FILED
1st JUDICIAL DISTRICT COURT
Rio Arriba County
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STEPHEN T. PACHECO
CLERK OF THE COURT
Tamara Snee

STATE OF NEW MEXICO
COUNTY OF RIO ARRIBA
FIRST JUDICIAL DISTRICT

Case No D-117-CV-2019-00129
Case assigned to Judge, Division VI

MARY R. SALAZAR, as personal representative of
the ESTATE OF WALTER STROOP,
and as guardian of W. N. S. II, a minor,

Plaintiff,

v.

BOARD OF COUNTY COMMISSIONERS
OF RIO ARRIBA COUNTY, RIO ARRIBA
COUNTY ADULT DETENTION FACILITY,
LARRY H. DEYAPP, individually and in his official capacity,
VITAL CORE HEALTH STRATEGIES, LLC,
and JOHN DOES 1 through 10, employees, staff,
agents of Rio Arriba County Adult Detention Facility
and/or Vital Core Health Strategies, LLC

Defendants.

COMPLAINT FOR WRONGFUL DEATH, BREACH OF CONTRACT, MEDICAL MALPRACTICE, NEGLIGENCE, NEGLIGENT HIRING, TRAINING AND SUPERVISION, NEGLIGENT OPERATION OF A CORRECTIONAL FACILITY, *RES IPSA LOQUITOR*, PUNITIVE DAMAGES AND LOSS OF CONSORTIUM

COMES NOW the Plaintiff, Mary R. Salazar, Personal Representative of the Estate of Walter Stroop and guardian of Walter N. Stroop III, a minor, by and through her attorneys, Guebert Bruckner Gentile, P.C., and Collins and Collins, P.C., and for her Complaint states as follows:

PARTIES

1. Plaintiff Mary R. Salazar was appointed Personal Representative of the Estate of Walter Stroop, deceased, February 28, 2019, and is a resident of Rio Arriba County, New Mexico.

2. Plaintiff Mary R. Salazar is the guardian of Walter N. Stroop II, a minor.

3. Prior to his death, Walter Stroop, deceased, was a resident of Rio Arriba County, New Mexico.

4. Prior to his death, Walter Stroop, deceased, was an inmate at Rio Arriba County Adult Detention Facility (hereinafter "RACADF") in Tierra Amarilla, New Mexico.

5. Defendant Board of County Commissioners of Rio Arriba County (hereinafter "Rio Arriba County") is a political subdivision of the State of New Mexico. Pursuant to NMSA 1978, §4-46-1, all suits or proceedings against a county are to be brought in the name of the board of county commissioners of that county. At all times material hereto, Rio Arriba County was a governmental entity and local public body as those terms are defined in the New Mexico Tort Claims Act, NMSA 1978, §41-4-3. At all times material hereto, Rio Arriba County owned, operated, supervised, directed and controlled the RACADF located in Tierra Amarilla, New Mexico. Pursuant to NMSA 1978, §4-44-19; NMSA 1978, §§33-3-3 through 33-3-8; and, NMSA 1978, §33-3-13, Rio Arriba County was statutorily obliged to provide for the confinement of inmates incarcerated under its jurisdiction and had a corresponding obligation to appropriate funds and otherwise provide the necessary funding to maintain and operate a facility for the safe incarceration and healthcare of inmates under its jurisdiction. Rio Arriba County is required to administer, manage and supervise the health care delivery system at RACADF.

6. Defendant Larry H. DeYapp is, upon information and belief, a resident of Rio Arriba County employed by Rio Arriba County as the administrator of RACADF. At all times material hereto, Defendant DeYapp supervised the operation and daily management of the RACADF, was responsible for the policies, practices, and customs of RACADF, and the implementation of, and adherence to, the same. Defendant DeYapp was also responsible for the screening, hiring, training, supervision, discipline, counseling and control of RACADF officers, staff, contractors, agents and employees. Defendant DeYapp is named in his individual and official capacity.

7. Upon information and belief, at all material times, John Does 1-10 were employed by Rio Arriba County as RACADF personnel responsible for providing correctional services at RACADF.

8. Upon information and belief, Rio Arriba County awarded a contract for health care delivery to CorrValues, LLC, in 2016, which CorrValues subsequently assigned to Defendant Vital Core Health Strategies, LLC.

