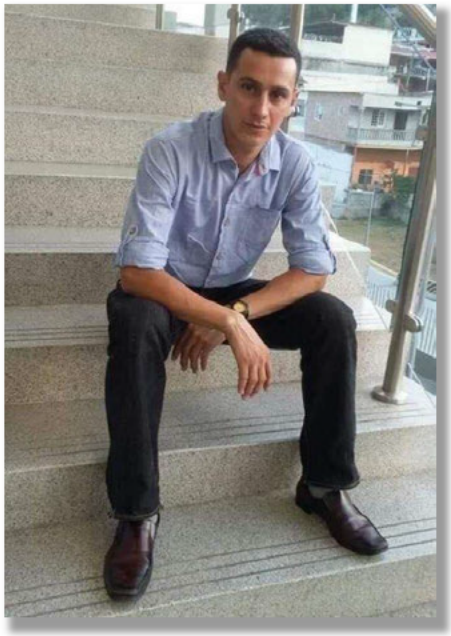
District Court Adams County, Colorado 1100 Judicial Center Drive Brighton, Colorado 80601	
Plaintiffs: **DORLING PERALTA RIVERA**, as next friend of **A.C.P. and J.C.P.**, minors, v. Defendant: **THE GEO GROUP, INC.**, a Florida Corporation, and **CARY WALKER, DO.**, an individual.	DATE FILED October 11, 2024 1:13 PM FILING ID: A6FA45C97B1AF CASE NUMBER: 2024CV31540 ▲ COURT USE ONLY ▲
Counsel for Plaintiffs Aaron Slade, #58087 Danielle C. Jefferis, #47213 Aaron Elinoff, #46468 Novo Legal Group, LLC 4280 Morrison Rd Denver, Colorado 80219 T: (303) 335-0250 F: (303) 296-4586 E: aslade@novo-legal.com E: danielle@novo-legal.com E: aaron@novo-legal.com	Case Number: Division: Courtroom:
COMPLAINT AND JURY DEMAND	

Dorling Peralta Rivera as next friend of minor Plaintiffs A.C.P. and J.C.P., by and through their attorneys, Aaron Slade, Danielle C. Jefferis, and Aaron Elinoff of Novo Legal Group, LLC, hereby files their Complaint and Jury Demand against Defendants The Geo Group, Inc. ("GEO") and Cary Walker, DO, and states as follows:

INTRODUCTION

Melvin Ariel Calero Mendoza should still be alive today. He died on October 13, 2022 when he was only 39 years old. His death shattered his young family he left behind: his two young children, and his partner Dorling. Melvin came to the United States to reunite with his family who were escaping from the dangers of Nicaragua where they had witnessed political turmoil, economic instability, and gang violence.



The final days of Melvin's life were spent in unbearable pain at the Aurora Contract Detention Facility ("ACDF"), an immigration detention center run by The GEO Group ("GEO"), a private, for-profit corporation that contracts with the U.S. Immigration and Customs Enforcement. He died because Defendants GEO and its only doctor, Cary Walker, failed to diagnose and treat a blood clot in his leg. The blood clot eventually traveled in Melvin's bloodstream to his lungs and caused a pulmonary embolism – a blockage in a crucial lung artery that stopped the blood flow to his lungs and caused his death.

Melvin's death was entirely preventable. In the weeks leading up to his death, he tried at least three times to get medical care from GEO because of unbearable pain in his right leg. Each time, Defendants failed to triage him appropriately, refer him to an appropriate medical provider for care, or correctly diagnose his medical concerns. Instead, Defendants tasked entry-level nurses to diagnose and treat Melvin without supervision, and outside the scope of their nursing licenses. As a result, Melvin received cursory, careless, and plainly inappropriate medical treatment consisting of over-the-counter pain medications and ice packs for his leg.

Defendants knew the medical care scheme they used at the ACDF was reckless, dangerous, and deficient, but they refused to fix it. During the time period immediately preceding Melvin's death, people detained at the ACDF had complained persistently and filed lawsuits because of Defendants' callous and deficient medical care. At the same time, internal investigations revealed widespread, systemic failures in the medical care at the ACDF, and public interest groups have published articles documenting the disturbing and pervasive problems with the medical care at the ACDF. Defendants also knew the consequences of failing to fix the systemic problems with the medical care scheme at the ACDF. Two people, Evalin-Ali Mandza and Kamyar Samimi died because of inadequate medical care at the ACDF in the years before Melvin was incarcerated there.

Melvin's children file this lawsuit seeking accountability for Defendants' reckless conduct and redress for the traumatic, untimely, and preventable loss of their father.

PARTIES, JURISDICTION, AND VENUE

1. Minor plaintiffs A.C.P. and J.C.P. are the surviving children of Melvin Ariel Calero Mendoza and currently reside outside the United States. The minor plaintiffs' interests are represented by their mother and next friend Dorling Peralta Rivera, pursuant to C.R.C.P. 317(c), who resides in the State of Florida.

2. Defendant GEO is a Florida corporation with its principal place of business located at 4955 Technology Way Boca Raton Florida, 33431. Its registered agent in Colorado is located at 155 E. Boardwalk #490, Fort Collins, Colorado 80525.

3. Defendant GEO owns, operates, and controls the Aurora Contract Detention Facility ("ACDF") a U.S. Immigration and Customs Enforcement ("ICE") Processing Center located at 3130 North Oakland Street, Aurora, Colorado 80010.

4. At the time of the events and omissions giving rise to this lawsuit, GEO contracted with ICE to, among other things, house and provide medical services to the civil detainees at the ACDF, where Melvin Calero Mendoza was detained between May 2, 2022 and October 13, 2022, the date of his death.

5. Defendant GEO employed the nurses, mid-level providers, and physician who were responsible for the care of Melvin Calero Mendoza during his detention. Defendant GEO is responsible for the policies, practices, customs, training, supervision, and oversight of GEO staff at the ACDF, including the medical staff who were responsible for providing medical services and care to Melvin Calero Mendoza.

6. Defendant Cary Walker is a Doctor of Osteopathy employed by Defendant GEO who worked as the Medical Director at the ACDF at the time Melvin Calero Mendoza was detained there. Cary Walker was responsible for training, supervising, oversight, and medical decision-making of the medical staff at the ACDF. Upon information and belief, Cary Walker's place of residence is in Colorado.

7. This Court has subject matter jurisdiction to hear this action under Colo. Const. art. VI, § 9. This action is a civil matter and the amount in controversy exceeds $25,000.

8. This Court has personal jurisdiction over Defendant GEO pursuant to § 13-1-124, C.R.S. because this lawsuit concerns the commission of tortious acts within the State of Colorado. Additionally, this Court's exercise of general jurisdiction over Defendant GEO comports with principles of Due Process because Defendant GEO has systematic and continuous contacts with the State of Colorado.

9. The Court has personal jurisdiction over Defendant Cary Walker pursuant to § 13-1-124, C.R.S. because this lawsuit concerns the commission of tortious acts within the State of Colorado.

10. Pursuant to C.R.C.P. 98, venue is proper in Adams County because the alleged tortious acts were committed there, and Defendants may be found there.

CERTIFICATE OF REVIEW

11. Pursuant to § 13-20-602, C.R.S., Plaintiffs' counsel certifies as follows.

12. Counsel has consulted with a medical professional with expertise in the areas of the alleged professional negligence alleged herein.

13. The medical professional meets the requirements of § 13-64-401, C.R.S.

14. The medical professional reviewed the known facts relevant to the allegations of professional negligence alleged herein.

15. Based on the review of those facts, the medical professional concluded that the filing of the claims against Defendant GEO and Defendant Cary Walker do not lack substantial justification within the meaning of § 13-17-102(4), C.R.S.

FACTUAL ALLEGATIONS

16. The United States Department of Homeland Security ("DHS") is a federal agency of which ICE is a part. ICE is a government service with the civil legal authority to detain certain non-citizens awaiting determinations on their immigration cases. Those non-citizens detained by ICE are held in civil immigration detention facilities throughout the United States.

