORRECTIONAL HEALTHCARE OF NEW MEXICO, LLC, KEN SMITH, DR. WENDY PRICE, DAVID SELVAGE, TRACY WHITTET, KYLE TENNISON, KYLE GONZALES, BEVERLY WOODBURY, ELIZABETH CHAVEZ, TITO VIDAL, DR. DIGNA CHRISTINA CRUZ-GROST, JAMES DILLON, DR. JAVIER VERA, DR. WINIFRED WILLIAMS, LAURIE ST. JACQUES, ISABELLE DOMINGUEZ, CHRIS MAURER, DANIELLE PINO AND DAVID MONTOYA, ANDRADE, MEDICAL DIRECTOR AT CNMCF, NURSING SUPERVISOR, CNMCF BEHAVIORAL STAFF SUPERVISOR, NENMCF BEHAVIORAL STAFF SUPERVISOR, MENTAL HEALTH SUPERVISOR, PRISON PROGRAMMING COORDINATOR, AND CNMCF CENTURION SUPERVISOR,

Defendants.

21-CV-1145 (JFR) (SCY)

FIRST AMENDED COMPLAINT AND DEMAND FOR JURY TRIAL

Plaintiff Trini Encinias, as personal representative of the estate of Adonus R. Encinias, deceased, by her attorneys, Collins & Collins, P.C. and Sandoval Firm, and pursuant to 42 U.S.C. §§ 1983, 1988, and 12101 et seq.; 29 U.S.C. § 701 et seq.; and 28 U.S.C. §§ 2201 and 2202, brings this action to redress violations of his Eighth and Fourteenth Amendments under the United States Constitution, the Americans with Disabilities Act, and the Rehabilitation Act, and alleges, based on personal knowledge as to his own conduct and otherwise on information and belief, as follows:

JURISDICTION AND VENUE

1. This action arises under the Eighth and Fourteenth Amendments to the United States Constitution; 42 U.S.C. §§ 1983 and 1988; the Americans with Disabilities Act (42 U.S.C. § 12101 et seq.); and the Rehabilitation Act (29 U.S.C. § 701 et seq.).

2. Subject matter jurisdiction in conferred by 28 U.S.C. §§ 1331 and 1343(a).

3. This Court has personal jurisdiction over each of the entity and individual Defendants because, upon information and belief, all Defendants are domiciled in the State of New Mexico and/or have substantial contacts in the State of New Mexico and purposefully availed themselves of conducting business in New Mexico.

4. Venue is proper here under 28 U.S.C. § 1391(b)(2), because, upon information and belief, a majority of the Defendants reside in this judicial district and the events and omissions giving rise to Plaintiff's claims occurred in this judicial district.

5. Plaintiff need not exhaust his administrative remedies under the Prison Litigation Reform Act, 42 U.S.C. § 1997e (hereinafter "PLRA"), because Mr. Encinias is currently not incarcerated, as he is deceased.

PARTIES

6. Plaintiff Trini Encinias ("Plaintiff") is the duly appointed personal representative of the estate of Adonus R. Encinias ("Mr. Encinias"), deceased.

7. At all times material to this complaint, the decedent, Mr. Encinias, was a resident of the State of New Mexico and incarcerated at the Central New Mexico Correctional Facility ("CNMCF") at or near the time of his death.

8. Defendant State of New Mexico ("New Mexico") is responsible for the custody, care, health, safety, and medical treatment of all individuals whom it incarcerates through its

criminal justice system. New Mexico has established and maintains the New Mexico Corrections Department ("NMCD") and CNMCF as constituent departments or agencies. At all relevant times, New Mexico, acting through NMCD and CNMCF, was responsible for the policies, practices, supervision, implementation, and conduct of all NMCD and CNMCF matters and for the appointment, training, supervision and conduct of all NMCD and CNMCF personnel, including the Defendants specifically named herein.

9. Defendants CNMCF and NMCD are entities of the State of New Mexico. NMCD manages and operates CNMCF, and both are engaged in the business of housing individuals who are in various stages of the criminal justice system. At all times relevant to this Complaint, NMCD and CNMCF were responsible for the custody, care, health, safety, and medical treatment of all detainees in its facilities.

10. At all times relevant herein, Mr. Encinias was a detainee at CNMCF, and New Mexico, NMCD, and CNMCF each had a duty to provide medical care and treatment to Mr. Encinias in a manner consistent with applicable and prevailing standards of medical care.

11. Centurion Correctional Healthcare of New Mexico, LLC ("Centurion") is contracted to provide medical services to NMCD prisoners, including CNMCF prisoners, by General Services Contract #16-770-1300-0097 (the "GSC"), which commenced on June 1, 2016 and ended on or about October 31, 2019.

12. Under its contract with NMCD and/or New Mexico, Centurion was acting as the apparent and actual agent, servant, and contractor of NMCD and/or New Mexico, and was responsible for the care, health, safety, and proper medical treatment of all detainees in NMCD's facilities, including Mr. Encinias. Pursuant to that contract, NMCD and/or New Mexico adopted Centurion's policies, practices, habits, customs, procedures, training, and supervision as its own,

and Centurion adopted NMCD's and/or New Mexico's policies, practices, habits, customs, procedures, training, and supervision as its own.

13. According to the "Health Services Addendum Between MHM Professionals, Inc., and Centurion Healthcare of New Mexico, LLC," Defendant MHM Health Professionals, Inc. ("MHM") agreed to provide medical personnel to Centurion for purposes of providing medical services to NMCD inmates, including those medical personnel providing medical services at CNMCF.

14. Upon information and belief, MHM is a Delaware for-profit corporation and is the employer of said medical personnel provided to Centurion for purposes of providing medical services to NMCD prisoners.

15. As a subcontractor operating under the contract between Centurion and NMCD/New Mexico, MHM was acting as the apparent and actual agent, servant, and contractor of NMCD and/or New Mexico, and was responsible for the care, health, safety, and proper medical treatment of all detainees in NMCD's facilities, including Mr. Encinias. Pursuant to MHM's contract with Centurion as a subcontractor under the GSC, MHM adopted Centurion's and NMCD's policies, practices, habits, customs, procedures, training, and supervision as its own, and NMCD, New Mexico, and Centurion adopted MHM's policies, practices, habits, customs, procedures, training, and supervision as their own.

16. Centurion and MHM are proper entities to be sued because they are corporations acting under the color of state law within the meaning of 42 U.S.C. § 1983.

17. Defendant Ken Smith was at all times material to this Complaint a natural person employed by the State of New Mexico as the Warden of CNMCF, acting in the capacity of agent, servant, and employee of New Mexico and within the scope of his employment as such. He is sued

herein in his individual capacity.

18. Defendant Wendy Price was at all times material to this Complaint a natural person employed by the State of New Mexico as the Behavioral Health Bureau Chief for NMCD, acting in the capacity of agent, servant, and employee of New Mexico and within the scope of her employment as such. She is sued herein in her individual capacity.

19. Defendant David Selvage, P.A., was at all times material to this Complaint a natural person employed by the State of New Mexico as the Health Services Administrator for NMCD, acting in the capacity of agent, servant, and employee of New Mexico and within the scope of his employment as such. He is sued herein in his individual capacity.

20. At all times alleged herein, Defendants Kyle Tennison, Kyle Gonzales, Tito Vidal, Andrade, Beverly Woodbury, Elizabeth Chavez, Isabelle Dominguez, Chris Maurer, Tracy Whittet, Dr. Digna Cristina Cruz-Grost, James Dillon, Dr. Javier Vera, Dr. Winifred Williams, Laurie St. Jacques, Danielle Pino, David Montoya, Medical Director at CNMCF, Nursing Supervisor, CNMCF Behavioral Staff Supervisor, NENMCF Behavioral Staff Supervisor, Mental Health Supervisor, Prison Programming Coordinator, and CNMCF Centurion Supervisor were agents and/or employees of either NMCD or MHM and/or Centurion, acting within the scope of their employment as such. They are sued herein in their individual capacities.

FACTUAL BACKGROUND

I. For about nine months leading up to his suicide, NMCD, Centurion, and MHM personnel uniformly failed to provide Mr. Encinias with constitutionally acceptable mental health care and programming.

21. Mr. Encinias was raised by his mother, Trini Encinias, in Albuquerque, Mexico. He came from a large family, which included three brothers and five sisters.

22. Mr. Encinias had a supportive family, but he battled substance abuse disorder and

addiction throughout his early adulthood.

23. At the age of 22, Mr. Encinias pleaded guilty to charges placing him in the custody and care of NMCD.

24. In addition to incarceration, The Honorable Benjamin Chavez of the Second Judicial District Court of the State of New Mexico also recommended that Mr. Encinias receive therapeutic treatment for substance abuse while incarcerated.

25. Upon his incarceration, Mr. Encinias was taking multiple psychotropic medications for mood disorders, including severe depression.

