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**UNITED STATES DISTRICT COURT**

**DISTRICT OF NEVADA**

CHARLA CONN, Administrator of the ESTATE OF BRENDA JEAN CLUSTKA, CHARLA CONN and DUSTIN CONN,

Plaintiffs,

vs.

CITY OF RENO, RPD OFFICER RYAN ASHTON, RPD OFFICER DAVID ROBERTSON,

Defendants.
_____/

**Case No. 3:05-cv-00595 HDM (RAM)**

**PLAINTIFF'S OPPOSITION TO MOTION TO FOR SUMMARY JUDGMENT**

## I. PRELIMINARY STATEMENT

RPD officer defendants Ryan Ashton and David Robertson had several options available to save Brenda Cluskta's life after she both attempted and threatened to commit suicide in their presence, but they couldn't be bothered—and they admitted as much. Her suicide attempts and threats "didn't count" and they do not acknowledge their duty to protect her from self-harm. The deliberate indifference these officers displayed is as outrageous as it is unlawful.

There is no doubt that Clustka – being transported to jail on civil protective custody, having committed no crime and bothered no one, with a mere .10 breathalyzer reading as she stood in a Reno

residential neighborhood – attempted suicide by choking herself with a seatbelt strap in the paddy wagon and screamed multiple times how she wanted to die. There is no doubt that Robertson and Ashton watched Clustka attempt suicide and heard her threats. There is no doubt they had been advised she was mentally ill. There is no doubt they knew all suicide attempts must be reported and officers **do not have discretion** to fail to file a report on such matters or notify jail staff.

On April 26, 2005, after witnessing Clustka's attempt to strangle herself and threats to kill herself, neither officer took any action to protect her. They failed to take her to a local hospital for suicide assessment and treatment, they failed to notify anyone at the jail, they failed to write an incident report, they even failed to alert any supervisor, jail staff, or trained jail medical officers to Clustka's suicide attempt and threats. Reporting the incident "never really crossed" Ashton's "mind." Robertson simply "didn't think about" relaying the information.

Even in hindsight after Clustka strangled herself to death in jail and this lawsuit was filed, both officers continue to insist they would do "**exactly**" the same thing again. Their extreme position starkly contradicts the testimony of RPD Deputy Chief James Johns, their immediate supervisor Sgt. David Evans, and Washoe County jail requirements as described by numerous Washoe County officials.

Robertson and Ashton deny all responsibility to report Clustka's suicide attempt and threats because she registered .10 on the breathalyzer and therefore was "intoxicated." They insist that suicide gestures and threats by intoxicated persons "don't count" and so they are free to ignore them. Robertson and Ashton's ignorance flies in the face of medical findings documenting a high correlation between intoxication and suicide, testimony by their superiors that it is important to take seriously the suicide threats of intoxicated persons, and experts in the field. That these officers insist they are free to ignore the suicide threats of intoxicated persons reveals an appalling lack of training and forms the basis for municipal liability.

While Clustka did not succeed in choking herself on April 26, 2005, less than 48 hours later, the morning of April 28, 2005, she did. In the interim, the jail briefly released and reincarcerated her. The evidence will show that several options were available to save Clustka had Robertson and Ashton only reported what they saw and heard. First, they could have taken her directly to a hospital under Nevada's Legal 2000 involuntary commitment procedure and informed emergency medical staff of what they saw and heard (see Exh 25, RPD Legal 2000 Training). Second, had jail staff been informed of Clustka's

suicidal act and statements, it would have had the option of refusing her admittance, instituting a Legal 2000, and sending her to a hospital for assessment and treatment. Third, the jail could have decided to admit her and keep her under suicide watch until she was detoxified, then send her to a hospital under a Legal 2000 as appropriate.

