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STATE OF NEW MEXICO
COUNTY OF SANTA FE
FIRST JUDICIAL DISTRICT COURT

JOLEEN K. YOUNGERS, PERSONAL REPRESENTATIVE OF WRONGFUL DEATH ESTATE OF KESLEY VIAL, deceased,

Plaintiff,

v.

CORECIVIC, INC. AND
DR. CHRISTOPHER CLANCY,

Defendants.

D-101-CV-2022-01722
Case No: _____
Judge:

COMPLAINT FOR NEGLIGENCE AND DAMAGES PURSUANT TO THE WRONGFUL DEATH ACT

Joleen K. Youngers, as the personal representative of the Wrongful Death Estate of Kesley Vial, by and through undersigned counsel, appears and files this Complaint and would show the following:

PARTIES, JURISDICTION AND VENUE

1. Plaintiff Joleen K. Youngers is the Personal Representative of the Wrongful Death Estate of Kesley Vial. Ms. Youngers resides in Santa Fe, New Mexico and was appointed pursuant to NMSA §41-2-1 et. seq.

2. CoreCivic, Inc. is a private, for-profit company that owns and operates correctional facilities throughout the United States – including the Torrance County Detention Facility (TCDF). It can be served by serving its registered agent, Kennedy, Moulton & Wells, P.C., 2201 San Pedro NE Bldg. 3 #200, Albuquerque, NM 87110.

3. Dr. Christopher Clancy was, at all times relevant, a medical doctor licensed to practice psychiatry and an employee of CoreCivic, Inc. He can be served at 103 South Saint Francis Drive, Suite B, Santa Fe, NM 87501.

4. This Court has jurisdiction over the parties and the subject matter of this litigation and venue is proper pursuant to NMSA § 38-3-1 and NMSA § 41-2-1 et. seq.

FACTUAL BACKGROUND

CoreCivic's Operation of the Torrance County Detention Facility

5. CoreCivic owns and operates the TCDF, which is located in Estancia, New Mexico. In mid-2017, the TCDF laid vacant. By 2019, the TCDF was re-opened.

6. In May of 2019, U.S. Immigration and Customs Enforcement (ICE) entered into an Intergovernmental Service Agreement (IGSA) with Torrance County, New Mexico for the County to hold persons in civil immigration custody on behalf of ICE.

7. Torrance County then contracted with CoreCivic to hold persons detained by ICE at the TCDF pursuant to the power granted to Torrance County through the IGSA it had signed with ICE.

8. The contract between Torrance County and CoreCivic incorporated the IGSA between Torrance County and ICE by reference.

9. CoreCivic is responsible for the training, supervision, and actions of its employees who have responsibility for the maintenance and operation of the TCDF. CoreCivic is responsible for the actions of its employees through the doctrine of *respondeat superior*.

10. CoreCivic maintains policies and procedures to ensure that individuals held in its custody at the TCDF are safe and has guaranteed in its policies, procedures, and agreements with

Torrance County that it will take reasonable steps to protect the health and safety of detained individuals.

11. As part of its duties as the private operator of the TCDF, CoreCivic is contractually obligated to comply with ICE's 2011 Performance-Based National Detention Standards (2011 PBNDS), the American Correctional Association (ACA) Standards for Adult Local Detention Facilities, the National Commission on Correctional Health Care (NCCHC) Standards for Health Services in Jails, the DHS Standards to Prevent, Detect, and Respond to Sexual Abuse and Assault in Confinement Facilities, and several other federal and state laws.

12. CoreCivic knows or should know that suicide is a leading cause of death among individuals held in custodial settings.

13. CoreCivic policies and the 2011 PBNDS require CoreCivic to create a facility-wide multidisciplinary suicide prevention committee to gather at least quarterly to provide input regarding all aspects of the facility's suicide prevention and intervention program – including policies and staff training.

14. CoreCivic policies and the 2011 PBNDS require that all staff in the facility who are interacting with detained persons must be trained on significant self-harm and suicide prevention. This requires CoreCivic staff to be trained and aware of warning signs of impending suicidal behavior, responding to suicidal and depressed individuals, proper and transparent communication between correctional and health care personnel, housing observation for persons at risk of suicide, and population-specific factors that increase an individual's suicide risk.

15. The same policies require staff to continually re-assess and "remain vigilant in recognizing" and reporting a person who is at risk of impending suicide.

