

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

**ADAM BAKER, Personal Representative
to the Estate of DOUGLAS EDMINSTEN,
deceased,**

Plaintiff,

v.

No. D-101-CV-2017-01908

Case assigned to Mathew, Francis J.

**MICHAEL DODDS, GILBERT GONZALES,
CASEY SALVADOR, and MICHAEL HILDENBRANDT,**

Defendants.

**COMPLAINT FOR THE RECOVERY OF DAMAGES CAUSED BY THE
DEPRIVATION OF CIVIL RIGHTS AND WRONGFUL DEATH**

Plaintiff brings this complaint for damages caused by the violation of his civil and constitutional rights. Plaintiff files this complaint under the federal Civil Rights Act, and the Constitution of the United States. Plaintiff also brings claims under the New Mexico Tort Claims Act and Wrongful Death Act. In support of this Complaint, Plaintiff alleges the following:

INTRODUCTION

This suit arises out of the death of Douglas Edminsten, a 50-year-old man who died in the custody of the Cibola County Detention Center. At the time of his death, Doug Edminsten was a pre-trial detainee awaiting trial on misdemeanor charges. Doug sought medical assistance from jail personnel beginning at 10:14 PM on July 7th, 2016. Doug reported to his jailors that he was suffering from abdominal pain and that he was vomiting blood. Jail personnel observed him and noted that he had a pale and yellow appearance, seemed weak and had a rapid heartbeat. Jailors also observed Doug falling down, lying on the floor and

vomiting blood. No medical treatment was given to Doug and he was ordered to return to his jail pod. Doug Edminsten died on the floor of his jail pod shortly after 5:25 AM on July 8th, 2016.

JURISDICTION AND VENUE

Jurisdiction over the subject matter of this action is conferred by 28 U.S.C. § 1331 and 42 U.S.C. §§ 1983 and 1988. Venue is proper as the Personal Representative is a resident of Santa Fe County, New Mexico.

PARTIES

1. Plaintiff Adam Baker, as Personal Representative to the Estate of Douglas Edminsten is an individual and resident of Santa Fe County, New Mexico. Mr. Edminsten was a pre-trial detainee in the custody and care of the Cibola County Detention Center (hereinafter “CCDC”) from June 14, 2016 to July 8, 2016. While incarcerated, Mr. Edminsten was completely dependent upon CCDC for his care and well-being.

2. Defendant Michael Dodds (hereinafter “Director Dodds”) was employed by Cibola County as the Director of CCDC. As the director of the CCDC Defendant Director Dodds had supervisory duties. At all material times, Defendant Director Dodds was acting under the color of state law and within the scope of his duties. Defendant Director Dodds is being sued in his individual capacity.

3. Defendant Gilbert Gonzales (hereinafter “Lt. Gonzales”) was employed by Cibola County as a Lieutenant and supervisor of CCDC. At all material times, Defendant Lt. Gonzales was acting under the color of state law and within the scope of his duties. Defendant Lt. Gonzales is being sued in his individual capacity.

4. Defendant Casey Salvador (hereinafter “Medical Salvador”) was employed by Cibola County to provide medical care including emergency medical care at CCDC. At all material times, Defendant Medical Salvador was acting under the color of state law and within the scope of her duties. Defendant Medical Salvador is being sued in her individual capacity.

5. Defendant Hildenbrandt (hereinafter “HSA Hildenbrandt”) was employed by Cibola County as a Registered Nurse and as the Health Services Administrator (HSA) for CCDC. At all material times, Defendant HSA Hildenbrandt was acting under the color of state law and within the scope of his duties. Defendant HSA Hildenbrandt is being sued in his individual capacity.

FACTUAL BACKGROUND

6. On July 8, 2016 Douglas Edminsten (hereinafter “Doug”) was a pre-trial detainee of the Cibola County Detention Center (hereinafter “CCDC”) in Grants, New Mexico.

7. Doug was 50 years old.

8. Doug was awaiting a trial on a misdemeanor charge of Driving While Intoxicated (DWI).

9. Doug was being held in the Golf Pod area of CCDC.

10. Golf Pod was a “General Population” section of CCDC, housing many inmates.

11. Upon information and belief, some of the other inmates in Golf Pod were pre-trial detainees, like Doug, while others were inmates who had been convicted of crimes.

