STATE OF NEW MEXICO
COUNTY OF SAN MIGUEL
FOURTH JUDICIAL DISTRICT COURT

EUGENIO S. MATHIS, as Personal Representative of the ESTATE OF JAMES RAMIREZ, deceased,

Plaintiff,

v.

No. D-412-CV-2023-00241
Aragon, Michael A.

CORECIVIC OF TENNESSEE; CIBOLA GENERAL HOSPITAL, INC.; JOSEPH R. BOUNDS; JOSHUA LARSON, MD; and JOHN DOES 1-10 in their individual and official capacities, (employees, staff, agents CoreCivic of Tennessee and Cibola General Hospital),

Defendants.

COMPLAINT FOR MEDICAL MALPRACTICE, WRONGFUL DEATH, AND RELATED CLAIMS

COMES NOW, the PLAINTIFF, EUGENIO S. MATHIS, as Personal Representative of the ESTATE OF JAMES RAMIREZ, by and through his attorneys COLLINS & COLLINS, P.C. (Parrish Collins) and GUEBERT GENTILE & PIAZZA P.C. (Elizabeth M. Piazza), and for his cause of action states as follows:

I. INTRODUCTION

James Ramirez was a federal detainee in the custody of CoreCivic in the Cibola County Correctional Facility (CCC). James had a history of schizophrenia with paranoia, including prior hospitalizations. CoreCivic personnel were aware of James Ramirez's paranoid chronic schizophrenia, including that he heard voices. Cell camera footage shows that James was having a severe medical and/or mental health crisis in his solitary cell. He was behaving bizarrely. He was unable to stand even when using the concrete bench bed or the sink for support. He fell,

repeatedly striking his head against the concrete in the cell including the concrete bed. After 26 minutes of repeated falls and injuries to himself, he was transferred to a medical observation cell, and a medical code was called at 7:35 a.m. For 4 hours, multiple security personnel had to keep James Ramirez pinned to the floor. During the 4 hours, correctional officers repeatedly called for medical assistance. None came. Instead, they were forced to hold James down on the floor as he thrashed, moaned, screamed incoherently, and struck his head against the concrete multiple times. Medical did not show up until 11:38 a.m. When Joseph R. Bounds RN (hereinafter "Bounds"), finally arrived on the scene, Bounds refused the requests for transport to a hospital. Knowing full well that James Ramirez could not speak, he insisted that James verbally requested a transfer to the hospital. During the interaction with James, Bounds did not examine James Ramirez even for the purpose of obtaining vital signs or consulting with the medical doctor to determine how to calm James down to prevent further physical injuries caused by the thrashing of his body and head against the concrete in the cell. Instead, having provided no medical care of any kind, Bounds simply left, telling the security personnel to contact him once James had verbally requested a transfer to the hospital, which James was apparently never able to do. The security personnel were forced to keep James Ramirez pinned to the floor until 1:15 p.m. when James was finally transferred to Cibola General Hospital at 1:15 p.m.

Unfortunately, James Ramirez' psychiatric condition continued to be ignored. Despite reports of James repeatedly smashing his face on the concrete and suspicions of drug or alcohol toxicity, the treating physician at CGH treated James only for physical injuries from his falls or as described to the doctor, repeatedly smashing his face on the concrete. The treating doctor took no psychological history, did not conduct any psychological testing, did not call in a psychiatrist or other mental health professional, and did not conduct any toxicology studies or other blood

testing to determine the cause of James's bizarre behavior, which included to Cibola General's knowledge repeatedly smashing his face on the concrete. Instead, James was sedated with multiple doses of Ativan and Haldol, and then Ketamine intravenously to take a CT scan for brain injuries. Following the CT scan, James was discharged back to CCC where he was placed in an isolation cell rather than a medical observation cell. He died the following morning.

II. PARTIES, JURISDICTION, AND VENUE

1. James Ramirez died on February 15, 2022, in Cibola County, New Mexico.

2. At all relevant times, and at the time of his death, James was a detainee at the Cibola County Correctional Center ("CCCC") in Cibola County, New Mexico.

3. Plaintiff, Eugenio Mathis, was appointed Personal Representative of the Estate of James Ramirez, deceased, on May 23, 2022, and is a resident of San Miguel County, New Mexico.

4. Plaintiff brings this action on behalf of the Estate.

5. Defendant CoreCivic, Inc. (hereinafter "CoreCivic") is a foreign for-profit corporation registered to do business in New Mexico with a registered agent for service of process at 2201 San Pedro NE, Bldg. 3 #200, Albuquerque, New Mexico 87110.