16. An individual who is identified as "at risk" for self-harm or suicide should be referred to a mental health provider, a comprehensive evaluation should be taken, and – if warranted – that person should be placed in a secure environment on a constant one-to-one visual observation.

17. A person who is at risk of suicide should not be placed in a location by themselves with objects or clothing that could be used in a suicidal manner.

18. CoreCivic policies, the 2011 PBNDS, and the standard of care require mental health professionals and correctional staff to have continuity of communication regarding detained individuals who are at higher risk for self-harm or suicide.

19. CoreCivic policies and the standard of care require qualified health professionals to recognize whether a detained person has a "serious mental illness" (SMI). Detained persons are classified as having an SMI if they have a mental disorder that is causing serious limitations on their activities of daily life or if they show significant symptoms of major depressive disorder with psychotic features, among other criteria.

20. If a detained person is characterized as having an SMI, CoreCivic's mental health professionals must create a comprehensive treatment plan and assign a treatment team to that detained person's care.

21. Contrary to the standard of care, CoreCivic's policies fail to require subsequent formal suicide risk assessments to be conducted by qualified mental health professionals after the initial risk assessment is performed.

22. The 2011 PBNDS and the standard of care require qualified mental health and medical professionals to conduct an extensive documented evaluation to determine a detained person's level of suicide risk, level of supervision, and need for transfer.

23. Detention centers such as TCDF have a duty to promulgate and implement procedures for monitoring and approving cell changes of detained individuals.

24. During the relevant time period, upon information and belief, CoreCivic did not have such a procedure, nor did it implement such a procedure.

25. Detention centers have a duty to maintain tight control over cell assignments in custodial detention settings. Cell assignment is an integral aspect of maintaining the safety of detained persons in a custodial setting. Cell assignments require a procedure of monitoring and approval that takes into account factors including histories of violence, vulnerability to sexual victimization, and mental health issues.

26. TCDF failed to maintain this level of control and failed to have a procedure of monitoring and approval in place as described above.

February to March 2022

27. From December 2020 to March 2022, ICE issued several Contract Discrepancy Reports regarding staffing shortages at the TCDF that were significantly impacting the safety, security, and care of individuals detained in that facility.

28. In early February 2022, the Department of Homeland Security Office of Inspector General (DHS OIG) conducted an unannounced in-person inspection of the TCDF to determine whether the TCDF was in compliance with the 2011 PBNDS.

29. In this inspection, the OIG staff found that the TCDF was not meeting the minimum medical staffing level requirements. Investigators noted that "[i]n addition to several staff expressing that the low staffing levels were problematic, we observed empty watch rooms and understaffed medical units." They also noted that "these medical unit vacancies impacted the level

of care detainees received....” The inspectors found that the lack of staffing impacted the level of care for detained persons who required “suicide watch.”

30. The inspectors also found that the TCDF failed to accurately document when detained individuals took their prescribed medication and when they refused.

31. On March 16, 2022, the DHS OIG publicly issued a management alert regarding the TCDF in which it recommended the *immediate removal* of all detainees from the TCDF. This management alert was addressed to the Acting Director of ICE.

32. In the management alert, the DHS OIG stated that it had determined that ICE must take immediate steps to address critical staffing shortages and unsanitary living conditions that led to health and safety risks at the TCDF.

33. In the management alert, the DHS OIG stated that critical understaffing at the TCDF prevented the facility from meeting contractual requirements that are meant to ensure ICE detainees reside in a safe, secure, and humane environment.

34. In the management alert, the DHS OIG identified that TCDF personnel did not properly supervise and monitor detainees in the housing units.

35. In the management alert, the DHS OIG documented excessive and avoidable unsanitary conditions, including non-functioning moldy sinks, clogged toilets full of human waste, mold, water leaks, hot water issues, and issues with access to drinking water.

36. In the management alert, the DHS OIG noted that the TCDF had an extensive list of backlogged work orders for facility repairs.

37. In the management alert, the DHS OIG recommended that ICE immediately relocate all detainees from the TCDF.

38. In the management alert, the DHS OIG also recommended that ICE place no detainees at the TCDF unless and until the facility ensures adequate staffing and appropriate living conditions.

39. At the time of the inspection, the TCDF was operating at 54% of required staffing under the IGSA – with around 133 full-time employees and 112 staffing vacancies.