17. ICE contracts with private, for-profit corporations to run, operate, and control some of its immigration detention facilities.

18. ICE selected and contracted with GEO, a private, for-profit corporation to run, operate, and control the ACDF.

19. GEO is the world's second-largest private prison company.

20. Currently, GEO operates and controls over 20 different immigration detention facilities through contracts with ICE.

21. The ACDF was the first GEO detention center to be awarded with a contract with ICE. Currently, the ACDF incarcerates approximately 1,500 people in ICE's civil custody.

22. GEO employees provide the security and medical care services at the ACDF.

23. A condition of the government contract between ICE and GEO is that GEO operates the ACDF in a manner compliant with federal and state laws and regulations, along with specific standards for safety, healthcare, and other aspects of detention operations.

24. Two of those of standards are the Performance Based National Detention Standards (PBNDS) and the National Commission on Correctional Health Care ("NCCHC") standards.

GEO's longstanding history of inadequate medical care at the ACDF.

25. For years the medical care at provided by GEO at the ACDF has fallen well below acceptable standards.

26. For example, in May 2017, Mohamed Dirshe, a detainee at the ACDF was brutally beaten by other prisoners because of his sexual orientation. Mohamed told GEO officers about his fears for his safety before the attack, but GEO staff failed to protect him. Mohamed suffered severe injuries including bleeding underneath his eye, bruising on his head, ringing in his ears, and blurry vision.

27. After the attack, GEO medical staff performed a cursory examination and gave Mohamed Tylenol as his only treatment. He received no emergency care, and for 36 hours following his attack, GEO staff left him in a wheelchair in an empty room, alone and confused. Mohamed did not receive outside medical care until nearly a month later when he was finally taken to Denver Health for an examination.

28. In 2018, a man detained by ICE suffered a severe injury to his knee, resulting in a large open wound. After his injury, he was transferred to the ACDF. While detained there, GEO failed to provide him medical treatment for his knee despite the man's numerous requests to see a doctor. Over time, his knee swelled severely and when he tried to walk, a mixture of fluids secreted from the large gash in his knee. The swelling in his knee expanded to his lower leg and foot. Eventually, he was unable to continue walking at all.

29. Also in 2018, yet another man detained by ICE suffered multiple gunshot wounds to his hand and abdomen. He underwent multiple emergency surgeries during which physicians removed some of the bullet fragments from his body and repaired some of his internal bleeding. He had a chest tube in place to drain blood from the cavity between his chest wall and lung. His physicians were not able to remove all of the bullet fragments from his body and at least one large fragment remained near his rib cage. Upon discharge from the hospital, he was advised that he needed to follow up with his physician for further evaluation and surgical planning.

30. ICE then transferred him to the ACDF where GEO failed to evaluate and treat him despite the man requesting numerous times to see a doctor. The remaining bullet fragment near his rib cage caused him unbearable and constant pain. GEO medical staff only provided him over-the-counter pain medications.

31. These stories are but a few examples of GEO's longstanding and pervasive failures to provide adequate medical care to the people incarcerated at the ACDF.

32. In August 2018, the DHS Office of Civil Rights and Civil Liberties conducted an internal investigation into GEO's degree of compliance with multiple medical standards of care for people incarcerated at the ACDF. The investigation was performed by DHS's own physician expert. The results of the investigation were published in a September 2018 report ("2018 CRCL report").

33. The 2018 CRCL report identified several alarming deficiencies in GEO's medical care, including:

- GEO medical staff at the ACDF responded in English to medical grievances that were submitted in Spanish.
- GEO had several examples of unacknowledged or untreated medical conditions of different severity at the ACDF.
- GEO's chronic care clinic system at the ACDF was "broken", and detainees were not receiving routinely scheduled chronic care clinic visits.
- GEO did not have an existing quality assurance or internal improvement program at the ACDF.
- GEO had several instances in which detainees' medical conditions were either not acknowledged or acknowledged but not addressed appropriately at the ACDF.

34. The 2018 CRCL report enumerated extensive changes for GEO to implement at the ACDF to bring it to compliance with medical standards of care.

35. A few months later, on January 29, 2019, the DHS Office of the Inspector General ("OIG") released a report describing ICE's failures to adequately hold detention facility contractors, like GEO, accountable for not meeting performance standards, including providing adequate medical care.[1]

36. On September 17, 2019, the American Civil Liberties Union ("ACLU") of Colorado released a comprehensive report examining the "atrocious conditions at ACDF," criticizing the lack of appropriate medical, mental health, and other necessary services there, and outlining the perverse financial incentives that resulted in the expansion of ICE's contract with

[1] John V. Kelly, *ICE Does Not Fully Use Contracting Tools to Hold Detention Facility Contractors Accountable for Failing to Meet Performance Standards*, OIG-19-18 (January 29, 2019).

Defendant GEO, even as questions about GEO's mismanagement, medical negligence, and other legal violations mounted.[2]

37. On February 11, 2022, attorneys filed a complaint with the DHS CRCL, OIG, and Office of the Immigration Detention Ombudsman on behalf of people detained or recently released from ACDF. The complaint described GEO's widespread failures to protect people incarcerated at the ACDF from the dangers of the COVID-19 pandemic, including:

- Failing to provide cleaning supplies and ensure adherence to proper masking procedure, resulting in multiple outbreaks of the virus at the ACDF;
- Failing to provide COVID-19 tests and vaccines;
- Failing to provide adequate medical care for those who contracted COVID-19;
- Holding people who contracted the virus in filthy, unsanitary isolation rooms, denying them phone calls with family, and refusing to provide them with crucial services like recreation and use of the law library;
- Failing to provide people with mental and physical disabilities with appropriate accommodations;
- Threatening to retaliate against individuals who spoke out against GEO's failures.

38. In March 2023, the ICE Office of Professional Responsibility ("OPR") Office of Detention Oversight ("ODO") conducted a compliance inspection of the ACDF. The purpose of the inspection was to ensure compliance with the PBNDS, the national detention standards GEO is contractually obligated to follow. The inspection revealed, among other findings:

- In several employee files, GEO's medical staff had no documentation for verifiable licensing, certifying, credentialing, and/or registering of staff in compliance with appliable state and federal requirements.
- Several people detained at the ACDF with possible emergency medical concerns had **no evaluation** by a qualified licensed health car provider within 2 working days.
- Several people detained at that ACDF had clinically significant findings on their initial health screenings but GEO medical staff did not initiate an immediate referral to health care provider after the screening.

[2] American Civil Liberties Union of Colorado, *Cashing In On Cruelty, Stories of death, abuse, and neglect at the GEO immigration detention facility in Aurora* (2019), accessed September 27, 2024, at https://www.aclu-co.org/sites/default/files/ACLU_CO_Cashing_In_On_Cruelty_09-17-19.pdf.

- GEO's medical director did not review several health assessments of people detained at the ACDF to determine the priority of treatment based on the reported health concern.

39. From October 17 - 19, 2023, the DHS OIG conducted an unannounced site inspection of the ACDF.[3] During their visit, they observed that GEO was still failing to provide medical health screenings for all people arriving at the ACDF before determining their custody classification them. A person's custody classification determines what services and resources they receive, including crucial medical services. As a result, people incarcerated at the ACDF were classified without consideration of their medical needs.

40. The 2023 DHS OIG inspection also revealed that GEO still failed to provide adequate and timely specialty medical care for the people incarcerated at the ACDF. Specialty care includes visits with a medical provider outside the ACDF for serious health concerns. The inspectors observed that in August and September 2023, 47 specialty medical appointments had been scheduled, and as of October 2023, 31 of those appointments had not yet occurred.

41. The above excerpts are but a few select examples among voluminous other documented instances of GEO's continuous and systemic failures of providing adequate medical care at the ACDF.