12. All of the men held in Golf Pod were isolated from the world outside of CCDC, and were entirely dependent upon their jailors for medicine, medical care and communication with the outside world.

13. Doug and his fellow inmates could not call 911 in a medical emergency, even if they wanted to.

14. Doug was at the mercy of his jailors if he needed emergency medical care.

15. At about 10:14 PM on July 7, 2017, inmates in Golf Pod were out of their bunks and attempting to get medical help for Doug.

16. Defendant Lt. Gonzales went to Golf Pod to talk to the inmates and ordered them to return to their bunks.

17. Later, at 10:29 PM, Inmate Julian Baca rubbed blood on the window of Golf Pod in an attempt to get medical attention for Doug.

18. Defendant Director Dodds was still at the facility, as he did not leave CCDC until 10:39 PM that night.

19. Defendant Medical Salvador was called to Golf Pod regarding an inmate in pain.

20. The inmate was Doug Edminsten.

21. Doug was notably pale.

22. Doug's skin also appeared yellow.

23. Doug advised Defendant Medical Salvador that he was in pain.

24. Doug described the pain as being in his abdomen.

25. Doug also informed Defendant Medical Salvador that he had been vomiting blood.

26. At 10:54 PM Defendant Medical Salvador had Doug walk to the medical unit of the detention center.

27. While in the medical unit, Doug vomited blood again.

28. Sometime after Doug arrived in the medical unit, Defendant Lt. Gonzales arrived.

29. Defendant Lt. Gonzales observed the blood that Doug had vomited.

30. Defendant Medical Salvador took Doug's vitals.

31. Doug's pulse rate was 144 beats per minute.

32. Defendant Lt. Gonzales asked Doug if he was okay.

33. Doug told Defendant Medical Salvador "no."

34. Defendant Medical Salvador contacted Defendant HSA Hildenbrandt.

35. Defendant Medical Salvador informed Defendant HSA Hildenbrandt of Doug's vitals, his symptoms, including the vomiting of blood and asked Defendant HSA Hildenbrandt what to do for Doug.

36. Defendant HSA Hildenbrandt told Defendant Medical Salvador to take no medical action at that time and to return Doug to the jail pod.

37. Defendant HSA Hildenbrandt knew that Doug had serious medical conditions.

38. Defendant HSA Hildenbrandt was aware that the vomiting of blood was a medical emergency.

39. Doug asked to remain in the medical unit.

40. Doug explained to Defendant Lt. Gonzales that the other inmates in Golf Pod would not let him rest.

41. At 11:19 PM Officer Lee walked Doug back to the jail pod.
42. Once at the housing unit, before entering the pod, Doug again vomited blood.
43. Doug then laid down on a table outside Golf Pod.
44. Defendant Lt. Gonzales arrived and observed Doug laying on his side on the table.
45. Defendant Lt. Gonzales asked Doug if he was okay.
46. Doug responded that he was not.
47. Doug did not want to return to the pod.
48. Defendant Lt. Gonzales ordered Doug to return to his bunk in Golf Pod.
49. Defendant Lt. Gonzales and another Corrections Officer physically lifted Doug to his feet.
50. Defendant Medical Salvador contacted Defendant HSA Hildenbrandt regarding Doug.
51. Defendant HSA Hildenbrandt had the opportunity to speak with and question Defendant Medical Salvador about Doug's symptoms.
52. Defendant HSA Hildenbrandt instructed Defendant Medical Salvador that Doug would be seen by medical personnel in the morning.
53. Throughout the night inmates in Golf Pod would call requesting assistance for Doug.
54. Inmates advised jail personnel that Doug was vomiting blood.
55. Doug appeared pale and in pain.
56. At about 1:45 AM Defendant Medical Salvador went outside for a "break."