6. At all times relevant, CoreCivic operated, supervised, directed, and controlled CCCC, including the operation of medical services, Defendant CoreCivic, Inc.

7. As a private prison management corporation, CoreCivic is a public body as defined in NMSA 1978, Section 41-4A-2.

8. At all times relevant to this Complaint, CoreCivic acted through its owners, officers, directors, employees, agents, or apparent agents, including but not limited to administrators, management, nurses, nurse practitioners, doctors, technicians, and other staff

personnel and is responsible for their acts or omissions pursuant to the doctrines of *respondeat superior*, agency or apparent agency.

9. All tortious conduct of individual Joseph Bounds hereinafter alleged is imputed to CoreCivic as a matter of law (collectively, "CCCC Defendants").

10. Defendant Cibola General Hospital, Inc. (hereinafter, "Cibola General") is a domestic non-profit organization with a principal place of business at 1016 E. Roosevelt Ave., Grants, NM 87020.

11. At all times relevant, Cibola General operated, supervised, directed, and controlled Cibola General Hospital, located in Grants, New Mexico.

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

13. All tortious conduct of individual Joshua Larson, MD, hereinafter alleged is imputed to Cibola General as a matter of law (collectively, "Cibola General Defendants").

14. At all times material to this Complaint, Defendant Joseph R. Bounds, RN was an employee of CoreCivic acting within the course and scope of his agency as a registered nurse.

15. Defendant Joshua Larson, MD, was, at all times material, an employee of Cibola General Hospital, was acting within the course and scope of his agency as a medical doctor.

16. A Tort Claims Notice and Notice of Claims under the New Mexico Tort Claims Act and the New Mexico Civil Rights Act, respectively, was sent timely on May 6, 2022.

17. This Court has jurisdiction over the subject matter of and the parties to this action under NMSA 1978, Sections 38-3-1 and 41-4A-3(B).

III. STATEMENT OF FACTS

A. Incarceration at CCCC

18. At times relevant to this Complaint, and at the time of his death, James was a 27- to 28-year-old man incarcerated at CCCC in Milan, New Mexico, under the supervision and control of CoreCivic.

19. On September 7, 2021, James was taken into the custody of CCCC.

20. James passed away on February 15, 2022, at the age of 28.

21. Upon information and belief, at an intake assessment on September 8, 2021, James reported existing diagnoses, treatment, and hospitalization for schizophrenia.

22. Upon information and belief, all defendants were aware of these diagnoses as CoreCivic medical personnel both diagnosed and treated James for paranoid schizophrenia. CCCC medical records indicate that James had hallucinations and heard voices of predators.

23. Upon information and belief, James also reported a recent surgery for multiple gunshot wounds.

24. Upon information and belief, on October 25, 2021, James complained to CoreCivic employee Nurse McGowan, R.N. of pain due to retained bullet fragments in his right lung, left armpit, left bicep, right knee, right inner thigh, inner left thigh, and above his left knee.

25. Upon information and belief, James requested that the bullets be removed but they were never removed prior to James' death.

26. As a result, these fragments caused James significant pain and suffering throughout his incarceration at CCCC. Upon information and belief, CoreCivic medical personnel provided no pain management of any kind other than ibuprofen.

27. Upon information and belief, on or around October 29, 2021, November 16, 2021, and January 12, 2022, James told CoreCivic employees, agents, and/or contractors [unknown first name] Nelson…, and [unknown first name] Dunning ADO or [unknown first name] Mirabal, respectively, that he feared for his life due to threats from other prisoners. Defendants determined, upon information and belief without any medical, mental health or psychiatric intervention of any kind, that there was no real threat but rather that James was paranoid.

28. These complaints should have warranted a psychological re-evaluation to determine if his fears were justified or a product of his paranoid schizophrenia.

29. Instead, on February 9, 2022, he was placed in solitary confinement as a result of his fears for his life.

30. There was an administrative review of his restrictive housing. The restrictive housing was approved. During the administrative review, upon information and belief, there was no medical or mental health risk assessment conducted nor were the long list of his anti-psychotic, anti-anxiety, anti-depressant, asthma, seizure, and blood pressure medications checked for propriety, effectiveness, or adverse interactions.

31. The solitary confinement likely worsened James' already severe mental health issues.

32. Upon information and belief, on February 14, 2022, James began to suffer from a severe medical and/or mental health episode while in his cell.

