FILED 1st JUDICIAL DISTRICT COURT
Rio Arriba County
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KATHLEEN VIGIL CLERK OF THE COURT
Jonathan Castaneda

STATE OF NEW MEXICO
COUNTY OF RIO ARRIBA
FIRST JUDICIAL DISTRICT

Case assigned to Lidyard, Jason

No. D-117-CV-2022-00307

MICHAEL P. JASSO, as Personal Representative
of THE ESTATE OF JUAN ARCHULETA, Deceased,

Plaintiff,

v.

BOARD OF COUNTY COMMISSIONERS OF
RIO ARRIBA COUNTY; LARRY H. DEYAPP, Individually
and in his Official Capacity; VITAL CORE HEALTH
STRATEGIES, LLC; and JOHN DOES 1-10 in their
individual and official capacities (employees, staff, agents of
Rio Arriba County Adult Detention Facility and/or Vital Core
Health Strategies, LLC),

Defendants.

COMPLAINT FOR NEGLIGENCE, MEDICAL MALPRACTICE, WRONGFUL DEATH, INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS, AND BREACH OF CONTRACT

Plaintiff, Michael P. Jasso, as the Personal Representative of the Wrongful Death Estate of Juan Archuleta, (hereinafter "Plaintiff"), by and through his attorneys, Collins & Collins, P.C. and DeLara | Supik | Odegard P.C., submits this Complaint for Medical Malpractice, Wrongful Death and Related Claims.

I. PARTIES, JURISDICTION AND VENUE

1. Juan Archuleta ("Mr. Archuleta") died on October 3, 2020, in Tierra Amarilla, New Mexico, County of Rio Arriba.

2. At all relevant times and at the time of his death, Mr. Archuleta was an inmate in the care and custody of the Rio Arriba County Adult Detention Facility ("RACADF").

3. Michael P. Jasso is the personal representative of the Estate of Juan Archuleta and brings this Complaint on behalf of the Estate.

4. Defendant Board of County Commissioners of Rio Arriba County ("the County") is a political subdivision of the State of New Mexico.

5. The allegations of the Complaint arise out of conduct occurring at the RACADF, and pursuant to NMSA 1978, § 4-46-1, Plaintiff's claims are brought against the County.

6. At all times material hereto, the County was a governmental entity and local public body as those terms of defined in the New Mexico Tort claims Act, NMSA 1978 § 41-4-3.

7. At all times material hereto, the County owned, operated, supervised, directed, and controlled the RACADF, located in Tierra Amarilla, New Mexico.

8. Pursuant to NMSA 1978, §§ 4-44-19, 33-3-3 through 33-3-8, and 33-3-13, the County was mandated by statute 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. The County is required to administer, manage, and supervise the health care system provided to inmates at the RACADF.

9. Upon information and belief, Defendant Larry H. DeYapp is a resident of the County of Rio Arriba and at all relevant times, was employed by Rio Arriba County as the administrator of the RACADF. At all relevant times, Defendant DeYapp supervised the operation and daily management of the RACADF, was responsible for the implementation of and adherence to of the policies, practices and customs of the RACADF. Defendant DeYapp is named in his individual and official capacities.

10. Upon information and belief, John Does 1-10 were employed by the County as personnel of the RACADF responsible for providing correctional services at the RACADF.

11. At all relevant times, Vital Core Health Strategies, LLC ("Vital Core") was contracted to provide health care services to inmates under the care and custody of the RACADF.

12. Defendant Vital Core is a foreign limited liability company licensed to do business in the state of New Mexico and may be served through its registered agent, CT Corporation System, 206 S. Coronado Avenue, Espanola, New Mexico 87532.

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

14. At all relevant times and upon information and belief, John Does 1-10 were employees, staff and/or agents of Defendant Vital Core and were responsible for supervising and providing health care services to inmates at the RACADF.

15. All acts complained of herein occurred in Rio Arriba County, state of New Mexico.

16. At all relevant times, June Archuleta was a resident of Rio Arriba County, state of New Mexico.

17. A Tort Claims Notice was sent timely on December 18, 2020.

18. This Court has jurisdiction over the subject matter and the parties to this action. NMSA 1978, §§ 38-3-1.1 and 41-4-18.