57. Defendant Lt. Gonzales was already outside taking a “break.”
58. During their “break” a Corrections Officer requested that Defendant Lt. Gonzales go to Golf Pod where Doug was located.
59. Defendant Lt. Gonzales remained on “break.”
60. A couple minutes later, a Corrections Officer requested that Defendant Medical Salvador go to Golf Pod.
61. After completing their “break” Defendants Salvador and Lt. Gonzales reentered the facility.
62. Defendant Lt. Gonzales told Defendant Medical Salvador not to go to Golf Pod.
63. Defendant Medical Salvador returned to medical without checking on Doug.
64. Defendant Lt. Gonzales called Defendant Medical Salvador a few minutes later.
65. Defendant Lt. Gonzales told Defendant Medical Salvador that Doug was “okay.”
66. Defendant Lt. Gonzales told Defendant Medical Salvador “there was no need for [her] to go down.”
67. Doug was bleeding internally.
68. Doug was dying.
69. Doug needed emergency medical care.
70. At about 3:30 AM on July 8, 2017, inmates called into master control advising that Doug appeared to be worse and needed medical attention.

71. At 3:32 AM inmates advised that Doug's "eyes were rolling back."
72. Inmate Sanchez kicked the door of Golf Pod to summon help for Doug.
73. Master Control called Defendant Medical Salvador by cell phone.
74. The Master Control Officer advised Defendant Medical Salvador that inmates said it was an emergency.
75. At 3:35 AM Defendant Medical Salvador responded to Golf Pod.
76. Inmates advised Defendant Medical Salvador that Doug was defecating blood.
77. Doug was seated on the toilet.
78. Doug was then helped by inmates to a table.
79. Doug sat at the table briefly.
80. Doug fell to the ground.
81. Doug was unable to walk.
82. At 3:47 AM Doug was taken to the medical unit in a wheel chair.
83. Doug was moaning as if in pain.
84. Doug was unable to follow Defendant Medical Salvador's instructions.
85. Doug was dying.
86. Defendant Lt. Gonzales contacted Defendant Director Dodds and advised him of Doug's condition.
87. Defendant Director Dodds advised Defendant Lt. Gonzales that he, Defendant Director Dodds, would call back after talking to Defendant HSA Hildenbrandt.
88. Defendant Director Dodds called Defendant HSA Hildenbrandt.

89. Defendant HSA Hildenbrandt told Defendant Director Dodds that he, Defendant HSA Hildenbrandt, had received notice of the situation.

90. Defendant HSA Hildenbrandt told Defendant Director Dodds that Doug was “stable.”

91. Defendant Director Dodds called and spoke with Defendant Medical Salvador.

92. Defendant Director Dodds told Defendant Medical Salvador that he had already spoken to Defendants Lt. Gonzales and HSA Hildenbrandt.

93. Defendant Director Dodds asked Defendant Medical Salvador about Doug’s condition.

94. Defendant Medical Salvador gave Defendant Director Dodds information regarding Doug.

95. After telling Defendant Director Dodds that Doug was “stable,” Defendant HSA Hildenbrandt called Defendant Medical Salvador and to find out what Doug’s condition was.

96. Defendant Medical Salvador gave Defendant HSA Hildenbrandt information about Doug’s symptoms.

97. Defendant HSA Hildenbrandt gathered sufficient information regarding Doug’s symptoms and conditions to take appropriate action.

98. Defendant HSA Hildenbrandt was informed that Doug was vomiting blood.

99. Defendant HSA Hildenbrandt ordered Defendant Medical Salvador to return Doug to general population.

100. At 4:01 AM, after less than 15 minutes in the medical unit, Doug was taken back to Golf Pod.

101. Defendant Director Dodds called Defendant Medical Salvador again.

102. Defendant Medical Salvador informed Defendant Director Dodds that Defendant HSA Hildenbrandt had ordered her to get a urine sample and blood labs.

