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STATE OF NEW MEXICO
COUNTY OF SANTA FE
FIRST JUDICIAL DISTRICT

Cause No. D-101-CV-2019-00720

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

Plaintiff,

v.

CENTRAL NEW MEXICO CORRECTIONAL FACILITY,
NEW MEXICO CORRECTIONS DEPARTMENT;
WARDEN KEN SMITH; WENDY PRICE,
NMCD BEHAVIORAL HEALTH BUREAU CHIEF;
ANTHONY ROMERO, DEPUTY/ACTING SECRETARY OF CORRECTIONS;
DAVID SELVAGE, NMCD HEALTH SERVICES ADMINISTRATOR;
ORION STRADFORD, NMCD BUREAU CHIEF;
MHM HEALTH PROFESSIONALS, INC.;
CENTURION CORRECTIONAL
HEALTHCARE OF NEW MEXICO, LLC; and
JOHN DOES 1 through 10, employees, staff, agents of
New Mexico Corrections Department, and/or
Centurion Correctional Healthcare of New Mexico, LLC,
and/or MHM Health Professionals, Inc., respectively),

Defendants.

FIRST AMENDED COMPLAINT FOR MEDICAL MALPRACTICE AND RELATED CLAIMS

COMES NOW the Plaintiff, Trini Encinias, Personal Representative of the Estate of Adonus Encinias, by and through her attorneys, Guebert Gentile & Piazza P.C., and Collins and Collins, P.C., and for her First Amended Complaint states as follows:

PARTIES

1. Plaintiff, Trini Encinias (hereinafter "Plaintiff") was appointed Personal Representative of the Estate of Adonus Encinias, deceased, on March 18, 2019, and is a resident of Bernalillo County, New Mexico (hereinafter "Plaintiff"). **Exhibit A**.

2. Plaintiff brings this action as the Personal Representative of the Estate of Adonus Encinias.

3. Prior to his death, Adonus Encinias was an inmate at Central New Mexico Correctional Facility (hereinafter "CNMCF") in Los Lunas, New Mexico.

4. Centurion Correctional Healthcare of New Mexico, LLC (hereinafter "Centurion") is contracted to provide medical services to New Mexico Corrections Department (hereinafter "NMCD") inmates by General Services Contract #16-770-1300-0097 (hereinafter "GSC"), including CNMCF which commenced on June 1, 2016 and continues to the present.

5. At all material times, Centurion acted through its owners, officers, directors, employees, agents or apparent agents, including, but not limited to, administrators, management, nurses, doctors, technicians and other staff, and is responsible for their acts or omissions pursuant to the doctrines of *respondeat superior*, agency or apparent agency.

6. According to the "Health Services Addendum Between MHM Professionals, Inc., and Centurion Healthcare of New Mexico, LLC," MHM Health Professionals, Inc. (hereinafter "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. **Exhibit B**.

7. Upon information and belief, MHM is a Delaware for profit corporation.

8. At all material times, MHM acted through its owners, officers, directors,

employees, agents or apparent agents, including, but not limited to, administrators, management, nurses, doctors, technicians and other staff, and is responsible for their acts or omissions pursuant to the doctrines of *respondeat superior*, agency and/or apparent agency.

9. Upon information and belief, MHM is the employer of said medical personnel provided to Centurion for purposes of providing medical services to NMCD inmates.

10. Defendants NMCD and the CNMCF are entities of the State of New Mexico.

11. The CNMCF is operated by NMDC.

12. NMCD manages and operates the CNMCF and is considered to be a resident of the State of New Mexico.

13. Defendant State of New Mexico has authorized NMCD to operate the CNMCF, in Los Lunas, Valencia County, New Mexico.

14. Defendant Warden Ken Smith was at all time material to this Complaint a natural person employed by the State of New Mexico as the Warden of Central New Mexico Correctional Facility.

15. Defendant Wendy Price, NMCD Behavioral Health Bureau Chief, was at all time material to this Complaint a natural person employed by the State of New Mexico as the Behavioral Health Bureau Chief for the New Mexico Department of Corrections.

16. Defendant Anthony Romero, NMCD Deputy/Acting Secretary of Corrections, was at all time material to this Complaint a natural person employed by the State of New Mexico as the Deputy/Acting Secretary of Corrections for the New Mexico Department of Corrections.

17. Defendant David Selvage, P.A., Health Services Administrator, was at all time material to this Complaint a natural person employed by the State of New Mexico as the Health Services Administrator for the New Mexico Department of Corrections.

18. Defendant Orion Stradford, Bureau Chief, was at all time material to this Complaint a natural person employed by the State of New Mexico as the Bureau Chief of the Office of Internal Audits and Standards Compliance for the New Mexico Department of Corrections.

19. John Does 1-10 are employees, staff or agents of NMCD and/or MHM and/or Centurion, respectively.

JURISDICTION AND VENUE

20. All acts complained of herein occurred in Los Lunas, Valencia County, State of New Mexico.

21. This Court has jurisdiction over this matter, and venue is proper before this Court.

22. Centurion's registered agent is in Espanola, New Mexico.

23. The contract for prison medical services between Centurion and the State of New Mexico was, upon information and belief, executed in Santa Fe, New Mexico.