II. STATEMENT OF FACTS

A. Medical Facts

19. On October 2, 2020, Juan Archuleta was arrested and booked into the RACADF.

20. The inmate screening report (completed by corrections staff) noted that Mr. Archuleta showed signs of being under the influence of alcohol or drugs, signs of substance withdrawal, and that he got sick when he stopped using alcohol/drugs.

21. The inmate screening report noted that Mr. Archuleta appeared sad with a withdrawn interview behavior and flat mood/affect and had slurred speech.

22. The inmate screening report also noted that Mr. Archuleta had a medical problem in need of immediate attention.

23. Other portions of the screening report were incomplete. For instance, the sections listing the specific symptoms of signs of being under the influence of alcohol or drugs and/or signs of substance withdrawal was left blank. The section regarding Mr. Archuleta's last use, substance, and amount was left blank. The section regarding the specific symptoms he experienced when he stopped using alcohol or drugs was left blank. The section providing information as to what medical condition Mr. Archuleta needed receiving immediate attention for was left blank.

24. Upon information and belief, the screening report was completed in approximately 4 minutes.

25. Juan Archuleta was given a medical and behavioral health admission screening completed on October 2, 2020, by medical staff. In this screening, it was noted that he mis-used alcohol. His use was described as constant – all day before his arrest. It was also noted that he mis-used illicit substances to include heroin. For both, it was noted that he experienced problems after stopping alcohol and heroin use, which was described as tremors and seizures.

26. Juan Archuleta was placed under withdrawal management for alcohol and opioid withdrawal. He was provided with a Clinical Institute Withdrawal Assessment Scale for Alcohol ("CIWA-Ar") score of 9 taken at 0900 on October 2, 2020, and a Clinical Opiate Withdrawal Symptoms ("COWS") score of 5 taken at 0800.

27. At 0900 on October 2, 2020, Mr. Archuleta's vital signs were taken. His blood pressure was high, and his respirations were on the high side. A "behavior code" was entered, but the number cannot be discerned (e.g., nausea, hallucinations, ataxia, etc.). This was the last charting of Mr. Archuleta's vital signs at the RACADF.

28. Mr. Archuleta's drug screen was inconclusive as it was noted that he was "unable to void." No further efforts were made to determine what substances were in Mr. Archuleta's system at any point in time before his death.

29. Despite Mr. Archuleta's CIWA-Ar and COWS scores and being placed under withdrawal management, he was not monitored again after 0900 on October 2, 2020, up to his death on the morning of October 3, 2020.

30. For alcohol withdrawal, Defendants' policies and procedures required Mr. Archuleta to be monitored for 7 days and to be reassessed every 4 hours for the first 24 hours, and then if stable, reassessed every 6 hours for the remainder of the 7 days. Juan Archuleta was not reassessed at any point in time after 0900 on October 2, 2020.

31. Mr. Archuleta was not appropriately monitored or treated for alcohol withdrawal symptoms, as he should have been reassessed at least six times during the first 24 hours at 1300, 1700, and 2100 on October 2, 2020, and at 0100, 0500, and 0900 on October 3, 2020. These assessments were not done.

32. Instead at approximately 0852 on October 3, 2020, Mr. Archuleta was found unresponsive in his cell, and after resuscitation efforts, he was pronounced dead at 0950 on October 3, 2020.

33. Mr. Archuleta was suffering from acute alcohol withdrawal and opiate withdrawal at the time of his death.

34. Mr. Archuleta had a history of chronic alcohol abuse and opiate abuse. This history was known to Defendants.

35. Experts in alcohol and opioid withdrawal recommend that persons "detoxing" never do so alone or without medical supervision.

36. Despite Mr. Archuleta's history and CIWA-AR and COWS scores, Mr. Archuleta was placed in a cell alone with a complete lack of monitoring by corrections staff and lack of monitoring and medical treatment by medical staff.

37. The failure to monitor and treat Mr. Archuleta was in violation of Defendants' policies and procedures and a breach of the standard of care based on his CIWA-Ar and COWS scores, his history of withdrawal symptoms to include seizures and tremors, and his history of alcohol use described as "constant" leading up to his arrest.

38. All Defendants, including unidentified John Doe Defendants, knew of Mr. Archuleta's history of alcohol abuse and his need of immediate medical attention, but acted with wanton, willful, and deliberate indifference by ignoring his medical needs, refusing to provide any level of monitoring by corrections staff, and refusing to provide any level of monitoring, assessment, and treatment by medical staff to the detriment of Mr. Archuleta.