26. Mr. Encinias repeatedly pled with prison staff and behavioral health staff to be admitted into the prison's Residential Substance Abuse Program and/or voluntary intensive outpatient treatment program ("IOP"), in one instance writing: "I wanna change the way I live my life and the ability to live and maintain living a life clean, healthy and sober…please help me! Please."

27. NMCD and Centurion personnel never honored these requests, despite Mr. Encinias' repeated pleas and the Court's recommendation.

28. While incarcerated, Mr. Encinias' medication regimen was adjusted to treat not only severe depression, but also chronic anxiety, seizures, tardive dyskinesia and akathisia, insomnia, hallucinations and psychosis. These medications, at various periods, included: Haldol, Duloxetine, Seroquel, Benztropine, Keppra, Sertraline, and Hydroxyzine.

29. Mr. Encinias' onslaught of new mental health symptoms and the resultant pharmacopeia of medications administered to him indicated that Mr. Encinias' mental health was rapidly deteriorating.

30. The mental health supervisor/lead possessed final decision-making authority and

responsibility to ensure that Mr. Encinias was provided with psychoeducational therapy after his February 21, 2018 intake based on (1) a prison counselor's recommendation that Mr. Encinias receive psychoeducational therapy, and (2) his clear demonstration of psychological deterioration with suicidal ideation. Mr. Encinias never received any such therapy and committed suicide shortly thereafter as a result.

31. Likewise, the prison programming coordinator/lead possessed final decision-making authority and responsibility to ensure that Mr. Encinias was assigned to participate in the prison's Residential Drug Abuse Program (RDAP) around February 21, 2018 based on his substance abuse history and the fact that a judge overseeing one of Mr. Encinias' criminal cases had just recommended such treatment in a judicial order. Mr. Encinias was never permitted to participate in the RDAP program despite his numerous pleas to be provided with substance abuse services.

32. Upon information and belief, the mental health supervisor/lead and prison programming coordinator/lead both knew that Mr. Encinias should have been provided with psychoeducational therapy and been allowed to participate in the RDAP program after his February 21, 2018 intake in order to ensure his physical and mental safety and that his psychological needs were being met.

33. Despite this knowledge, the mental health supervisor/lead and prison programming coordinator/lead knowingly or recklessly declined to ensure that Mr. Encinias was provided with psychoeducational therapy and signed up for the RDAP program at this time or any time thereafter prior to his suicide.

34. As a result, Mr. Encinias did not receive adequate psychiatric and substance abuse care, his mental health rapidly deteriorated as evidenced by months of increasingly alarming and

concerning behavior, and he suffered psychotic breaks that led to his suicide.

35. The conduct of the mental health supervisor/lead and prison programming coordinator/lead severely violated acceptable standards of care. Upon information and belief, there was no justifiable reason for failing to ensure that Mr. Encinias was provided with psychoeducational therapy and admitted into the RDAP program.

36. At the time of the mental health supervisor/lead's actions and the prison programming coordinator/lead's actions, Mr. Encinias' need for additional mental health and drug rehabilitation treatment was obvious from both his medical files and his alarming behaviors, which were clear indicators that he was suffering from persistent and severe mental disturbance. Accordingly, the mental health supervisor/lead must have known about and consciously disregarded an excessive risk to Mr. Encinias' mental health and safety.

37. On April 3, 2018, Defendant Dr. Javier Vera evaluated Mr. Miera and noted that he had PTSD, psychosis, and depression, yet Defendant Vera did not take any steps to see that Mr. Miera was provided with additional mental health services.

38. On May 2, 2018, Mr. Encinias told behavioral health staff that he was "really depressed and had a lot of emotional issues," including some from past childhood trauma and victimization. These facts were noted in his medical file.

39. Yet, no precautions were taken by behavioral health staff despite what Mr. Encinias disclosed.

40. On May 7, 2018, Mr. Encinias wrote a goodbye letter to his mother, telling her how much he loved her and expressing his regret that he could not be with her on Mother's Day. He then attempted to overdose on medication. This was his first suicide attempt while incarcerated.

41. Despite his suicide attempt and 2-page suicide letter, Mr. Encinias was not placed

on suicide watch at that time.

42. The NENMCF behavioral staff supervisor/lead possessed final decision-making authority and responsibility to ensure that behavioral health staff appropriately evaluated Mr. Encinias regarding whether he should have been placed on suicide watch in May 2018 while housed at NENMCF after NMCD intercepted the goodbye letter from Mr. Encinias to his mother dated May 7, 2018, the same day as his first attempted suicide. Despite the very clear 2-page suicide letter, Mr. Encinias was not placed on suicide watch after being taken to the medical unit around this time.

43. Upon information and belief, the NENMCF behavioral staff supervisor/lead knew that Mr. Encinias should have been placed on suicide watch in May 2018 in order to ensure his physical and mental safety and that his psychological needs were being met.

44. Despite this knowledge, the NENMCF behavioral staff supervisor/lead knowingly or recklessly declined to ensure that Mr. Encinias was placed on suicide watch.

45. As a result, Mr. Encinias did not receive adequate follow up psychiatric care, his mental health rapidly deteriorated, and he suffered psychotic breaks that led to his suicide.

46. The NENMCF behavioral staff supervisor/lead's conduct severely violated acceptable standards of care. Upon information and belief, there was no justifiable reason for failing to ensure that Mr. Encinias was placed on suicide watch.

47. At the time of the NENMCF behavioral staff supervisor/lead's actions, Mr. Encinias' need for additional mental health treatment was obvious from both his medical files and his alarming behaviors, which were clear indicators that he was suffering from persistent and severe mental disturbance. Accordingly, the NENMCF behavioral staff supervisor/lead must have known about and consciously disregarded an excessive risk to Mr. Encinias' mental health and

safety.

48. By June 2018, Mr. Encinias was being kept in restrictive housing or segregation.

49. On July 6, 2018 Mr. Encinias expressed to behavioral health staff that his depression was worsening.

50. Mr. Encinias requested that his medications be adjusted. In response, records indicate: "[Mr. Encinias] was encouraged to submit a mental health request with his specific medication requests and was informed that this provider would copy the request and make sure the psychiatric medical provider would receive it. [Mr. Encinias] was provided with a request form, material on anxiety, and a sheet to help with sleep difficulties."

51. Mr. Encinias also requested to see a therapist. Records indicate: "[Mr. Encinias] also was very adamant about receiving weekly and more if possible [sic] counseling so that he could express his feelings. [Mr. Encinias] was informed that RDC [at CNMCF] is a temporary, transitional facility that does not provide long-term therapy; he kept interrupting and stated it was his right to have therapy. . . . He was informed that he can be provided with printed material on many subjects, including sexual abuse, substance abuse, depression, anxiety . . ."

52. On July 18, 2018, Mr. Encinias reported that his depression was worsening and that he had recently attempted suicide. Records indicate: "[Mr. Encinias] reported he had attempted suicide on May 7, 2018. However, no crisis paperwork was found in his file from that date. . . . . For Chrono purposes, this claim is considered unreliable."

53. On August 20, 2018, Defendants Isabelle Dominguez and her supervisor, Defendant Chris Maurer, completed a behavioral health check form for Mr. Encinias, and noted that he was "disheveled, hopeless, [and] depressed." The notes indicate that he was having hallucinations, psychologically fragile, and decompensating. Despite this fact, the form indicates

that a treatment plan was "not applicable." He was not referred to counseling or given any additional treatment.

54. On August 22, 2018, Mr. Encinias attempted suicide for the second time, this time by cutting his arms.

55. On August 23, 2018, Defendant Dr. Digna Christina Cruz-Grost ("Defendant Cruz") conducted a psychological examination of Mr. Encinas and noted that "[m]ore psych meds are NOT the answer" and that he needed programming, but she did not take any steps to ensure that he was enrolled in mental health programming.

56. On August 27, 2018, Defendant Maurer conducted an assessment of Mr. Miera, and noted that he was depressed, but he never attempted to provide Mr. Miera with additional mental health services either.

57. On September 4, 2018, Mr. Encinias submitted a NMDC Health Services Request Form, stating the nature of his problem in one sentence: "I need to see mental health for depression, I'm almost at a breaking point."

58. Mr. Encinias was evaluated by Defendant Cruz again on September 14th and 15th, but no attempts were made to provide him with the mental health counseling that he desperately requested and needed.

59. On October 15, 2018, Mr. Encinias met with behavioral health staff. Records indicate: "I spoke with [Mr. Encinias] and gave him a book on how to better himself. He requested to be seen once a week. I explained to him I would see what I could do."

60. On November 8, 2018, Mr. Encinias was transferred from SNMCF to an outside hospital for a colonoscopy, and he returned to CNMCF on November 9, 2018. Although his medical file was transported to the hospital, it did not return to CNMCF until November, 19, 2018.

Despite the fact that CNMCF personnel did not have access to Mr. Encinias' medical file when he returned on November 9th, Defendant Tito Vidal completed a mental status examination form indicating that he had reviewed Mr. Encinias' mental health file. Defendant Vidal did not get this form signed by a supervisor as required.