24. Jurisdiction and venue are proper over John Does 1-10 pursuant to NMSA § 38-3-1 (A).

25. This Court has jurisdiction over the subject matter of Plaintiff's New Mexico Tort Claims Act claims against the State of New Mexico and New Mexico Corrections Department and John Doe employees, staff and agents under NMSA § 41-4-18 and NMSA § 38-3-1 (A).

26. Jurisdiction over MHM is proper in New Mexico State District Court due to lack of complete diversity of named Defendants under 28 U.S.C.A. § 1332.

27. Plaintiff has given timely notice to the State of New Mexico and NMCD pursuant to the provisions of the Tort Claims Act, NMSA 1978, § 41-4-16.

28. Jurisdiction over all parties and claims are proper under Article II, § 10, of the New Mexico Constitution and the law of negligence under New Mexico law.

29. Adonus Encinias is deceased and, therefore, the Prison Litigation Reform Act is inapplicable.

STATEMENT OF FACTS

30. Adonus Encinias (hereinafter "Mr. Encinias") was raised by his mother, Trini Encinias, in Albuquerque, Mexico.

31. Mr. Encinias came from a large family which included three brothers and five sisters.

32. At the age of 22 years old, Mr. Encinias pled guilty to charges placing him in the custody and care of the New Mexico Department of Corrections.

33. In addition to incarceration, Judge Benjamin Chavez also recommended that Mr. Encinias receive therapeutic treatment for substance abuse while incarcerated.

34. Upon his incarceration, Mr. Encinias repeatedly pled with prison staff and behavioral health staff to be admitted into the prison's Residential Substance Abuse Program or voluntary IOP (intensive outpatient treatment).

35. Mr. Encinias submitted multiple requests, 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."

36. NMCD, CNMCF and Centurion, their respective, employees staff and agents, never honored these requests, despite Mr. Encinias's repeated pleas and the Court's recommendation.

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

38. While incarcerated, Mr. Encinias's 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.

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

40. 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.

41. No precautions were taken.

42. 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.

43. This was his first suicide attempt while incarcerated.

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

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

46. 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."

47. 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 […]"

48. 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 […]"

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

50. 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."

51. 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."

52. On November 14, 2018, Mr. Encinias was again seen by behavioral health staff. Records 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."

53. 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."

54. 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."

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

56. 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."

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

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

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

60. 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.

61. Medical problems increase the risk of suicide.

62. 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.

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

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

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

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

67. Mental illness indicates a higher risk of suicide.

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

69. Trauma increases the risk of suicide.

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

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

72. 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.

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

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

75. 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).

76. 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.

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

78. As records indicate, Mr. Encinias's risk of suicide increased throughout his incarceration, yet reasonable measures were not taken by CNMCF, Centurion and/or MHM to address or intervene regarding this disturbing trend, and Mr. Encinias's increasing risk of suicide.

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

80. Given CNMCF's history of suicide, and the risks inherent in keeping suicidal inmates in segregation, CNMCF should have known or knew and should have trained its agents and employees to recognize and intervene in light of the suicidal risk factors displayed by Mr. Encinias.

81. 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.

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

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

84. NMCD, the State of New Mexico, Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford failed to enforce critical terms of the GSC essential to the protection of the health and safety of NMCD inmates.

85. NMCD, the State of New Mexico, Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford failed to compel ACA and NCCHC medical accreditation for CNMCF.

86. NMCD, the State of New Mexico, Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford have 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.

87. NMCD, the State of New Mexico, Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford failed to compel ACA and NCCHC accreditation for CNMCF.

88. NMCD, the State of New Mexico, Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford failed to hold Centurion to the standards of the ACA or NCCHC.

89. NMCD, the State of New Mexico, Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford failed to hold Centurion to the standard of care under New Mexico law.

90. NMCD, the State of New Mexico, Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford failed to establish any standard of care for Centurion's provision of medical/behavioral healthcare for NMCD inmates.

91. NMCD, the State of New Mexico, Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford 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.

92. NMCD, the State of New Mexico, Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford failed to take corrective action against Centurion despite clear knowledge of the negligent and reckless provision of medical/behavioral health care by Centurion.

93. 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 New Mexico Corrections Department (NMCD).

94. New Mexico Corrections Department is the agency responsible for the management and oversight of NMCD correctional facilities including CNMCF.

95. NMCD is responsible, on behalf of the State of New Mexico, for the provision of proper, necessary and competent medical care of NMCD inmates, including those at CNMCF and for Mr. Encinias.

96. NMCD contracted with Centurion for the provision of medical/behavioral health services to NMCD inmates.

97. Centurion by the terms of the GSC was contracted by NMCD for the purposes of providing medical/behavioral health care to inmates in the New Mexico Department of Corrections prison system, including Mr. Encinias.

98. The term of the GSC began on June 1, 2016 and continues to the present.

99. By contract with the State of New Mexico, Centurion is solely responsible for Medical/behavioral health care to inmate patients at CNMCF.

100. The GSC delegation of responsibility for medical care to NMCD inmates does not lessen the duties of the State of New Mexico or NMCD to insure proper, necessary and competent medical/behavioral health care to NMCD inmates.

101. NMCD's duty to provide proper, necessary and competent medical/behavioral health care to NMCD remains intact despite the assignment of said duties to outside contractors, including Centurion.