9. At all times material to, Defendant Vital Core Health Strategies, LLC (hereinafter "Vital Core") was, upon information and belief, the entity contracted to provide health care services to inmates confined in RACADF.

10. Defendant Vital Core is a foreign limited liability company licensed to do business in New Mexico. Defendant Vital Core's agent for service of process is CT Corporation System, 206 S. Coronado Ave., Espanola, NM 87532.

11. At all material times, Vital Core 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.

12. Upon information and belief, at all material times, John Does 1-10 were employed by Vital Core and/or RACADF as personnel responsible for supervising and providing health care services to inmates at RACADF.

13. Upon information and belief, at all material times, Levi Maes, M.D., was the medical director for RACADF and was an employee and/or agent of Rio Arriba County and/or Vital Core.

14. Upon information and belief, at all material times, Jolene Martinez, R.N., provided medical care to inmates at RACADF and was an employee and/or agent of Rio Arriba County and/or Vital Core.

15. Upon information and belief, at all material times, Lindy Stone, C.M.A., provided medical care to inmates at RACADF and was an employee and/or agent of Rio Arriba County and/or Vital Core.

16. Upon information and belief, at all material times, John/Jane Doe, EMT-basic, provided medical care to inmates at RACADF and was an employee and/or agent of Rio Arriba County and/or Vital Core.

17. Upon information and belief, at all material times, Detention Officer Joella Cowan, Detention Officer Adeline Martinez, Detention Officer Timothy Gallegos, Detention Officer Matthew Leyba, and Detention Officer Dale Ream were employees and/or agents of Rio Arriba County.

JURISDICTION AND VENUE

18. Plaintiff incorporates the preceding paragraphs as though fully set forth herein.

19. Pursuant to NMSA 1978 §41-4-18(B) venue is proper as Plaintiff resides in Rio Arriba County.

20. This Court has jurisdiction over the subject matter and parties to this action pursuant to the Court's general jurisdiction, N.M. Const. art. VI §13, NMSA 1978, §38-3-1.1, and NMSA 1978 §41-4-18.

21. Plaintiff has given timely notice to the Board of Commissioners of Rio Arriba County pursuant to the provisions of the Tort Claims Act, NMSA 1978, § 41-4-16.

22. 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.

STATEMENT OF FACTS

23. On or about November 11, 2018, Walter Stroop was arrested by Espanola Police Officer Karl Romero for stealing two packs of steaks from the Walmart in Espanola, NM.

24. Mr. Stroop told Officer Romero that he "stole the meats because he needs money for his medication."

25. Officer Romero transported Mr. Stroop to Espanola Presbyterian Hospital to be medically cleared for incarceration.

26. Presbyterian records from this encounter indicate Mr. Stroop had been diagnosed with chronic congestive heart failure.

27. Presbyterian and Christus St Vincent records also indicate Mr. Stroop, at various times from 2016 onwards, had significantly elevated bilirubin levels evidencing cirrhosis and/or

renal failure, elevated troponin levels evidencing myocardial infarctions, and abnormal ECGs indicating myocardial infarctions as well as an AV conduction block, sinus node dysfunction and/or non-specific intraventricular conduction blocks

28. Upon information and belief, these Presbyterian and Christus St. Vincent records, including test results, ECGs, and diagnoses, were contained in Mr. Stroop's RACADC inmate file and available to Vital Core providers and RACADF staff.

29. On November 11, 2018, Presbyterian providers cleared Mr Stroop for incarceration at RACADC, but discharged him with the following medications: aspirin 81 mg; atorvastatin 40 mg; carvedilol 12.5 mg; clopidogrel 75 mg; and lisinopril 10 mg.

30. Mr. Stroop, who waived his right to an attorney, was sentenced to twenty-one (21) days of confinement at RACADC, beginning on November 11, 2018, with his ordered date of release on December 2, 2018 at 11:00 a.m

31. On November 12, 2018 John/Jane Doe EMT-Basic conducted an initial assessment/intake of Mr. Stroop, listing congestive heart failure as a health concern.

32. During this initial assessment/intake, Mr. Stroop reported chest pain and was severely hypertensive, with a blood pressure of 189/128.