40. As of March 4, 2022, the TCDF was at approximately 46% of the required staffing under the IGSA.

41. In March 2022, ICE notified CoreCivic that "continued lapses in PBNDS requirements are directly putting … detainees in direct harm," including due to limited staffing that "has resulted in unmanned positions within the pods, control pods, and hallway positions."

42. In May 2022, an ICE inspection of the TCDF took place. ICE found that the clinical medical authority was not reviewing comprehensive health assessments to determine the priority for treatment of detained individuals. The inspection noted that "[t]his is a repeat deficiency" at the TCDF.

43. As of July 2022, the TCDF was still only at approximately 66% of the required staffing under the IGSA.

Kesley Vial's Detention: April 22 to June 15, 2022

44. Kesley Vial was a 23-year-old young man from Brazil who entered the United States to seek asylum on or around April 22, 2022.

45. Upon entering the United States, Mr. Vial turned himself in to U.S. Border Patrol and requested asylum. Mr. Vial was placed in expedited removal proceedings.

46. Mr. Vial was transferred from U.S. Border Patrol custody to ICE custody. On April 29, 2022 Mr. Vial was transferred to the TCDF to await resolution of his request for asylum.

47. Upon arrival at the facility, Mr. Vial received an initial intake screening from a registered nurse. The nurse did not record any history of mental health problems. He was placed in "general population" housing.

48. On May 2, 2022, records show that Mr. Vial received a mental health screening. This assessment was conducted by Licensed Professional Counselor (LPC) Reev Pierce. The assessment documents that Mr. Vial reported a history of suicidal ideation beginning at 14 years of age and no depression or suicidal ideation since that age. Mr. Pierce classified him as a Mental Health Level of Care (LOC) I – which is the lowest-risk LOC on a scale of 1 to 4.

49. On or about June 6, 2022, Mr. Vial underwent a credible fear interview with an Asylum Officer regarding his asylum claim, without counsel. On June 13, 2022, Mr. Vial underwent a hearing in front of an Immigration Judge regarding his asylum claim, also without counsel. On June 13, 2022, Mr. Vial's order of removal from the United States became final.

50. Despite this final order, Mr. Vial continued to be held in the TCDF for more than two months without any clear knowledge of when he would be removed to Brazil.

51. While detained in the TCDF, Mr. Vial was assigned an ICE Deportation Officer who was responsible for effectuating his final removal order.

52. Mr. Vial's mental health condition significantly deteriorated during his time in the TCDF, as a result of what Mr. Vial described as the "psychological torture" of not knowing how long he would be held there.

Kesley Vial's Detention: June 15 to July 18, 2022

53. On June 15, 2022, Mr. Vial had another mental health visit with LPC Pierce. Mr. Vial informed LPC Pierce that he was crying a lot, he was having trouble sleeping, and he was

engaged in self-harm – he had hurt his hand with a spoon. He also disclosed a history of self-mutilation. LPC Pierce made no change to Mr. Vial's LOC.

54. The following day, on June 16, 2022, Mr. Vial had a telehealth appointment with a psychiatrist, Dr. Christopher Clancy. In this meeting, Dr. Clancy documented that Mr. Vial reported a history of self-mutilation and prior encounters with a psychologist. He informed Dr. Clancy that he had attempted suicide twice in the past. He made clear he has suffered from chronic depression and anxiety. He informed Dr. Clancy that he felt depressed, was having trouble sleeping, lacked appetite, and was having crying spells. Mr. Vial informed Dr. Clancy that sometimes he was having suicidal ideation and was thinking about hanging himself or jumping from the second floor. He disclosed that he had tried to mutilate his hand while detained in the TCDF and that this self-harm gave him a sense of relief. Mr. Vial informed Dr. Clancy that he would prefer to die if he were to be sent back to Brazil but that he had no plan to act on his suicidal ideation while detained.

55. Dr. Clancy diagnosed Mr. Vial as having a recurrent severe Major Depressive Disorder without psychotic features and informed the LPCs of his self-harming behavior and intermittent suicidal ideation. Dr. Clancy prescribed Mr. Vial medications for depression, anxiety, and insomnia, including Sertraline – also known as Zoloft – which is known to increase the risk of self-harm and suicidal ideation for individuals in Mr. Vial's age group.