102. The collective behavior of the aforementioned NMCD defendants in conspiracy with Centurion and MHM has led to inadequate suicide prevention and treament for inmates at suicide risk, including Plaintiff.

103. The collective behavior of the aforementioned NMCD Defendants in conspiracy.

104. With Centurion and MHM has led to the routine denial of basic mental healthcare for inmates at suicide risk including Plaintiff.

105. The collective behavior of the aforementioned NMCD Defendants in conspiracy with Centurionand MHM has led to the routine denial of basic minimal healthcare.

106. The collective behavior of the aforementioned NMCD Defendants in conspiracy with Centurion and MHM has led to the routine denial of basic mental healthcare.

107. The collective behavior of the aforementioned NMCD Defendants in conspiracy with Centurion and MHM has led to a failure to provide basic suicide prevention and treatment, which has led to multiple inmate suicides, including two suicides on December 2, 2018.

COUNT I – NEGLIGENCE against CENTURION and MHM

108. Plaintiff realleges Paragraphs 1 through 107 pursuant to NMRA Rule 1-010(C).

109. For the period complained of herein, Centurion and MHM acting through their employees, agents, apparent agents, or contractors, who were acting within the scope of their employment, agency, apparent agency, or contract, were negligent in the care and services they provided to Mr. Encinias while he was an inmate and patient.

110. Defendants' negligence included, but was not limited to:

A. Failing to provide adequate staff, adequately paid staff, and adequately trained staff at CNMCF to care for inmates such as Mr. Encinias, with the full knowledge that such inadequate staffing practices would place inmates such as Mr. Encinias at risk for injuries;

B. Negligently hiring, retaining and supervising staff at CNMCF, with the full knowledge that such negligent staffing practices would place inmates such as Mr. Encinias at risk for injuries;

C. Failing to provide proper suicide prevention planning, suicide prevention monitoring, suicide prevention policies and procedures, suicide prevention equipment, and suicide prevention training, so that Mr. Encinias was allowed to commit suicide without proper monitoring, prevention and treatment;

D. Failing to provide and implement proper care plans that would adequately meet Mr. Encinias's needs, including his risk for suicide;

E. Allowing Mr. Encinias to remain unattended and unmonitored despite Mr. Encinias's known risk for suicide;

F. Failing to provide a safe environment;

G. Failing to ensure that Mr. Encinias received adequate supervision and assistance devices to prevent suicide;

H. Failing to have adequate and effective policies, procedures, staff and equipment to adequately supervise Mr. Encinias;

I. Failing to provide services to attain or maintain the highest practicable physical, mental and psycho-social well-being of Mr. Encinias in accordance with a written plan of care;

J. Failing to adequately monitor Mr. Encinias;

111. These acts and failures to act by Defendants and their employees, agents, apparent agents and contractors, were willful, wanton and in reckless disregard for the safety and well being of Mr. Encinias. This is particularly so in regard to allowing Mr. Encinias to commit suicide without properly correcting the care plan or attending to the suicide risk and allowing Mr. Encinias to remain unattended in solitary confinement despite his behavioral health history, suicide attempts and high risk of suicide.

112. All acts or omissions done by Defendants and their employees, contractors, agents or apparent agents, were done within the scope of those persons' employment, contract, agency or apparent agency.

113. All acts complained of herein were authorized, participated in, or ratified by Defendants, or their administrators, managers, officers or directors or shareholders.

114. As a proximate result of the acts or omissions of Defendants, and their willful, wanton and reckless misconduct, Mr. Encinias: (1) was allowed to commit suicide at CNMCF on December 2, 2018; (2) Mr. Encinias's wrongful death was the result of the misconduct of Defendants.

COUNT II - MEDICAL MALPRACTICE against CENTURION and MHM and JOHN DOES 1-10

115. Plaintiff realleges Paragraphs 1 through 114 pursuant to NMRA Rule 1-010(C).

116. In undertaking the diagnosis, care and treatment of Mr. Encinias, Defendants have a duty to possess and apply the knowledge, skill, and care that is used by reasonably well-qualified healthcare providers in the local community.

117. Defendants breached their duties and were grossly negligent and reckless in the management of Mr. Encinias's health and safety.

118. Defendants' negligence and recklessness include, but are not limited to:

A. Failure to evaluate, treat and manage Mr. Encinias's severe psychiatric condition;

B. Failure to develop, employ, and follow appropriate policies and procedures with regard to the assessment, treatment, and management Mr. Encinias's severe psychiatric condition;

C. Failure to create an appropriate treatment plan;

D. Failure to implement an appropriate treatment plan;

E. Failure to take the reasonable steps to acquire proper treatment of Mr. Encinias;

F. Failure to refer Mr. Encinias to appropriate specialists;

G. Failure to timely transfer Mr. Encinias to an appropriate psychiatric facility or behavioral health facility;

H. Failure to protect and preserve the health of Mr. Encinias; and

I. Failure to implement any suicide prevention whatsoever, despite Mr. Encinias’s chronic suicide risk.

119. Defendants' failure to assess, treat and manage Mr. Encinias's severe psychiatric condition was reckless, wanton and in utter disregard for the safety and welfare of Mr. Encinias.

120. The negligent and reckless acts and omissions of Defendants were the direct and proximate cause of Mr. Encinias's wrongful death.

