FILED
2ND JUDICIAL DISTRICT COURT
Bernalillo County
4/29/2024 11:01 AM
KATINA WATSON
CLERK OF THE COURT
Jacqueline B Trujillo

STATE OF NEW MEXICO
COUNTY OF BERNALILLO
SECOND JUDICIAL DISTRICT COURT

SANDRA LENTE, Personal Representative
To the Estate of APRIL PETERSON, deceased.

PLAINTIFF,

v. No. D-202-CV-2024-03525

BOARD OF COUNTY COMMISSIONERS
FOR THE COUNTY OF BERNALILLO,

DEFENDANT.

COMPLAINT FOR DAMAGES

Plaintiff Sandra Lente, as duly appointed Personal Representative of the Estate of April Peterson, by and through her counsel (Jason T. Wallace, Shayne C. Huffman, and Levi A. Monagle, Huffman Wallace & Monagle, LLC) brings this Complaint for damages pursuant to the New Mexico Tort Claims Act, NMSA 1978 §§ 41-4-1, et. seq., and the New Mexico Civil Rights Act, NMSA 1978 §§ 41-4A-1, et. seq.

Jurisdiction and Venue

1. Plaintiff Sandra Lente, as Personal Representative to the Estate of April Peterson, is a resident of Bernalillo County, New Mexico. Plaintiff is April Peterson's mother.

2. April Peterson was an inmate at the Bernalillo County Metropolitan Detention Center (hereinafter, "MDC") for approximately twenty-six (26) hours until her death in the early morning of June 21, 2023.

3. While incarcerated, Ms. Peterson was completely dependent on MDC for her care and well-being.

4. Defendant Board of Commissioners of the County of Bernalillo (hereinafter, "Bernalillo County") is sued pursuant to NMSA 1978, §4-46-1. Bernalillo County is a political subdivision of the State of New Mexico. Bernalillo County is the employer of the corrections officers named in this Complaint.

5. Bernalillo County is directly liable and vicariously liable for the acts and omissions of its employees at MDC.

6. All events alleged in this complaint occurred in Bernalillo County, NM.

7. The Court has jurisdiction over all parties and over the subject matter of all claims.

8. Venue is appropriate pursuant to NMSA 1978, § 41-4-18.

Facts: The Incarceration and Death of April Peterson

9. Ms. Peterson was booked into MDC in the early morning hours of June 20, 2023.

10. As part of her booking process, Ms. Peterson's person was searched for weapons.

11. As part of her booking process, Ms. Peterson's person was searched for illegal narcotics.

12. As part of her booking process, Ms. Peterson was scanned by a metal detector.

13. As part of her booking process, Ms. Peterson was scanned by a body scanner.

14. This body scanner is known as the "Soter RS."

15. The Soter RS is a full body scanner.

16. The Soter RS detects objects on or in the human body that are separate from human tissue.

17. MDC uses the Soter RS to determine if there are foreign objects in an inmate's body.

18. As part of the intake/booking process, MDC passes each inmate through the Soter RS body scanner.

19. The Soter RS did not detect any foreign objects on or in Ms. Peterson's body.

20. As part of her booking process, Ms. Peterson underwent a medical evaluation.

21. Medical staff asked Ms. Peterson if she needed substance abuse services.

22. Ms. Peterson informed medical staff that she did need substance abuse services.

23. Ms. Peterson informed medical staff that she used methamphetamines and fentanyl daily.

24. Medical staff notes on Ms. Peterson stated that Ms. Peterson's "presentation" was "consistent with reported drug use."

25. Medical staff placed Ms. Peterson on a "fentanyl watch."

26. After Ms. Peterson's medical evaluation, she was relocated to the Residential Drug Treatment pod (the "RDT").

27. Upon admission to the RDT, Ms. Peterson was escorted by two female COs to a shower room.

28. While in the shower room, Ms. Peterson was asked to remove her clothing, turn her back to the two COs, spread her legs, and squat down.

29. When Ms. Peterson did this, the COs searched Ms. Peterson's body cavities for signs of contraband.

30. The two COs did not observe any contraband in or protruding from Ms. Peterson's body cavities.

31. The two COs placed Ms. Peterson's personal clothing into a paper bag and gave Ms. Peterson her inmate uniform, which Ms. Peterson clothed herself in.