103. At 4:21 AM Defendant Lt. Gonzales entered Golf Pod.

104. At that time, Doug was laying on the floor of Golf Pod.

105. Two inmates stood over Doug on the floor

106. Defendant Lt. Gonzales observed Doug laying on the floor of Golf Pod.

107. Defendant Lt. Gonzales walked past Doug laying on the floor of Golf Pod.

108. Defendant Lt. Gonzales took no action to assist Doug as he lay dying on the floor of Golf Pod.

109. Defendant Lt. Gonzales did not attempt to put Doug in his bunk.

110. Defendant Lt. Gonzales made no effort to move Doug to the Medical Unit.

111. Defendant Lt. Gonzales left the pod and left Doug laying on the floor.

112. Defendant Lt. Gonzales did not summon medical care for Doug.

113. Defendant Lt. Gonzales left Doug to die on the floor of Golf Pod, tended to by inmates.

114. At 4:39 AM Doug was still on the floor of Golf Pod.

115. Corrections Officer Lee was present.

116. Two inmates were attending to Doug.

117. One inmate was holding Doug's head.

118. The other inmate was reading to him from a book.

119. Upon information and belief, that book was a bible.
120. At 4:58 AM inmates again called for medical assistance for Doug.
121. The inmates advised jail personnel that Doug was not breathing.
122. At 5:02 AM Defendant Lt. Gonzales was called via radio to respond to Golf Pod.
123. At about that time Defendant Medical Salvador was called via cell phone by master control.
124. Master Control advised Defendant Medical Salvador that Doug was not moving.
125. Defendant Medical Salvador arrived at Golf pod a couple minutes after being called.
126. Defendant Medical Salvador found Doug on the floor of the jail.
127. Doug was being tended to by inmates.
128. Defendant Medical Salvador checked Doug's pulse and could not feel a pulse.
129. Doug's body was cold.
130. Doug's lips were blue.
131. Defendant Medical Salvador couldn't see if Doug's chest was rising or falling.
132. Doug was still alive.
133. Defendant Lt. Gonzales arrived at the pod and was told Doug was dead.
134. Defendant Lt. Gonzales left the pod.

135. At 5:04 AM Defendant Lt. Gonzales called Defendant Director Dodds and told him that Doug was dead.

136. Doug was still alive.

137. At 5:07 AM Defendant Lt. Gonzales called New Mexico State Police and requested an officer respond regarding Doug's death.

138. Doug was still alive.

139. At about 5:10 AM Defendant Lt. Gonzales ordered that the other inmates in Golf Pod be moved to another pod.

140. Doug was still alive

141. Defendant Lt. Gonzales then asked Defendant Medical Salvador if she was sure Doug was dead.

142. Defendant Medical Salvador advised Defendant Lt. Gonzales that she did not feel a pulse.

143. Defendant Lt. Gonzales then asked Defendant Medical Salvador to check Doug's pulse using her pulse-oximeter.

144. At 05:26 AM Defendants Lt. Gonzales and Salvador returned to Golf pod with the pulse-oximeter.

145. Doug still had a pulse.

146. Doug was still alive.

147. From the first request for help at 10:14 PM to the 5:26 AM discovery that Doug still had a pulse, he received no medical treatment.

148. At 5:27AM Defendant Lt. Gonzales ordered Master Control to call 911 and request an ambulance.

149. Defendant Lt. Gonzales had the authority to issue such orders.

150. Defendant Lt. Gonzales could have ordered the staff to call an ambulance at any time that evening.

151. Fire and Rescue personnel arrived at the facility within 5 minutes of the 911 call.

152. Eventually, Doug was pronounced dead.

153. After his death, Defendants' altered Doug's medical records.

**COUNT I: VIOLATION OF THE FOURTEENTH AMMENDMENT: INADEQUATE
MEDICAL CARE, INHUMANE CONDITIONS OF CONFINEMENT
(All Defendants)**

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

155. At all material times, Plaintiff had a Fourteenth Amendment right to humane conditions of confinement and adequate medical care.

156. Rather than treat Plaintiff's medical condition Defendants Director Dodd, Lt. Gonzales, Medical Salvador, and HSA Hildenbrandt chose to ignore Doug's requests for medical assistance.

157. Defendants Director Dodd, Lt. Gonzales, Medical Salvador, and HSA Hildenbrandt also ignored other inmates' requests to provide medical care for Doug.

158. Doug's actions and appearance, as well as his medical history, made it obvious he was in need of emergency medical care on the night of his death.

159. Doug's medical emergency was obvious to other inmates, who repeatedly attempted to convince jail personnel to help Doug.

160. From at or about 10:15 PM July 7, 2016 until his death sometime after 5:26 AM July 8, 2016, Doug Edminsten was suffering from a serious and life threatening medical condition.

161. Doug's medical emergency was obvious, as evidenced by the actions of his fellow inmates.

162. Defendants ignored the information available and took no action to treat Doug's obvious medical symptoms.

163. Doug's symptoms and history should have resulted in transport to a hospital as soon as he and others reported that he had vomited blood.