The longstanding history of detainee deaths while in ICE custody, including the ACDF.

42. GEO's longstanding, systemic failures in providing adequate healthcare have caused the death of numerous people incarcerated at the ACDF and other immigration detention centers operated by GEO nationwide.

43. As of June 2024, ICE reported that 70 people have died in an immigration detention center since January 1, 2017.[4]

44. GEO was one of the biggest contributors to those deaths.

45. Of the immigration detention facilities that caused the highest numbers of detainee deaths between 2017 and 2024, GEO operated and controlled one third of them.[5]

46. In 2021, medical researchers at the University of Southern California examined detainee death reports from deaths in ICE detention between 2011 and 2018. Several of those deaths occurred at facilities operated by GEO. The researchers documented persistent themes of delays in care, grossly substandard care, and failures of emergency response across those deaths.

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[3] Joseph V. Cuffari, Ph.D, *Results of an Unannounced Inspection of ICE's Denver Contract Detention Facility in Aurora, Colorado*, OIG-24-29 (June 12, 2024).
[4] American Civil Liberties Union et al., *Deadly Failures: Preventable Deaths in U.S. Immigration Detention* (2024).
[5] *Id*.

The researchers concluded that many of the deaths they examined were likely preventable and that ICE had violated its own medical standards in "the vast majority of cases."[6]

47. In June 2024, the ACLU, the Physicians for Human Rights, and American Oversight published a comprehensive report analyzing the deaths of 52 people whom ICE reported to have died in its custody between January 1, 2017 and December 31, 2021.[7] Several of those deaths occurred at facilities operated by GEO.

48. The results of the ACLU's analysis revealed that systemic failures in medical and mental health care caused preventable deaths in immigration detention and that **95 percent of the deaths were preventable or possibly preventable if appropriate medical care had been provided**, among other disturbing findings.

49. GEO has an alarming history of detainee deaths specifically at the ACDF because of inadequate medical care and emergency response.

50. On April 12, 2012, Evalin-Ali Mandza, a 46-year-old detainee at the ACDF, clutched his chest and rolled back and forth in pain. In response, GEO medical staff failed to operate an electrocardiogram machine due to unfamiliarity with the equipment. An hour later, GEO medical staff called for an ambulance to take Evalin-Ali to a hospital. After he arrived in the emergency room, he went into cardiac arrest and died.

51. On December 2, 2017, Kamyar Samimi, a 64-year-old detainee at the ACDF, died in custody after two weeks of horrific opioid withdrawals that GEO medical staff neglected and ignored. GEO medical staff knew that Kamyar had opioid use disorder but failed to treat him with the appropriate withdrawal protocol and repeatedly failed to properly treat and respond to his severe withdrawal symptoms. As a result, Kamyar went into cardiac arrest and died at a local hospital.

52. The 2018 CRCL Report, written by a DHS physician expert, commented specifically on Kamyar's death. The words of DHS's own expert highlight the severity of GEO's longstanding, systemic failures in providing adequate healthcare and the dangerous consequences of allowing them to continue:

> [T]he complete lack of medical leadership, supervision and care that [Kamyar] was exposed to is simply astonishing and stands out as one of the most egregious failures to provide optimal care in my experience . . . . It truly appears that [ACDF's] system failed at every aspect of care possible beginning from using the correct withdrawal assessment tool to performing basic nursing functions including the ability to recognize medical emergency situations to an astonishing lack of physician supervision, leadership and accountability.

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[6] Parveen Parmar et al., *Mapping factors associated with deaths in immigration detention in the United States*, 2011 2018: A thematic analysis, The Lancet Regional Health Americas, Vol. 2 (October 2021).
[7] American Civil Liberties Union et al., *Deadly Failures: Preventable Deaths in U.S. Immigration Detention* (2024).

Defendants' failure to remedy, address, or fix its systemic failures.

53. The above incidents, complaints, investigations, studies, and reports collectively put GEO and Cary Walker, DO on notice of the disturbing and deadly consequences of its systemic failures in providing adequate medical care at the ACDF and the risks inherent in failing to fix them.

54. As alleged in detail below, GEO and Dr. Walker ignored those risks and took no or inadequate action to remedy, address, or fix its systemic failures in providing adequate medical care at the ACDF during the time period leading up to Melvin Calero Mendoza's death.

55. As a result, GEO and Dr. Walker failed to prevent Melvin Calero Mendoza's death, continuing the disturbing pattern of inadequate medical care and detainee deaths at the ACDF.

Mr. Calero Mendoza's journey to seek political asylum in the United States.

56. Melvin Ariel Calero Mendoza was born in Nicaragua. In high school, he met his partner Dorling Peralta Rivera. The couple later had two children together: A.C.P in 2007 and J.C.P in 2015.

57. Melvin worked at a distribution center and studied business administration off and on while providing for his young family.

58. Melvin loved soccer. His favorite team was FC Barcelona, and he watched them play whenever he could.

59. Melvin and Dorling desired a better life for themselves and their two young children. Nicaragua had become dangerous and untenable. Political turmoil had shaken the country for years, food prices were rising, and gang violence was rampant.

60. Melvin and Dorling feared for the safety of themselves and their children if they continued to stay in Nicaragua.

61. In 2020, Dorling made the difficult decision to leave Nicaragua and seek asylum in the United States. Her children stayed with Melvin and their grandmother in Nicaragua.

62. After entering the United States, Dorling diligently pursued her asylum application. To her joy and relief, the United States granted her asylum in 2020 and issued her authorization to begin working in the United States.

63. She settled in Miami, Florida, and got a job as a childcare provider and later cleaning offices at an office building. Dorling immediately began sending money back to Melvin and her children.

64. She and Melvin had a plan: Melvin would make the journey to the United States next and seek political asylum as she did. Once he gained his status, they would work on getting their children to the United States. In the meantime, the children would remain with their grandmother in Nicaragua.

65. In 2022, Melvin began traveling from Nicaragua to the Mexico–United States border to join Dorling and begin their lives together in America.

66. His journey was demanding, tiring, and long, but Melvin was up for the task. He was a healthy, fit, 38-year-old man determined to reunite his family.

67. It took Melvin a month to get to the border by car and foot.

68. Melvin called Dorling on the phone when he got to the border in April 2022.

69. Dorling could hear the excitement in Melvin's voice when he called her, telling her he reached the border. Melvin told Dorling his plan to turn himself in to U.S. immigration authorities and begin the asylum application process.

70. Melvin entered the United States on April 13, 2022, near El Paso, Texas.

71. The United States Customs and Border Protection ("CBP") detained him. They ran multiple criminal background checks and found he had no criminal history. Melvin informed CBP he was there seeking asylum in the United States because of his fear of harm or persecution should he be returned to Nicaragua.

72. CBP transferred Melvin to ICE custody, which then ordered Melvin detained in civil immigration detention while he pursued his asylum claim.

73. Initially, ICE detained Melvin at the Torrance County Detention Facility ("TCDF") in Estancia, New Mexico. He arrived there on April 16, 2022.

74. On April 21, 2022, Melvin underwent an initial health screening by a Nurse Practitioner at the TCDF. He reported no current symptoms or complaints.

75. On May 1, 2022, ICE transferred Melvin from the TCDF to the ACDF in Colorado.

GEO's reckless, dangerous, and deficient medical care scheme.

76. At the time Melvin was incarcerated at the ACDF, GEO's medical care scheme was reckless, dangerous, and deficient. As a matter of policy, GEO and Dr. Walker tasked entry-level nurses with triaging detainee health concerns, making assessments and diagnoses, and deciding on treatment plans for a wide breadth of detainee health concerns. Those tasks exceeded the appropriate level of care that the entry-level nurses were able to perform and should have only been done by a higher-level provider or physician.

77. At the time of Melvin's death, GEO employed one physician at the ACDF, Dr. Walker, for all the detainees incarcerated there. Dr. Walker served as the facility's medical director and had control and oversight over the medical care scheme at the ACDF, including the medical training, policies, practices, and customs at the ACDF along with final medical decision-making for all detainee health cases. He also had supervisory oversight over all of the GEO medical staff working at the ACDF.