32. The two COs then escorted Ms. Peterson to cell #9 within the RDT.

33. Ms. Peterson did not share RDT cell #9 with another inmate.

34. While Ms. Peterson was in RDT cell #9, she was visited by medical staff.

35. Ms. Peterson was given medication by medical staff.

36. Ms. Peterson was monitored by COs of the RDT from approximately 1:25am on June 20, 2023, until approximately 9:55am on the same day.

37. At approximately 9:55am on June 20, 2023, Ms. Peterson was moved from the RDT to Restricted Housing Unit Pod 7 (“RHU 7”).

38. RHU 7 is a detoxification pod in which inmates with addiction are monitored for symptoms of drug and alcohol withdrawals as their bodies readjust to sobriety.

39. The purpose of Ms. Peterson’s placement in RHU 7 was so that she could be monitored as she went through the detoxification process.

40. As part of the detoxification process, medical staff (nurses and sometimes a doctor) visit and address the medical needs of the inmates in RHU 7.

41. Ms. Peterson was provided a plastic bed, which was low to the ground, and which was one of several similar beds placed in a row in the middle of RHU 7’s common area.

42. Each of these beds is numbered.

43. Ms. Peterson was assigned to bed #82.

44. Ms. Peterson was not placed in one of the many cells which exist in RHU 7.

45. Ms. Peterson was one of several inmates who spent June 20 and June 21, 2023 assigned to RHU 7.

46. At approximately 11:04 pm on June 20, 2023, MDC Corrections Officer (“CO”) Jason Malizia started his shift in RHU 7.

47. Among other duties, CO Malizia was required to conduct routine welfare checks on Ms. Peterson and the other inmates detained in RHU 7.

48. Upon information and belief, CO Malizia did not properly conduct his welfare checks on Ms. Peterson.

49. RHU 7 has an officer desk located in the common area of the pod.

50. The officer desk includes a computer that COs use to, among other things, log their welfare checks of the inmates.

51. At approximately 11:47pm on June 20, 2023, CO Maliza used the officer computer to navigate to www.youtube.com in the computer's browser.

52. MDC policy prohibits COs from visiting YouTube on the computer located in RHU 7 while they are on-duty.

53. From 11:47am on June 20, 2023 until Ms. Peterson was found unconscious and not breathing at approximately 3:09am on June 21, 2023, CO Malizia watched multiple videos on YouTube.

54. CO Malizia used the computer in RHU 7 to watch Major League Baseball highlights on YouTube.

55. CO Malizia used the computer in RHU 7 to watch KRQE News on YouTube.

56. CO Malizia used the computer in RHU 7 to watch movies.

57. In all, CO Malizia visited YouTube forty-eight times between 11:47am on June 20, 2023 and 3:09am on June 21, 2023.

58. At approximately 1:11am on June 21, 2023, CO Malizia began watching "You Don't Mess With The Zohan" on YouTube.

59. At approximately 1:24am on June 21, 2023, CO Malizia used the computer in RHU 7 to play a game: Bricks Breaker Quest Classic.

60. At approximately 2:06am on June 21, 2023, CO Malizia again used the computer in RHU 7 to play Bricks Breaker Quest Classic.

61. Upon information and belief, using the computer in RHU 7 to watch YouTube is a violation of MDC's Computer Use Policy.

62. Upon information and belief, using the computer in RHU 7 to play video games is a violation of MDC's Computer Use Policy.

63. At approximately 2:08am, Ms. Peterson approached CO Malizia before going to the restroom.

64. Upon information and belief, when Ms. Peterson approached CO Malizia at 2:08am, CO Malizia was still using YouTube to watch "You Don't Mess With The Zohan."

65. Ms. Peterson returned from the restroom shortly before 2:15am.

66. After Ms. Peterson returned from the restroom, CO Malizia played another game of Bricks Breaker Quest Classic at approximately 2:15am.

67. CO Malizia played yet another game of Bricks Breaker Quest Classic at approximately 2:25am.

68. At approximately 3:11 am, CO Malizia found Ms. Peterson laying on her bed unresponsive.

69. At approximately 3:11 am on June 21, 2023, CO Malizia used his radio to initiate a code 10-43, which stands for Medical Emergency.