121. Plaintiff is entitled to compensatory damages for the negligent acts and omissions of Defendants.

COUNT III – NEGLIGENT OPERATION OF A MEDICAL FACILITY against NMCD, Centurion and/or MHM

122. Plaintiff realleges Paragraphs 1 through 121 pursuant to NMRA Rule 1-010(C).

123. NMCD agents and employees failed to provide Mr. Encinias with adequate mental health care, including:

a. Failing to conduct mental health rounds;

b. Failing to send Mr. Encinias to the Mental Health Treatment Unit ("MHTCU") for appropriate care;

c. Failing to provide mental health counseling or mental health programming;

d. Interacting with Mr. Encinias primarily from cell-side, violating HIPPA, and leading to ineffective encounters;

e. Failing to place Mr. Encinias on suicide watch or to care for him when on suicide watch;

f. Instead of performing any of the above, NMCD kept Mr. Encinias in the restrictive housing unit ("RHU") without basic mental health treatment, leading to his deterioration and suicide.

124. Additionally, NMCD failed to monitor, oversee and audit the provision of mental health care provided by Centurion and MHM providers.

125. NMCD has authority over all NMCD correctional facilities including CNMCF.

126. NMCD has authority and control over the operation of all medical facilities within NMCD correctional facilities including those within CNMCF.

127. NMCD is the contracting party to General Services Contract #16-770-1300-0097 (GSC) entered into between NMCD and Centurion on June 6, 2016.

128. Upon information and belief, MHM agreed to provide medical personnel to Centurion for purposes of providing medical services to NMCD inmates. *See* **Exhibit B**.

129. NMCD has sole authority, control and responsibility over the execution, implementation and enforcement of the GSC.

130. NMCD has allowed numerous serious breaches and violations of the GSC, ACA and NCCHC that led to the death of Mr. Encinias.

131. NMCD, Centurion and/or MHM are entrusted with the medical/behavioral health care of New Mexico inmates who have no other source of medical/behavioral health care.

132. NMCD's medical staff at CNMCF lacked sufficient expertise to assess, treat and manage Mr. Encinias's mental health conditions.

133. NMCD was negligent in failing to properly refer Mr. Encinias to be seen by a Psychiatrist or behavioral health provider who could effectively treat him.

134. By failing to either: (1) properly treat Mr. Encinias's behavioral health conditions, or (2) properly refer Mr. Encinias to be seen by a physician who could effectively treat him, NMCD breached its duty to treat Mr. Encinias in a reasonably prudent manner.

135. Such conduct amounts to negligence in running a medical facility.

136. Such conduct amounts to negligence in the treatment of Mr. Encinias.

137. The actions of NMCD were negligent, willful, wanton, and in gross and reckless disregard for Mr. Encinias's well-being.

138. Defendants State of New Mexico, NMCD, CNMCF, Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford have knowingly allowed, aided and abetted in Centurion's failure to obtain and maintain ACA and NCCHC accreditation.

139. Defendant Centurion has violated ACA and NCCHC standard, amounting to breach of contract, and breach of the GSC.

140. Defendant Centurion has failed to abide by numerous ACA and NCCHC minimum mandatory standards, including but not limited to:

a. ACA 4-4346 (ref. 3-4353), which states: "Clinical services are available to offenders in a clinical setting at least five days a week and are performed by a physician or other qualified health care professional."

b. ACA 4-4347 (ref. 3-4330), which states: "Continuity of care is required from admission to transfer or discharge from the facility…"

c. ACA 4-4348 (ref. 3-4360), which states: "Offenders who need health care beyond the resources available, as determined by the responsible physician, are transferred under appropriate security provisions to a facility where such care is on call or available 24 hours per day."

d. ACA 4-4350 (ref. 3-4353), which states: "A written treatment plan is required for offenders requiring close medical supervision, including chronic and convalescent care. This plan includes directions to health care and other personnel regarding their roles in care

and supervision of the patient, and is approved by the appropriate licensed physician…or mental health practitioner..."

e. ACA 4-4351 (ref. 3-4350), which states: "(MANDATORY) There is a written plan for 24-hour emergency medical, dental, and mental health services availability."

f. ACA 4-4363 (ref. 3-4344), which states: "(MANDATORY) All intersystem transfer offenders receive a health screening by a health-trained or qualified health care personnel which commences on their arrival at the facility. All findings are recorded on a screening form approved by the health authority."

g. ACA, 4-4364 (new), which states: "Health screens will be reviewed at each facility by health-trained or qualified health care personnel. Procedures will be in place for continuity of care."

h. ACA 4-4368 (ref. 3-4336), which states: "(MANDATORY) There is a mental health program that includes at a minimum: crisis intervention and management of acute psychiatric episodes; stabilization of the mentally ill and the prevention of psychiatric deterioration in the correctional setting; provision for referral and admission to licensed mental health facilities for offenders whose psychiatric needs exceed the treatment capability of the facility."

i. ACA 4-4371 (new), which states: "(MANDATORY) Mental health examinations include, but are not limited to: assessment of suicidal potential and person-specific circumstances that increase suicide potential; review of history of psychotropic medication; review of history of psychotherapy; referral to treatment, as indicated; development and implementation of a treatment plan."

j. ACA 4-4373 (ref. 3-4364), which states: "(MANDATORY) There is a written suicide prevention plan that is approved by the health authority and reviewed by the facility or program administrator. The plan includes staff and offender critical incident debriefing that covers the management of suicidal incidents, suicide watch, assaults, prolonged threats, and death of an offender or staff member. It ensures a review of critical incidents by administration, security, and health services. All staff with responsibility for offender supervision are trained on an annual basis in the implementation of the program. Training should include but is not limited to: identifying the warning signs and symptoms of impending suicidal behavior; understanding the demographic and cultural parameters of suicidal behavior, including incidence and variance in precipitating factors; responding to suicidal and depressed offenders; communication between correctional and health care personnel; referral procedures; housing observation and suicide watch level procedures; follow-up monitoring of offenders who make a suicide attempt."