33. Around 7:35 a.m., a medical response was called because James was behaving erratically, speaking incoherently, and had a busted lip from where he had fallen in his cell.

34. James was escorted to a medical observation cell and placed on a thirty-minute watch.

35. As evidenced by the CoreCivic security video, at approximately 9:00 a.m., James repeatedly fell, hitting the concrete bed, the sink, the walls, and the floor numerous times, causing him significant physical injuries. Medical and security staff did not enter his cell until approximately 9:26 a.m. By this time, both James and the cell were covered in blood.

36. Security staff held James down on the ground to keep him from further injuring himself. From the outset, when the guards entered his medical observation cell, there were a minimum of three guards in the cell restraining James.

37. James was placed in a soft head brace and hard restraints on his ankles and wrists.

38. Despite these restraints, James continued to thrash and free his head from the brace and hit his head on the walls and the floor. The difficulty keeping James's head in the brace would go on for nearly five hours while security staff were forced to restrain James due to the lack of response from CoreCivic medical personnel.

39. As evidenced by the CoreCivic security video, a male officer asked a female who had stepped into James's cell to call for someone from medical.

40. A few minutes later, a female officer stated that she was going to try to find "Bounds," referring to Defendant Joseph Bounds.

41. As James continued to intermittently thrash, moan, and scream incoherently, the male officer asked the female if medical was going to give James something to calm him down. She replied that medical "just wants to wait it out."

42. Around twenty minutes later, a male officer asked a female officer if she had heard from medical. She called Bounds, who was not at CCCC at this time, who stated that he had not heard anything about the ongoing situation with James and that the officers would probably have to use restraints.

43. The woman additionally stated that she told Bounds that if anything were to happen to James, there was not a nurse on site to assist.

44. By this time, there were bloody bandages all around James' body and blood on the walls and floor around him.

45. At one point, a woman states that "they" think James is malingering and is behaving this way to avoid going to court. It is not clear who "they" is.

46. Around the same time, a male officer asked a female officer to find Bounds because the officers just sitting there restraining James was not helping and "this guy needs to go to the hospital."

47. A few moments later, a female enters and states that Bounds was busy on a conference call and that Bounds is always on conference calls.

48. Another woman states that she will call Bounds because James really needed a sedative.

49. Throughout this time, the officers expressed their frustration at not being able to reach Bounds or anyone from medical.

50. One female stated that she would call Dr. Ivens, but another stated that Bounds is supposed to make that call. A third officer asks, "what are we supposed to do, just wait for Bounds?"

51. At this point, it had been two or three hours since the security officers had called for help.

52. One officer even stated that "this is crazy."

53. About thirty minutes later, a male officer asked if they had heard anything from medical, to which another male officer responded "no."

54. Finally, NP Bounds arrived at James's cell and told the officers "as soon as you [James] can say 'I give you permission to take me to the hospital,' he can go get his lip sutured, and they can evaluate him and treat him from there and see what's up, so we just need him to get with it enough to say okay I give consent to go to the hospital."

55. Bounds then repeatedly asked James his name, even though James could not speak coherently at the time.

56. Finally, Bounds tells James that "If you just talk to me, we can get you to the hospital and get you fixed up real quick, they have better drugs than we do."

57. As Bounds left the cell, with officers still restraining James to prevent further injury, Bounds stated that "[James] thinks he's on drugs anyway."

58. Bounds then stated that if things did not improve after an hour, even though the medical/mental health episode had been ongoing for four hours at this point, that he would talk to Dr. Ivens. He stated that, despite his belief that James's situation was not life-threatening, he would see if he could play the "emergency card."

59. Bounds did not evaluate James.

60. Bounds did not perform any testing or diagnostics.

61. Bounds did not even take James' vital signs.

62. Bounds left without providing any medical care at all to James leaving him bleeding in a severe medical, and psychiatric crisis, pinned to the floor by multiple security officers.

63. Dr. Ivens never came to the cell and Bounds never returned to see James over the next hour and a half.

64. Instead, the officers were left alone with James with no medical assistance. They continued to restrain James and tried to get him to verbalize that he wanted to go to the hospital. James could not answer.

65. Around 1:00 p.m., nearly six hours after the incident began, James was finally referred to an outside medical facility, Cibola General Hospital, for further treatment.