70. CO Malizia's code 10-43 was in reference to Ms. Peterson.

71. CO Malizia wrote an Incident Report in which he detailed what happened.

72. CO Malizia stated that at approximately 3:10 am, he was conducting a welfare check of RHU 7 when he noticed that Ms. Peterson's mouth and eyes were wide open.

73. CO Malizia stated that he watched Ms. Peterson for movement.

74. CO Malizia then began calling her name.

75. After several attempts at getting Ms. Peterson to respond to her name, CO Malizia began to "try and feel for a pulse."

76. CO Malizia was joined by CO Hernandez, and CO Hernandez also attempted to locate a pulse.

77. CO Hernandez could not find one.

78. MDC Sgt. Carlos Chavez then entered RHU 7 with an automated external defibrillator ("AED") and instructed COs Malizia and Hernandez to move Ms. Peterson's body from the bed to the floor and to remove her shirt.

79. Sgt. Chavez then began attaching the AED pads to Ms. Peterson's bare chest.

80. The AED never delivered a shock.

81. Teams of medical personnel entered RHU 7 and performed manual chest compressions until Ms. Peterson was declared deceased at approximately 3:54 am.

Facts: Inmate Observation and Welfare Checks

82. MDC Policy Sec. 8.38-1 is titled "Inmate Observation and Welfare Checks."

83. The purpose of MDC Policy Sec. 8.38-1 "is to ensure that inmates are supervised at all times through direct staff supervision and that welfare checks are conducted at established intervals necessary to ensure the safety of inmates in custody as well as the security of the institution.

84. MDC Policy Sec. 8.38-1 states "[t]he policy of Bernalillo County Metropolitan Detention Center (MDC) is to have established procedures for the on-going observation of inmates requiring varying degrees of supervision along with periodic welfare checks at appropriate intervals based on the identified needs of the inmate."

85. MDC Policy Sec. 8.38-1 states that "Constant Observation is utilized for inmates who require constant, uninterrupted observation due to acute or emergent medical or mental health needs that necessitates a one-to-one (1:1) supervision ratio."

86. MDC Policy Sec. 8.38-1 states that "Routine Welfare Checks are utilized for inmates who are able to function in less restrictive housing condition classified as (General Population) and require less intensive supervision and observation.

87. MDC Policy Sec. 8.38-1 states that "Routine Welfare Checks are conducted by the assigned Corrections Officer on irregular intervals not to exceed sixty (60) minutes between checks."

88. MDC Policy Sec. 8.38-1 states that "30-Minute checks are to be utilized for inmates that require more routine welfare checks or are housed in restrictive housing units, HSU medical housing units and PAC housing units but do not require constant observation or 15-minute welfare checks. 30-minute checks are conducted by the assigned Corrections Officers on irregular intervals not to exceed (30) minutes between checks."

89. MDC Policy Sec. 8.38-1 states that "the requirements and processes described [in the policy] apply to all staff members at MDC" and that "[a]rea managers and supervisors are responsible for maintaining associated documents and records, for ensuring that staff members have access to up-to-date information and policies, and for ensuring that staff members are trained in all policy updates."

90. MDC Policy Sec. 8.38-1 states that, "in order to minimize predictability and improve the overall security of the facility, 30-minute welfare checks are conducted by the assigned Corrections Officer on irregular intervals not to exceed thirty (30) minutes between checks.

91. MDC Policy Sec. 8.38-1 states that, “when conducting the 30-minute welfare checks of inmates in assigned cell or bunk areas, the officer must stand at the cell door or the dormitory room entrance for a time period that allows for the observation of the flesh and body movement of all inmates assigned to the cell or bunk area.”

92. MDC Policy Sec. 8.38-1 states that the “corrections officer conducting the 30-minute welfare check is responsible for documenting the check on the OMS Activity Log at the time that the check began using the Welfare Checks event code. The Corrections officer will also utilize the handheld CorreTrak device and scan QR codes within the pod tiers.”