61. On either November 9, 2018 or November 14, 2018, Mr. Encinias was seen by Defendant Cruz for anxiety and a movement disorder, which can be caused by antipsychotic drugs. Defendant Cruz did not change Mr. Encinias' treatment plan or order that he receive additional mental health services. Instead, she noted that he should return to the clinic in 14 days—an appointment which never occurred.

62. Records from November 14, 2018 indicate: "[Mr. Encinias] disclosed that voices are currently telling him he needs to 'do good, to stay out of trouble.' . . . Inmate disclosed that he disclosed [sic] this [sic] voices being both male and female but not anyone he knows."

63. On November 17, 2018, records indicate: "[Mr. Encinias] reported that he wanted to kill himself because the 'holiday was coming up.' . . . [Mr. Encinias] would not contract for safety during this visit but instead kept making the statement that he wanted to 'kill himself.' [Mr. Encinias] disclosed that he was going to attempt self-harm and will be going to heaven to be with his father."

64. On November 18, 2018, records indicate: "[Mr. Encinias] appeared to be in tears. . . . [Mr. Encinias] was unable to identify any coping mechanism that he could use to deal with his thoughts only that he did not wanted [sic] to 'kill himself' and the demon had left his body."

65. On November 19, 2018, Mr. Encinias was transferred to CNMCF and seen by behavioral health therapist Defendant Beverly Woodbury saw Mr. Encinias and noted that there was "no change" in his mental health status, yet she took no efforts to see that he was provided

with additional mental health services.

66. The nursing supervisor/lead nurse possessed final decision-making authority and responsibility to ensure that CNMCF/Centurion nursing staff completed Mr. Encinias' required Medical Receiving Screening upon his transfer to CNMCF on November 19, 2018, which would have revealed that, according to his medical records, he was due for a psychiatric appointment by November 28, 2018, which he never received. Mr. Encinias died by suicide a few days later, on December 2, 2018.

67. Upon information and belief, the nursing supervisor/lead nurse knew that a Medical Receiving Screening was required in order to ensure proper continuation of medical care and that the prisoner's psychological needs were being met.

68. Despite this knowledge, the nursing supervisor/lead nurse knowingly or recklessly declined to ensure that Mr. Encinias received this screening.

69. As a result, Mr. Encinias never received the psychiatric appointment previously ordered or any follow up psychiatric care, his mental health rapidly deteriorated, and he suffered psychotic breaks that led to his suicide.

70. The nursing supervisor/lead nurse's conduct severely violated acceptable standards of care. Upon information and belief, there was no justifiable reason for failing to complete Mr. Encinias' Medical Receiving Screening or for the failure to implement follow up psychiatric care.

71. At the time of the nursing supervisor/lead nurse's actions, Mr. Encinias' need for additional mental health treatment was obvious from both his medical files and his alarming behaviors, which were clear indicators that he was suffering from persistent and severe mental disturbance. Accordingly, the nursing supervisor/lead nurse must have known about and consciously disregarded an excessive risk to Mr. Encinias' mental health and safety.

72. On November 21, 2018, Defendant Vidal released Mr. Encinias from suicide watch and immediately placed him into solitary confinement without any additional mental health support services despite knowing that he was suffering severe schizophrenic symptoms. He also did not utilize the correct forms in noting this transfer.

73. The nursing supervisor/lead nurse possessed final decision-making authority and responsibility to ensure that CNMCF/Centurion nursing staff completed Mr. Encinias' required NMCD Pre-Lockdown Evaluation Form (#236) prior to placing Mr. Encinias in the Restrictive Housing Units (RHU) on November 21, 2018. This form requires nurses to complete a mental status examination, among other things. However, neither the form nor the mental status examination were completed, and Mr. Encinias died by suicide 12 days after placement in the RHU.

74. Upon information and belief, the nursing supervisor/lead nurse knew that a NMCD Pre-Lockdown Evaluation was required in order to ensure that RHU placement was medically safe given the prisoner's mental state and that the prisoner's psychological needs were being met.

75. Despite this knowledge, the nursing supervisor/lead nurse knowingly or recklessly declined to ensure that Mr. Encinias received this Pre-Lockdown Evaluation.

76. As a result, Mr. Encinias never received any follow up psychiatric care, his mental health rapidly deteriorated, and he suffered psychotic breaks that led to his suicide.

77. The nursing supervisor/lead nurse's conduct severely violated acceptable standards of care. Upon information and belief, there was no justifiable reason for failing to complete Mr. Encinias' Pre-Lockdown Evaluation Form or for the failure to implement follow up psychiatric care.

78. At the time of the nursing supervisor/lead nurse's actions, Mr. Encinias' need for

additional mental health treatment was obvious from both his medical files and his alarming behaviors, which were clear indicators that he was suffering from persistent and severe mental disturbance. Accordingly, the nursing supervisor/lead nurse must have known about and consciously disregarded an excessive risk to Mr. Encinias' mental health and safety.

79. Likewise, the mental health supervisor/lead possessed final decision-making authority and responsibility to ensure that Mr. Encinias' 12 RHU Mental Status Examinations between April 6, 2018 and November 21, 2018 were completed properly and with proper documentation, including the Pre Lockdown Evaluations, 75% of which were missing in Mr. Encinias' case.

80. Upon information and belief, the mental health supervisor/lead knew the proper procedures for conducting and documenting RHU Mental Status Examinations and knew that Mr. Encinias should have been provided with proper examinations in order to ensure his physical and mental safety and that his psychological needs were being met.

81. Despite this knowledge, the mental health supervisor/lead knowingly or recklessly declined to ensure that Mr. Encinias received proper RHU Mental Health Examinations during this time period.

82. As a result, Mr. Encinias did not receive adequate psychiatric care, his mental health rapidly deteriorated, and he suffered psychotic breaks that led to his suicide.

83. The mental health supervisor/lead's conduct severely violated acceptable standards of care. Upon information and belief, there was no justifiable reason for failing to ensure that Mr. Encinias received proper RHU Mental Status Examinations.

84. At the time of the mental health supervisor/lead's actions, Mr. Encinias' need for additional mental health treatment was obvious from both his medical files and his alarming

behaviors, which were clear indicators that he was suffering from persistent and severe mental disturbance. Accordingly, the mental health supervisor/lead must have known about and consciously disregarded an excessive risk to Mr. Encinias' mental health and safety.

85. On November 22, 2018, Defendant Beverly Woodbury violated NMCD's behavioral health crisis intervention and suicide prevention policy by failing to complete the required clinical assessment of Mr. Encinias after his suicide watch was terminated. Defendant Woodbury left the entire assessment form blank other than writing Mr. Encinias' name, age, birthdate, sex, and race/ethnicity.

86. Despite the fact that this critical assessment form contains no pertinent information and is essentially blank, Defendant Woodbury's supervisor, Defendant Elizabeth Chavez, signed off to approve the incomplete form.

87. Mr. Encinias was last seen by behavioral health staff on November 27, 2018. At that time, Defendant Woodbury noted that there were no mental health concerns, and she did not provide any mental health treatment plan for Mr. Encinias.

88. On or about the morning of December 2, 2018, CNMCF staff found Mr. Encinias hanging in his cell.

89. The Office of the Medical Investigator listed the cause of death as "hanging" and the manner of death as "suicide."

90. Upon information and belief, Defendants Kyle Tennison and Kyle Gonzales were guards at CNMCF who observed Mr. Encinias' alarming suicidal behaviors during the time period leading up to his death. They failed to see that Mr. Encinias was provided with the proper mental health programming despite his clear mental deterioration and successful prior attempts at self harm. They also failed to properly monitor and document his activities during the four hours

leading up to his suicide.

91. Defendant Dr. James Dillon was Centurion's Chief of Psychiatry at the time; Defendant Winifred Williams was Centurion's Medical Director at CNMCF; Defendant Dr. Andrade was Centurion's Medical Director at SNMCF; Defendant Laurie St. Jacques was Centurion's Health Services Administrator at CNMCF; Defendant Danielle Pino was Centurion's Director of Nursing at CNMCF; Defendant David Montoya was Centurion's Regional Director of Nursing; and Defendant Tracey Whittet was Centurion's Director of Quality Improvement, and they were each responsible for overseeing the provision of mental health services to Mr. Encinias in the months immediately leading up to his suicide.

92. These individuals were able to identify major shortcomings in the mental health care provided to Mr. Encinias while drafting the report of the Suicide Review Committee regarding Mr. Encinias' death, and they should have identified and corrected these shortcomings prior to Mr. Encinias' injuries.

93. Similarly, the CNMCF Centurion supervisor/lead possessed final decision-making authority regarding how mental health policies, practices, and procedures would be implemented by medical and/or mental health personnel at CNMCF during the time period of February through November 2018. The CNMCF Centurion supervisor/lead had the responsibility to ensure that these policies, practices, and procedures were being implemented correctly during this time period and that medical and mental health personnel at CNMCF were sufficiently trained and supervised in these policies, practices, and procedures. And Defendant Medical Director at CNMCF was responsible for overseeing the provision of all medical services to Mr. Encinias. Both individuals allowed Mr. Encinias' mental health needs to go completely unaddressed, which ultimately caused his suicide.