39. The failure to monitor and treat Mr. Archuleta was grossly negligent and/or constitutes deliberate indifference to a known medical need and such failures caused or contributed to Mr. Archuleta's death.

40. Defendants have a duty to operate the RACADF in a reasonable and prudent manner, which includes the operation of the medical facility within the RACADF.

41. The County and Vital Core have a known history of recent and ongoing inmate deaths related to poor or absent medical care, and poor or absent supervision of inmates under their custody and care. These inmate deaths include inmates who have died as a result of complications due to alcohol and/or opiate withdrawal.

42. Based on this history, Defendants knew or should have known of the dangers associated with alcohol and opiate withdrawal.

43. Defendants knew or should have known of the need to train their employees and/or agents on their policies and procedures and the appropriate standards in monitoring inmates and treating inmates suffering from withdrawal, including Mr. Archuleta.

44. The County has a non-delegable duty to provide for proper, necessary and competent medical care for all inmates at the RACADF, including Mr. Archuleta.

45. The County and Mr. DeYapp are responsible for the management and oversight of the RACADF, including its medical contractor, Defendant Vital Core.

46. Defendants the County and Mr. DeYapp failed to properly oversee, monitor, supervise, or manage Defendant Vital Core's operation of the medical facility at the RACADF and the provision of medical services to inmates, including Mr. Archuleta.

47. Defendants the County and Mr. DeYapp failed to take corrective action against Vital Core despite clear knowledge of the negligent and reckless provision of medical services provided to inmates at the RACADF, including Mr. Archuleta.

48. These Defendants failures to act with respect to Vital Core was grossly negligent and/or deliberately indifferent based upon their prior knowledge of numerous inmate deaths associated with lack of supervision and care.

B. Widespread patterns and practices

49. All Defendants maintained widespread patterns, practices and de facto standard operating procedures in the operations at the RACADF, to the harm of all inmates, including Mr. Archuleta, and caused and contributed to his death, including:

a) Failing to report, diagnose, and properly examine and treat prisoners with serious medical and/or mental health conditions;

b) Delaying or denying patient referrals to necessary emergency or other offsite medical services;

c) Understaffing its medical and mental health facilities;

d) Failing to provide adequate medical documentation or communicate changes in patient conditions to the appropriate correctional officers and/or medical or mental health staff;

e) Potential alteration, concealment and destruction of medical records;

f) Failing to hire, retain, train, and supervise its employees and agents on procedures necessary to protect patients' health;

g) Failing to reprimand, provide additional training, retrain or take any other corrective action against Vital Core medical providers engaging in cruel, callous and unconstitutional denial of medical care to inmates;

h) Ignoring and failing to supervise and monitor inmates who are suffering from alcohol or opiate withdrawal by both correctional and medical staff.

50. The County and Vital Core have a longstanding policy and practice, directed, supervised and/or ratified by supervisory personnel of the County and Vital Core under which employees and agents of these Defendants, including correctional officers and medical personnel, failed or refused to: (1) report, diagnose, and properly examine, monitor, and treat prisoners with serious medical and/or mental health conditions, including failing to provide proper medications to inmates and reassessment of inmates with serious medical and/or mental health conditions; (2) respond to prisoners who requested medical and/or mental health services; (3) respond to prisoners who exhibited clear signs of a medical and/or mental health need or illness; (4) adequately document and communicate the medical and mental health needs of prisoners to the appropriate correctional officers and/or medical or mental health staff; (5) timely refer prisoners for emergency or other offsite medical services, or (6) intervene in any way to protect the health and safety of inmates.

51. These widespread practices amounted to Standard Operating Procedures in the operation of the RACADF.

52. All Defendants knew of the substantial risk of serious or fatal consequences that the above practices caused in the past as well as the ongoing harm to inmates, including Mr. Archuleta, yet they colluded and conspired to maintain those policies and practices.

53. All Defendants were complicit and acquiesced in the denial of proper and necessary medical care to Mr. Archuleta through their failures to follow written policies and procedures and instead implement a pattern and practice of denying medical care.

54. All Defendants conspired together to deny Mr. Archuleta necessary and proper medical care leading to physical pain, severe emotional and psychological pain and suffering, and wrongful death.