66. The Office of the Medical Investigator (OMI) Report for James lists the following injuries, likely all incurred while he was on medical observation:

I. Blunt trauma, minor
  A. Head and neck
    1. Fracture, nasal bone
    2. Lacerations
      i. Lips
      ii. Forehead
    3. Contusions involving the face and head
    4. Abrasions involving the face
    5. Bilateral periorbital ecchymoses
    6. Subscapular hemorrhage
      i. Frontal scalp
      ii. Temporal scalp, bilateral
    7. Subgaleal hemorrhage
      i. Temporal skull, bilateral
      ii. Parietal skull, bilateral
    8. Hemorrhage
      i. Temporal muscle, bilateral
      ii. Right side of neck, soft tissue

67. James was finally transported to Cibola General around 1:15 p.m., nearly six full hours after the medical code was called at 7:30 a.m.

B. Cibola General Hospital

68. Upon transport to Cibola General, James was seen by Joshua Larson, M.D.

69. The chief complaint is stated as "Brought in by corrections by repeatedly smashing face on concrete. Altered mental status, baseball sized lump on forehead, laceration to right side of head."

70. James's medical records also note that he appeared intoxicated, but it was unclear what substance he had used, if any.

71. Yet, despite believing that James was intoxicated, upon information and belief, Dr. Larson did not order any blood tests, toxicology, drug tests or drug screens.

72. Without performing a toxicology screening, Dr. Larson ordered that James be administered multiple doses of Ativan and Haldol, which did not calm James down. Finally, Dr. Larson ordered Ketamine intravenously, and James underwent a CT scan.

73. Remarkably, Dr. Larson stated that James was alert and oriented with no motor or sensory changes.

74. Remarkably, Dr. Larson also stated that James was cooperative with an appropriate mood and affect.

75. Yet, a nurse stated that she could not obtain any information from James due to cognitive impairment.

76. This nurse also calculated that James had a Glasgow coma scale of 13, indicating he had likely suffered a traumatic brain injury.

77. Knowing that James had a history of schizophrenia and had been smashing his face repeatedly on the concrete, Dr. Larson did not call in or refer James to a mental health professional to evaluate James for his severe mental health crisis.

78. It does not appear that Dr. Larson took any notes on, or inquired into James psychiatric history, the circumstances related to smashing his face on the concrete repeatedly, or

the fact that James had to be restrained by numerous correctional officers for close to 5 hours prior to transfer to Cibola General.

79. It does not appear from Dr. Larson's notes that he consulted with RN Bounds, Dr. Ivens or any other CoreCivic medical personnel. Likewise, it does not appear that any CoreCivic medical personnel attempted to consult with Dr. Larson.

80. Instead, James was given only a physical examination, provided patient education materials and presrciptions and sent back to the correctional facility.

81. James likely never reviewed these materials due to his condition.

82. James did not sign any paperwork form Cibola General, likely due to the inability to do so.

83. James was instructed to follow up with his primary care provider within 1 to 2 days.

84. James died the day following his visit to Cibola General.

CAUSES OF ACTION

COUNT I MEDICAL MALPRACTICE (CoreCivic and Cibola General Hospital)

85. Plaintiff incorporates by reference, as if fully set forth herein, each and every allegation contained in the paragraphs above.

86. At all relevant times, CoreCivic and Cibola General, acting through their employees, agents, apparent agents, and/or contractors, were negligent in the medical care and services they provided to James.

87. In undertaking the diagnosis, care and treatment of James, CoreCivic, Cibola General Hospital, by and through their respective employees, staff, and agents, had a duty to possess and apply the knowledge, skill, and care that is used by reasonably well-operated

medical facilities and well-qualified healthcare providers under similar circumstances, giving due consideration to the locality involved, CoreCivic and Cibola General, and their respective employees, staff, and agents, breached their duties owed to James and committed medical malpractice and were negligent in the management of his health and well-being.

88. CoreCivic's negligence includes, but is not limited to:

a. Failure to implement adequate staffing levels and adequately trained staff at CCCC to care for detainees with full knowledge that such inadequate staffing practices would place detainees such as James at risk for injury and death;

b. Negligently hiring, retaining, and supervising staff at CCCC with full knowledge that such staffing practices would place detainees such as James at risk for injury and death;

c. Failure to implement proper mental health crises management protocols and/or to follow mental health crises management protocols, including mental health supervision, assessment, monitoring, and training, such that James died without proper monitoring, prevention, and treatment;

d. Failure to provide and implement proper care plans that would have addressed James's medical needs;

e. Failure to provide a safe environment for detainees, including James; and

f. Failure to recognize James's emergent need for medical care and/or a higher level of medical care than could be provided at CCCC.