141. Defendants State of New Mexico, NMCD, CNMCF, Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford have been complicit in the failure to obtain or maintain ACA and NCCHC through its failure to enforce the GSC.

142. Defendants State of New Mexico, NMCD, CNMCF, Warden Ken Smith, Bureau Chief, Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford have knowingly allowed and been complicit in the violation of the ACA and NCCHC minimum mandatory standards.

143. Defendants State of New Mexico, NMCD, CNMCF, Warden Ken Smith Bureau Chief, Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator

David Selvage, and Bureau Chief Orion Stradford have failed to properly maintain oversight and enforcement of the GSC.

144. The failures of Defendants Centurion, State of New Mexico, NMCD, CNMCF, Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford led to the death of Mr. Encinias.

145. As a result of the foregoing, Mr. Encinias suffered wrongful death, pain and suffering, and severe psychological and emotional distress for which Plaintiff is entitled to damages, including punitive damages.

COUNT IV – NEGLIGENT HIRING, TRAINING AND SUPERVISION against CENTURION and MHM

146. Plaintiff realleges Paragraphs 1 through 145 pursuant to NMRA Rule 1-010(C).

147. Centurion and/or MHM had a duty to properly screen, supervise, educate, and train its employees regarding proper treatment of inmates with psychiatric illness, mood disorders, and chronic risk for suicide.

148. On information and belief, Centurion and/or MHM failed to properly train and supervise its employees, contractors, or agents in such a manner to properly and adequately assess, treat and manage Mr. Encinias's mental health conditions and chronic risk for suicide.

149. Centurion and/or MHM are liable for damages caused by their employees and other agents while working within the scope of their employment under the doctrines of *respondeat superior* and agency, in an amount not presently determinable but to be proven at trial.

150. Defendant Centurion is bound by the GSC to obtain and maintain American Correctional Association (ACA) and National Commission on Correctional Health Care (NCCHC) accreditation under the terms of the GSC.

151. Defendant Centurion has never sought, obtained or maintained either ACA or NCCHC accreditation for the medical facilities and services at CNMCF as required by the GSC.

152. The ACA and NCCHC set mandatory minimum standards for training of both medical personnel and non-medical personnel in the provision of medical services in a prison.

153. Defendant Centurion has violated numerous ACA and NCCHC minimum mandatory standards related to hiring, training and supervision.

154. The failures of Defendants Centurion and MHM led to the death of Mr. Encinias.

155. As a result of the foregoing, Mr. Encinias suffered wrongful death, pain and suffering, and severe psychological and emotional distress, for which Plaintiff is entitled to damages, including punitive damages.

COUNT V – INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS against CENTURION and MHM

156. Plaintiff realleges Paragraphs 1 through 155 pursuant to NMRA Rule 1-010(C).

157. Defendants intentionally placed Mr. Encinias in segregation ("solitary confinement").

158. Defendants intentionally denied Mr. Encinias proper and necessary behavioral health care.

159. Defendants intentionally denied Mr. Encinias access to the appropriate specialists for his behavioral conditions.

160. Defendants denied Mr. Encinias social support and privileges available to other inmates by intentionally placing him in solitary confinement.

161. Defendants knew that placing Mr. Encinias in solitary confinement would exacerbate his mental illness.

162. The conduct of Defendants was extreme, outrageous and intentional.

163. Mr. Encinias suffered severe emotional distress as a result of the conduct of Defendants.

164. As a result of the foregoing, Mr. Encinias has suffered wrongful death, pain and suffering, and severe psychological and emotional distress, for which Plaintiff is entitled to damages, including punitive damages.

COUNT VI – *RESPONDEAT SUPERIOR* AND AGENCY against CENTURION and MHM

165. Plaintiff realleges Paragraphs 1 through 164 pursuant to NMRA Rule 1-010(C).

166. Centurion and/or MHM are responsible to Mr. Encinias under the doctrine of *respondeat superior* for the conduct of its employees and agents.

167. Centurion and/or MHM are responsible to Mr. Encinias under the doctrine of agency for the conduct of its employees and agents.

COUNT VII – *RES IPSA LOQUITOR* against CENTURION and MHM

168. Plaintiff realleges Paragraphs 1 through 167 pursuant to NMRA Rule 1-010(C).

169. The injuries and damages, suffered by Mr. Encinias were proximately caused by Defendants.

170. It was Defendants' responsibility to manage and control their medical staff and the care and treatment of Mr. Encinias.

171. The events causing the injuries and damages to Mr. Encinias were of a kind which would not ordinarily occur in the absence of negligence on the part of Defendants.