III. COUNT I – NEGLIGENCE OPERATION OF A PUBLIC BUILDING AGAINST ALL DEFENDANTS UNDER NEW MEXICO COMMON LAW AND TORT CLAIMS ACT

55. Plaintiff realleges all prior paragraphs of this Complaint as if fully set forth herein pursuant to Rule 1-010(C) NMRA.

56. At all relevant times, the Defendants, 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 operation of the RACADF.

57. In operating the RACADF, all Defendants were under a duty to use ordinary care to avoid or prevent what a reasonably prudent person would foresee as an unreasonable risk of injury to another.

58. The County and Mr. DeYapp have the authority and control over the RACADF, along with a consequent duty to operate the facility so as not to endanger the health and safety of those utilizing the facility, including inmates.

59. Defendants failed to enforce any standards of care related to the monitoring of inmates and related to the medical care of inmates. Instead, Defendants implemented and ratified dangerous practices leading to extreme medical neglect of inmates under the care of Defendants, including Mr. Archuleta.

60. The Defendants customs and practices created a general condition of unreasonable risk to inmates at the RACADF due to negligent safety practices concerning identifying and addressing the medical needs of inmates.

61. The Defendants practice of breaching their own written policies and procedures and practice of breaching their duties in the operation of the RACADF caused a foreseeable risk of injury to all inmates, created a specific foreseeable risk to Mr. Archuleta, and was the cause of Mr. Archuleta's death.

62. Defendants failed to exercise reasonable care to prevent and correct these dangerous conditions at the RACADF, and in doing so, ignored the threats to prisoners' health and safety.

63. At all relevant times, Defendants were acting within the scope of their duties in the operation and/or maintenance of the RACADF, as they were acting in relation to safety policies necessary to protect those who used this public building.

64. As a result of the acts or omissions of Defendants, Mr. Archuleta suffered injury, including death, emotional distress, and pain and suffering.

65. Specific to the County and Mr. DeYapp, immunity for any "public employee" is waived under NMSA 1978, § 41-4-6 as Plaintiff's injuries arose from an unsafe, dangerous, and defective condition on property owned and operated by the government.

IV. COUNT II – NEGLIGENT OPERATION OF A MEDICAL FACILITY AGAINST ALL DEFENDANTS UNDER NEW MEXICO COMMON LAW AND TORT CLAIMS ACT

66. Plaintiff realleges all prior paragraphs of this Complaint as if fully set forth herein pursuant to Rule 1-010(C) NMRA.

67. In operating the RACADF medical facility, all Defendants were under a duty to use ordinary care to avoid or prevent what a reasonably prudent person would foresee as an unreasonable risk of injury to another.

68. The County and Mr. DeYapp have authority and control over the RACADF and the medical until within the RACADF.

69. Defendant Vital Core had authority and control over the operation of the medical until within the RACADF, and such operations were required to be in compliance with written policies and procedures.

70. Defendants did not enforce any standards of care related to the operation of the medical unit at the RACADF. Instead, Defendants implemented and ratified dangerous practices leading to extreme medical neglect of inmates under the care of Defendants, including Mr. Archuleta.

71. The actions of all Defendants in the operation of the medical facility at the RACADF caused harm to all inmates, including Mr. Archuleta.

72. As a result of the acts or omissions of Defendants, Mr. Archuleta suffered injury, including death, emotional distress, and pain and suffering.

73. Specific to the County and Mr. DeYapp, immunity for any "public employee" is waived under NMSA 1978, § 41-4-9 as Plaintiff's injuries arose from the operation of the RACADF's medical facility and these "public employees" were acting within the scope of their duties.

V. COUNT III – MEDICAL PRACTICE AGAINST DEFENDANT VITAL CORE

74. Plaintiff realleges all prior paragraphs of this Complaint as if fully set forth herein pursuant to Rule 1-010(C) NMRA.

75. At all relevant times, Defendant 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. Archuleta.

76. In undertaking the diagnosis, care, and treatment of Mr. Archuleta, Defendant Vital Core had a duty to possess and apply the knowledge, skill, and care that was ordinarily used by reasonably well-operated medical facilities and well-qualified healthcare providers under similar circumstances, giving due consideration to the locality involved.

77. Defendant Vital Core and its employees, staff, and agents breached their duties and were negligent in the management of Mr. Archuleta's health and well-being.