94. Upon information and belief, the abovementioned supervisors and directors knew that the mental health policies and procedures being implemented at NMCD from February through November 2018 were severely deficient and risked endangering the physical and mental health of the prisoners in NMCD's custody who were in need of mental health services during this time.

95. Upon information and belief, these supervisors and directors was aware that medical and mental health personnel were inadequately trained and supervised on proper mental health policies and procedures, and that this inadequate training and supervision risked endangering the physical and mental health of the prisoners in NMCD's custody who were in need of mental health services during this time.

96. Despite this knowledge, these supervisors and directors knowingly or recklessly declined to ensure that constitutionally adequate policies, practices and procedures were being implemented or that medical and mental health personnel at NMCD prisons were being adequately trained and supervised.

97. As a result, Mr. Encinias did not receive adequate psychiatric care, his mental health rapidly deteriorated, and he suffered psychotic breaks that led to his suicide.

98. The conduct of these supervisors and directors severely violated acceptable standards of care. Upon information and belief, there was no justifiable reason for failing to ensure that proper mental health policies, practices and procedures were being implemented and that the related training and supervision of these policies was also adequate.

99. At the time of these supervisors' and directors' actions, Mr. Encinias' need for additional mental health treatment was obvious from both his medical files and his alarming behaviors, which were clear indicators that he was suffering from persistent and severe mental

disturbance. Accordingly, these supervisors and directors must have known about and consciously disregarded an excessive risk to Mr. Encinias' mental health and safety.

100. On July 9, 2020, District Court Judge Matthew J. Wilson issued an Order Granting Motion for Spoliation Sanctions in District Court Case No. D-101-CV-2019-00720, which is related to the present Complaint.

101. Judge Wilson found that the New Mexico Department of Corrections did not preserve the surveillance video showing the outside of Mr. Encinias' jail cell for the four hours preceding his suicide. This evidence is relevant to establish whether personnel at the prison facility were properly doing their jobs by maintaining a routine inspection of Mr. Encinias' jail cell before his suicide.

102. The New Mexico Department of Corrections Defendants' destruction of the surveillance video constitutes spoliation of evidence and has unfairly prejudiced Plaintiff in the prosecution of her claim.

103. Minimal video tape recovered from the New Mexico State Police show Mr. Encinias had his cell completely blockaded and obscured for at least half of this time.

104. Records indicate that, "[a]ccording to staff, the hanging appeared to have been coordinated to coincide with custody rounds, but the rounds on that particular day took place a few minutes late, though not so late that the resuscitation was entirely ineffective."

105. Resuscitation efforts were "ineffective" to the extent Mr. Encinias died as the result of hanging.

106. Another CNMCF inmate housed in segregation had also committed suicide just hours prior.

107. By December 2, 2018, records indicate Mr. Encinias had endured severe medical

problems, including: two (2) myocardial infarctions; pulmonary septic emboli; deep vein thrombi; seizures; gastrointestinal bleeds and polyps; and, Hepatitis C.

108. Medical problems increase the risk of suicide.

109. By December 2, 2018, records indicate Mr. Encinias had suffered a traumatic brain injury in transport to the Metro Detention Center, resulting in short term memory loss and mood disruptions.

110. Traumatic Brain injuries and chronic traumatic encephalopathy increase the risk of suicide.

111. By December 2, 2018, records indicate Mr. Encinias had substance use disorder and, despite multiple requests, was not receiving treatment.

112. Substance use disorder, especially when untreated, increases the risk of suicide.

113. By December 2, 2018, records indicate Mr. Encinias was prescribed multiple psychotropic medications to treat mood disorders.

114. Mental illness indicates a higher risk of suicide.

115. By December 2, 2018, records indicate Mr. Encinias had endured trauma as a child and young adult.

116. Trauma increases the risk of suicide.

117. By December 2, 2018, records indicate Mr. Encinias had attempted suicide twice since his incarceration.

118. Previous suicide attempts, especially recent attempts, indicate a marked increase in present suicide risk.

119. By December 2, 2018, records indicate Mr. Encinias had made multiple requests to see behavioral health staff and psychiatrists to address his hopeless and depressed mood and

suicidality. The requests were rarely, if ever, honored.

120. Feelings of hopelessness, lack of agency and powerlessness increase the risk of suicide.

121. By December 2, 2018, records indicate Mr. Encinias had spent the majority of the year he was incarcerated in segregation, and he was incarcerated in segregation up until his death.

122. Dr. Stuart Grassian, a Board-Certified Psychiatrist with extensive experience in evaluating the psychiatric effects of solitary confinement, explained that incarceration in solitary can cause either "severe exacerbation or recurrence of preexisting illness, or the appearance of an acute mental illness in individuals who had previously been free of any such illness." Stuart Grassian, *Psychiatric Effects of Solitary Confinement*, 22 Wash. U. J.L. & Pol'y 325, 333 (2006).

123. Recent research on longtime solitary prisoners has recorded the severe side effects suffered by many, including hallucinations and perception disorders, panic attacks, loss of memory and paranoia amounting to a form of delirium that can often lead to suicide attempts.

124. Mr. Encinias was already ill by the time he was placed in segregation, and he decompensated rapidly from that point onward.

125. Given Mr. Encinias' mental health history, even the brief history gleaned from his incarceration, Centurion and MHM knew or should have known of Mr. Encinias' increased suicide risk, and they should have trained their agents and employees to care for patients at chronic risk for suicide, and to make the appropriate recommendations, treatment plans, housing plans and referrals.

126. Given NMCD's history of inmates committing suicide at its facilities, and the risks inherent in keeping suicidal inmates in segregation, NMCD, Centurion and MHM knew or should have known that placing Mr. Encinias in segregation would increase his risk of committing suicide,

and should have trained its agents and employees to recognize the suicidal risk factors displayed by Mr. Encinias and intervene in light of those factors.

127. Neither Centurion nor NMCD were accredited by the American Corrections Association ("ACA") or the National Commission on Correctional Health Care ("NCCHC") at times relevant to this Complaint.

128. The ACA and NCCHC establish mandatory minimum standards for correctional healthcare.

129. Failure to maintain accreditation suggests failure to establish and maintain minimum standards in correctional healthcare.

130. The CNMCF behavioral staff supervisor/lead possessed final decision-making authority and responsibility to ensure that CNMCF/Centurion behavioral health staff followed NMCD policies regarding Behavioral Health Crisis Intervention and Suicide Prevention during July through November 2018 when Mr. Encinias was placed on therapeutic (suicide) watch.

131. Per NMCD policy, Mr. Encinias was required to have been assessed by a behavioral health clinician daily while on suicide watch, including weekends and holidays. During this time period, Mr. Encinias was not evaluated daily by a licensed behavioral health staff member in violation of NMCD policy and in the critical months leading up to his suicide.

132. Per NMCD policy, Mr. Encinias was also required to have been evaluated by the assigned clinician or clinical supervisor no later than three working days after his release from suicide watch to ensure that he was no longer suicidal and determine the need for further behavioral health treatment. However, Mr. Encinias was never evaluated after his July, August, and November 2018 transitions out of suicide watch.

133. Upon information and belief, the CNMCF behavioral staff supervisor/lead knew

that NMCD policies required Mr. Encinias to be assessed by a behavioral health clinician daily and be assessed by a clinical or clinical supervisor within three working days of his release from suicide watch in order to ensure the physical and mental safety of Mr. Encinias and that his psychological needs were being met.

134. Despite this knowledge, the CNMCF behavioral staff supervisor/lead knowingly or recklessly declined to ensure that Mr. Encinias received these assessments.

135. As a result, Mr. Encinias did not receive adequate follow up psychiatric care, his mental health rapidly deteriorated, and he suffered psychotic breaks that led to his suicide.

136. The CNMCF behavioral staff supervisor/lead's conduct severely violated acceptable standards of care. Upon information and belief, there was no justifiable reason for failing to ensure that Mr. Encinias received these assessments.

137. At the time of the CNMCF behavioral staff supervisor/lead's actions, Mr. Encinias' need for additional mental health treatment was obvious from both his medical files and his alarming behaviors, which were clear indicators that he was suffering from persistent and severe mental disturbance. Accordingly, the CNMCF behavioral staff supervisor/lead must have known about and consciously disregarded an excessive risk to Mr. Encinias' mental health and safety.

138. The mental health supervisor/lead possessed final decision-making authority and responsibility to ensure that appropriate mental health treatment was provided to Mr. Encinias while he was housed at CNMCF in the months leading up to his suicide, particularly in the months of July through November 2018, when Mr. Encinias was placed on suicide watch three times yet provided no additional form of mental health treatment.

139. NMCD policy states that prisoners fitting Mr. Encinias' description must be given a clinical assessment and treatment plan, including weekly clinical sessions for at least a month.