33. Jolene Martinez, R.N., called medical director, Levi Maes, M.D.

34. Jolene Martinez, R.N., noted the conversation as follows: "Notified Dr Maes, ordered clonidine 0.1 mg now, then clonidine 0.1 mg BID, will continue to monitor." Clonidine had not been prescribed previously.

35. Records indicate Mr. Stroop was given clonidine 0.1 mg BID for the duration of his incarceration.

36. Clonidine is contraindicated in patients with sinus node dysfunction, AV conduction block, recent myocardial infarction, and congestive heart failure: "[T]he hypotensive effects of clonidine may decrease perfusion and worsen ischemia in patients with cerebrovascular disease, recent myocardial infarction, or severe heart failure. The sympatholytic action of clonidine may worsen sinus node dysfunction and AV block […]"

37. Mr. Stroop's recent medical records, which RACADF possessed, including test results, ECGs and diagnoses, indicate Mr Stroop in fact had sinus node dysfunction and/or an AV conduction block, recent myocardial infarctions, and chronic congestive heart failure

38. Mr. Stoop's 0.1 mg BID dose of clonidine was never titrated or reduced, and he was not properly monitored for worsening heart failure and/or further myocardial infarction.

39. While the clonidine may have addressed superficial hypertension, Mr. Stoop's underlying heart condition and health continued to decline. As such, Mr Stroop continued to complain of chest pain and generally feeling poorly.

40. Upon information and belief, RACADF and/or Vital Core staff contacted Espanola Police Officer Romero and/or the Espanola Police Department ("EPD") between November 14, 2018 and December 2, 2018 requesting EPD transport Mr. Stroop to a hospital because he was "sick."

41. Upon information and belief, Officer Romero and/or EPD told RACADF and/or Vital Core staff that this was not their department's job.

42. In fact, it was RACADF and/or Vital Core's duty to provide Mr. Stroop with adequate medical care and/or access to medical care.

43. The last set of vitals for Mr. Stroop were recorded on November 23, 2018.

44. On the morning of December 2, 2018, Mr. Stroop was preparing to be released. Detention Officer Joella Cowan recorded the encounter: "[Walter Stroop] asked me again if I knew what time he was being released [sic] I informed he [sic] I had not had a chance to check as I was busy. I took the tray and observed he had not eaten much [sic] he informed me he planned to eat with his family when he got home, he also joked with me that he was never comings [sic] back to jail."

45. At around 10:49 am, Detention Officer Cowan unlocked Mr. Stroop's cell and found him unresponsive on the floor.

46. According to Lindy Stone, C.M.A., she received a "call for medical" around 10:55 am, and began CPR sometime thereafter.

47. EMTs arrived in Mr. Stroop's cell around 11.25 am, and were escorted by RACADF staff from the jail out to their ambulance, because RACADF did not possess necessary supplies for resuscitation efforts.

48. Varying accounts note Mr. Stroop's time of death as 11:56 and 12:16.

49. Mr. Stroop, who was found minutes before he was to be released, left behind his mother, Plaintiff, Mary R. Salazar, his son, Walter N. Stroop a minor, and brothers, Michael Stroop and Anthony Stroop.

50. RACADF and Vital Core have a recent history of inmates dying while incarcerated due to poor medical care, poor supervision or lack thereof. Around the time of Mr. Stroop's death, two inmates were also found unresponsive in their cells, and later pronounced dead at local hospitals.

51. Given RACADF and Vital Core recent experience of inmates dying due to poor medical care, poor supervision or lack thereof, RACADF and Vital Core Health Strategies LLC

should have known or knew and should have been trained to address Mr. Stroop's chronic health conditions.

52. The Vital Core policy and procedure manual, defining standards of care and incorporating American Corrections Association (ACA) and National Commission on Correctional Health Care (NCCHC) guidelines, was reviewed and approved by medical director Levi Maes, M.D., on November 7, 2018.

53. However, RADACF was not accredited by the American Corrections Association (ACA) or the National Commission on Correctional Health Care (NCCHC) at times relevant to this Complaint.

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

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

56. RACADF, Larry DeYapp and the Board of Commissioners of Rio Arriba County, failed to compel ACA and NCCHC accreditation for RACADF.