78. In addition to Dr. Walker, GEO employed one Physician Assistant ("PA"), eight Registered Nurses ("RN"), and six Licensed Practical Nurses ("LPN") for the approximately 1,500 detainees incarcerated there at any given time.

79. PAs and RNs are considered "mid-level providers" and hold critically different roles than LPNs.

80. In contrast to PAs and RNs, LPNs are entry-level nursing employees. LPNs do not attend a formal nursing or medical program like RNs or PAs do; rather, they attend a short course of classes at a university or college. LPN programs do not award a college degree; rather, successful LPN students receive a training certificate upon completion of most programs.

81. LPN programs in Colorado are nine to eleven months long. The programs emphasize treatment of patients with simple, predictable health concerns. LPNs learn "to identify normal from abnormal in each of the body systems and to identify changes in the patient's condition, which are then reported to the RN or MD for further or 'full' assessment."[8]

82. As such, LPNs in Colorado are not supposed to make patient diagnoses, medical assessments, nor medical treatment decisions.

83. LPNs in Colorado also are not supposed to triage any patient health concerns.

84. At the time of Melvin's death, GEO used an electronic health record system to document each encounter that a detainee had with the medical staff there.

85. GEO preprogrammed its electronic health record system with the GEO Group Nursing Assessment Protocols ("GGNAP"). Those protocols prescribed a set of tasks for LPNs to follow when responding to detainee sick call requests.

86. Alarmingly, under GEO's preprogrammed health record system, GEO LPNs follow the GGNAP protocols without appropriate supervision from a higher-level medical provider with the knowledge, training, and authority to make critical health decisions.

87. GEO's preprogrammed health record system does not have any alerts or triggers for its LPNs to refer patients to a higher-level provider based on abnormal exam findings or pain management guidance.

88. GEO trained its LPNs to follow the preprogramming protocols without exception, and even instructed LPNs not to use their own clinical judgment and critical thinking skills.

89. As a result of the above, GEO LPNs routinely triaged detainee health concerns, made medical assessments and diagnoses, and decided on treatment plans for a wide breadth of detainee health concerns, without supervision.

90. All those tasks were outside the LPN scope of practice in Colorado and exceeded the appropriate level of care that an LPN is able to perform.

GEO's reckless, dangerous, and deficient medical care scheme fails to detect, diagnose, and treat a dangerous blood clot in Melvin's right leg.

91. After his transfer from the TCDF, Melvin arrived at the ACDF on May 2, 2022. A GEO LPN completed his intake screening. Melvin said he felt okay but was tired. The LPN noted that Melvin's blood pressure was 154/96, which is highly elevated.

[8] Colorado Department of Regulatory Agencies Division of Professions and Occupations, *Board of Nursing: Practice Act and Laws*, DPO.COLORADO.GOV, https://dpo.colorado.gov/Nursing/Laws (last visited October 2, 2024).

92. With a blood pressure reading that high, GEO nursing protocols required the LPN to immediately notify a higher-level medical provider for further consultation and to obtain an electrocardiogram ("EKG").

93. At minimum, the LPN should have re-checked Melvin's blood pressure to confirm the elevated reading.

94. Because GEO's preprogrammed health care system did not trigger the LPN to do so, the LPN did not take any of the above actions and simply noted normal findings on his chart and cleared him for housing in general population at the ACDF.

95. The following day, on May 3, 2022, Dr. Walker apparently reviewed and approved the LPN's intake screening for Melvin without comment.

96. Even though Melvin arrived at the ACDF on May 2, 2022, GEO medical staff did not give him a comprehensive health screening until May 21, 2022, 19 days later.

97. According to the PBNDS, the national detention standards GEO is contractually obligated to follow, GEO medical staff were supposed to give Melvin a comprehensive health screening within 14 days of his arrival.

98. A GEO RN performed Melvin's health screening on May 21, 2022. Melvin's blood pressure was again elevated at 133/80. The RN noted that his clinical evaluation was within normal limits apart from his eye exam. The RN noted that Melvin's eyes sometimes got red after prolonged periods of reading.

99. Dr. Walker again apparently reviewed and approved the RN's health screening without comment on May 23, 2022.

100. From May 21, 2022 until August 31, 2022, Melvin did not request any medical services at the ACDF.

101. On August 25, 2022, Melvin sent GEO a request to change his bed from the top bunk to the bottom bunk. GEO denied his request and told Melvin to put in a sick call request. The GEO employee who responded to Melvin did not document any rationale for denying his request for the bottom bunk.

102. On August 31, 2022, Melvin submitted a sick call request asking to see a doctor because of pain and swelling in his right foot. A GEO LPN triaged Melvin's sick call request and made the decision that he should be seen just by an LPN, not a higher-level provider, despite his presentation.

103. The following day, on September 1, 2022, a GEO LPN evaluated Melvin in response to his sick call request. Melvin reported stabbing pain that was 10 out of 10 in severity. Melvin's blood pressure was again elevated at 146/83.

104. Melvin told the LPN that he injured his foot 25 days ago while playing soccer, but it worsened the previous day when he climbed into his upper bunk bed. He told the LPN that he had asked GEO for a bottom bunk. Melvin said that not bearing weight on his foot helped with his pain.

105. The LPN followed the preprogrammed set of instructions embedded in GEO's health record system for "Musculoskeletal Pain/Trauma." The LPN gave Melvin Tylenol and Ibuprofen, told him to stay off his right leg for 48 hours, instructed him on using an ice pack and warm compresses, and told him to return to medical if his symptoms persist or worsen.

106. The LPN did not refer Melvin to a higher-level provider for further evaluation or medical decision-making despite his abnormal exam findings of 10 out of 10 pain in his right lower leg 25 days after his reported injury and his continued high blood pressure.

107. GEO's programmed healthcare system did not alert nor trigger the LPN to refer Melvin to a higher-level provider for care.

108. Had the LPN referred Melvin to a higher-level provider for further evaluation, the provider could have given Melvin further work-up to rule out a musculoskeletal injury as the source of his pain. The ruling out of a potential musculoskeletal injury would have indicated a different source for Melvin's persistent pain in his right leg, such as a blood clot.

109. Dr. Walker did not review the GEO LPN's evaluation of Melvin on September 1, 2022.

110. Failing to detect, diagnose, and treat a blood clot is extremely dangerous. After enough time, an untreated blood clot can travel in the bloodstream to the lungs and cause a pulmonary embolism — a blockage in a crucial lung artery that stops blood flow to the lungs and is almost always fatal.

111. Typical symptoms of a blood clot include pain and swelling in the back of one leg.

112. An ultrasound examination is the preferred method for detecting and diagnosing a potential blood clot in a person's leg. Ultrasounds are inexpensive, easy to perform, and were readily available at the ACDF.

113. With proper detection, blood clots are easily treatable with blood thinning medications.

114. On September 11, 2022, Melvin submitted a second sick call request noting that he had toe pain. A GEO LPN triaged Melvin's sick call request and again made the decision that he should be seen by just an LPN, not a higher-level medical provider.

115. The following day, on September 12, 2022, a GEO LPN evaluated Melvin in response to his second sick call request. Melvin reported sharp right foot pain that was 8 out of 10 in severity. He mentioned pain specifically in his right big toe. He reported the onset of his injury was 25 days ago while he was playing soccer. This time, Melvin told the LPN that nothing helped relieve his pain.

116. The LPN followed the exact same preprogrammed set of instructions embedded in GEO's medical record system for "Musculoskeletal Pain/Trauma" even though that protocol did not remedy his health concern the last time. The LPN gave Melvin more Ibuprofen, instructed him on using an ice pack and warm compresses, and told him to return to medical if his symptoms persist or worsen — all despite the fact that those instructions had provided no relief for Melvin's severe pain the first time around.