However, Mr. Encinias was never provided with an assessment or treatment plan in the months leading up to his suicide, in clear violation of NMCD policy.

140. Upon information and belief, the mental health supervisor/lead knew that Mr. Encinias should have received this assessment and treatment plan in order to ensure his physical and mental safety and that his psychological needs were being met.

141. Despite this knowledge, the mental health supervisor/lead knowingly or recklessly declined to ensure that Mr. Encinias was provided with this assessment and treatment plan.

142. As a result, Mr. Encinias did not receive adequate psychiatric care, his mental health rapidly deteriorated, and he suffered psychotic breaks that led to his suicide.

143. The mental health supervisor/lead's conduct severely violated acceptable standards of care. Upon information and belief, there was no justifiable reason for failing to ensure that Mr. Encinias received this assessment and treatment plan.

144. At the time of the mental health supervisor/lead's actions, Mr. Encinias' need for additional mental health treatment was obvious from both his medical files and his alarming behaviors, which were clear indicators that he was suffering from persistent and severe mental disturbance. Accordingly, the mental health supervisor/lead must have known about and consciously disregarded an excessive risk to Mr. Encinias' mental health and safety.

145. NMCD, the State of New Mexico, Ken Smith, Dr. Wendy Price, and David Selvage failed to enforce critical terms of the GSC essential to the protection of the health and safety of NMCD inmates.

146. NMCD, the State of New Mexico, Ken Smith, Dr. Wendy Price, and David Selvage failed to obtain ACA and NCCHC medical accreditation for CNMCF.

147. NMCD, the State of New Mexico, Ken Smith, Dr. Wendy Price, and David Selvage

allowed Centurion to operate the medical/behavioral health facilities and provide medical/behavioral health services to CNMCF inmates, including Mr. Encinias, despite the lack of ACA and NCCHC accreditation since the inception of the GSC.

148. NMCD, the State of New Mexico, Ken Smith, Dr. Wendy Price, and David Selvage failed to hold Centurion to the standards of the ACA, the NCCHC, New Mexico law, and the constitution.

149. NMCD, the State of New Mexico, Ken Smith, Dr. Wendy Price, David Selvage failed to properly oversee, monitor, supervise and manage Centurion's operation of medical facilities and provision of medical services to CNMCF inmates, including Mr. Encinias.

150. NMCD, the State of New Mexico, Ken Smith, Dr. Wendy Price, and David Selvage failed to take corrective action against Centurion despite clear knowledge of the constitutionally inadequate provision of medical and behavioral health care by Centurion.

151. The State of New Mexico and NMCD have a non-delegable duty to provide for proper, necessary and competent medical/behavioral health care for all inmates in the care of NMCD, which they repeatedly failed to do.

II. Centurion had a persistent and widespread pattern and practice of failing to meet the standards of care in treating patients in the medical unit, effectively denying them medical care, and this practice caused Mr. Encinias' death.

152. Centurion maintained various widespread patterns and practices which violated Mr. Encinias' constitutional rights and contributed to his untimely death, including: (1) failing to report, diagnose, and properly examine and treat prisoners with serious medical and/or mental health conditions; (2) severely understaffing its medical and mental health facilities; (3) failing to provide adequate medical documentation or communicate changes in patient conditions to the appropriate correctional officers and/or medical or mental health staff; (4) delaying or denying

patient referrals to necessary emergency or other offsite medical services; and (5) failing adequately to train and supervise its employees and agents on procedures necessary to protect patients' health.

153. In essence, Centurion's medical care of NMCD prisoners effectively amounted to no medical care at all. *See, e.g., Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980) ("[D]eliberate indifference to inmates' health needs may be shown by . . . proving there are such systemic and gross deficiencies in staffing, facilities, equipment, or procedures that the inmate population is effectively denied access to adequate medical care.").

A. Centurion had a pattern and practice of failing to report, diagnose, and treat warning signs of serious medical and mental health conditions, which were contributing factors to Mr. Encinias' death.

154. Centurion failed to report, diagnose, and treat the warning signs of serious conditions for many other patients in circumstances comparable to those of Mr. Encinias. For example:

- In *Jade Hetes v. Centurion et al.*, No. D-101-CV-2019-00113 (N.M. 1st Dist. Ct), Centurion failed to timely report, diagnose, and treat signs of severe mental illness, which resulted in the patient's death from suicide.

- In *Manuela Vigil v. Centurion et al.*, No. D-101-CV-2018-00033 (N.M. 1st Dist. Ct.), Centurion failed to timely report, diagnose, and treat signs of abscesses, which resulted in the patient's death.

- In *Michael Wilder v. Centurion et al.*, No. D-101-2018-00608 (N.M. 1st Dist. Ct.), Centurion failed to timely report, diagnose, and treat sign of a broken collarbone, which resulted in the patient suffering lengthy, extended pain. No corrective surgery was ever conducted for years following the accident prior to Mr. Wilder's release from prison.

- In *Jerry Sisneros v. Centurion et al.*, No. D-101-CV-2019-00598 (N.M. 1st Dist. Ct.), Centurion failed to timely report, diagnose, and treat signs of diskitis and osteomyelitis, which resulted in the patient's needlessly extended suffering and over a month of avoidable off-site care.

- In *Gerald Wilson v. Centurion et al.*, No. D-101-CV-2019-00691 (N.M. 1st Dist. Ct.), Centurion failed to timely report, diagnose, and treat signs of discitis and osteomyelitis,

which resulted in the patient developing severe sepsis and lifelong spinal disabilities, and being hospitalized for 35 days.

- In *George Yribe v. Centurion et al.*, No. D-101-CV-2019-00633 (N.M. 1st Dist. Ct.), Centurion failed to timely report, diagnose, and treat signs of diskitis and osteomyelitis, which resulted in the patient developing serious and permanent injury.

- In *Dominick Mora-Solis v. Centurion et al.*, No. D-101-CV-2019-00627 (N.M. 1st Dist. Ct.), Centurion failed to timely report, diagnose, and treat signs of a severe pressure ulcer, sepsis, and acute chronic osteomyelitis, which resulted in permanent injuries to the patient.

155. The preceding cases and others illustrate Centurion's persistent refusal to refer inmate patients out to third-party medical providers for the provision of care unavailable through Centurion within NMCD's facilities.

156. The preceding cases, among others, also establish that Centurion was on notice of these widespread unconstitutional practices prior to Mr. Encinias' death and thereby knew or should have known that additional safeguards should have been put in place to address patients' signs of serious medical and mental health conditions.

157. Accordingly, it can be inferred that Centurion intentionally failed to report, diagnose, treat or refer for treatment inmate patients showing serious warning signs of grave illness despite the known and obvious risk to patient safety.

158. Centurion's widespread practice of failing to report, diagnose, treat or refer for treatment despite clear warning signs of serious medical and mental health conditions shares a close factual relationship with the events in Mr. Encinias' case, and accordingly, the widespread practice was the moving force behind his injuries and death.

159. Significantly, Centurion personnel failed to conduct full-scale clinical assessments six times in Mr. Encinias' case alone, which establishes a pattern and practice of insufficient reporting, diagnoses, and treatment of serious medical and/or mental health conditions. Although Mr. Encinias satisfied NMCD's criteria mandating that mental health assessments be conducted

on six difference instances based on his medical records, Centurion personnel failed to conduct these clinical assessments, which include a thorough review of the patient's medical history and a mental status examination during which a formal diagnosis is made.

160. Because no evaluation or diagnosis was completed and no formal report was created, Mr. Encinias was never provided with any treatment other than the bare minimum to place him in solitary confinement. He was never provided with increased behavioral health counseling or programming despite his clear need for additional services. Moreover, he was never placed in the facility's inpatient psychiatric unit despite clearly meeting five of the seven placement criteria and only needing to meet one of the criteria to qualify for such placement. Ultimately, his lack of proper mental health support caused him to commit suicide.

161. As such, Centurion's policy and practice of failing to report, diagnose, treat warning or refer for treatment inmates showing signs of serious medical and mental health conditions proximately caused Mr. Encinias' death.

B. Centurion had a pattern and practice of severely understaffing its medical and mental health facilities, which was a moving force behind Mr. Encinias' death.

162. The fact of Centurion's chronic understaffing of medical positions during the time period leading up to Mr. Encinias' death is indisputable. It is widely known and documented. As emphasized in the October 23, 2018 New Mexico Legislative Finance Committee (hereinafter LFC) program evaluation of NMCD (the "Committee Report"): "Both state and contractor medical positions are frequently understaffed, threatening the quality of care provided. The Corrections Department's Office of the Medical Director, state employees who are responsible for overseeing the care, opportunities, and education necessary for patients to improve their health, including medical provider contract oversight, had a 25 percent vacancy rate as of October 2018"—two months before Mr. Encinias' death.

163. In particular, the Committee Report noted that "Centurion . . . struggled to recruit and retain staff, incurring fines of $1.1 million in each of the last two fiscal years for critical vacancies including dentists, licensed nurse practitioners, pharmacists, and medical directors."