57. RACADF, Larry DeYapp and the Board of Commissioners of Rio Arriba County failed to hold Vital Core Health Strategies LLC to the standards of the ACA or NCCHC, or other pertinent standards ensuring the health and safety of inmates

58. RACADF, Larry DeYapp and the Board of Commissioners of Rio Arriba County failed to hold Vital Core Health Strategies LLC to the standard of care under New Mexico law.

59. RACADF, Larry DeYapp and the Board of Commissioners of Rio Arriba County failed to establish any standard of care for Vital Core's provision of medical care for RACADF inmates.

60. RACADF, Larry DeYapp and the Board of Commissioners of Rio Arriba County failed to properly oversee, monitor, supervise and manage Vital Core's operation of medical facilities and provision of medical services to RACADF inmates, including Mr. Stroop.

61. RACADF, Larry DeYapp and the Board of Commissioners of Rio Arriba County failed to take corrective action against Vital Core despite clear knowledge of the negligent and reckless provision of medical care by Vital Core.

62. Likewise, Vital Core failed to take corrective action against RACADF, including addressing any deficiencies in RACADF's operation or the contract, which may have adversely affected its ability to provide care to RACADF inmates.

63. RACADF and the Board of Commissioners of Rio Arriba County have a non-delegable duty to provide for proper, necessary and competent medical care for all inmates in the care of RACADF.

64. Board of Commissioners of Rio Arriba County is the entity responsible for the management and oversight of RACADF.

65. RACADF is responsible, on behalf of the Board of Commissioners of Rio Arriba County, for the provision of proper, necessary and competent medical care of RACADF inmates, including Mr. Stroop.

66. RACADF contracted with Vital Core for the provision of medical services to RACADF inmates.

67. RACADF's duty to provide proper, necessary and competent medical care remains intact despite the assignment of said duties to outside contractors, including Vital Core.

COUNT I – NEGLIGENCE AGAINST ALL DEFENDANTS

68. Plaintiff realleges Paragraphs 1 through 67 pursuant to NMRA Rule 1-010(C)

69. For the period complained of herein, RACADF and Vital Core 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. Stroop while he was an inmate at RACADF.

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

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

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

C. Failing to provide proper medical crisis prevention planning, medical crisis prevention monitoring, medical crisis prevention policies and procedures, medical crisis prevention equipment, and medical crisis prevention training, so that Mr. Stroop was allowed to suffer medical crisis without proper monitoring, prevention and treatment;

D. Failing to provide and implement proper care plans that would adequately meet Mr. Stroop's needs, including his health condition;

E. Allowing Mr. Stroop to remain unattended and unmonitored despite Mr. Stroop's health condition,

F. Failing to provide a safe environment;

G. Failing to ensure that Mr. Stroop received adequate supervision and assistance devices to prevent medical crisis;

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

I. Failing to provide services to attain or maintain the highest practicable care for Mr. Stroop's health and well-being in accordance with a written plan of care;

J. Failing to adequately monitor Mr Stroop's health and safety;

71. 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. Stroop. This is particularly so in regard to allowing Mr. Stroop's health to deteriorate without properly correcting the care plan or attending to his health condition, despite his medical history and current complaints.

72. 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.

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

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

COUNT II - MEDICAL MALPRACTICE AGAINST VITAL CORE HEALTH SERVICES LLC, ITS EMPLOYEES, AND JOHN DOES 1-10

75. Plaintiff realleges Paragraphs 1 through 74 pursuant to NMRA Rule 1-010(C).

76. In undertaking the diagnosis, care and treatment of Mr. Stroop, 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.

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

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

A Failure to evaluate, treat and manage Mr. Stroop's health condition;

B. Failure to develop, employ, and follow appropriate policies and procedures with regard to the assessment, treatment, and management Mr. Stroop's health 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. Stroop;

F. Failure to refer Mr. Stroop to appropriate specialists,

G Failure to timely transfer Mr. Stroop to an appropriate medical facility;

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

I. Failure to provide any care whatsoever, despite Mr. Stroop's medical history and current health condition.

J. Failure to prescribe appropriate medications to Mr. Stroop, in light of his chronic health conditions;

K. Failure to diagnose and treat Mr. Stroop, in light of the records and information available.

79. Defendants' failure to assess, treat and manage Mr. Stroop's health condition was reckless, wanton and in utter disregard for the safety and welfare of Mr. Stroop.