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

a) Failing to implement adequate staffing levels and adequately trained staff at the RACADF to care for inmates with full knowledge that such inadequate staffing practices would place inmates such as Mr. Archuleta at risk for injury and death;

b) Negligently hiring, retaining, and supervising staff at the RACADF, with full knowledge that such staffing practices would place inmates such as Mr. Archuleta at risk for injury;

c) Failing to implement proper withdrawal management protocols and/or to follow written withdrawal management protocols, including withdrawal supervision, assessment, monitoring, and training such that Mr. Archuleta died without proper monitoring, prevention, and treatment;

d) Failing to provide and implement proper care plans that would address the medical needs of Mr. Archuleta;

e) Failing to provide a safe environment for inmates, including Mr. Archuleta;

f) Failing to have adequate and effective policies, procedures, staff and equipment to adequately diagnose, monitor, treat and manage Mr. Archuleta's medical condition;

g) Failing to recognize Mr. Archuleta's emergent need for medical care and/or a higher level of care that could not be provided at the RACADF.

79. Defendant Vital Core, through its employees, agents, and contractors, breached their duties and were, at minimum, negligent in the diagnosis, treatment, and management of Mr. Archuleta's health and safety.

80. These acts and failures to act by Defendant Vital Core, and its employees, agents, and contractors, were willful, wanton and in reckless disregard for the safety and well-being of Mr. Archuleta.

81. All acts or omissions done by Defendant Vital Core and its employees, agents, and contractors, were done within the scope of their employment, agency, or contractor.

82. All acts complained of herein were authorized, participated in, or ratified by Defendant Vital Core, and/or its administrators, managers, officers, directors, or shareholders.

83. As a result of the acts or omissions of Defendant Vital Core, and its willful, wanton, and reckless conduct Mr. Archuleta suffered injury, including death, emotional distress, and pain and suffering.

VI. COUNT IV – NEGLIGENT HIRING, TRAINING AND SUPERVISION AGAINST ALL DEFENDANTS UNDER NEW MEXICO TORT LAW AND TORT CLAIMS ACT

84. Plaintiff realleges all prior paragraphs of this Complaint as if fully set forth herein pursuant to Rule 1-010(C) NMRA.

85. Defendants were each responsible and had a duty to properly screen, supervise, educate, and train their employees, agents, and/or contractors operating the RACADF.

86. Defendants were each responsible and had a duty to properly screen, supervise, educate, and train their employees, agents, and/or contractors regarding the proper treatment of inmates suffering from alcohol and opiate withdrawal.

87. Defendants failed to train and supervise its employees, contractors, or agents in such a manner as to accurately assess, treat, and manage inmates experiencing withdrawal symptoms, such as Mr. Archuleta, and/or to render aid to inmates with ongoing and emergent medical conditions.

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

89. These Defendants failed to take corrective action against employees, agents or contractors who it knew were not providing appropriate care in the management of inmates experiencing withdrawal symptoms, such as Mr. Archuleta.

90. Defendants 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 inmates generally and specifically, the medical condition of Mr. Archuleta.

91. These failures, along with Defendants refusal to implement safety protocols to protect inmates such as Mr. Archuleta created dangerous conditions arising from the operation of the RACADF.

92. The Defendants, in the exercise of reasonable care, should have been aware of the risks of alcohol and opiate withdrawal to inmates such as Mr. Archuleta and should have protected against the resulting harm by controlling the conduct of the County and Vital Core personnel over which they had supervisory authority, including the individual Doe medical personnel and corrections officers.

93. These supervisory Defendants failed to use ordinary care in their training, staffing, and supervising practices and had knowledge that their practices created an unreasonable risk of injury to Mr. Archuleta and similarly situated RACADF inmates.

94. These dangerous conditions were severe and foreseeable such that Defendants had a duty of care to oversee, discover, and prevent the RACADF personnel's dangerous responses to the ongoing management of prisoner medical care and medical emergencies.

95. Defendants violated their duty of care and failed to provide services necessary to safely operate a public prison facility and medical facility.

96. As a result of the acts or omissions of Defendants, Mr. Archuleta suffered injury, including death, emotional distress, and pain and suffering.