93. Ms. Peterson was subject to 30-minute welfare checks.

94. CO Malizia was required to perform 30-minute welfare checks on Ms. Peterson.

95. A Welfare Check Quality Assurance Audit was conducted on CO Malizia’s logged welfare checks from the night of Ms. Peterson’s death.

96. The Quality Assurance Audit found that only 44.44% of CO Malizia’s welfare checks were conducted within thirty (30) minutes of each other and at irregular intervals as required by MDC policy.

97. The Quality Assurance Audit found that CO Malizia only performed 77.78% of the welfare checks he was required to perform per MDC policy.

98. Of the 30-minute welfare checks CO Malizia performed on Ms. Peterson, CO Malizia did not properly observe the body flesh and body movement of Ms. Peterson.

Facts: MDC Computer Usage Policy

99. MDC Policy MIS 5.07 is MDC’s Computer Usage/Email/Internet policy.

100. The purpose of MIS 5.07 is "to outline Staff responsibilities in the legal, ethical, and appropriate use of [MDC] computers. In an effort to maintain confidentiality of stored data, files, computers and networks, protect the proprietary rights of third parties and of the Department in the use of commercial software, and provide the highest use of Department computer resources."

101. MIS 5.07 provides that "the policy of Bernalillo County Metropolitan Detention Center (MDC) is that all staff use computers in accordance with Bernalillo County policy and administrative instructions."

102. MIS 5.07 provides that COs should not "do anything with County Internet access resources that would otherwise be considered illegal or grossly inappropriate. Downloading erotica, playing games, sending non-County business mass mailings and running a private business are obvious examples."

103. Between the time CO Malizia began his shift in RHU 7 in the late evening of June 20, 2023 and the time Ms. Peterson was declared deceased in the early morning hours of June 21, 2023, CO Malizia used the officer computer located in RHU 7.

104. CO Malizia's browser history from the night of Ms. Peterson's death shows that CO Malizia visited YouTube.com approximately forty-eight times within an approximately four-hour stretch.

105. CO Malizia visited YouTube to watch movies, view baseball highlights, brows news stories, and play video games.

106. CO Malizia used the computer in RHU 7 on multiple occasions to play games.

107. When CO Malizia was not conducting a welfare check, he spent the majority of his time on the computer in RHU 7.

108. CO Malizia was not properly monitoring the inmates he was assigned to monitor.

109. Sgt. Chavez wrote an incident report about Ms. Peterson's death.

110. Sgt. Chavez wrote in his incident report that he responded to CO Malizia's code 10-43, and that when Sgt. Chavez entered RHU 7, he saw COs Malizia and Hernandez "standing next to" Ms. Peterson's bed.

111. Sgt. Chavez wrote in his incident report that he "walked over" to CO Malizia and asked what was happening.

112. Sgt. Chavez wrote that CO Malizia responded by saying "she's not breathing."

113. Neither CO Malizia nor CO Hernandez performed chest compressions on Ms. Peterson until Sgt. Chavez arrived at RHU 7.

114. Neither CO Malizia nor CO Hernandez administered Narcan to Ms. Peterson upon finding her unresponsive in the MDC detox pod.

Facts: Ms. Peterson's Acquisition of Drugs from Someone within MDC

115. Upon information and belief, Ms. Peterson died from an overdose of fentanyl and methamphetamine she acquired while in custody at MDC.

116. Ms. Peterson passed away approximately twenty-six (26) hours into her custody at MDC.

117. Ms. Peterson was booked into MDC without narcotics in her possession.

118. Ms. Peterson was able to obtain narcotics while she was in MDC's custody.

119. Ms. Peterson's overdose could not have resulted from drugs she ingested twenty-six (26) hours before being placed in the custody of MDC.

120. Upon information and belief, MDC's staff and corrections officers are not checked for possession of narcotics upon their entry to MDC's premises.

121. It is both illegal and against MDC policy for Bernalillo County employees to traffic illegal narcotics to inmates.

122. Upon information and belief, vendors who supply MDC with goods or services are not screened for possession of narcotics.

123. It is both illegal and against MDC policy for vendors to traffic illegal narcotics to inmates.

124. Upon information and belief, inmates in MDC obtain access to illegal narcotics that enter the jail via CO and/or vendor traffic.