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

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

COUNT III – NEGLIGENT OPERATION OF A MEDICAL FACILITY AGAINST VITAL CORE HEALTH STRATEGIES, LLC AND RACADF

82. Plaintiff realleges Paragraphs 1 through 81 pursuant to NMRA Rule 1-010(C).

83. RACADF and Vital Core are entrusted with the medical care of RACADF inmates who have no other source of medical care.

84. Vital Core Health Strategies, LLC's medical staff at RACADF lacked sufficient expertise to assess, treat and manage Mr. Stroop's medical condition and current health.

85. Vital Core Health Strategies, LLC was negligent in failing to properly refer Mr. Stroop to be seen by a physician or health provider who could effectively treat him.

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

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

88. Such conduct amounts to negligence in the treatment of Mr. Stroop

89. The actions of Vital Core were negligent, willful, wanton, and in gross and reckless disregard for Mr. Stroop's health and well-being.

90. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp have knowingly allowed, aided and abetted in Vital Core's failure to maintain ACA and NCCHC minimum mandatory standards at RACADF.

91. Defendant Vital Core has violated numerous provisions of ACA and NCCHC.

92. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp have knowingly allowed and been complicit in the violation of the ACA and NCCHC minimum mandatory standards.

93. The failures of Defendants Vital Core Health Strategies, LLC, RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp led to the death of Mr. Stroop.

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

COUNT IV – BREACH OF CONTRACT AGAINST VITAL CORE HEALTH STRATEGIES, LLC AND RACADF

95. Plaintiff realleges Paragraphs 1 through 94 pursuant to NMRA Rule 1-010(C).

96. RACADF has allowed Vital Core Health Strategies, LLC to breach its service contract on numerous occasions, by failing to provide proper behavioral health care to inmates.

97. Vital Core Health Strategies, LLC has breached its service contract by failing to meet its own policies and procedures, as outlined in the documents reviewed and signed by medical director Levi Maes, M.D., on November 7, 2018

98. Vital Core Health Strategies, LLC has breached the following provisions, including but not limited to:

A. **VitalCore General Health Policy #: J-A-03.00, "Medical Autonomy and Provision of Treatment":** "Clinical decisions and actions regarding healthcare provided to patients to meet their serious medical, dental and behavioral needs are made by qualified healthcare professionals for clinical purposes." ACA Mandatory; NCCHC Essential. Qualified healthcare professionals are defined as: M.D.s, P.A.s, RNs, NPs, and others who by their education, credentials, and experience are permitted by law to evaluate and care for patients.

Upon information and belief, John/Jane Doe EMT-Basic evaluated Mr Stroop, and Lindy Stone, C.M.A., rendered care Neither are qualified healthcare professionals.

B. **VitalCore General Health Policy #: J-A-06.00, "Quality Assurance Performance Improvement":** "VitalCore's continuous quality improvement program shall establish a quality assurance-based format that also meets the current Medicaid (CMS) service model and include performance improvement. Quality Assurance Performance Improvement (QAPI) monitors and improves healthcare delivered in the facility." ACA Mandatory; NCCHC Essential.

Upon information and belief, no such program existed or was implemented at RACADF at all times material hereto.

C. **VitalCore General Health Policy #: J-A-10.00, "Procedure in Event of Inmate Death":** "All deaths are reviewed to determine the appropriateness of clinical care; to

ascertain whether changes to policies, procedures or practices are warranted; and to identify issues that require further study." ACA Mandatory; NCCHC Essential.

Upon information and belief, no such review was conducted regarding Mr. Stroop's death, or the deaths of other inmates at RACADF.

D. **VitalCore General Health Policy #: J-C-04.00, "Clinical Performance Enhancement":** "A training program, established or approved by the Responsible Health Authority in cooperation with the facility administrator, guides the health-related training of correctional officers who work with patients. Ensure that correctional officers are appropriately trained in their responsibility for early detection of illness or injury, are appropriately trained to respond to life-threatening situations (within four (4) minutes) after a medical emergency is called) and are made aware of potential emergencies or procedures." NCCHC Essential.