97. Specific to the County and Mr. DeYapp, immunity is waived for any "public employee" under NMSA 1978, § 41-4-6 because Defendants' negligent training, staffing, and supervision were directly tied to the operation of the RACADF building. The RACADF was ordinarily dangerous even in the absence of Defendants' inadequate supervision and training, and

these dangerous conditions required supervision and were known or should have been known to Defendants.

VII. COUNT V – INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS AGAINST DEFENDANT VITAL CORE

98. Plaintiff realleges all prior paragraphs of this Complaint as if fully set forth herein pursuant to Rule 1-010(C) NMRA.

99. Defendant Vital Core, acting through its employees, agents, and contractors, intentionally denied Mr. Archuleta proper and necessary medical care.

100. Defendant Vital Core, acting through its employees, agents, and contractors, ignored Mr. Archuleta's medical needs leaving him to die alone in his cell, unattended, suffering from the effects of alcohol and opiate withdrawal.

101. Mr. Archuleta suffered severe emotional distress as a result of the conduct of Defendant.

102. All acts or omissions done by Defendant Vital Core and its employees, agents, and contractors, were done within the scope of their employment, agency, or contractor.

103. These acts and failures to act by Defendant Vital Core, and its employees, agents, and contractors, were willful, wanton and in reckless disregard for the safety and well-being of Mr. Archuleta.

104. All acts complained of herein were authorized, participated in, or ratified by Defendant Vital Core, and/or its administrators, managers, officers, directors, or shareholders.

VIII. COUNT VI – *RES IPSA LOQUTOR* AGAINST ALL DEFENDANTS UNDER NEW MEXICO TORT LAW AND TORT CLAIMS ACT

105. Plaintiff realleges all prior paragraphs of this Complaint as if fully set forth herein pursuant to Rule 1-010(C) NMRA.

106. The injuries and damages suffered by Mr. Archuleta were caused by the wanton, willful, and reckless actions and inactions of all Defendants.

107. It was the responsibility of the County and Vital Core to manage and control their security and medical staff regarding the care and treatment of Mr. Archuleta.

108. The events causing the injuries and damages of Mr. Archuleta were of a kind which would not ordinarily occur in the absence of negligence on the part of the County, Vital Core, and their employees, agents, or contractors.

109. The doctrine of *res ipsa loquitur* is applicable as a theory of negligence, causation, and damages in this case.

110. As a result of the acts or omissions of Defendants, Mr. Archuleta suffered injury, including death, emotional distress, and pain and suffering.

IX. COUNT VII – BREACH OF CONTRACT AGAINST THE COUNTY AND VITAL CORE

111. Plaintiff realleges all prior paragraphs of this Complaint as if fully set forth herein pursuant to Rule 1-010(C) NMRA.

112. The County entered a written contract with Vital Core to provide medical services to inmates at the RACADF.

113. As an inmate of RACADF, Mr. Archuleta was an intended third-party beneficiary of the contract.

114. As a direct and proximate result of the acts and omissions set for herein, Defendant Vital Core breached the contract.

115. As a direct and proximate result of the act and omissions set forth herein, Defendant County failed to take any corrective action against Vital Core and allowed Vital Core to breach

the contract through its failure to provide contractually sufficient medical care to inmates, including Mr. Archuleta. Through these actions, the County breached the contract.

116. As a direct and proximate result of the Defendants breach of contract, Mr. Archuleta suffered harm and damage.

X. RELIEF REQUESTED

WHEREFORE, Plaintiff requests judgment as follows:

A. The statutory damages allowable under the New Mexico Tort Claims Act against the County and Mr. DeYapp in an amount to be determined at trial for pain and suffering, severe emotional distress, and the wrongful death of Mr. Archuleta, inclusive of all recoverable damages permitted under the Wrongful Death Act;

B. Compensatory damages against Defendant Vital Core in an amount to be determined at trial for pain and suffering, severe emotional distress, and the wrongful death of Mr. Archuleta, inclusive of all recoverable damages permitted under the Wrongful Death Act;

C. Compensatory and consequential damages to be determined at trial for breach of contract against the County and Vital Core;

D. Punitive damages in an undetermined amount against Defendant Vital Core;

E. Costs incurred by Mr. Archuleta, including pre-judgment and post-judgment interest; and

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

Respectfully submitted,

COLLINS & COLLINS, P.C.

By *   /s/ Parrish Collins*

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