56. Upon information and belief, Dr. Clancy did not obtain informed consent from Mr. Vial regarding the increased risk of self-harm and suicidal ideation posed by the medications prescribed.

57. On June 19, 2022, Mr. Vial again met with LPC Pierce and stated that he was waking up four to five times during the night. LPC Pierce said he would follow up with Mr. Vial within one month.

58. On June 30, 2022, Mr. Vial met again with Dr. Clancy. In this visit, Dr. Clancy documented that Mr. Vial continued to experience anxiety but was feeling better and had improved sleep. Dr. Clancy increased Mr. Vial's prescribed dosage of Sertraline from 50 mg to 100 mg. At this point, Mr. Vial did not believe he would be detained in the TCDF for another two months.

59. On July 13, 2022, Mr. Vial met again with LPC Pierce. Mr. Vial informed him that he had been assaulted in his housing unit. LPC Pierce documented he would follow up with Mr. Vial within 30 days.

Kesley Vial's First Attempted Deportation: July 18 to July 27, 2022

60. On July 18, 2022, ICE took Mr. Vial out of the TCDF for a transfer to El Paso and then to Arizona for a scheduled removal to Brazil on about July 21.

61. Upon information and belief, Mr. Vial was placed by ICE in a seat of an airplane for his deportation to Brazil on or around July 21, 2022, but was taken off the airplane before it departed without explanation.

62. By July 22, 2022, Mr. Vial was still in Arizona and had not been flown to Brazil. He reported to mental health personnel at the ICE detention facility in Arizona that he was requesting an increase in his medication dosage because he was feeling depressed. He reported auditory hallucinations, past suicide attempts, and an eight-year history of psychiatric treatment. A psychiatric advanced practice provider in Arizona diagnosed him with depression and anxiety.

63. Without notice or information about what was happening or why, Mr. Vial was simply transported from Arizona to El Paso, and back to the TCDF where he arrived on July 27,

2022. Mr. Vial was not informed as to the reasons for his aborted deportation or notified when he would, in fact, be deported.

Kesley Vial's Re-Detention and Decline: July 27 to August 16, 2022

64. At the TCDF, Mr. Vial had another intake screening by Licensed Practical Nurse (LPN) Amanda Jarvis on or about July 28, 2022. He informed her that he was "not in a good place," that he needed to see a doctor and that he had gone three days without his prescribed medications. LPN Jarvis referred him to the mental health unit on an urgent basis.

65. On July 28, 2022, Mr. Vial met with LPC Jutta Fournier for a mental health assessment as part of his intake. She noted that he had been off his medications for three days and that auditory hallucinations were restarting for him as a result. She noted that he endorsed violent or homicidal ideation and that he had increased anxiety. She noted he had a history of victimization and that he was having an "[a]bnormal emotional response to … incarceration." She assigned him an LOC II, signifying that she determined he would be able to function in general population with outpatient mental health treatment, and referred him to Dr. Clancy.

66. On that same day, Mr. Vial had a telehealth appointment with Dr. Clancy. Mr. Vial informed Dr. Clancy that he had been on a deportation flight and he didn't know why he was re-detained. He informed Dr. Clancy that he hadn't been able to sleep much recently and that he had a diminished appetite. Dr. Clancy noted that Mr. Vial had gone three days without Sertraline and prescribed Sertraline to be administered at 100 mg daily. Dr. Clancy stated he would follow up in two to three weeks.

67. Two days later, on July 30, 2022, CoreCivic security personnel recorded that Mr. Vial was being held in a one-person cell in the medical unit.

68. On July 31, 2022, LPC Pierce conducted a suicide risk screening for Mr. Vial. LPC Pierce noted that Mr. Vial had risk factors including a family history of suicide attempts or diagnosis requiring hospitalization, diagnosis associated with suicidal behavior, anxiety, and an "abnormal response to incarceration." He noted that Mr. Vial was receiving psychotropic medication. He also noted that Mr. Vial "told officers he would harm himself if he didn't get to stay in his cell."

69. In the July 31, 2022 assessment, LPC Pierce noted that Mr. Vial stated he was "being psychologically tortured because ... I was taken off the plane and re-arrested." LPC Pierce assessed Mr. Vial as having "depressed/anxious mood" and difficulty sleeping but found no evidence of psychosis. LPC Pierce noted that Mr. Vial should be returned to his assigned housing and have a follow-up appointment with Dr. Clancy on August 4.