Upon information and belief, no such training program was implemented, and as a consequence, no one recognized Mr. Stroop's health crisis, or responded within an appropriate time frame.

E. **VitalCore General Health Policy #: J-D-05.00, "Hospital and Specialty Care":** "Arrangements are made to provide hospitalization and specialty care to patients in need of these services." ACA Mandatory; NCCHC Essential.

Upon information and belief, no such care was provided to Mr. Stroop, as evidenced by Plaintiff's factual allegations.

F. **VitalCore General Health Policy #: J-E-01.00, "Information on Health Services":** "Within twenty-four (24) hours of their arrival at a facility, information about the availability of, and access to, health care services is communicated orally and in writing to patients in a form and language they understand." ACA Mandatory; NCCHC Essential

Upon information and belief, no such information was provided to Mr. Stroop.

G. **VitalCore General Health Policy #: J-E-02.00, "Receiving Screening":** "Receiving screening is a process of structured inquiry and observation intended to identify potential emergency situations among new arrivals and to ensure that patients with known illnesses and those on medications are identified for further assessment and continued treatment." ACA Mandatory; NCCHC Essential.

Upon information and belief, the screening, if any, that Mr. Stroop received was grossly inadequate, and/or was not properly relied upon or referenced throughout his incarceration.

H. **VitalCore General Health Policy #: J-E-02.00, "Admission Screening":** "The offender will have a comprehensive health assessment completed within fourteen (14) days of the screening by the Physician, Physician Assistant, Advanced Practice Registered Nurse (APRN), or trained Registered Nurse (RN)." ACA Mandatory; NCCHC Essential.

Upon information and belief, no such assessment was ever conducted on Mr. Stroop

I. **VitalCore General Health Policy #: J-E-08.00, "Emergency Services":** "The facility provides 24-hour emergency medical, behavioral health, and dental services." ACA Mandatory; NCCHC Essential.

Upon information and belief, no such services were provided at all times material hereto.

J. **VitalCore General Health Policy #: J-G-01.00, "Chronic Disease Services and Special Needs":** "Patients with chronic diseases are identified and enrolled in a chronic disease program to decrease the frequency and severity of the symptoms, prevent disease progression and complication, and foster improved function. Individuals with chronic disease, special needs, or other significant health conditions and disabilities receive ongoing multidisciplinary care and treatment planning aligned with standards." ACA Mandatory; NCCHC Essential.

Upon information and belief, no such services were provided at all time material hereto.

K **VitalCore General Health Policy #: J-G-03.00, "Infirmary Care":** "Infirmary care is provided to patients with an illness or diagnosis that requires daily monitoring." ACA Mandatory; NCCHC Essential.

Upon information and belief, no such care was provided to Mr. Stroop.

99. As an inmate of RACADF, Mr. Stroop was a third-party beneficiary of this service contract, and the terms reviewed and agreed to by medical director Levi Maes, M.D.

100. As a direct and proximate result of the acts and omissions set forth herein, Vital Core Health Strategies, LLC breached its service contract.

101. In breaching its service contract, Vital Core Health Strategies, LLC's actions were willful, malicious, wanton, or in reckless disregard for the health and well-being of Mr. Stroop.

102. As a direct and proximate result of this contractual breach by Defendants, Mr. Stroop suffered those damages set forth in this Complaint.

103. Additionally, Plaintiff is entitled to damages for breach of contract as a third-party beneficiary of the aforementioned service contract.

COUNT V – NEGLIGENCE PER SE AGAINST ALL DEFENDANTS

104. Plaintiff realleges Paragraphs 1 through 103 pursuant to NMRA Rule 1-010(C)

105. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp have knowingly allowed, aided and abetted in Vital Core's failure to comply with minimum mandatory ACA and NCCHC standards.

106. Defendant Vital Core has violated numerous provisions of ACA and NCCHC in providing services at RACADF.

107. The ACA violations by Defendants include but are not limited to:

A. ACA standard 4-4350 which provides for a mandatory written treatment plan that is required for offenders requiring close medical supervision.