172. The doctrine of *Res Ipsa Loquitur* is applicable as a theory of negligence, causation and damages in this case.

173. As a result of the foregoing, Mr. Encinias has suffered wrongful death, pain and suffering, and severe psychological and emotional distress, for which Plaintiff is entitled to damages, including punitive damages.

COUNT VIII – NEGLIGENT OPERATION AND MAINTENEANCE OF CNMCF against NMCD and WARDEN KEN SMITH

174. Plaintiff realleges Paragraphs 1 through 173 pursuant to NMRA Rule 1-010(C).

175. NMCD and Warden Ken Smith were negligent in their operation and maintenance of CNMCF.

176. The immunity granted pursuant to Section 41-4-4(A) NMSA 1978 does not apply to negligent operation and maintenance of buildings such as CNMCF.

177. For the period complained of herein, NMCD acting through its employees, agents, apparent agents, or contractors, who were acting within the scope of their employment, agency, apparent agency, or contract, were negligent in the care and services they provided to Mr. Encinias while he was an inmate and patient.

178. Defendants' negligence included, but was not limited to:

A. Failing to provide adequate staff, adequately paid staff, and adequately trained staff at CNMCF to care for inmates such as Mr. Encinias, with the full knowledge that such inadequate staffing practices would place inmates such as Mr. Encinias at risk for injuries;

B. Negligently hiring, retaining and supervising staff at CNMCF, with the full knowledge that such negligent staffing practices would place inmates such as Mr. Encinias at risk for injuries;

C. Failing to provide proper suicide prevention planning, suicide prevention monitoring, suicide prevention policies and procedures, suicide prevention equipment, and suicide prevention training, so that Mr. Encinias was allowed to commit suicide without proper monitoring, prevention and treatment;

D. Failing to provide and implement proper care plans that would adequately meet Mr. Encinias's needs, including his risk for suicide;

E. Allowing Mr. Encinias to remain unattended and unmonitored despite Mr. Encinias's known risk for suicide;

F. Failing to provide a safe environment;

G. Failing to ensure that Mr. Encinias received adequate supervision and assistance devices to prevent suicide;

H. Failing to have adequate and effective policies, procedures, staff and equipment to adequately supervise Mr. Encinias;

I. Failing to provide services to attain or maintain the highest practicable physical, mental and psycho-social well-being of Mr. Encinias in accordance with a written plan of care;

J. Failing to adequately monitor Mr. Encinias;

179. These acts and failures to act by Defendants and their employees, agents, apparent agents and contractors, were willful, wanton and in reckless disregard for the safety and well -being of Mr. Encinias. This is particularly so in regard to allowing Mr. Encinias to commit

suicide without properly correcting the care plan or attending to the suicide risk and allowing Mr. Encinias to remain unattended in solitary confinement despite his behavioral health history, suicide attempts and high risk of suicide.

180. All acts or omissions done by Defendants and their employees, contractors, agents or apparent agents, were done within the scope of those persons' employment, contract, agency or apparent agency.

181. All acts complained of herein were authorized, participated in, or ratified by Defendants, or their administrators, managers, officers or directors or shareholders.

182. As a proximate result of the acts or omissions of Defendants, and their willful, wanton and reckless misconduct, Mr. Encinias: (1) was allowed to commit suicide at CNMCF on December 2, 2018; (2) Mr. Encinias's wrongful death was the result of the misconduct of Defendants.

183. Additionally, NMCD, Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford negligently failed to oversee Centurion in the provision of healthcare, including behavioral health, to NMCD inmates, which contributed to the death of Mr. Encinias.

184. NMCD, the State of New Mexico and Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford failed to take corrective action against Centurion in clear face of recurrent and consistent negligent and reckless behavioral healthcare to NMCD inmates which contributed to the death of Mr. Encinias.

185. NMCD, the State of New Mexico and Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator

David Selvage, and Bureau Chief Orion Stradford negligently, intentionally and knowingly placed inmates with severe mental illness and at chronic suicide risk in solitary confinement without due consideration of the immediate danger of suicide which contributed to the death of Mr. Encinias.

186. NMCD, the State of New Mexico and Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford negligently failed to enforce critical terms of the GSC including but not limited to failure to compel CNMCF and/or Centurion accreditation by the ACA and NCCHC which contributed to the death of Mr. Encinias.

187. NMCD, the State of New Mexico and Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford negligently failed to hold Centurion to standards and guidelines of the ACA or NCCHC.

188. NMCD, the State of New Mexico and Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford negligently failed to hold Centurion to the medical standard of care established under New Mexico law which contributed to the death of Mr. Encinias.

189. NMCD, the State of New Mexico and Warden Ken Smith, Bureau Chief Wendy Price, and Deputy Secretary Anthony Romero, Health Services Administrator David Selvage, and Bureau Chief Orion Stradford failed to establish or enforce any standards at all for Centurion's provision of proper, necessary and competent medical care to NMCD inmates.

190. Additionally, NMCD and Warden Ken Smith were operating CNMCF in a manner that prevented proper observation of Mr. Encinias.

191. There were no surveillance cameras with an unobstructed view into Mr. Encinias's cell.

192. Surveillance footage of the restrictive housing unit ("RHU") is not preserved to investigate incidents such as suicides, creating a risk of harm to all inmates in the RHU, including Mr. Encinias.