117. The LPN did not refer Melvin to a higher-level provider for further evaluation or medical decision-making despite the fact he presented with a similar medical complaint only 10 days after his prior evaluation on September 1 and his abnormal exam findings of 8 out of 10 pain in his right foot 25 days after his reported injury.

118. GEO's programmed healthcare system did not alert nor trigger the LPN to refer Melvin to a higher-level provider for care.

119. Had the LPN referred Melvin to a higher-level provider for further evaluation, the provider again could have given Melvin further work-up to rule out a musculoskeletal injury as the source of his pain. The ruling out of a potential musculoskeletal injury would have indicated a different source for Melvin's persistent pain in his right leg, such as a blood clot.

120. Dr. Walker did not review the GEO LPN's evaluation of Melvin on September 12, 2022.

121. A higher-level provider would have been in an even better position to diagnose and treat the blood clot in Melvin's leg on September 12 than on September 1, because by that point Melvin had already exhausted the musculoskeletal protocol the prior LPN followed. Knowing that, a higher-level provider would have been more likely to suspect a different source for the persistent pain in Melvin's right leg, such as a blood clot.

122. On September 28, 2022, Melvin submitted a third sick call request noting that he had foot pain. A GEO LPN triaged Melvin's sick call request and made yet another decision that he should be seen by just an LPN, not a higher-level medical provider.

123. The following day, on September 29, 2022, a GEO LPN evaluated Melvin in response to his third sick call request. Melvin reported pain in his right calf after playing soccer two days prior. He reported his right calf was swollen and he had sharp pain that was 10 out of 10 in severity. The LPN observed that Melvin's gait was slightly unsteady, that he had decreased range of motion, and his oxygen saturation level was low at 93 percent.

124. An oxygen saturation level of 93 is extremely low, especially for a healthy man of Melvin's age. That symptom alone should have triggered concern and further evaluation by a competent medical provider, let alone that symptom combined with Melvin's continued pain and periodic elevated blood pressure.

125. The LPN again followed the same preprogrammed set of instructions embedded in GEO's medical record software for "Musculoskeletal Pain/Trauma" even though that protocol did not remedy his health concern the last two times. The LPN gave Melvin more Ibuprofen, told him to elevate his leg and apply ice 3-4 times over the next 24 hours, instructed him on the use of ice packs and warm compresses, and told him to return to medical if his symptoms persist or worsen.

126. The LPN did not refer Melvin to a higher-level provider for further evaluation or medical decision-making despite the fact he returned for a third time within 29 days with the same complaint of pain in his right lower extremity. GEO's own sick call policy requires LPNs refer detainees who report to medical more than twice for the same complaint to a higher-level provider.

127. Furthermore, the LPN did not refer Melvin to a higher-level provider for additional evaluation or medical decision-making despite his abnormal exam findings of 10 out of 10 pain in his right calf, subjective swelling, unsteady gait, decreased range of motion, and low oxygen saturation.

128. GEO's programmed healthcare system did not alert nor trigger the LPN to refer Melvin to a higher-level provider for care.

129. Had the LPN referred Melvin to a higher-level provider, the provider again could have given Melvin further work-up to rule out a Musculoskeletal injury as the source of his pain. The ruling out of a potential musculoskeletal injury would have indicated a different source for Melvin's persistent pain in his right leg, such as a blood clot.

130. Furthermore, a higher-level provider could have ordered an ultrasound to rule out a blood clot in Melvin's leg based on his presentation on September 29, 2022. At that point, Melvin met the Wells criteria for a risk of Deep Vein Thrombosis ("DVT")—the medical condition that causes blood clots. An ultrasound is a simple and readily available diagnostic tool and the preferred method for diagnosing DVT.

131. Dr. Walker did not review the GEO LPN's evaluation of Melvin on September 29, 2022.

The undiagnosed and untreated blood clot in Melvin's right leg causes his death on October 13, 2022.

132. On October 13, 2022, Melvin woke up and climbed down from his top bunk bed. GEO never accommodated his request for a bottom bunk.

133. At 10:47 AM, he walked into the common area of his unit where there are tables, along with a water fountain and microwave.

134. Melvin walked over to the water fountain, filled a cup with water and then walked over to the table with the microwave. He set his cup down and leaned forward, pausing with his arms extended in front of him, bracing the table for support.

135. After several seconds, Melvin stood up and took one staggering step back before suddenly collapsing backward. His body violently hit the ground and he struck his head on a wall behind him.

136. Other detainees rushed around Melvin and helped him into a chair. His breathing was labored, he was frothing from the mouth, and his fists were clenched.

137. At 10:49 AM a GEO staff member announced a medical emergency via radio.

138. According to GEO reports, GEO medical staff arrived at 10:51 AM with an oxygen tank, a wheelchair, and an emergency bag that contained an automated external defibrillator.

139. By the time GEO medical staff attended to Melvin, GEO reports indicate that he had lost control of his bladder and urinated on himself. He was pale, sweaty, and his hands were cool to the touch. Melvin was only semiconscious and able to acknowledge questions but unable to speak.

140. GEO's reports indicate that a GEO RN put an oxygen mask on Melvin and administered supplemental oxygen.

141. By 10:52 AM, GEO reports indicate that Melvin's pulse rate was only 48 beats per minute, his respiratory rate was elevated at 18 breaths per minute, and his oxygen saturation was 89 percent.

142. GEO medical staff placed Melvin on a gurney and transported him to the intake area of ACDF to await emergency medical services.

143. According to GEO's reports, while on the gurney, Melvin began speaking. He said he felt pain. A GEO RN asked him the location of his pain and he pointed to the middle of his abdomen. He then said in Spanish, "I feel like I'm going to die."

GEO officers needlessly delay crucial emergency medical services.

144. At 10:52 AM, a GEO staff member radioed to a GEO detention officer and asked him to call emergency medical services ("EMS").

145. The GEO officer called 911 immediately thereafter but was unable to answer basic questions from the dispatcher, delaying Melvin crucial EMS intervention.

146. When asked for the address of the emergency, the GEO officer could not remember the address of the ACDF.

147. Twice during the call, the GEO officer had to yell out to another GEO officer, asking for the correct address of the ACDF.

148. When the dispatcher asked the GEO officer for the nature of the emergency, he simply said it's a "medical emergency" and that he did not know what happened.

149. The dispatcher asked what part of the complex they needed to access to get to Melvin. In response, the GEO officer told the dispatcher to "standby" and proceeded to place the call on hold for nearly 40 seconds.

150. The GEO officer then told the dispatcher to send EMS to the "back gate" and failed to give any other details.

151. The dispatcher again asked the GEO officer about what symptoms Melvin was experiencing. The GEO officer repeated that he didn't know.

152. The dispatcher asked how old Melvin was. In response, the GEO officer again told the dispatcher to "stand by" and waited another 13 seconds before saying "everyone is over the age of 21."

153. Needing more specific information, the dispatcher appropriately told the GEO officer that "it changes everything if they're like 60-something."

154. The dispatcher asked for Melvin's specific age or the year he was born. In response, the GEO officer again put the dispatcher on hold and did not respond for a full minute.

155. When he returned to the call, the GEO officer told the dispatcher that Melvin was in his "late-twenties" when in reality Melvin was 39 years old.

156. Because of the disorganized responses and needless delays caused by the GEO officer, paramedics from the Aurora Fire Department did not arrive at the ACDF until 11:04 AM and the ambulance did not arrive until 11:06 AM.

157. It was not until 11:11 AM, nearly 20 minutes after the initial call to 911, that EMS officers placed Melvin in the ambulance and transported him to the UC Health Hospital.

158. At 11:15 AM, Melvin arrived in the emergency department of the hospital. Upon his arrival, he had no pulse present and had stopped breathing. Paramedics and hospital staff tried to save Melvin's life with advance cardiac life support medications and performing cardiopulmonary resuscitation.