B ACA standard 4-4350 which requires that that mandatory written treatment plan include directions to health care and other personnel regarding their roles in the care and supervision of the patient, and is to be approved by the appropriate licensed physician.

C. ACA Standard 4-4348 requiring that offenders who need health care beyond the resources available in the facility 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 Standard 4-4348 which specifically states that treatment of an offender's condition should not be limited to resources and services available within a facility.

E. ACA Mandatory Standard 4-4359 which further requires that with chronic conditions that the treatment plan address the monitoring of medications, laboratory testing, the use of chronic care clinics, health record forms, and specialist consultation and review.

108. Defendant Vital Core has violated its own policies and procedure which correspond with mandatory ACA requirements, and essential NCCHC requirements. Such violations include but are not limited to: VitalCore General Health Policies J-A-03.00, J-A-06 00, J-A-10.00, J-C-04 00, J-D-05.00, J-E-01.00, J-E-02 00, J-E-08 00, J-G-01 00, and J-G-03.00 (described fully above).

109. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp have been complicit in the failure to comply with minimum mandatory ACA and NCCHC standards through its failure to enforce the terms of the service contract with Vital Core.

110. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp have failed to properly maintain oversight and enforcement of the service contract with Vital Core

111. The failures of Defendants Vital Core Health Strategies, LLC, RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp led to the death of Mr. Stroop.

112. As a result of the foregoing, Defendants' negligence per se, Mr Stroop 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 – NEGLIGENT HIRING, TRAINING AND SUPERVISION AGAINST ALL DEFENDANTS

113. Plaintiff realleges Paragraphs 1 through 112 pursuant to NMRA Rule 1-010(C).

114. Vital Core had a duty to properly screen, supervise, educate, and train its employees regarding proper treatment of inmates with health conditions, and medical emergencies.

115. On information and belief, Vital Core failed to properly train and supervise its employees, contractors, or agents in such a manner to properly and adequately assess, treat and manage Mr. Stroop's health conditions

116. Vital Core is 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.

117. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp 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.

118. On information and belief, RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp failed to properly train and supervise its employees, contractors, or agents in such a manner to properly and adequately assess, treat and manage Mr. Stroop's health conditions.

119. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp 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.

120. The failures of Defendants Vital Core, RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp led to the death of Mr. Stroop.

121. As a result of the foregoing, Mr. Stroop's wrongful death, pain and suffering, and severe psychological and emotional distress, for which Plaintiff is entitled to damages, including punitive damages.

COUNT VII – NEGLIGENCE AGAINST RACADF, BOARD OF COMMISSIONERS OF RIO ARRIBA COUNTRY, AND LARRY DEYAPP

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

123. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp negligently failed to oversee Vital Core in the provision of healthcare, including behavioral health, to RACADF inmates, which contributed to the death of Mr. Stroop.

124. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp failed to take corrective action against Vital Core in clear face of recurrent and

consistent negligent and reckless behavioral healthcare to RACADF inmates which contributed to the death of Mr. Stroop.

125. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp negligently, intentionally and knowingly confined Mr. Stroop in cell A-5, despite his chronic health conditions and need for immediate medical attention.

126. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp negligently failed to hold Vital Core to standards and guidelines of the ACA or NCCHC.

127. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp negligently failed to hold Vital Core to the medical standard of care established under New Mexico law which contributed to the death of Mr. Stroop.

128. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp failed to establish or enforce any standards at all for Vital Core's provision of proper, necessary and competent medical care to RACADF inmates.

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

COUNT VIII – INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS AGAINST ALL DEFENDANTS

130. Plaintiff realleges Paragraphs 1 through 129 pursuant to NMRA Rule 1-010(C)

131. Defendants intentionally denied Mr. Stroop proper and necessary health care.

132. Defendants intentionally denied Mr. Stroop access to the appropriate specialists for his health conditions.

133. Defendants knew that denying Mr. Stroop access to appropriate medical care would exacerbate his health conditions.

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

135. Mr. Stroop suffered severe emotional distress as a result of the conduct of Defendants.

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

COUNT IX – *RESPONDEAT SUPERIOR* AND AGENCY AGAINST ALL DEFENDANTS

137. Plaintiff realleges Paragraphs 1 through 136 pursuant to NMRA Rule 1-010(C).

138. Vital Core Health Strategies, LLC is responsible to Mr. Stroop under the doctrine of *respondeat superior* for the conduct of its employees and agents

139. Vital Core Health Strategies, LLC is responsible to Mr. Stroop under the doctrine of agency for the conduct of its employees and agents.

140. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp have a non-delegable duty to provide proper and necessary behavioral healthcare to inmates in the custody of NMCD and RACADF

141. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp have violated the duty by its failure to properly screen, hire, manage, supervise, train or exert contractual control over Defendants Vital Core Health Strategies, LLC.

142. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp have knowingly allowed and been complicit in the violation of the ACA and NCCHC minimum mandatory standards for healthcare in a correctional setting.

143. The failures of Defendants Vital Core Health Strategies, LLC, RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp led to the death of Mr. Stroop.

COUNT X – *RES IPSA LOQUITOR* AGAINST ALL DEFENDANTS

144. Plaintiff realleges Paragraphs 1 through 143 pursuant to NMRA Rule 1-010(C).

145. The injuries and damages, suffered by Mr. Stroop were proximately caused by Defendants.

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

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

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

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

COUNT X – NEGLIGENT OPERATION AND MAINTENEANCE OF RACADF AGAINST RACADF, BOARD OF COMMISSIONERS OF RIO ARRIBA COUNTY, AND LARRY DEYAPP

150. Plaintiff realleges Paragraphs 1 through 149 pursuant to NMRA Rule 1-010(C)

151. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp were negligent in their operation and maintenance of RACADF.

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

153. Defendants RACADF, Board of Commissioners of Rio Arriba County, and Larry DeYapp were operating RACADF in a manner that prevented proper observation of Mr. Stroop.

154. There were no surveillance cameras with an unobstructed view into Mr. Stroop's cell.

155. The window into Mr Stroop's cell did not afford an unobstructed view into Mr. Stroop's cell.

156. Mr. Stroop's cell was situated where RACADF guards could not properly observe Mr. Stroop.

157. As a direct and proximate result of these negligent acts and omissions, Mr Stroop suffered a medical emergency, and was so concealed detention officers did not discover him until after he could not be resuscitated.

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

COUNT XI – WRONGFUL DEATH AGAINST ALL DEFENDANTS

159. Plaintiff realleges Paragraphs 1 through 158 pursuant to NMRA Rule 1-010(C)

160. 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. Stroop.

161. 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.

162. Defendants breached their duty by failing to ensure that Mr. Stroop received appropriate health care.

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

DAMAGES

164. Plaintiff realleges Paragraphs 1 through 163 pursuant to NMRA Rule 1-010(C).

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

166. 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. Stroop, 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. Stroop, and hedonic damages, or damages for the loss of value of Mr. Stroop's life itself, all to Plaintiff's damage in an amount to be determined by the Court at trial.

167 In the alternative, as a direct and proximate result of the actions of Defendants enumerated above. Mr. Stroop 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.

168. 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 Stroop, 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.

COUNT XI – LOSS OF CONSORTIUM AGAINST ALL DEFENDANTS

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

170. Plaintiff Mary R. Salazar, mother of Walter Stroop, deceased, shared a household with him, and the two relied on each other for financial support. Mary R. Salazar shared a close familial relationship with Walter Stroop, and they were mutually dependent upon each other.

171. Plaintiff Walter N. Stroop II, a minor, and for whom Mary R. Salazar is legal guardian, is the son of Walter Stroop, deceased Walter N. Stroop, a minor, shared a close familial relationship with Walter Stroop, deceased, and they were mutually dependent upon each other.

172. Defendants' negligent acts and omissions that caused Mr. Stroop's death have caused Mary R Salazar and Walter N Stroop II to lose the love and companionship of their son and father, respectively

173. As such, damages for loss of consortium are applicable.

WHEREFORE, Plaintiff Mary R. Salazar, Personal Representative of the Estate of Walter Stroop, and guardian of Walter N. Stroop III, a minor, requests compensatory and punitive damages, costs, pre- and post-judgment interest and such other relief as permitted by law against Defendants.

GUEBERT BRUCKNER GENTILE, 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
alysan@collinsattorneys.com
Attorneys for Plaintiff

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