164. Critically, the Committee Report further confirmed that "[t]he Mental Health Bureau, responsible for providing services to inmates in state prisons, had a 40 percent total vacancy rate, of which most were behavioral and mental health therapists." And Centurion suffered critical mental health vacancies in 2017 and 2018, for which it incurred roughly $500,000 in fines, "including mental health director, drug and alcohol counselors, a psychologist, and a regional director."

165. More specifically, in the year 2018, CNMCF had no health services administrator, licensed practical nurse for Mental Health, psychiatric health doctor, nurse manager, or psychiatrist, among other vacancies.

166. As of October 2018, two months before Mr. Encinias' suicide, CNMCF had 13 unfilled behavioral health provider positions, an alarming vacancy rate of 50%. Even more alarmingly, CNMCF had a 100% vacancy rate for its mental health providers—zero mental health providers were in the prison in the critical months leading to Mr. Encinias' suicide.

167. The LFC report's covered the period through October 2018, just over one month prior to Mr. Encinias' death. However, it is unlikely that these staffing shortages were corrected in the interim prior to Mr. Encinias' death.

168. Centurion's pattern and practice of severe understaffing, particularly regarding mental health personnel, is clearly a primary cause of the constitutional violations concerning Mr. Encinias' mental health treatment leading up to his suicide.

169. Upon information and belief, Mr. Encinias was unable to receive psychiatric

treatment and his requested mental health programming due to the severe shortage of mental healthcare providers at the prison. Numerous important mental health protocols were violated, critical assessments and evaluations foregone, and reports missing in Mr. Encinias' file due to this severe staffing shortage, including the unfilled positions dedicated to oversight of medical services contract compliance. It was this lack of mental health care and contract oversight that exacerbated Mr. Encinias' mental health issues and eventually caused his psychotic breaks and suicide.

170. Simply put, Mr. Encinias received no psychiatric services largely because there were zero mental health providers working in CNMCF in the months leading up to his suicide.

171. Through the Committee Report and its own records of vacancies, Centurion was put on notice that this severe understaffing was substantially certain to cause constitutional violations regarding its patients' medical treatment, yet it chose to disregard that risk and, for years, continued to display a pattern and practice of severe shortages in medical staff, and mental healthcare providers in particular.

172. Despite the clear lack of sufficient staffing to provide proper psychiatric care for inmates suffering severe mental health crisis at CNMCF, including Mr. Encinias, Centurion had a policy of refusing to refer inmates out for specialist care no matter how severe medical condition or illness which is reflected in the other lawsuits cited above where each and every inmate was only referred to an emergency department when the inmate was literally on the verge of death and would without question be hospitalized for at least 24 hours relieving Centurion of any financial responsibility for the critically necessary medical care.

173. Thus, Centurion had a policy of severe understaffing, or no staffing at all, of critical medical and in this case mental health personnel while also having a policy against referring inmate patients to outside specialist thus insuring grave harm or death to untreated inmates.

174. In this way, Centurion acted with deliberate indifference to prisoners' healthcare needs. *See, e.g., Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980) (finding deliberate indifference to prisoners' healthcare needs where "gross deficiencies in staffing" and procedures cause the prisoner population to be "effectively denied access to adequate medical care").

C. Centurion also had a pattern and practice of failing to provide adequate medical documentation and failing to communicate changes in patient conditions, both of which contributed to Mr. Encinias' death.

175. Centurion failed to provide adequate medical documentation and failed to communicate changes in patient conditions for many other patients in circumstances similar to those of Mr. Encinias. For example, in *Jerry Sisneros v. Centurion et al.*, No. D-101-CV-2019-00598 (N.M. 1st Dist. Ct.), Centurion failed to adequately record vitals, which contributed to the patient's delayed diagnoses and treatment for diskitis and osteomyelitis.

176. Notably, the Committee Report referenced an audit of Centurion released in June 2018 that put Centurion on notice that its charts fell short of industry best practices, and some charts were "illegible or inaccurate, not filled out and submitted timely, and not used consistently." The Committee Report also emphasized that documentation of certain test results was missing, and intake forms were not completed for all prisoners as required.

177. Despite clear language in the GSC indicating that Electronic Health Records ("EHR") were required for constitutionally adequate medical care, both Centurion and NMCD opted against implementation of an EHR.

178. The preceding cases and report, among others, establish that Centurion was on notice of these widespread unconstitutional practices prior to Mr. Encinias' death and thereby knew or should have known that additional safeguards should have been put in place to address the inadequate medical documentation and communication of changes in patient conditions.

179. Accordingly, it can be inferred that Centurion intentionally failed to adequately document patient conditions and failed to adequately communicate changes in those conditions despite the known and obvious risk to patient safety.

180. Centurion's widespread practice of failing to provide adequate medical documentation and communicate changes in patient conditions shares a close factual relationship with the events in Mr. Encinias' case, and accordingly, the widespread practice was the moving force behind his injuries and death.

181. Notably, Mr. Encinias' case alone reveals sufficient evidence of Centurion's widespread practice of providing inadequate medical documentation and communication about patient conditions. For example, in Mr. Encinias' 284-day period of incarceration, medical and behavioral health staff violated NMCD policies at least 27 times solely regarding Mr. Encinias' care: Nursing staff failed to perform the required NMCD medical receiving screens four times; Centurion personnel failed to perform nine NMCD pre-lockdown evaluations and a November 2018 psychiatric encounter; personnel violated policies concerning suicide watch eleven times; and behavioral health staff never conducted two full clinical assessments during Mr. Encinias' 180-day screens in August 2020.

182. Because Centurion personnel did not adequately document or otherwise communicate Mr. Encinias' rapidly deteriorating medical and mental health condition to the appropriate personnel, he was not provided with the medical and mental health treatment that he clearly needed, which caused him to succumb to his suicidal ideation.

183. Accordingly, Centurion's policy and practice of providing inadequate medical documentation and failing to communicate changes in patient conditions to appropriate personnel proximately caused Mr. Encinias' death from suicide.

D. Centurion failed to adequately train or supervise its individuals despite knowing that such training and discipline was necessary to protect patient health, and this failure was a moving force behind Mr. Encinas' death.

184. As outlined in the Committee Report, in 2018, the New Mexico Medical Review Association conducted an audit of Centurion's medical services in prisons and recommended that staff be better educated by both Centurion and NMCD on chart documentation standards and consistency and in completing prisoner intake forms correctly. According to Centurion's auditors, the need for additional training and supervision was apparent and should have been prioritized.

185. Similarly, the extensive violations of NMCD protocol in Mr. Encinias' case provide compelling evidence that Centurion had a widespread pattern and practice of failing to adequately train and supervise its personnel. As discussed in more detail above, Centurion medical and behavioral health staff violated NMCD policies at least 27 times related to just Mr. Encinias' care. And 27 significant violations regarding a single prisoner in a period of 284 days suggests the presence of a more systemic lack of training and oversight.

186. As such, Centurion's widespread failures to train and supervise its personnel were a primary cause of the constitutional violations suffered by Mr. Encinias. Each of the 27 NMCD policy violations deprived Mr. Encinias of the opportunity to be evaluated, diagnosed, and to be prioritized in receiving the mental health treatment that he so desperately needed. Because mental health personnel were not adequately trained or supervised to ensure that these NMCD policies were followed, Mr. Encinias never received the opportunity to obtain additional psychiatric services. Consequently, his mental health rapidly deteriorated and he suffered a series of psychotic breaks that ended in his suicide.

187. Training and supervision regarding proper medical treatment protocol and documentation was required because, as Centurion knew or should have known to a moral

certainty, Centurion's personnel would commonly confront situations where they would need to assess the severity and emergency nature of patients' medical conditions. This is the one of the primary tasks that these personnel were hired to do.

188. Additionally, documenting and assessing the next steps in a patient's medical treatment is precisely the type of complex and important decision that requires training and supervision, as making the wrong choice in these instances will frequently cause the deprivation of prisoners' constitutional rights.

189. As evinced by Mr. Encinias' situation and the others cited in subsection A of this section, Centurion's widespread pattern of deficient training and supervision presents an obvious potential to violate patients' constitutional rights, because there has been a growing history where prisoners are denied serious medical care to which they are entitled, and they suffer from long-term disability or death as a result.

190. Centurion was alerted to an obvious deficiency in its training and supervision through the many prior lawsuits against it alleging unconstitutional medical care. It was also put on notice of these deficiencies through the 2018 audit results requiring that it provide better training and oversight of its personnel.

191. Centurion's failure to do so is further evidence of its deliberate indifference to the constitutional violations caused by its widespread deficiencies in training and supervising.

III. Mr. Encinias was discriminated against due to his mental health diagnoses in violation of both the ADA and Rehab Act.

192. At the time that Mr. Encinias was housed at CNMCF and in the custody of NMCD, he faced substantial impairments of major life activities due to his mental disability, which was confirmed through various mood disorder diagnoses.

193. CNMCF and NMCD were both on notice of Mr. Encinias' disability, because his

mental health diagnoses were constantly being documented in his prison file, and he was frequently sent to the RHU on suicide watch.