159. At 12:32 PM, a physician at UC Health pronounced Melvin dead.

160. An autopsy revealed that Melvin died because a blood clot in his right leg traveled to his lungs and caused a pulmonary embolism. The pulmonary embolism stopped blood flow to his lungs and ultimately caused his death.

161. Had Melvin received a proper medical evaluation, the blood clot in his leg could have been easily diagnosed with an ultrasound and treated with blood thinning medications.

162. In the weeks leading to Melvin's death, GEO had at least three separate chances to diagnose and treat the blood clot in Melvin's leg, but failed to do so, causing his death.

A.C.P's and J.C.P.'s damages.

163. A.C.P. and J.C.P. have suffered and continue to suffer irreparable emotional harm, grief, anguish, lack of companionship and lack of support because of Melvin's needless and untimely death.

164. The news of Melvin's death shattered his family. The dream of Melvin, Dorling, and their children living together in the United States had transformed into a nightmare.

165. In the years following his death, A.C.P. and J.C.P. have struggled to accept that their father is gone.

166. J.C.P. cries when he thinks of his father. He misses his dad deeply. J.C.P has struggled in school since his father died.

167. The death of her father has forever changed A.C.P. Nearly two years later, she still cannot accept that her father is dead.

CLAIMS FOR RELIEF

COUNT 1 – Negligence
(brought by Plaintiff A.C.P. pursuant to § 13-21-202, C.R.S.)
Against Defendant The GEO Group, Inc.

168. Plaintiff A.C.P. hereby incorporates all other paragraphs of this Complaint as if fully set forth herein.

169. Plaintiff A.C.P. is Melvin Calero Mendoza's child and heir, and is a proper plaintiff under § 13-21-202, C.R.S.

170. Defendant GEO owns and operates the ACDF and is sole provider of medical services, treatment, and care to the detainees incarcerated there.

171. At all times Defendant GEO owed Melvin, a detainee at the ACDF, a duty to exercise reasonable care in him providing medical services, including but not limited to diagnosis, treatment, and care.

172. Detainees in GEO's custody are reliant on GEO's medical staff to care for all of their medical needs.

173. GEO's extensive history of detainee deaths, incidents, complaints, investigations, official reports, and studies in the years leading up to Melvin's death collectively put GEO on notice of the disturbing and deadly consequences of its systemic failures in providing adequate medical care at the ACDF and the risks inherent in failing to fix them.

174. GEO ignored those risks and took no or inadequate action to remedy, address, or fix its systemic failures in providing adequate medical care at the ACDF during the time period leading up to Melvin's death.

175. GEO breached its duty to exercise reasonable care in providing Melvin medical services. Its breaches include, but are not limited to:

(a) Tasking and entrusting its LPNs to practice outside the scope of their license as defined in the Colorado Nurse Practice Act, §§ 12-255-101 – 136, C.R.S.;

(b) Tasking and entrusting its LPNs to conduct sick call triaging;

(c) Tasking and entrusting its LPNs to make medical assessments and treatment decisions rather than reporting any abnormal findings to an RN, PA, or physician for further evaluation and decision-making;

(d) Implementing a preprogrammed electronic health record system without alerts nor triggers for LPNs to refer patients for a higher-level provider based on abnormal exam findings or pain management guidance;

(e) Training its LPNs to follow its preprogrammed electronic health record system without reasonable exceptions based on clinical judgment and critical thinking skills;

176. GEO knew or should have known the serious risks inherent in engaging in the above breaches, including put not limited to, failing to diagnose and treat serious and potentially deadly health conditions.

177. GEO engaged in the above breaches in willful and wanton disregard of the serious risks for its detainee patients, including Melvin.

178. GEO's breaches caused the blood clot in Melvin's right leg to go undiagnosed and untreated despite three separate medical visits for right lower extremity pain in the weeks leading up to his death on September 1, 2022, September 12, 2022, and September 29, 2022.

179. The undiagnosed and untreated blood clot in Melvin's leg caused his death on October 13, 2022, when the blood clot traveled to his lung and caused a fatal pulmonary embolism.

180. As such, GEO's breaches were the but-for and proximate cause of Melvin's death.

181. Because of GEO's breaches, Plaintiff A.C.P.'s father is dead. As a result, A.C.P. has suffered and continues to suffer irreparable emotional harm, grief, anguish, lack of companionship, lack of support, pain and suffering along with other economic and non-economic damages and losses.

COUNT 2 – Negligence
(brought by Plaintiff J.C.P. pursuant to § 13-21-202, C.R.S.)
Against Defendant The GEO Group, Inc.

182. Plaintiff J.C.P. hereby incorporates all other paragraphs of this Complaint as if fully set forth herein.

183. Plaintiff J.C.P. is Melvin Calero Mendoza's child and heir, and is a proper plaintiff under § 13-21-202, C.R.S.

184. Defendant GEO owns and operates the ACDF and is sole provider of medical services, treatment, and care to the detainees incarcerated there.

185. At all times Defendant GEO owed Melvin, a detainee at the ACDF, a duty to exercise reasonable care in him providing medical services, including but not limited to diagnosis, treatment, and care.

186. Detainees in GEO's custody are reliant on GEO's medical staff to care for all of their medical needs.

187. GEO's extensive history of detainee deaths, incidents, complaints, investigations, official reports, and studies in the years leading up to Melvin's death collectively put GEO on notice of the disturbing and deadly consequences of its systemic failures in providing adequate medical care at the ACDF and the risks inherent in failing to fix them.

188. GEO ignored those risks and took no or inadequate action to remedy, address, or fix its systemic failures in providing adequate medical care at the ACDF during the time period leading up to Melvin's death.

189. GEO breached its duty to exercise reasonable care in providing Melvin medical services. Its breaches include, but are not limited to:

(a) Tasking and entrusting its LPNs to practice outside the scope of their license as defined in the Colorado Nurse Practice Act, §§ 12-255-101 – 136, C.R.S.;

(b) Tasking and entrusting its LPNs to conduct sick call triaging;

(c) Tasking and entrusting its LPNs to make medical assessments and treatment decisions rather than reporting any abnormal findings to an RN, PA, or physician for further evaluation and decision-making;

(d) Implementing a preprogrammed electronic health record system without alerts nor triggers for LPNs to refer patients for a higher-level provider based on abnormal exam findings or pain management guidance;

(e) Training its LPNs to follow its preprogrammed electronic health record system without reasonable exceptions based on clinical judgment and critical thinking skills;

190. GEO knew or should have known the serious risks inherent in engaging in the above breaches, including put not limited to, failing to diagnose and treat serious and potentially deadly health conditions.

191. GEO engaged in the above breaches in willful and wanton disregard of the serious risks for its detainee patients, including Melvin.

192. GEO's breaches caused the blood clot in Melvin's right leg to go undetected, undiagnosed and untreated despite three separate medical visits for right lower extremity pain in the weeks leading up to his death on September 1, 2022, September 12, 2022, and September 29, 2022.

193. The undiagnosed and untreated blood clot in Melvin's leg caused his death on October 13, 2022, when the blood clot traveled to his lung and caused a fatal pulmonary embolism.

194. As such, GEO's breaches were the but-for and proximate cause of Melvin's death.

195. Because of GEO's breaches, Plaintiff J.C.P.'s father is dead. As a result, J.C.P. has suffered and continues to suffer irreparable emotional harm, grief, anguish, lack of companionship, lack of support, pain and suffering along with other economic and non-economic damages and losses.

COUNT 3 – Negligence (Vicarious Liability)
(brought by Plaintiff A.C.P. pursuant to § 13-21-202, C.R.S.)
Against Defendant The GEO Group, Inc.

196. Plaintiff A.C.P. hereby incorporates all other paragraphs of this Complaint as if fully set forth herein.

197. Plaintiff A.C.P. is Melvin Calero Mendoza's child and heir, and is a proper plaintiff under § 13-21-202, C.R.S.

198. Defendant GEO owns and operates the ACDF and is sole provider of medical service to the detainees incarcerated there.