70. Upon information and belief, during at least August 1 and August 2, 2022, Defendants maintained Mr. Vial on suicide watch. He was clothed in a suicide smock and held in a one-person cell in the TCDF medical unit. Personnel completed confinement watch logs for Mr. Vial during those two days.

71. On August 4, 2022, Mr. Vial met with LPC Fournier. He informed her that his sleep remained disrupted, he was waking up several times per night, and he was concerned that the medications were not helping him. LPC Fournier made a plan to follow up two weeks later even though Mr. Vial told her that he expected to be deported to Brazil in fewer than two weeks.

72. On the same day, Mr. Vial had a telehealth appointment with Dr. Clancy. Dr. Clancy documented that Mr. Vial reported thinking he was being watched, that he did not trust anyone, that he was "paranoid" and sometimes thought someone might harm him and was sleeping poorly. Mr. Vial requested "anti-psychotic medication." Dr. Clancy noted that he planned to adjust

Mr. Vial's medications to address anxiety, insomnia, and paranoid ideation. Dr. Clancy prescribed for Mr. Vial to continue taking Sertraline. He also prescribed Aripiprazole – also known as Abilify –an anti-psychotic medication.

73. On August 5, 2022, Nurse Practitioner (NP) Gloria Wiggins conducted an initial health appraisal for Mr. Vial. She noted that he had a prior hospitalization related to mental health and anxiety. She found that his active problems included anxiety, major depressive disorder, and paranoia, and noted that a psychiatric consult was indicated.

74. On August 8, 2022, CoreCivic personnel moved Mr. Vial from the medical cell to general population, specifically to cell 108 in housing unit 8A. He was moved thereafter to cell 210, which he shared with another Brazilian national, Weslei Vitor, whom he had befriended.

75. Unit 8A is a large triangle-shaped housing unit largely comprised of a common area. On the back wall of the unit, there are twenty cells, ten of which are on the lower level and ten on the upper level accessible via stairs and a walkway. Each of the cells has a bunkbed.

76. On August 10, 2022, Mr. Vial met with LPC Pierce. Mr. Vial again told LPC Pierce that he still had trouble sleeping and did not know when he would be leaving the facility. LPC Pierce set him up for a follow-up appointment within 30 days.

77. Late at night on August 15, 2022, Mr. Vial received a COVID-19 test in preparation for a scheduled transfer from the TCDF to El Paso. At that point, he believed he would be leaving the TCDF on August 16, 2022, for removal to Brazil. But he remained in the facility without an explanation.

78. Mr. Vial became distraught after he did not depart the TCDF on August 16, 2022.

Kesley Vial's Suicide: August 17, 2022

79. On August 17, 2022, Mr. Vial sent a message to his ICE Deportation Officer at 4:37 a.m. via a tablet in his housing unit, saying that he needed to know why he was still detained at the TCDF. His ICE Deportation Officer responded at 6:52 a.m. stating that his deportation flight would be rescheduled for "01/09/2022."

80. At 8:15 a.m., CoreCivic staff escorted Mr. Vial to the food services department where he was assigned to work. Upon arriving to the kitchen, Mr. Vial nearly fainted and told the staff that he felt dizzy. He was sent to the medical unit.

81. At 8:38 a.m., Mr. Vial arrived at the medical unit and told the nurse that he was dizzy, hadn't eaten breakfast, and was amenable to going back to his housing unit.

82. Mr. Vial returned to housing unit 8A at some point prior to 10:44 a.m.

83. At 10:44 a.m., Mr. Vial sent a message on a tablet to his ICE Deportation Officer saying, "[F]or God's sake … I have a problem with [a]nxiety and depression, it's been 4 months since I've been in prison, I can't stand it More [*sic*], I beg you, leave me on this flight or buy the ticket."

84. While Mr. Vial was in housing unit 8A, he approached a CoreCivic staff member who was issuing razors to detained persons for shaving. Mr. Vial told the staff member that he was not doing well and he did not want to accept a razor "until I get to speak to medical." The staff member referred him to a registered nurse.

85. When Mr. Vial met with the registered nurse, he was visibly upset and agitated. He said he needed to talk to a psychologist about his deportation. He requested to speak with mental health and "[h]uman rights." Mr. Vial requested "to be placed in [a] separate cell, such as in medical," for the night.