193. The furnishings inside the cell were situated such that guards could not properly observe Mr. Encinias.

194. The window into Mr. Encinias's cell did not afford an unobstructed view into Mr. Encinias's cell.

195. Mr. Encinias's cell was situated where CNMCF guards could not properly observe Mr. Encinias.

196. As a direct and proximate result of these negligent acts and omissions, Mr. Encinias was able to hang himself until he died, and was so concealed guards did not discover his dead body for a prolonged period of time.

197. As a result of the foregoing, Mr. Encinias has suffered wrongful death, pain and suffering, and severe psychological and emotional distress, for which Plaintiff is entitled to damages.

COUNT IX – CIVIL CONSPIRACY against CENTURION AND MHM

198. Plaintiff realleges Paragraphs 1 through 197 pursuant to NMRA Rule 1-010(C).

199. The facts set forth above illustrate a civil conspiracy on the part of Defendants collectively to commit Counts I - XII above.

200. As a result of said conspiracy, Mr. Encinias suffered severe physical and emotional distress as a result of the conduct of Defendant NMCD and Defendant Centurion.

201. Plaintiff is entitled to recovery for his injuries and damages, including but not limited to, physical injuries, pain and suffering, and severe psychological and emotional distress.

202. Plaintiff is entitled to punitive damages against Defendant NMCD and Defendant Centurion.

COUNT X – WRONGFUL DEATH against ALL DEFENDANTS

203. Plaintiff realleges Paragraphs 1 through 202 pursuant to NMRA Rule 1-010(C).

204. Defendants, acting through their employees, administrator, agents, servants, representatives, officers, directors, designees, physicians, counselors, nurses, nurse's aides, and/or contractors, who were acting within the scope of their employment, agency, apparent agency or contract, were negligent in the care and services they provided to Mr. Encinias.

205. Defendants failed to use ordinary care in providing the appropriate treatment and care that a reasonable and prudent correctional facility would have provided under the same or similar circumstances.

206. Defendants breached their duty by failing to ensure that Mr. Encinias received proper precautions to prevent suicide, and adequate and proper supervision in an appropriate manner.

207. As a direct and proximate result of Defendants' actions and/or inactions, Mr. Encinias suffered physical and psychological pain, suffering and ultimately death.

DAMAGES

208. Plaintiff realleges Paragraphs 1 through 207 pursuant to NMRA Rule 1-010(C).

209. As a direct and proximate result of the actions of Defendants enumerated above, Mr. Encinias sustained serious personal injuries, which caused or contributed to his tragic and untimely death.

210. As a direct and proximate result of the actions of Defendants enumerated above, Plaintiff is entitled to an award of monetary damages for the pain and suffering experienced prior to the death of Mr. Encinias, the aggravating circumstances attending his death, the reasonable expenses of necessary medical care and treatment and funeral and burial, the monetary worth of the life of Mr. Encinias, and hedonic damages, or damages for the loss of value of Mr. Encinias's life itself, all to Plaintiff's damage in an amount to be determined by the Court at trial.

211. In the alternative, as a direct and proximate result of the actions of Defendants enumerated above, Mr. Encinias experienced pain and suffering, loss of enjoyment of activities, hedonic damages, or loss of the value of life itself, all to Plaintiff's damage in an amount to be determined by the Court at trial.

212. The acts and omissions complained of in the causes of action stated above are egregious in reckless, wanton and total disregard to the rights of Mr. Encinias, that in addition to the actual damages ascertained and demonstrated by a preponderance of the evidence, that punitive damages or exemplary damages to punish and deter these types of acts and omissions from occurring in the future are appropriate.

WHEREFORE, the Plaintiff Trini Encinias requests compensatory damages, punitive damages against Centurion, costs, pre-judgment interest against Centurion, post-judgment interest and such other relief as permitted by law against Defendants.

GUEBERT GENTILE & PIAZZA P.C.

By *_/s/ David S. Ketai_*

Terry R. Guebert
Robert Gentile
David S. Ketai
P.O. Box 93880
Albuquerque, NM 87109
(505) 823-2300
tguebert@guebertlaw.com
rgentile@guebertlaw.com
dketai@guebertlaw.com
Attorneys for Plaintiff

and

COLLINS & COLLINS, P.C.

By *_/s/ Parrish Collins_*

Parrish Collins
Alysan Boothe Collins
P.O. Box 506
Albuquerque, NM 87103-0506
(505) 242-5958
parrish@collinsattorneys.com
alysan@collinsattorneys.com
Attorneys for Plaintiff

I HEREBY CERTIFY that on the 16th day of March, 2020, I filed the forgoing First Amended Complaint for Medical Malpractice and Related Claims electronically through the State of New Mexico's Odyssey File & Serve system, requesting that the following counsel be served through Odyssey:

Mary T. Torres
Law Offices of Mary T. Torres
201 3rd Street NW Suite 500
Albuquerque, NM 87102
(505) 944-9030
mtt@marytorreslaw.com
Attorney for New Mexico Corrections Department

Alfred A. Park
James J. Grubel
Park & Associates, LLC
6100 Uptown Blvd N.E., Suite 350
Albuquerque, NM 87110
(505) 246-2805
apark@parklawnm.com
jgruebel@parklawnm.com
Attorneys for Centurion and MHM Health Professionals