125. Upon information and belief, Ms. Peterson passed away as a result of ingesting fentanyl and/or methamphetamine in close proximity to her death.

126. Upon information and belief, the only people who are screened for possession of illegal narcotics upon entry to the MDC premises are the inmates themselves.

127. Since every inmate passes through the Sotor RS body scanner, illegal narcotics are often present within MDC is because they are trafficked-in by people employed by or contracted with Defendant Bernalillo County.

128. Upon information and belief, Ms. Peterson was able to obtain fentanyl and/or methamphetamine by means other than bringing the drugs into MDC herself.

129. Ms. Peterson's ability to obtain fentanyl and/or methamphetamine within MDC was the direct and proximate cause of her death.

COUNT I: NEGLIGENT OPERATION OF A BUILDING, NMSA 1978, § 41-4-6

130. Plaintiff restates each of the preceding allegations as though fully stated herein.

131. MDC is a building used to detain persons charged with criminal offenses.

132. Defendant Bernalillo County operated and maintained MDC at all material times.

133. Defendant Bernalillo County created and approved policies for the safe and humane operation of MDC and required all employees to abide by the policies.

134. Defendant Bernalillo County had a "duty to exercise reasonable and ordinary care for the protection of the life and health of the person in custody." *City of Belen v. Harrel*, 1979-NMSC-081, ¶ 15, 93 N.M. 601.

135. Defendant Bernalillo County breached this duty to Ms. Peterson.

136. Defendant Bernalillo County's breach of this duty to Ms. Peterson was the proximate cause of her death.

137. Defendant Bernalillo County had a duty to ensure all employees followed institutional policies at all times to protect the life and health of persons in custody.

138. Defendant Bernalillo County breached this duty to Ms. Peterson.

139. Defendant Bernalillo County's breach of this duty to Ms. Peterson was the proximate cause of her death.

140. MDC policy required MDC employees in RHU 7 conduct welfare checks at least every thirty minutes.

141. During these checks, MDC employees were required to check for signs of "flesh and movement."

142. Employees at MDC were known to disregard their duties, including performance of welfare checks, which happened in this case.

143. Inmates frequently complained about the failures of MDC employees in conducting their duties while on shift.

144. Defendant Bernalillo County was aware employees at MDC frequently shirked their duties as described.

145. Despite this knowledge and despite continued complaints by inmates, Defendant Bernalillo County failed to ensure MDC staff were conducting their duties as required by policy, law, and best practice.

146. Individuals detained at MDC, including Ms. Peterson, are completely dependent on MDC staff for their care.

147. Defendant Bernalillo County has a duty to supervise its staff to ensure they are present and acting in accordance with policy, law, and best practice.

148. Defendant Bernalillo County failed to ensure staff followed safety protocol and performed their duties in a way that ensured the safety of inmates in their custody and care.

149. Ms. Peterson's death resulted from CO Malizia's failure to adhere to MDC policy and procedure.

150. Ms. Peterson's death resulted from CO Malizia's failure to act in response to finding her unresponsive in her bed.

151. Ms. Peterson's death resulted from CO Hernandez' failure to act in response to not finding a pulse.

152. At all times material to this complaint, COs Malizia and Hernandez were acting within the course and scope of their duties.

153. Ms. Peterson's death resulted, at least in part, from the failures of COs Malizia and Hernandez to appropriately perform the duties required of their positions as correctional officers.

154. Defendant Bernalillo County's failure to supervise MDC staff, including COs Malizia and Hernandez, created unsafe and dangerous conditions at MDC.

155. As a direct and proximate result of negligence by Defendant Bernalillo County, CO Malizia, and CO Hernandez, Ms. Peterson lost her life.

156. As a direct and proximate result of negligence by Defendant Bernalillo County, Ms. Peterson was able to access the narcotics to which she was addicted, overdosed on them, and lost her life.

157. Defendant Bernalillo County's contracting with vendors who traffic illegal narcotics into the MDC premises created unsafe and dangerous conditions at MDC.

158. As a direct and proximate result of negligence by Defendant Bernalillo County, Ms. Peterson was able to access the narcotics to which she was addicted, overdosed on them, and lost her life.