86. In the early afternoon, various other detained individuals and at least one CoreCivic detention officer saw that Mr. Vial was visibly upset. The detention officer decided that Mr. Vial needed to meet with mental health staff because of his condition.

87. At about 2:16 p.m., while the detention officer was escorting Mr. Vial to the mental health office, CoreCivic Captain Huggins encountered them and saw that Mr. Vial was "crying his eyes out." Cpt. Huggins watched as Mr. Vial punched a wall in the hallway and then sat on the ground, continuing to cry. Cpt. Huggins took over escorting Mr. Vial to the mental health office.

88. When he arrived at the mental health office, Mr. Vial was red-faced, crying, and extremely distraught. A registered nurse briefly assessed the injury to his hand and noted that he was not able to fully form a fist and had bruising and swelling. Mr. Vial told her that he hit the wall because of receiving bad news.

89. Mr. Vial met with LPC Fournier in the mental health office. She noted that he was "very upset" and "shaking." Though he denied suicidal ideation, he told LPC Fournier that he would "never" get out of the TCDF. LPC Fournier made a plan to simply follow up with Mr. Vial the next day. She sent Mr. Vial back to his housing unit in general population.

90. LPC Fournier did not put Mr. Vial on suicide watch or classify him as high risk for suicide. She did not communicate to CoreCivic security staff that he should be closely monitored. There is no evidence that she conducted a full suicide risk assessment or evaluation of his mental health condition at that time.

91. While Mr. Vial was being escorted back from the mental health office to housing unit 8A, he encountered his ICE Deportation Officer, who was in the facility with another ICE Deportation Officer. Cpt. Huggins was also present. Mr. Vial told the ICE Deportation Officers

that he wanted to be deported immediately. He became tearful and increasingly agitated. Mr. Vial told them that he "wanted the death penalty" if he was not going to be allowed to leave.

92. The two ICE Deportation Officers went to LPC Fournier's office and asked about Mr. Vial's job assignment in the kitchen because they were concerned about his access to knives. LPC Fournier did not ask for Mr. Vial to be brought back to the mental health office for any further assessment or evaluation. She said he was cleared and "appeared to be stable."

93. Around 2:45 p.m., Mr. Vial returned to housing unit 8A, still tearful, and sat down in front of cell 206. He then went into this unoccupied cell. A friend went into cell 206 briefly to check on him and comfort him. Mr. Vial was sitting at the foot of the bed with his head down.

94. Around the same time, CoreCivic personnel at the TCDF began a routinely scheduled population "count." In preparation for "count," detained persons in the housing units are supposed to go to their assigned cells and the cell doors are locked. CoreCivic detention officers then conduct a count to make sure all detained individuals are present.

95. Around 2:49 p.m., Mr. Vial went to his assigned cell, cell 210, which he shared with his friend, Mr. Vitor. The door of cell 210 was already locked for count. Mr. Vial asked a CoreCivic staff member to permit him to enter the cell.

96. While the CoreCivic staff member watched, Mr. Vial entered cell 210, grabbed a sheet, exited cell 210, and walked back to cell 206, to which he was not assigned. The CoreCivic staff member permitted Mr. Vial to enter cell 206 by himself with the sheet and close the door behind him.

97. Around 29 minutes later, at approximately 3:19 p.m., a CoreCivic detention officer conducting "count" looked into cell 206 and saw Mr. Vial hanging from the sheet which he had tied to a shelf.

98. Mr. Vial was not breathing. He received significant CPR and defibrillator intervention prior to the arrival of Emergency Medical Services (EMS).

99. EMS did not find a pulse in Mr. Vial until around 4:04 p.m. EMS transferred Mr. Vial to an ambulance at around 4:20 p.m. and transported him first to Presbyterian Kaseman Hospital and then to University of New Mexico Hospital (UNMH) in Albuquerque, New Mexico. He was diagnosed with anoxic brain injury.

100. Over the next week, Mr. Vial was held in the intensive care unit of UNMH but never regained consciousness.

101. On August 24, 2022, Mr. Vial was pronounced deceased due to suicide by hanging.

CAUSES OF ACTION

I. NEGLIGENCE (AS TO DEFENDANT CORECIVIC, INC.)

102. Plaintiff incorporates and adopts by reference all the facts and allegations contained in the preceding paragraphs of this Complaint.