Had Robertson and Ashton only reported what they saw and heard, these several life-saving options were available, all of which would have entailed appropriate intervention by qualified medical and psychiatric staff. Because Robertson and Ashton failed to do so, no preventive precautions were taken and Clustka lost a critical opportunity to receive the desperately needed suicide intervention, intervention she required and kept her alive.[1]

## II. DISPUTED MATERIAL FACTS NECESSITATING TRIAL

### A. Before Committing Suicide, Brenda Clustka Accumulated a Well-Documented History of Mental Illness, Suicide Attempts, and Legal 2000's

#### 1. Clustka's History of Mental Illness, Suicide Attempts, and Legal 2000's

On September 14, 2001, pursuant to a Legal 2000 involuntary commitment, Brenda Clustka was accepted for treatment at the Northern Nevada Mental Health Institute (NMHI). (Exh 1, COR 1029). She slashed her wrists with a piece of glass (Exh 1, COR 1061-1062). Her history of impairment recited longstanding use of anti-psychotic medications (Exh 1, COR 1036). A breathalyzer test indicated she had been drinking. She was discharged with prescription medication and instructions to enroll in weekly "Lifeskills" outpatient therapy at Washoe Medical Center (WMC) (Exh 1, COR 1068). Clustka remained suicide free for almost two years.

On August 17, 2003 pursuant to her second Legal 2000, Clustka was admitted to St. Mary's Hospital for overdosing on over-the-counter medication, slashing her wrists, and stating she "wanted to die" (Exh 2). A nurse recorded that she was legally intoxicated with a breathalyzer reading of .11 on admission. West Hills Hospital later diagnosed her as suffering from major depression with alcohol abuse and certified her Legal 2000 admission to NMHI. At NMHI she was kept for two days and discharged with prescriptions for medication and therapy (Exh 2). She remained suicide free for eight months.

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[1] Clustka had numerous documented suicide attempts. The most recent was April 25, 2005, the day before her interaction with defendants. Had she been taken again on April 26, 2006, for the second attempt in two days – she would very likely have become an inpatient and received the care she required to prevent her death.

On April 3, 2004, Clustka was again taken on a hospital on a Legal 2000. Clustka's third suicidal incident followed a high period of alcohol abuse. (Exh 3, COR 528). After a workup, WMC certified her for the Legal 2000 and transfer to NMHI (Exh 3, COR 480-484; COR 562 ). Clustka was hospitalized 72 hours and remained suicide free approximately one year.

Pursuant to a fourth Legal 2000, Clustka was again brought in by Reno police and admitted to WMC on April 25, 2005, **the day before her interaction with Robertson and Ashton**. Assessed with "acute suicidal ideation," she was transferred to NMHI (Exh 4, COR 898; 472-473). After denying suicidal thoughts and assuring staff she would not drink, she was discharged after an overnight stay with recommendations for alcohol rehabilitation and counseling (Exh 4).

**2. Although Advised of Brenda Clustka's "Mental Illness," Defendants Failed To Do A Legal 2000 on April 26, 2005**

On April 26, 2005,[2] shortly after being released from NMHI, Clustka was again drinking alcohol and wandering about a residential area in Reno. Officers Robertson and Ashton picked her up and transported her to jail on a civil protective custody hold. Before transporting her, they learned that Clustka was mentally ill and had a history of violence and substance abuse. On the way to jail, Robertson and Ashton saw through the paddy wagon surveillance camera Clustka attempt to choke herself by wrapping the seatbelt around her neck. When they stopped the paddy wagon and unwound the seatbelt strap from around her neck, Clustka threatened to kill herself (Exh 5, Ashton's Report Following Clustka's Death at the Jail, 5:18-19; 6:1-6; see also Exh 6, Ashton's report dated April 28, 2005).

Despite being advised of Clustka's "Mental Illness," Robertson and Ashton failed to do a Legal 2000, failed to report her suicide attempt to jail staff, and failed to notify a superior as to what they had witnessed. As a result, no special precautions were taken to protect Clustka from suicide.

**3. Clustka Hangs Herself On April 28, 2005**

Clustka hung herself with a bed sheet on April 28, 2005, in the Washoe County Jail.

**B. All Witnesses Acknowledge a Strong Relationship Between Mental Illness and Suicide, Providing Protections to Prevent The Mentally Ill from Killing Themselves**

All witnesses acknowledge a high correlation between mental illness and suicide. Gail Singletary, registered nurse and health services administrator at the Washoe County jail, testified that of the seven jail

[2] More facts will follow concerning this date as it is the date of Clustka's interaction with defendants Robertson and Ashton.

suicides in two years, the majority were identified as having psychiatric issues (Exh 7, 12:4-13). Singletary, who has an extensive background in psychiatric nursing, testified: (1) there is a correlation between suicide and depression (Exh 7, 19:7-9); (2) persons with mental health history are at higher risk of suicide (Exh 7, 28:25-29:4); (3) persons with a history of one or more suicide attempts are at a greater risk than persons who have never made an attempt (Exh 7, 21:3-7); and (4) persons with a prior risk of suicide are at higher risk for future suicide (Exh 7, 36:21-37:1). In other words, Brenda Clustka fit the profile of someone at higher risk of suicide.