194. At the times relevant to this complaint, Mr. Encinias was suffering from debilitating, persistent, and long-term depression and mood disorders. Because of his diagnoses, he could barely take care of himself and lost nearly all motivation and practical ability to complete even basic life tasks like eating, bathing, and maintaining proper hygiene. Even more, he would often engage in self harm due to his disability.

195. While facing these substantial impairments to his daily activities, Mr. Encinias sought the reasonable accommodation of being given access to psychological services so that he could participate in and receive the benefits of the other opportunities offered in the prison.

196. He requested to receive regular and ongoing counseling and to participate in treatment programs, but the prison would not grant this accommodation in any form. In his June 1, 2018 application for admission into the prison Behavioral Health Services' Residential Substance Abuse Program (RDAP), he wrote: "I wanna change the way I live my life and the ability to live and maintain living a life clean, healthy and sober. Please." In this application, he also expressed a desire to "learn other ways to be happy sober." Additionally, he signed a form on June 21, 2018 agreeing to be placed in prison's voluntary intensive outpatient treatment program (IOP). And finally, on July 6, 2018, he asked the RHU Sergeant to receive regular counseling "so that he could express his feelings." Yet, none of his requested accommodations were granted.

197. Upon information and belief, Mr. Encinias would have been eligible and able to participate in the full array of prison educational, religious, recreation, and group programs if he had not been disabled by his severe mental illness. However, because Mr. Encinias suffered from severe depression and mental illness, his mental state would not allow him to participate in all of

the prison's otherwise-available educational, religious, recreational and group programming.

198. However, upon information and belief, if CNMCF and NMCD would have provided Mr. Encinias with mental health counseling or other mental health programming accommodations, he would have transitioned into a more stable mental state that would have allowed him to receive the full benefit of CNMCF and NMCD's educational, religious, recreation, and group programming.

199. Despite the fact that Mr. Encinias repeatedly pleaded for mental health accommodations, CNMCF and NMCD were unwilling to even attempt to provide Mr. Encinias with this type of accommodation.

200. Furthermore, any accommodation that CNMCF or NMCD may claim to have made was unreasonably inadequate, because Mr. Encinias' prison medical records reveal that he was frequently suicidal in the months leading up to his death, and he attempted suicide on May 7, 2018 and August 22, 2018 before succeeding in his attempt on December 2, 2018.

201. Because of his debilitating mental state, he was frequently sent to the RHU on suicide watch, where he was unable to access most of the prison's educational, religious, recreation, and group programming. Even if he had been allowed access to these programs while in the RHU, he was not provided with sufficient mental health service accommodations to bring him to a mental state where he could actually participate in these programs. Accordingly, Mr. Encinias was denied meaningful access to these programs.

202. CNMCF and NMCD knew that Mr. Encinias required further mental health service accommodations in order to participate in the prison's educational, religious, recreation, and group programs because his prison records clearly specified (1) a long history of RHU suicide watch placements through which Mr. Encinias' access to prison programs was strictly limited, (2)

repeated attempts by Mr. Encinias to obtain his requested accommodation of additional mental health services, and (3) a persistent history of severe mental illness and suicidal ideation.

203. Both CNMCF and NMCD, through their employees and agents, acted with deliberate indifference to the strong likelihood that their practices of denying Mr. Encinias his requested mental health services would likely result in a violation of Mr. Encinias' federally protected right not to be discriminated against because of his mental disability. Despite this knowledge, CNMCF and NMCD failed to provide Mr. Encinias with any meaningful mental health supports.

204. Importantly, Mr. Encinias' requested accommodation to receive mental health support would not have fundamentally altered the nature of the prison's services, programs, or activities or created an undue burden on the prison staff. Each of the accommodations suggested by Mr. Encinias was already available and widely utilized by other individuals in the prison without issue. Upon information and belief, CNMCF and NMCD had no rational reason to deny these services to Mr. Encinias, who was one of the prisoners with arguably the most need for such accommodations. Accordingly, there is no true security or institutional concern regarding Mr. Encinias' requested accommodations. On the contrary, analogous accommodations are commonplace and cause little to no burden on the prison.

205. Because CNMCF and NMCD failed to provide Mr. Encinias with a reasonable accommodation, Mr. Encinias was made to suffer more pain and punishment than non-disabled prisoners, and he was thereby discriminated against solely because of his disability. His mental state was left to deteriorate until he was subjected to regular RHU placement, which ultimately exacerbated his mental deterioration and led to his death. In addition to these physical injuries and other harms, the fact that Mr. Encinias was made to endure intentional discrimination by CNMCF

and NMCD was intrinsically harmful by its very nature, thereby further compounding his injuries and suffering.

206. Moreover, upon information and belief, CNMCF and NMCD have a widespread pattern and practice of excluding the mentally ill from the prison's programs, services, and activities by uniformly placing mentally ill prisoners in solitary confinement even when there is no valid penological reason for doing so.

IV. Damages Sought

207. As a direct result of Defendants' unlawful conduct, Mr. Encinias suffered tremendous pain, injuries, anguish, suffering, and, ultimately, death, which entitles his Estate to compensatory and special damages by way of survival.

208. Further, Plaintiff is entitled to attorney's fees and costs pursuant to U.S.C. §§ 1988 and 12205, and 29 U.S.C. § 794a, in addition to pre-judgment interest and costs as allowed by federal law.

209. Plaintiff is also entitled to punitive damages against each of the Defendants, as their actions were done with malice or, minimally, with reckless indifference to Mr. Encinias' federally protected rights.

CLAIMS FOR RELIEF

FIRST CLAIM FOR RELIEF:
8th and 14th Amendments to the U.S. Constitution
Deliberate Indifference to Serious Medical Need (42 U.S.C. § 1983)
(against MHM, Centurion, Ken Smith, Dr. Wendy Price, David Selvage, Tracy Whittet, Kyle Tennison, Kyle Gonzales, Beverly Woodbury, Elizabeth Chavez, Tito Vidal, Dr. Digna Christina Cruz-Grost, James Dillon, Dr. Javier Vera, Dr. Winifred Williams, Laurie St. Jacques, Isabelle Dominguez, Chris Maurer, Danielle Pino, David Montoya, Dr. Andrade, Medical Director at CNMCF, Nursing Supervisor, CNMCF Behavioral Staff Supervisor, NENMCF Behavioral Staff Supervisor, Mental Health Supervisor, Prison Programming Coordinator, and CNMCF Centurion Supervisor in their individual capacities)

210. Each paragraph of this Complaint is incorporated as if fully restated herein.

211. The abovenamed Defendants each possessed responsibility for the decisions that resulted in the violation of Mr. Encinias' constitutional right to be free from cruel and unusual punishment regarding the deliberate indifference to his serious medical needs while in NMCD custody, as described more fully above.

212. These Defendants were aware of and deliberately disregarded the substantial risk of harm to Mr. Encinias that would ensue because of their failures to provide him with constitutionally adequate medical and mental health care, as described more fully above.

213. The deliberate indifference of the abovenamed Defendants caused Mr. Encinias' debilitating psychotic breaks (his harm), which ultimately led him to commit suicide while in NMCD custody.

214. Mr. Encinias' psychotic breaks were sufficiently serious injuries that a reasonable doctor or patient would find them important and worthy of immediate treatment. Indeed, without treatment, self-harm and suicide attempts commonly ensue, which is precisely what occurred in Mr. Encinias' case leading up to his death.

215. Moreover, Mr. Encinias' psychotic breaks significantly affected his daily activities, as he lost the ability to care for even his most basic needs, including his ability to refrain from self-harm.

216. Because Mr. Encinias' psychotic breaks caused him to commonly engage in severe self-harm, his injury caused by the abovenamed Defendants also resulted in the existence of chronic and substantial pain. Additionally, the emotional anguish that Mr. Encinias experienced during and after these psychotic breaks was also chronic and substantial.

217. The abovenamed Defendants are not shielded by qualified immunity for their

deliberate indifference to Mr. Encinias' serious medical needs because of the well-documented 10th Circuit precedent notifying medical and prison personnel that the Eighth Amendment is violated when such personnel fail to take reasonable measures to provide a patient with access to medical attention and/or deny medical care to a patient with serious psychological needs, as occurred in Mr. Encinias' case with each of the defendants named herein.

SECOND CLAIM FOR RELIEF:
8th and 14th Amendments to the U.S. Constitution
Policy & Practice of Denial of Medical Care (42 U.S.C. § 1983)
(against Centurion and MHM)

218. Each paragraph of this Complaint is incorporated as if fully restated herein.

219. As a private corporation acting pursuant to its agreement with NMCD to provide medical services to New Mexico State prisoners, Centurion was at all times relevant to the events described in this Complaint acting under color of law and, as the provider of healthcare services to prisoners incarcerated at CNMCF, was responsible for the creation, implementation, oversight, and supervision of all policies and procedures followed by employees and agents of Centurion and CNMCF/NMCD.