103. Defendant and its staff were under the duty to exercise reasonable care for the safety of its detainees, including Mr. Vial.

104. Further, Defendant had a special relationship with Plaintiff as a detainee held against his will that required a special duty of care to Plaintiff.

105. Defendant knew or should have known that its staffing was deficient and that it was resulting in inadequate care for detainees in the TCDF in 2022.

106. Defendant knew or should have known that Mr. Vial had a serious and obvious mental health condition that put him at risk of suicide or serious self-harm.

107. Defendant knew or should have known that Mr. Vial should have been closely monitored or placed on suicide watch.

108. Warden George Dedos, Acting Warden Emeterio Chavez, Deputy Warden Michael Sedgwick, and all TCDF personnel mentioned above were employees of CoreCivic, Inc. at the TCDF and were acting within the scope of their employment. Therefore, CoreCivic, Inc. is vicariously liable for the actions of these employees.

109. At all times, Defendant owed Plaintiff the duty to act with reasonable care including, but not limited to the duties of:

a. Providing appropriate personnel in the care of individuals with suicide risk factors;

b. Selecting, hiring, training, reviewing, periodically supervising, evaluating competency, and retaining counselors, physicians, employees and agents;

c. Identifying, monitoring, and responding to suicidal and depressed detainees;

d. Maintaining communication between correctional and mental health personnel regarding detainees who are at risk of suicide or self-harm;

e. Properly documenting administration of medication to detainees;

f. Ensuring access to medical care and mental health care for persons with deteriorating mental health conditions; and

g. Creating and enforcing procedures for the monitoring of detainees in their housing unit and cell assignments.

110. As described above, Defendant breached these duties and failed to prevent Mr. Vial's suicide, which was foreseeable under the circumstances.

111. Defendant's negligence was an actual and proximate cause of Mr. Vial's death and the Estate's damages.

II. MEDICAL NEGLIGENCE (AS TO DEFENDANTS CORECIVIC, INC. AND DR. CLANCY)

112. Plaintiffs incorporate and adopt by reference all the facts and allegations contained in the preceding paragraphs of this complaint.

113. Dr. Clancy and CoreCivic, Inc. (Medical Defendants) were under the duty to possess and apply the knowledge and to use the skill and care ordinarily used by well-qualified correctional medicine entities and correctional medical providers practicing under similar circumstances.

114. Medical Defendants knew or should have known that medical staffing at the TCDF was deficient and that it was resulting in inadequate care for detainees in the TCDF in 2022.

115. Medical Defendants knew or should have known that Mr. Vial had a serious and obvious mental health condition that put him at risk of suicide or serious self-harm and he had put both Defendant detention staff and Medical Defendants on notice that he needed to have his mental condition monitored.

116. Medical Defendants knew or should have known that Mr. Vial should have been closely monitored or placed on suicide watch.

117. LPC Fournier, LPC Pierce, Dr. Clancy, and all medical staff mentioned above were employees of CoreCivic, Inc. at the TCDF, thus CoreCivic, Inc. is vicariously liable for the negligence of these individuals.

118. Defendant CoreCivic, Inc. acting through its employees, agents, apparent agents, or contractors, failed to exercise ordinary care and failed to possess and apply the knowledge and to use the skill and care ordinarily used by reasonably well-qualified healthcare providers,

physicians, nurses, nurse practitioners, technicians, etc., operating under similar circumstances, giving due consideration to the locality involved.

119. As described above, Defendants breached these duties and failed to prevent Mr. Vial's suicide, which was foreseeable under the circumstances.

120. Defendant CoreCivic, Inc.'s negligent care, management and treatment of Mr. Vial was an actual and proximate cause of Mr. Vial's death and the Estate's damages.

REQUEST FOR RELIEF

Wherefore, Plaintiff respectfully requests that this Court enter judgment against Defendants as follows:

1. Enter judgment in favor of Plaintiff and against all Defendants;

2. Award all damages available for injuries and damages pursuant to the New Mexico Wrongful Death Act;

3. Award punitive damages;

4. Award costs, pre- and post-judgment interest on all damages as allowed by law; and

5. Award such further relief as the Court deems just, equitable, and appropriate.

Date: September 26, 2023

Respectfully submitted,

ACLU OF NEW MEXICO

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