89. Cibola General's negligence includes, but is not limited to:

a. Failure to properly supervise its medical personnel,

b. Failure to evaluate, treat, and manage James's medical condition;

c. Failure to take the reasonable steps to acquire proper treatment of James; and

d. Failure to protect and preserve James's health.

90. CoreCivic and Cibola General, through their employees, agents, and contractors, breached their duties and were, at minimum, negligent in the diagnosis, treatment, and management of James's health and safety.

91. These acts and failures to act by CoreCivic and Cibola General, by and through their employees, agents, and contractors, were willful, wanton, and in reckless disregard for James's safety and well-being.

92. All acts and/or omissions of CoreCivic and Cibola General, by and through their employees, agents, and contractors, were done within the scope of its employment, agency, or contract.

93. All acts complained of herein were authorized, participated in, or ratified by CoreCivic and Cibola General, and/or their administrators, managers, officers, directors, or shareholders.

94. As a direct and proximate result of the negligent acts and omissions by CoreCivic and Cibola General, and their employees, staff and agents, James suffered a rapid deterioration in his health, along with physical, emotional, and psychological pain and suffering not presently determinable, but to be proven at the time of trial.

95. As a direct and proximate result of the negligent acts and omissions by CoreCivic and Cibola General, and their employees, staff and agents, James suffered and unnecessary, avoidable, and wrongful death.

96. CoreCivic and Cibola General's failure to assess, treat, and manage James's medical condition by and through their employees, staff, and/or agents was reckless and wanton with utter disregard for the safety and welfare of James, for which Plaintiff is entitled to punitive damages.

COUNT II NEGLIGENCE
(CoreCivic and Cibola General Hospital)

97. Plaintiff incorporates by reference, as if fully set forth herein, each and every allegation contained in the paragraphs above.

98. Defendants owed a duty of ordinary care to Mr. Ramirez.

99. Defendants, their employees, staff, and / or agents failed to use ordinary care in furnishing health care treatment for Mr. Ramirez, thereby causing him injury, damage, and death.

100. Defendants CoreCivic and Cibola General Hospital breached their duties and were, at minimum, negligent in the diagnosis, treatment, and management of James's health and safety.

101. At all times relevant herein, the relationship of doctor-patient and medical provider-patient existed between Mr. Ramirez and Defendants.

102. At all times relevant herein, Defendants expressly and impliedly warranted to Mr. Ramirez that everything necessary and proper were being done by them for him to maintain his health; however, Defendants breached said warranties.

103. Defendants are responsible for the damages allowed by law to Mr. Ramirez.

104. As a direct and proximate result of the negligence by Defendants, Mr. Ramirez suffered physical injuries, pain and suffering, loss of enjoyment of life, and death.

105. Defendants' negligence was wanton, willful, reckless, and malicious, allowing for an award of punitive damages against Defendants.

COUNT III MEDICAL MALPRACTICE
(Joseph Bounds, NP and Joshua Larson, M.D.)

106. Plaintiff incorporates by reference, as if fully set forth herein, each and every allegation.

107. Defendants Bounds and Larson owed a duty to possess and apply the knowledge, skill and care that is used by reasonably well-qualified healthcare providers under similar circumstances, giving due consideration to the locality involved.

108. Defendants Bounds and Larson breached their duties owed to Mr. Ramirez and committed medical malpractice.

109. Joseph Bounds recklessly failed to provide any medical care or psychiatric care at all to Mr. Ramirez despite an acute and severe medical and psychiatric crisis which included physical injuries.

110. Joshua Larson, M.D. was at a minimum negligent in the provision of medical care to Mr. Ramirez despite an acute and severe medical and psychiatric crisis.

111. Joshua Larson, M.D. recklessly failed to provide any significant medical intervention for Mr. Ramirez' acute and severe medical and psychiatric crisis.

112. Joshua Larson, M.D. failed to order or conduct any toxicology despite suspicions of adverse psychiatric consequences from drug use.

113. Joshua Larson, M.D. failed to order or conduct any toxicology prior to administering Ativan, Haldol, and Ketamine to determine possible drug interaction risks.

114. Joshua Larson, M.D. failed to order or conduct any toxicology to ascertain possible adverse drug interactions from the cocktail of drugs prescribed by CoreCivic medical personnel.

115. Joshua Larson, M.D. failed to even attempt to make a psychiatric referral to determine what had caused and continued to cause James's bizarre behavior, so-called smashing his face against the concrete or inability to communicate.