199. Defendant GEO employs the LPNs who triaged, evaluated and treated Melvin at the ACDF.

200. The LPNs employed by GEO owed Melvin a duty to exercise reasonable care in providing him medical services, including but not limited to, diagnosis, treatment, and care at the ACDF.

201. The LPNs, acting within the scope of their employment and as an agent of GEO, breached their duty to exercise reasonable care. Their breaches include, but are not limited to:

(a) Failing to triage Melvin's sick call requests as appropriate for a higher-level provider on September 1, 12, and 29, 2022;

(b) Failing to refer Melvin to a higher-level provider for further evaluation after he presented with abnormal examination findings on September 1, 12, and 29, 2022;

(c) Failing to refer Melvin to a higher-level provider for further evaluation when he presented more than twice with the same medical complaint in violation of GEO's sick call policy;

(d) Misdiagnosing and misclassifying Melvin's complaints as musculoskeletal pain/trauma when he presented with symptoms consistent with a blood clot.

202. The LPNs' breaches caused the blood clot in Melvin's right leg to go undiagnosed and untreated despite three separate medical visits for right lower extremity pain in the weeks leading up to his death on September 1, 12, and 29, 2022.

203. The undiagnosed and untreated blood clot in Melvin's leg caused his death on October 13, 2022, when the blood clot traveled to his lung and caused a fatal pulmonary embolism.

204. As such, the LPNs' breaches were the but-for and proximate cause of Melvin's death.

205. The LPNs' breaches occurred while they were acting within the scope of their employment and as an agent of GEO. As such, GEO is vicariously liability for their conduct.

206. The LPNs' breaches were in willful and wanton disregard of the serious risks for its detainee patients, including Melvin.

207. Because of the LPNs' breaches, Plaintiff A.C.P.'s father is dead. As a result, A.C.P. has suffered and continues to suffer irreparable emotional harm, grief, anguish, lack of companionship, lack of support, pain and suffering along with other economic and non-economic damages and losses.

COUNT 4 – Negligence (Vicarious Liability)
(brought by Plaintiff J.C.P. pursuant to § 13-21-202, C.R.S.)
Against Defendant The GEO Group, Inc.

208. Plaintiff J.C.P. hereby incorporates all other paragraphs of this Complaint as if fully set forth herein.

209. Plaintiff J.C.P. is Melvin Calero Mendoza's child and heir, and is a proper plaintiff under § 13-21-202, C.R.S.

210. Defendant GEO owns and operates the ACDF and is sole provider of medical service to the detainees incarcerated there.

211. Defendant GEO employs the LPNs who triaged, evaluated and treated Melvin at the ACDF.

212. The LPNs employed by GEO owed Melvin a duty to exercise reasonable care in providing him medical services, including but not limited to, diagnosis, treatment, and care at the ACDF.

213. The LPNs, acting within the scope of their employment and as an agent of GEO, breached their duty to exercise reasonable care. Their breaches include, but are not limited to:

(a) Failing to triage Melvin's sick call requests as appropriate for a higher-level provider on September 1, 12, and 29, 2022;

(b) Failing to refer Melvin to a higher-level provider for further evaluation after he presented with abnormal examination findings on September 1, 12, and 29, 2022;

(c) Failing to refer Melvin to a higher-level provider for further evaluation when he presented more than twice with the same medical complaint in violation of GEO's sick call policy;

(d) Misdiagnosing and misclassifying Melvin's complaints as musculoskeletal pain/trauma when he presented with symptoms consistent with a blood clot.

214. The LPNs' breaches caused the blood clot in Melvin's right leg to go undiagnosed and untreated despite three separate medical visits for right lower extremity pain in the weeks leading up to his death on September 1, 12, and 29, 2022.

215. The undiagnosed and untreated blood clot in Melvin's leg caused his death on October 13, 2022, when the blood clot traveled to his lung and caused a fatal pulmonary embolism.

216. As such, the LPNs' breaches were the but-for and proximate cause of Melvin's death.

217. The LPNs' breaches occurred while they were acting within the scope of their employment and as an agent of GEO. As such, GEO is vicariously liability for their conduct.

218. The LPNs' breaches were in willful and wanton disregard of the serious risks for its detainee patients, including Melvin.

219. Because of GEO's breaches, Plaintiff J.C.P.'s father is dead. As a result, J.C.P. has suffered and continues to suffer irreparable emotional harm, grief, anguish, lack of companionship, lack of support, pain and suffering along with other economic and non-economic damages and losses.

COUNT 5 – Negligence (Vicarious Liability)
(brought by Plaintiff A.C.P. pursuant to § 13-21-202, C.R.S.)
Against Defendant The GEO Group, Inc.

220. Plaintiff A.C.P. hereby incorporates all other paragraphs of this Complaint as if fully set forth herein.

221. Plaintiff A.C.P. is Melvin Calero Mendoza's child and heir, and is a proper plaintiff under § 13-21-202, C.R.S.

222. Defendant GEO owns and operates the ACDF and is sole provider of security and emergency response services to the detainees incarcerated there.

223. Defendant GEO employs the detention officers who were responsible for security and requesting emergency medical services.

224. The detention officers employed by GEO owed Melvin a duty to exercise reasonable care in arranging for emergency medical services after he collapsed in the common area of his housing unit on October 13, 2022.

225. The detention officers who arranged for emergency medical services breached their duty to exercise reasonable care when they failed to promptly provide accurate information to the

911 dispatcher including, but not limited to, the address of the ACDF, Melvin's age, or the nature of Melvin's medical emergency.

226. The detention officers' breaches caused needless delay of crucial emergency medical services that could have prevented Melvin's death on October 13, 2022.

227. As such, the detention officers' breaches were the but-for and proximate cause of Melvin's death.

228. The detention officers' breaches occurred while they were acting within the scope of their employment and as an agent of GEO. As such, GEO is vicariously liability for their conduct.

229. The detention officers' breaches were in willful and wanton disregard of the serious risks for the detainee incarcerated at the ACDF, including Melvin.

230. Because of the detention officers' breaches, Plaintiff A.C.P.'s father is dead. As a result, A.C.P. has suffered and continues to suffer irreparable emotional harm, grief, anguish, lack of companionship, lack of support, pain and suffering along with other economic and non-economic damages and losses.

COUNT 6 – Negligence (Vicarious Liability)
(brought by Plaintiff J.C.P. pursuant to § 13-21-202, C.R.S.)
Against Defendant The GEO Group, Inc.

231. Plaintiff J.C.P. hereby incorporates all other paragraphs of this Complaint as if fully set forth herein.

232. Plaintiff J.C.P. is Melvin Calero Mendoza's child and heir, and is a proper plaintiff under § 13-21-202, C.R.S.

233. Defendant GEO owns and operates the ACDF and is sole provider of security and emergency response services to the detainees incarcerated there.

234. Defendant GEO employs the detention officers who were responsible for security and requesting emergency medical services.

235. The detention officers employed by GEO owed Melvin a duty to exercise reasonable care in arranging for emergency medical services after he collapsed in the common area of his housing unit on October 13, 2022.

236. The detention officers who arranged for emergency medical services breached their duty to exercise reasonable care when they failed to promptly provide accurate information to the 911 dispatcher including, but not limited to, the address of the ACDF, Melvin's age, or the nature of Melvin's medical emergency.

237. The detention officers' breaches caused needless delay of crucial emergency medical services that could have prevented Melvin's death on October 13, 2022.

238. As such, the detention officers' breaches were the but-for and proximate cause of Melvin's death.

239. The detention officers' breaches occurred while they were acting within the scope of their employment and as an agent of GEO. As such, GEO is vicariously liability for their conduct.

240. The detention officers' breaches were in willful and wanton disregard of the serious risks for the detainee incarcerated at the ACDF, including Melvin.