164. Vomiting of Blood (Hematemesis) is a medical emergency.

165. Medical emergencies require immediate treatment.

166. The failure to provide emergency treatment for hematemesis can result in death.

167. Defendant Medical Salvador was aware of Doug's hematemesis and did not provide or secure medical treatment for Doug.

168. Defendant Lt. Gonzales was aware of Doug's hematemesis and did not provide or secure medical treatment for Doug.

169. In fact, at times, Defendant Lt. Gonzales ordered Defendant Medical Salvador not to assist Doug, telling Defendant Medical Salvador not to go to Golf Pod when she was summoned by other jail personnel.

170. Defendant Lt. Gonzales actively delayed and prevented medical care for Doug.

171. Defendant Lt. Gonzales actively prevented medical care for Doug by telling Defendant Medical Salvador that Doug was “okay.”

172. At the time Defendant Lt. Gonzales told Defendant Medical Salvador Doug was “okay,” Doug was bleeding internally.

173. Defendant Lt. Gonzales actively delayed medical care for Doug by failing to report Doug’s condition when he observed Doug on the floor of Golf Pod at 4:21 am.

174. Defendant HSA Hildenbrandt was aware of Doug’s hematemesis and did not provide or secure medical treatment for Doug.

175. Defendant HSA Hildenbrandt was aware that Doug had pre-existing impaired liver function.

176. Defendant HSA Hildenbrandt knew that the liver is the primary producer of blood clotting factors.

177. Defendant HSA Hildenbrandt knew that when the liver is damaged, its ability to produce clotting factors is diminished.

178. Defendant HSA Hildenbrandt also knew that people like Doug, with cirrhosis, are at increased risk of bleeding and death.

179. Despite this knowledge, Defendant HSA Hildenbrandt took no action to provide emergency care for Doug, knowing that Doug had vomited blood.

180. In fact, Defendant HSA Hildenbrandt ordered others to send Doug back to the pod.

181. Defendant HSA Hildenbrandt actively delayed and prevented medical care for Doug.

182. Defendant Director Dodd was aware of Doug's hematemesis and did not provide or secure medical treatment for Doug.

183. Defendant Director Dodd ordered his staff not to call an ambulance for Doug.

184. Defendant Medical Salvador was deliberately indifferent to Doug's serious and obvious medical condition.

185. Defendant Lt. Gonzales was deliberately indifferent to Doug's serious and obvious medical condition.

186. Defendant HSA Hildenbrandt was deliberately indifferent to Doug's serious and obvious medical condition.

187. Defendant Director Dodd was deliberately indifferent to Doug's serious and obvious medical condition.

188. Doug was suffering an obvious, painful and life threatening medical emergency.

189. Doug requested to remain in the medical pod when he first arrived there late on July 7, 2016.

190. The request was reasonable in light of his medical conditions.

191. The medical unit of CCDC is separate from the general population pods.

192. When inmates are sick, or otherwise physically unable to care for themselves they are vulnerable.

193. Inmates that are in a vulnerable physical condition due to illness should be separated from the general inmate population.

194. Inmates in general population may intentionally harm a vulnerable inmate.

195. Inmates may also harm a medically vulnerable inmate inadvertently, as they are not trained to render medical assistance.

196. The medical unit is staffed by personnel trained to provide medical care.

197. The medical unit is also designed to separate medically vulnerable inmates from other inmates who might harm them.

198. From 10:14 PM through his death on the floor of Golf Pod, Doug was extremely vulnerable due to his medical condition.

199. While in the medical unit Doug was monitored by medical personnel.

200. In Golf Pod, Doug's only medical assistance came from inmates.

201. Doug was ordered to return to Golf Pod.

202. Defendant Lt. Gonzales ordered that Doug return to Golf Pod.

203. Defendant HSA Hildenbrandt ordered that Doug return to Golf Pod.

204. Defendant Director Dodds ordered that Doug return to Golf Pod.

205. Requiring Doug to leave the medical unit and return to Golf Pod was inhumane and created a substantial risk of serious harm.

206. In Golf Pod, inmates moved Doug from place to place in the pod, including from his bunk to the toilet, to a table, and this eventually resulted in him falling to the floor.

207. These inmates were attempting to provide medical assistance to Doug.

208. These inmates were providing human compassion in their attempt to provide comfort to Doug.

209. Upon information and belief, these inmates were not trained in medicine or first aid.

210. Despite these good intentions on the part of the inmates of Golf Pod, requiring Doug to remain in Golf Pod in an obvious medical crisis was outrageous.