/s/ David S. Ketai

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FILED
2nd JUDICIAL DISTRICT COURT
Bernalillo County
3/18/2019 8:44 AM
James A. Noel
CLERK OF THE COURT
Edna Kasuse

STATE OF NEW MEXICO
COUNTY OF BERNALILLO
SECOND JUDICIAL DISTRICT COURT

IN THE MATTER OF THE WRONGFUL DEATH
OF **ADONUS ENCINIAS**, Deceased. No. D-202-CV-2019-01392

ORDER APPOINTING PERSONAL REPRESENTATIVE TO PURSUE WRONGFUL DEATH CLAIM IN ACCORDANCE WITH § 41-2-3 NMSA 1978

THIS MATTER comes before the Court on the Petition of Trini Encinias, for appointment as personal representative of the wrongful death estate of Adonus Encinias. The Court has reviewed the petition, and being fully advised in the premises, finds that good cause exists for granting the petition for appointment of personal representative of the wrongful death estate of Adonus Encinias.

THEREFORE, THIS COURT ORDERS that:

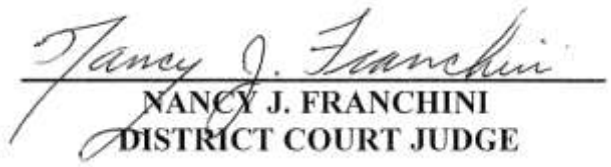
A. The Petition is granted.

B. The Petitioner, Trini Encinias, is hereby appointed Wrongful Death Personal Representative of the Estate of Adonus Encinias, deceased, for the sole purpose of pursuing a wrongful death claim, pursuant to the New Mexico Wrongful Death Act, NMSA 1978 §41-2-1, et seq.

C. The Petitioner will perform her fiduciary function as wrongful death personal representative in accordance with and pursuant to the New Mexico Wrongful Death Act, NMSA 1978 §41-2-1, et seq.

D. The Petitioner will distribute any funds or proceeds of said wrongful death claim in accordance with and pursuant to the law.

EXHIBIT A



Submitted by:

COLLINS & COLLINS, PC

/s/ Parrish Collins
Parrish Collins
P.O. Box 506
Albuquerque, NM 87103
(505) 242-5958
parrish@collinsattorneys.com
Attorneys for Petitioner

HEALTH SERVICES ADDENDUM

BETWEEN MHM HEALTH PROFESSIONALS, INC. AND

CENTURION CORRECTIONAL HEALTHCARE OF NEW MEXICO, LLC

1. Agreement to be Bound. The undersigned Centurion Correctional Healthcare of New Mexico, LLC ("Centurion of NM"), a Centurion Operating Subsidiary, hereby agrees, effective as of the date hereof, to become a party to that certain Staffing Services Agreement, dated as of June 26, 2013, by and among MHM, MHM Health Professionals, Inc. ("MHM Staffing"), Centurion, and CGI (the "Staffing Agreement"), for all purposes of the Staffing Agreement.

2. Services. MHM Staffing hereby agrees to provide the Health Services to Centurion of NM under the terms of the Staffing Agreement. Centurion of NM shall resell the services of MHM Staffing to the appropriate New Mexico correctional authority or authorities.

3. Fees. Unless this Health Services Addendum is terminated pursuant to Section 3.2 of the Staffing Agreement, as compensation for the Services provided by MHM Staffing to Centurion of NM, Centurion of NM agrees to pay MHM Staffing, in accordance with Section 2.4 of the Staffing Agreement, the sums of: $343,000 (Three Hundred and Forty-Three Thousand Dollars and No Cents) for the contract period commencing on June 1, 2016 and terminating on May 31, 2017; $358,000 (Three Hundred and Fifty-Eight Thousand Dollars and No Cents) for the contract period commencing on June 1, 2017 and terminating on May 31, 2018; $370,000 (Three Hundred and Seventy Thousand Dollars and No Cents) for the contract period commencing on June 1, 2018 and terminating on May 31, 2019; and $383,000 (Three Hundred and Eighty-Three Thousand Dollars and No Cents) for the contract period commencing on June 1, 2019 and terminating on May 31, 2020.

4. Subcontractors. Centurion of NM hereby provides its prior written approval to MHM Staffing for the hiring or engaging of one or more subcontractors to perform the following types of Services: CQI; specialty provider care; medical, mental health or dental provider care; and other positions that, from time to time, MHM Staffing is unable to staff with employees.

5. Wiring Information. All payments required by the Staffing Agreement and this Health Services Addendum shall be paid by wire transfer to MHM Staffing.

6. Defined Terms. Capitalized terms used but not defined herein shall have the respective meanings ascribed to such terms in the Staffing Agreement.

EXHIBIT B

IN WITNESS WHEREOF, the Parties have duly executed this Agreement as of this 22nd day of June, 2016.

CENTURION OPERATING SUBSIDIARY:

CENTURION CORRECTIONAL HEALTHCARE OF NEW MEXICO, LLC

By: _____
Name: Jason Harrold
Title: Chair, Board of Managers

Address for notices:

1447 Peachtree Street, N.E.
Suite 500
Atlanta, GA 30309

ACCEPTED:
MHM HEALTH PROFESSIONALS, INC.

By: _____
Name: Michael Pinkert
Title: Chief Executive Officer