116. The actions and inactions of Joshua Larson were grossly negligent, reckless, and callously indifferent to the medical and psychiatric needs of James Ramirez.

COUNT IV NEGLIGENCE
(Joseph Bounds, NP and Joshua Larson, M.D.)

117. Plaintiff incorporates by reference, as if fully set forth herein, each and every allegation contained in the paragraphs above.

118. Defendants Bounds and Larson owed a duty of ordinary care to Mr. Ramirez.

119. Defendants Bounds and Larson failed to use ordinary care in furnishing health care treatment for Mr. Ramirez, thereby causing him injury, damage, and death.

120. Defendants Bounds and Larson breached their duty of ordinary care, including but not limited to:

a. Failing to provide any medical care or psychiatric care at all to Mr. Ramirez despite an acute and severe medical and psychiatric crisis which included physical injuries.

b. Failing to provide medical care to Mr. Ramirez despite an acute and severe medical and psychiatric crisis.

c. Failing to provide any significant medical intervention for Mr. Ramirez' acute and severe medical and psychiatric crisis.

d. Failing to order or conduct any toxicology despite suspicions of adverse psychiatric consequences from drug use.

e. Failing to order or conduct any toxicology prior to administering Ativan, Haldol, and Ketamine to determine possible drug interaction risks.

f. Failing to order or conduct any toxicology to ascertain possible adverse drug interactions from the cocktail of drugs prescribed by CoreCivic medical personnel.

g. Failing to even attempt to make a psychiatric referral to determine what had caused and continued to cause James's bizarre behavior, so-called smashing his face against the concrete or inability to communicate.

121. Defendants Bounds and Larson breached their duties and were negligent in the diagnosis, treatment, and management of James's health and safety.

122. Defendants Bounds and Larson are jointly and severally liable for the damages allowed by law to Mr. Herrera.

123. As a direct and proximate result of the negligence by Defendants Bounds and Larson, Mr. Ramirez suffered physical injuries, pain and suffering, loss of enjoyment of life, and death.

124. Defendants Bounds' and Larson's negligence was wanton, willful, reckless, and malicious, allowing for an award of punitive damages against Defendants.

COUNT V NEGLIGENT HIRING, TRAINING AND SUPERVISION (CoreCivic)

125. Plaintiff incorporates by reference, as if fully set forth herein, each and every allegation contained in the paragraphs above.

126. CoreCivic had a duty to properly screen, supervise, educate, and train its employees, agents, and/or contractors regarding the proper treatment of detainees suffering from mental health crises.

127. CoreCivic failed to train and supervise its employees, contractors, or agents in such a manner as to accurately assess, treat, and manage detainees experiencing mental health crises, such as James, and/or to render aid to prisoners with ongoing and emergent medical conditions.

128. Upon information and belief, CoreCivic failed to follow through with or otherwise enforce policies and related contract provisions regarding prisoners with medical issues, which they were responsible for overseeing.

129. Upon information and belief, CoreCivic failed to take corrective action against employees, agents, or contractors who it knew were not providing appropriate care in the management of detainees experiencing mental health crises, such as James.

130. CoreCivic failed to properly screen, supervise, educate, and train its employees, contractors, and agents in the symptoms, diagnosis, treatment, referral, or intervention of medical conditions of detainees and prisoners generally, and specifically James's emergent medical condition.

131. CoreCivic, in the exercise of reasonable care, should have been aware of the risk of mental health crises to detainees such as James and should have protected against the resulting harm by controlling the conduct of its employees, agents, and contractors, over which it had supervisory authority.

132. CoreCivic, acting by and through these supervisory actors, failed to use ordinary care in its training, staffing, and supervising practices and had knowledge that its practices created an unreasonable risk of injury to James and other similarly situated CCCC detainees.

133. These dangerous conditions were severe and foreseeable such that CoreCivic had a duty of care to oversee, discover, and prevent its personnel's dangerous responses to the ongoing management of detainee medical care and medical emergencies.

134. CoreCivic's negligent hiring, training, and supervision were the proximate cause of James's injuries including, but not limited to, death, pain and suffering, and severe psychological and emotional distress, entitling Plaintiff to compensatory and punitive damages.

135. The actions and inactions of Joseph Bounds, NP, and Joshua Larson, M.D. were the proximate cause of James's injuries including, but not limited to, death, pain and suffering, and severe psychological and emotional distress, entitling Plaintiff to compensatory and punitive damages.