211. Defendant Lt. Gonzales ordered that Doug remain in Golf Pod.

212. Defendant HSA Hildenbrandt ordered that Doug remain in Golf Pod.

213. Defendant Director Dodds ordered that Doug remain in Golf Pod.

214. Continuing Doug's confinement in Golf Pod rather than the medical pod was inhumane and created a substantial risk of serious harm to Doug.

215. Doug remaining on the floor of Golf Pod, rather than in a cot in the medical unit, was inhumane and/or created a substantial risk of serious harm.

216. As a proximate and foreseeable result of Defendants' deliberate indifference to Doug's serious, obvious medical conditions, Doug suffered injuries including pain and suffering, emotional distress, exacerbation of his medical condition, and subsequent death.

217. Doug's conditions of confinement amounted to punishment of a pre-trial detainee in violation of the Fourteenth Amendment to the United States Constitution.

218. Judged by contemporary standards of decency, the conditions of Doug's confinement, imposed by the defendants, involved the wanton and unnecessary infliction of pain, were grossly disproportionate to the severity of his crimes and entailed serious deprivation of basic human needs.

219. As a proximate and foreseeable result of Defendants' actions, Doug was subjected to inhumane conditions of confinement. As a result of these inhumane conditions of confinement, Doug suffered injuries including pain and suffering, emotional distress, exacerbation of his medical condition, and subsequent death.

220. Defendants Medical Salvador, Director Dodds, Lt. Gonzales and HSA Hildenbrandt acted in reckless, willful and/or wanton disregard for Doug's civil rights warranting an award of punitive damages.

**COUNT II: NEGLIGENT PROVISION OF MEDICAL CARE;
LOST CHANCE OF SURVIVAL
(All Defendants)**

221. Plaintiff restates each of the preceding allegations as it fully stated herein.

222. The Cibola County Detention Center is responsible for the provision of medical care for inmates housed within CCDC.

223. The Sovereign Immunity granted pursuant to Subsection A of Section 41-4-4 NMSA is waived for medical facilities pursuant to Section 41-4-9 NMSA.

224. The standard of care requires jail personnel to take appropriate action in response to medical emergencies suffered by inmates of the CCDC.

225. This duty includes recognition and treatment of emergency medical conditions.

226. Vomiting blood, rapid heartbeat, pale and jaundiced skin and complaints of abdominal pain, as reported by Doug, and as observed by Defendants Lt. Gonzales and Medical Salvador are signs of an obvious medical emergency.

227. Defendants Medical Salvador, Lt. Gonzales, Director Dodd and HSA Hildenbrandt were aware of Doug's symptoms.

228. Instead of taking action to address Doug's medical emergency, Defendants repeatedly ignored his symptoms and deprived him of medical care.

229. Defendants breached their duty to Doug Edminsten.

230. As a result of Defendants' failure to provide medical care, Doug's medical emergency went untreated for hours.

231. As a result of the Defendants' failure to provide medical care, Doug bled to death on the floor of CCDC.

232. Between 4:21 AM and 5:25 AM, Doug Edminsten was alive and unconscious on the floor of the CCDC.

233. Between 4:21 AM and 5:25 AM Defendants took no action to provide medical care or treatment to Doug, and treated him as if he were already dead.

234. At 5:26 AM Defendant Medical Salvador, at the direction of Defendant Lt. Gonzales, used a pulse oximeter on Doug and determined he had a pulse.

235. Only then, more than seven hours after the initial reports of Doug's vomiting blood, did Defendants call for an ambulance.

236. Defendants breached their duty to provide adequate medical care to inmates locked within CCDC.

237. Defendants' negligence deprived Doug of a chance of survival.

238. Defendants' negligence was a proximate cause of this lost chance of survival.

239. As a result of the negligent acts and omissions by the Defendants, Doug suffered physical injuries, pain and suffering and ultimately death.

WHEREFORE, Plaintiff requests judgment as follows:

1. Compensatory damages in an as yet undetermined amount, jointly and severally against all Defendants.

2. Punitive damages in an as yet undetermined amount severally against the individually named Defendants.

3. Reasonable costs and attorney's fees incurred in bringing this action.

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

Respectfully submitted,

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