241. Because of GEO's breaches, Plaintiff J.C.P.'s father is dead. As a result, J.C.P. has suffered and continues to suffer irreparable emotional harm, grief, anguish, lack of companionship, lack of support, pain and suffering along with other economic and non-economic damages and losses.

COUNT 7 – Professional Medical Negligence
(brought by Plaintiff A.C.P. pursuant to § 13-21-202, C.R.S.)
Against Defendant Cary Walker, D.O.

242. Plaintiff A.C.P. hereby incorporates all other paragraphs of this Complaint as if fully set forth herein.

243. Plaintiff A.C.P. is Melvin Calero Mendoza's child and heir, and is a proper plaintiff under § 13-21-202, C.R.S.

244. At the time of Melvin's death on October 13, 2022, Cary Walker, DO was the only physician employed by GEO and working at the ACDF.

245. Dr. Walker served as the facility's medical director and had control and oversight over the medical care scheme at the ACDF, including the medical training, policies, practices, and customs along with final medical decision-making for all detainee health cases. He also had supervisory oversight over all of the GEO medical staff working at the ACDF.

246. At all times, Dr. Walker owed Melvin a duty to exercise reasonable care in the control and supervision of his LPN subordinates and the medical decision making on Melvin's case.

247. Dr. Walker breached his duty to exercise reasonable care. Those breaches include, but are not limited to:

(a) Failing to identify the need for greater supervision of his LPN subordinates who routinely triaged detainee health concerns, made medical assessments and diagnoses, and decided on treatment plans for a wide breadth of detainee health concerns, all outside the scope of their practice under the Colorado Nurse Practice Act, §§ 12-255-101 – 136, C.R.S.;

(b) Failing to review, authorize, remedy, or correct the actions of his LPN subordinates that were outside the scope of their practice under the Colorado Nurse Practice Act, §§ 12-255-101 – 136, C.R.S.

(c) Failing to communicate with his LPN subordinates about the triage, assessment, diagnosis, and treatment of Melvin on September 1, 12, and 29, 2022;

(d) Failing to review, authorize, remedy, or correct the medical decisions made by his LPN subordinates about the triage, assessment, diagnosis, and treatment of Melvin on September 1, 12, and 29, 2022.

248. As the sole physician, medical director, and direct supervisor of the medical staff at the ACDF, Dr. Walker had continuous and systematic control over the actions of his LPN subordinates in their diagnosis, assessment, decision-making, and treatment of Melvin.

249. Dr. Walker's breaches caused the blood clot in Melvin's right leg to go undiagnosed and untreated despite three separate medical visits for right lower extremity pain in the weeks leading up to his death on September 1, 12, and 29, 2022.

250. The undiagnosed and untreated blood clot in Melvin's leg caused his death on October 13, 2022, when the blood clot traveled to his lung and caused a fatal pulmonary embolism.

251. As such, Dr. Walker's breaches were the but-for and proximate cause of Melvin's death.

252. Dr. Walker's breaches were in willful and wanton disregard of the serious risks for his detainee patients incarcerated at the ACDF, including Melvin.

253. Because of Dr. Walker's breaches, Plaintiff A.C.P.'s father is dead. As a result, A.C.P. has suffered and continues to suffer irreparable emotional harm, grief, anguish, lack of companionship, lack of support, pain and suffering along with other economic and non-economic damages and losses.

COUNT 8 – Professional Medical Negligence
(brought by Plaintiff J.C.P. pursuant to § 13-21-202, C.R.S.)
Against Defendant Cary Walker, D.O.

254. Plaintiff J.C.P. hereby incorporates all other paragraphs of this Complaint as if fully set forth herein.

255. Plaintiff J.C.P. is Melvin Calero Mendoza's child and heir, and is the proper plaintiff under § 13-21-202, C.R.S.

256. At the time of Melvin's death, Cary Walker, DO was the only physician employed by GEO and working at the ACDF.

257. Dr. Walker served as the facility's medical director and had control and oversight over the medical care scheme at the ACDF, including the medical training, policies, practices, and customs along with final medical decision-making for all detainee health cases. He also had supervisory oversight over all of the GEO medical staff working at the ACDF.

258. At all times, Dr. Walker owed Melvin a duty to exercise reasonable care in the control and supervision of his LPN subordinates and the medical decision making on Melvin's case.

259. Dr. Walker breached his duty to exercise reasonable care. Those breaches include, but are not limited to:

(a) Failing to identify the need for greater supervision of his LPN subordinates who routinely triaged detainee health concerns, made medical assessments and diagnoses, and decided on treatment plans for a wide breadth of detainee health concerns, all outside the scope of their practice under the Colorado Nurse Practice Act, §§ 12-255-101 – 136, C.R.S.;

(b) Failing to review, authorize, remedy, or correct the actions of his LPN subordinates that were outside the scope of their practice under the Colorado Nurse Practice Act, §§ 12-255-101 – 136, C.R.S.

(c) Failing to communicate with his LPN subordinates about the triage, assessment, diagnosis, and treatment of Melvin on September 1, 12, and 29, 2022;

(d) Failing to review, authorize, remedy, or correct the medical decisions made by his LPN subordinates about the triage, assessment, diagnosis, and treatment of Melvin on September 1, 12, and 29, 2022.

260. As the sole physician, medical director, and direct supervisor of the medical staff at the ACDF, Dr. Walker had continuous and systematic control over the actions of his LPN subordinates in their diagnosis, assessment, decision-making, and treatment of Melvin.

261. Dr. Walker's breaches caused the blood clot in Melvin's right leg to go undiagnosed and untreated despite three separate medical visits for right lower extremity pain in the weeks leading up to his death on September 1, 12, and 29, 2022.

262. The undiagnosed and untreated blood clot in Melvin's leg caused his death on October 13, 2022, when the blood clot traveled to his lung and caused a fatal pulmonary embolism.

263. As such, Dr. Walker's breaches were the but-for and proximate cause of Melvin's death.

264. Dr. Walker's breaches were in willful and wanton disregard of the serious risks for his detainee patients incarcerated at the ACDF, including Melvin.

265. Because of GEO's breaches, Plaintiff J.C.P.'s father is dead. As a result, J.C.P. has suffered and continues to suffer irreparable emotional harm, grief, anguish, lack of companionship, lack of support, pain and suffering along with other economic and non-economic damages and losses.

RELIEF REQUESTED

WHEREFORE, Plaintiffs respectfully request that this Court enter judgment in their favor against Defendants, and award them all relief as allowed by law and equity, including, but not limited to the following:

(a) Compensatory damages, including but not limited to those for economic and non-economic losses, consequential damages, emotional harm, grief, anguish, lack of companionship, lack of support, pain and suffering;

(b) Noneconomic Damages exceeding any statutory limitation because of clear and convincing evidence of justification to exceed any applicable statutory cap pursuant to § 13-21-102.5, C.R.S.;

(c) Exemplary Damages pursuant to § 13-21-102, C.R.S.;

(d) The present value of all compensatory damages, including but not limited to those for derivative and non-derivative economic and non-economic losses, consequential damages, emotional harm, grief, anguish, lack of companionship, lack of support, pain and suffering at the highest lawful rate pursuant to § 13-64-302, C.R.S.;

(e) Past and future economic compensatory damages exceeding any statutory limitation because of good cause shown that the present value of past and future economic damages exceed any statutory limitation and that application of any statutory limitation would be unfair pursuant to § 13-64-302(b), C.R.S.

(f) Pre and Post Judgement Interest;

(g) Litigation Costs;

(h) Declaratory relief and other appropriate equitable relief; and

(i) Such further relief as justice requires.

JURY DEMAND

Plaintiffs demand a trial to a jury on all issues to triable.

Respectfully submitted this 11th day of October, 2024.

/s/ Aaron Slade
Aaron Slade, #58087

/s/ Danielle C. Jefferis
Danielle C. Jefferis, #47213

/s/ Aaron Elinoff
Aaron Elinoff, #46468

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