COUNT VI INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS
(All Defendants)

136. Plaintiff incorporates by reference as if fully set forth herein, each and every allegation contained in the paragraphs above.

137. In violation of the New Mexico Constitution, Article II, Sections 4, 8, 13, and 18, CoreCivic and Cibola General, acting by and through their employees, agents, and contractors, engaged in inexplicable dehumanizing, degrading and intentionally cruel, callous, and wanton abuse of James as he suffered from a mental health crisis and as he was dying.

138. The only purpose for this behavior was the intentional infliction of emotional distress on James.

139. All acts complained of herein were authorized, participated in, or ratified by CoreCivic and Cibola General, and/or their administrators, managers, supervisors, officers, directors, or shareholders.

140. As a result of the foregoing, James suffered serious injuries, including death, pain and suffering, and severe psychological and emotional distress, for which Plaintiff is entitled to damages, including punitive damages.

COUNT VII CIVIL CONSPIRACY TO DENY PLAINTIFF MEDICAL CARE
(All Defendants)

141. Plaintiff incorporates by reference, as if fully set forth herein, each and every allegation contained in the paragraphs above.

142. The facts illustrated above show a conspiracy on the part of CoreCivic and Cibola General to deny James necessary, proper, and constitutionally minimal medical care.

143. CoreCivic and Cibola General, NP Bounds, Dr. Ivens and Dr. Larson, by and through their respective employees, staff, and agents, conspired to remand James's back to CCCC custody without proper evaluation and treatment.

144. In furtherance of the conspiracy, each of the co-conspirators committed overt acts and was an otherwise willful participant in joint activity.

145. As a result of said conspiracy, James suffered physical injuries, severe emotional and psychological harm, pain and suffering, and death.

146. James's death was caused by CoreCivic and Cibola General, including but not limited to the individually named Defendants, who acted pursuant to the policies and practices described more fully above.

147. Plaintiff is entitled to recovery for James's injuries and damages, including but not limited to, physical injuries, pain and suffering, and severe psychological and emotional distress.

148. Plaintiff is entitled to damages, including punitive damages, against CoreCivic and Cibola General.

COUNT VIII VIOLATION OF THE INHERENT RIGHT TO LIFE UNDER ARTICLE II, § 4 OF THE NEW MEXICO STATE CONSTITUTION (CoreCivic)

149. Plaintiff incorporates by reference as if fully set forth herein, each and every allegation contained in the paragraphs above.

150. The New Mexico Civil Rights Act provides that "A person who claims to have suffered a deprivation of any rights, privileges or immunities pursuant to the bill of rights of the constitution of New Mexico due to acts or omissions of a public body or person acting on behalf of, under color of or within the course and scope of the authority of a public body may maintain an action to establish liability and recover actual damages and equitable or injunctive relief in any New Mexico district court."

151. The New Mexico Constitution, Bill of Rights, states that the enjoyment of "life and liberty" and the pursuit of safety and happiness are "natural, inherent and inalienable" rights. N.M. Const. Art. II, § 4.

152. CoreCivic, as James's custodian, had an obligation to provide James with living conditions and medical care at least sufficient to keep him alive.

153. In this case, as set forth above, CoreCivic, and its respective agents, employees, and apparent agents, violated James's right to happiness and safety as set forth in the New Mexico Constitution.

154. James suffered serious physical and emotional injuries and needlessly lost his life as a result of the wrongful conduct of CoreCivic.

155. The actions, inactions, and failures to act by CoreCivic, acting by and through its employees, agents, and contractors, were willful, wanton, and in reckless disregard for James's safety and well-being.

156. CoreCivic is liable to Plaintiff under the New Mexico Civil Rights Act for violation of James's inherent right to safety and happiness.

COUNT IX VIOLATION OF THE RIGHT TO DUE PROCESS UNDER ARTICLE II, § 18 OF THE NEW MEXICO STATE CONSTITUTION
(CoreCivic)

157. Plaintiff incorporates by reference as if fully set forth herein, each and every allegation contained in the paragraphs above.

158. The New Mexico Constitution states that the government may not deprive any person of life "without due process of law."

159. In this case, as set forth above, CoreCivic, by and through its agents, employees, and apparent agents, violated James's right to due process before he was deprived of his life as set forth in the New Mexico Constitution.