220. Mr. Encinias' injuries were proximately caused by Centurion's policies and practices.

221. Centurion maintains a policy, practice, and custom of under-reporting the severity of medical and mental health emergencies and denying appropriate medical and mental health care to prisoners. On information and belief, Centurion medical staff working in CNMCF are trained to ignore or under-report symptoms of medical and mental health emergencies, which amounts to deliberate indifference to the serious medical needs of prisoners presenting symptoms of such emergencies, including Mr. Encinias.

222. On information and belief, Centurion supervises its employees to ignore or under-

report symptoms of medical and mental health emergencies, which amounts to deliberate indifference to the serious medical needs of prisoners presenting symptoms of such emergencies, including Mr. Encinias.

223. On information and belief, Centurion ratifies the conduct of its employees who ignore or under-report symptoms of medical and mental health emergencies through review and approval of these employees' performance, and through the decision to continue the employment of such individuals who ignore and under-report medical and mental health emergencies of NMCD prisoners, which amounts to deliberate indifference to the serious medical needs of prisoners presenting symptoms of such emergencies, including Mr. Encinias.

224. At all times relevant to this Complaint, Centurion had notice of a widespread practice by its employees and agents at CNMCF under which prisoners with serious medical conditions, such as Mr. Encinias, were routinely denied access to proper or sufficient medication and medical attention. Upon information and belief, it was common to observe prisoners of CNMCF with clear symptoms of serious medical and/or mental concerns whose requests for medical care were routinely denied or completely ignored. Upon information and belief, a significant portion of these denials of medical and mental health care resulted in substantial injury or death.

225. More specifically, there was a widespread practice under which employees and agents of Centurion and NMCD, including correctional officers and medical personnel, failed or refused to: (1) report, diagnose, and properly examine and treat prisoners with serious medical and/or mental health conditions, including failing to provide proper medications to prisoners with serious medical and/or mental health conditions; (2) respond to prisoners who requested medical and/or mental health services; (3) respond to prisoners who exhibited clear signs of medical and/or

mental health need or illness; (4) adequately document and communicate the medical and mental health needs of prisoners to the appropriate correctional officers and/or medical or mental health staff; or (5) timely refer prisoners for emergency or other offsite medical services.

226. Additionally, there was a widespread practice under which Centurion personnel severely understaffed its medical and mental health facilities and failed adequately to train and supervise its personnel on necessary medical and mental health procedures.

227. These widespread practices were allowed to proliferate because Centurion directly encouraged, and was the moving force behind, the specific misconduct at issue. Centurion also failed to adequately train, supervise, and control correctional officers and medical personnel by failing to adequately punish and discipline prior instances of similar misconduct, thereby directly encouraging future abuses like those which harmed Mr. Encinias.

228. Centurion knew of the substantial risk of serious or fatal consequences that could be caused by its unconstitutional policies, practices, customs, failures to train, and failures to supervised, as occurred in Mr. Encinias' case.

229. Centurion is sued herein for maintaining these policies, practices, and customs; for failing to train and supervise; and for ratifying its employees' and agents' misconduct, all of which amounts to deliberate indifference to prisoners' serious medical and/or mental health needs.

230. These policies and conduct were the moving force behind the violations of Mr. Encinias' constitutional rights and his death. Mr. Encinias' injuries were caused by employees and contractors of NMCD and Centurion, including but not limited to the individually-named Defendants, who acted pursuant to the policies and practices of Centurion while engaging in the misconduct described in this Complaint.

231. Upon information and belief, Centurion maintained these policies and practices in

order to maximize profit and without regard to its constitutional and medical obligations to NMCD prisoners who were entrusted to Centurion's care.

232. As a subcontractor for Centurion operating under the contract between Centurion and NMCD/New Mexico, MHM adopted Centurion's and NMCD's policies, practices, habits, customs, procedures, training, and supervision as its own, and it is accordingly liable for Centurion's unconstitutional policies and practices as if they were its own, particular because these police and practices were proliferated by its own employees, which it provided to Centurion.

THIRD CLAIM FOR RELIEF:
Americans with Disabilities Act (42 U.S.C. § 12101 *et seq.*)
(against New Mexico, NMCD, and CNMCF)

233. Each paragraph of this Complaint is incorporated as if fully restated herein.

234. At the times relevant to this Complaint, Mr. Encinias had a disability within the meaning of the Americans with Disabilities Act, as he had been diagnosed with various mood disorders, including severe depression.

235. Aside from his disability, Mr. Encinias was otherwise qualified to participate in, and receive the benefits of, the programs, services, and activities offered by CNMCF and NMCD, which are described in this Complaint.

236. CNMCF and NMCD are both public entities as defined in 42 U.S.C. § 12131(1), as both are instrumentalities of the State of New Mexico.

237. Under Title II of the ADA, CNMCF and NMCD are responsible for ensuring that individuals in its custody with known disabilities are provided with reasonable accommodations to prevent discrimination on the basis of disability and are not, on the basis of disability, excluded from participation in or denied the benefits of its services, programs, or activities because of their disabilities.

238. Despite Mr. Encinias' known and obvious disability, CNMCF and NMCD failed to reasonably accommodate his disability and discriminated against him, as described herein.

239. Both CNMCF and NMCD knew that Mr. Encinias was disabled and that he required an accommodation, yet they did not provide him with an accommodation.

240. Solely because of Mr. Encinias' disability, CNMCF and NMCD excluded and denied him access to, and the benefits of, each program, service, and activity described herein. Thus, Mr. Encinias has been subjected to discrimination in each program, service, or activity as a result of his disability.

241. CNMCF and NMCD engaged in this discriminatory practice with malice or, minimally, with reckless indifference to Mr. Encinias' federally protected rights.

242. Mr. Encinias has been injured as a result of this discrimination, as described elsewhere in this Complaint.

243. Finally, CNMCF and NMCD are not shielded by qualified immunity for their violations of the Americans with Disabilities Act, as qualified immunity is not available for such claims.

FOURTH CLAIM FOR RELIEF:
Rehabilitation Act (29 U.S.C. § 701 et seq.)
(against New Mexico, NMCD, and CNMCF)

244. Each paragraph of this Complaint is incorporated as if fully restated herein.

245. At the times relevant to this Complaint, Mr. Encinias was handicapped within the meaning of the Rehabilitation Act, as he had been previously diagnosed with various mood disorders, including severe depression.

246. Aside from his disability, Mr. Encinias was otherwise qualified to participate in, and receive the benefits of, the programs, services, and activities offered by CNMCF and NMCD,

which are described in this Complaint.

247. Both CNMCF and NMCD receive federal financial assistance.

248. Under the Rehabilitation Act, CNMCF and NMCD are responsible for ensuring that individuals in its custody with known disabilities are provided with reasonable accommodations to prevent discrimination on the basis of disability and are not, on the basis of disability, excluded from participation in or denied the benefits of its services, programs, or activities because of their disabilities.

249. Despite Mr. Encinias' known and obvious disability, CNMCF and NMCD failed to reasonably accommodate his disability and discriminated against him, as described herein.

250. Both CNMCF and NMCD knew that Mr. Encinias was disabled and that he required an accommodation, yet they did not provide him with an accommodation.

251. Solely because of Mr. Encinias' disability, CNMCF and NMCD excluded and denied him access to, and the benefits of, each program, service, and activity described herein. Thus, Mr. Encinias has been subjected to discrimination in each program, service, or activity as a result of his disability.

252. CNMCF and NMCD engaged in this discriminatory practice with malice or, minimally, with reckless indifference to Mr. Encinias' federally protected rights.

253. Mr. Encinias has been injured as a result of this discrimination, as described elsewhere in this Complaint.

254. Finally, CNMCF and NMCD are not shielded by qualified immunity for their violations of the Rehabilitation Act, as qualified immunity is not available for such claims.

RELIEF REQUESTED

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

(a) Monetary damages against Centurion, MHM, and individual Defendants sued under 42 U.S.C. § 1983 in their individual capacities in an amount to be determined at trial to compensate Plaintiff for the injuries he sustained as a result of the events and conduct alleged herein;

(b) Monetary damages against Defendants sued under 42 U.S.C. § 12132 et seq. and 29 U.S.C. § 701 et seq. in an amount to be determined at trial to compensate Plaintiff for the injuries he sustained as a result of the events and conduct alleged herein;

(c) Punitive damages against individual Defendants sued in their individual capacities in an amount to be determined at trial;

(d) Statutory interest on any and all damages awarded to Plaintiff;

(e) Reasonable attorneys' fees and costs under 42 U.S.C. §§ 1988 and 12205, and 29 U.S.C. § 794a; and

(f) Such other and further relief as the Court may deem just and proper, including injunctive and declaratory relief.

JURY DEMAND

Plaintiff hereby demands a trial by jury pursuant to Federal Rule of Civil Procedure 38(b) on all issues in this case so triable.

Dated: Albuquerque, New Mexico
December 22, 2021

Respectfully submitted,

SANDOVAL FIRM

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-and-

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