159. Defendant Bernalillo County's immunity is waived pursuant to NMSA 1978, Section 41-4-6.

COUNT II: NEGLIGENT MAINTENANCE/OPERATION OF A MEDICAL FACILITY, NMSA 1978 § 41-4-9

160. Plaintiff restates each of the preceding allegations as if fully stated herein.

161. Defendant Bernalillo County had a duty to appropriately maintain the medical facility within MDC.

162. Defendant Bernalillo County had a duty to ensure medical staff were adequately trained in emergency medical response.

163. Defendant Bernalillo County had a duty to ensure all medical equipment in the facility was operational and appropriately maintained.

164. As part of this obligation, Defendant Bernalillo County had a duty to periodically check that the medical equipment to be used on inmates at MDC was fully charged and operational.

165. As part of this obligation, Defendant Bernalillo County had a duty to train it's CO's assigned to detox pods to recognize the signs of withdrawal and to intervene before an inmate dies of it.

166. Defendant Bernalillo County failed to appropriately maintain the AEDs at MDC.

167. As a result, one or more AEDs used on Ms. Peterson when she was discovered to be unconscious failed to provide a charge.

168. Ms. Peterson's was not the first death to occur in the last two years at MDC in which AEDs were found to be uncharged and inadequately prepared for operation.

169. Upon information and belief, Defendant Bernalillo County provides its employees with access to Narcan, to be utilized upon inmates in the event of an apparent narcotics overdose.

170. Defendant Bernalillo County's employees failed to administer Narcan to Ms. Peterson upon discovering her to be unresponsive in a detox pod.

171. Defendant Bernalillo County breached the duty of care owed to Ms. Peterson by failing to ensure the facility medical equipment was operational and functioning in preparation for an emergency medical response.

172. Defendant Bernalillo County breached the duty of care owed to Ms. Peterson by failing to train and supervise COs Malizia and Hernandez on withdrawal recognition and prevention when assigning them to monitor inmates housed in detox pods.

173. These actions and omissions by Defendant Bernalillo County proximately caused Ms. Peterson's death.

174. In the alternative, Defendant Bernalillo County's actions and omissions deprived Ms. Peterson of a chance of survival.

175. Defendant Bernalillo County's negligent maintenance of the medical facility within MDC caused Ms. Peterson to suffer physical injuries and death.

176. Defendant Bernalillo County's immunity is waived pursuant to NMSA 1978, Section 41-4-9.

COUNT III: VIOLATION OF THE NEW MEXICO CIVIL RIGHTS ACT, NMSA 1978 § 41-4A-1 et seq.
(Defendant Board of County Commissioners of the County of Bernalillo)

177. Plaintiff restates each of the preceding allegations as though fully stated herein.

178. Defendant Bernalillo County's failure to protect Plaintiff while she was in their control and custody deprived Plaintiff of numerous rights secured to Plaintiff under the constitution of New Mexico (including but not limited to those rights secured to Plaintiff by Article II, Sections 4, 13, and 18).

179. The failures by Defendant Bernalillo County, and COs Malizia and Hernandez to follow law, policies, procedures, and job requirements resulted in the death of Ms. Peterson while she was detained at MDC.

180. Ms. Peterson's rights under Article II, Sections 4, 13, and 18 of the New Mexico Constitution are afforded greater protections than her rights under the United States Constitution.

181. Ms. Peterson suffered serious harm and death as a direct result of the deprivation of her state constitutional rights by Defendant Bernalillo County and its COs Malizia and Hernandez, and these deprivations of rights are the proximate cause of Ms. Peterson's death in the Defendant's custody.

WHEREFORE, Plaintiff requests judgment against Defendant Bernalillo County in an amount reasonable to compensate April Peterson's estate for damages, for interest including pre-

judgment interest, costs, reasonable attorneys' fees, and such other and further relief as this Court may deem appropriate.

Respectfully submitted,

HUFFMAN WALLACE & MONAGLE LLC

/s/ Jason Wallace 04/29/24
JASON WALLACE
LEVI A. MONAGLE
SHAYNE C. HUFFMAN
NM Bar No.: 148454
122 Wellesley Dr. SE
Albuquerque, NM 87106
(505) 255-6300, (505) 255-6323 Fax

Attorneys for Plaintiff