160. Through their acts and omissions, they violated James's constitutional rights.

161. James needlessly lost his life in detention, even though he had never been sentenced for his alleged crimes.

162. The actions, inactions, and failures to act by CoreCivic, acting by and through its employees, agents, and contractors, were willful, wanton, and in reckless disregard for James's safety and well-being.

163. These Defendants are liable to Plaintiff under the New Mexico Civil Rights Act.

COUNT X INDIFFERENCE TO A SERIOUS MEDICAL NEED IN VIOLATION OF ARTICLE II, § 13 OF THE NEW MEXICO STATE CONSTITUTION
(CoreCivic)

164. Plaintiff incorporates by reference as if fully set forth herein, each and every allegation contained in the paragraphs above.

165. As set forth above, CoreCivic, and its agents, employees, and apparent agents, were aware that James was showing signs and symptoms of a severe mental health crisis.

166. Despite such knowledge, CoreCivic, by and through its agents, employees, and apparent agents, including Defendant Bounds, failed to provide James with proper medical care, failed to provide access to medical care, failed to intervene to obtain necessary medical care, and otherwise failed to take any action to protect against cruel and unusual punishment regarding the deliberate indifference to his serious medical needs.

167. CoreCivic's deliberate indifference caused James to experience extensive and unnecessary pain for nearly 6 hours and to suffer an unnecessary death.

168. These failures resulted not only from the individual acts of CoreCivic, by and through its agents, employees, contractors, and apparent agents, but also through the policies, practices, and customs of CoreCivic to deny necessary medical care to detainees and, in the process of doing so, expose detainee patients to dehumanizing and degrading cruelties that seemingly only served to make James suffer.

169. These policies, practices, customs, and patterns include:

a. Failure to report, diagnose, and properly examine and treat detainees with serious medical conditions;

b. Failure to respond to detainees who exhibit clear signs of serious medical conditions;

c. Failure to appropriately screen detainees for signs and symptoms of mental health crisis;

d. Denial or delayed patient referrals to necessary emergency medical services;

e. Failure to provide adequate medical documentation or to communicate significant information about a patient's condition to medical providers;

f. Failure to adequately hire, retain, train, and supervise employees and agents on procedures necessary to protect the health and safety of detainees suffering from mental health crises;

g. Failure to reprimand, retrain, or take corrective action against personnel engaging in unconstitutional denial of medical conduct; and

h. Failure to report, diagnose, properly examine, monitor, and treat mental health crises, and instead denying detainee's access to medical services.

170. These policies and practices were ratified by CoreCivic, by and through its agents and employees, and were the moving force behind the deprivation of James's rights.

171. The actions, inactions, and failures to act by CoreCivic, acting by and through its employees, agents, and contractors, were willful, wanton, and in reckless disregard for James's safety and well-being.

172. The acts and omissions of CoreCivic violated James's rights under the New Mexico Constitution.

COUNT XI VIOLATION OF SUBSTANTIVE DUE PROCESS RIGHTS GUARANTEED UNDER ARTICLE II, § 18 OF THE NEW MEXICO STATE CONSTITUTION (CoreCivic)

173. Plaintiff incorporates by reference as if fully set forth herein, each and every allegation contained in the paragraphs above.

174. The New Mexico Constitution guarantees a fundamental right to be protected against the unlawful invasion of a person's personal safety and bodily integrity. Substantive due

process rights include the rights to personal autonomy, bodily integrity, self-dignity, and self-determination.

175. In this case, as set forth above, CoreCivic, and its agents, employees, and apparent agents, violated James's substantive due process rights.

176. Moreover, CoreCivic failed to intervene to protect James's rights, which was a cause of his injuries and damages.

177. The actions, inactions, and failures to act by CoreCivic, acting by and through its employees, agents, and contractors, were willful, wanton, and in reckless disregard for James's safety and well-being.

178. The acts and omissions of CoreCivic violated James's rights under the New Mexico Constitution.

WHEREFORE, PLAINTIFF requests judgment as follows:

A. Compensatory damages against all Defendants, jointly and severally, in an amount to be determined by this Court as adequate for James's pain, suffering, injuries and death;

B. Compensatory damages against all Defendants, jointly and severally, in an amount to be determined by this Court as adequate for CoreCivic's intentional infliction of emotional distress;

C. Punitive damages in an as of yet undetermined amount against CoreCivic, Cibola General Hospital, Joseph Bounds, NP, and Joshua Larson, M.D.;

D. Costs incurred by Plaintiff, including pre-judgment and post-judgment interest; and

E. Such other and further relief as the Court deems just and proper.

Respectfully Submitted:

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