This evidence is crucial. Here, the officers testified that while they were aware of a connection between mental illness and suicide, nonetheless, they insisted the connection could be disregarded if the person was intoxicated. (Exh 8, 49:4-8, 58:9-24; Exh 9, 97:22-98:1, 107:8-11). These officers were **not trained** to know that all suicide attempts and threats must be treated seriously or to know that police officers **do not have discretion** to ignore suicide attempts by intoxicated persons.

### C. NRS 433A.115 Gives Police Officers Authority to Take Mentally Ill Persons Who Attempt Suicide to Emergency Medical Care by Involuntary Commitment

NRS § 433A.115 gives police officers authority to involuntarily commit mentally ill persons who attempt or threaten suicide by taking them to an emergency medical facility **whether or not they are intoxicated** (Exh 10). All Washoe County personnel, RPD administrators, and the defendants themselves recognize that they may make an involuntary mental health commitment of a person who threatens suicide and is mentally unstable. Nevada's Civil Protective Custody Statute, NRS 458.270, similarly, **mandates** that an intoxicated person taken into custody be taken **immediately** to an "appropriate medical facility if his condition appears to require emergency medical treatment" (see Exh 10, Exh 26).

RPD Deputy Chief James Johns, a self-identified policymaker (Exh 11, 5:6-7), testified that a "Legal 2000" occurs when an officer is dealing with an individual who demonstrates a potential threat to his or herself (Exh 11, 45:13-21). In considering a Legal 2000, the issue is "whether or not the person is exhibiting those behavior traits that would lead the officer to believe the individual is a threat to his or herself" (Exh 11, 46:22-25). Even if a person is accused of a heinous crime, an officer may take the person to a hospital on a Legal 2000 (Exh 11, 47:6-13). Washoe County Sheriff's Department Lt. Milt Perry agreed, stating that instead of booking such persons, officers may cite and take them directly to the hospital on a Legal 2000 (Exh 13, 55:11-23, 64:5-9).

RPD Sgt. Evans testified that officers conduct Legal 2000 holds when someone threatens to harm his or herself. (Exh 12, 21:11-13). If an officer is confronted with someone who threatens to kill his or herself, the person is taken on a Legal 2000 to be assessed and evaluated (Exh 12, 33:3-24, 23:2-4, 42:1-6). "If she's making statements about killing herself we're going to make sure that she is taken to a safe place" (Exh 12, 22:19-21). According to Evans, someone with medical training is in a better position to evaluate such a person than a police officer. (Exh 11, 25:7-26:2).

**D. Robertson and Ashton's Insistence that the Suicide Threats of an Intoxicated Person May be Ignored Is Contradicted by All**

Defendant Ashton agreed that if an officer is transporting a person who is "about to harm themselves," he is aware that person should be taken to a medical facility (Exh 8, 46:7-13). Robertson further agreed that someone who has mental illness and indicates intent to engage in self-harm should be checked out a "qualified professional" (Exh 9, 104:17-22, 102:19-103:3; 85:12-19). Robertson acknowledged that if he is aware someone is about to harm his or herself, it is "his job" and RPD policy to take every precaution so that suicide does not happen (Exh 9, 86:20-87:4).

However, both Robertson and Ashton wrongly insist they are entitled to ignore suicide threats by persons who are intoxicated (Exh 9, 106:23-107:1). According to Robertson, the suicidal statements of an intoxicated person like Clustka "don't count" (Exh 9, 107:8-11). Ashton agreed, testifying that a statement concerning suicide from an intoxicated person is not credible (Exh 8, 58:9-24). Nothing in RPD policy or Nevada law supports these defendants' contention they may ignore suicide attempts or threats by an intoxicated person.

In fact, Robertson and Ashton's testimony that the suicide threats of an intoxicated person may be ignored is contrary to the testimony of all RPD officials, all Washoe County officials, NMHI psychiatrist Dr. Jeffrey Caplan, and jail health administrator Gail Singletary. These individuals testified that the suicide threats of intoxicated persons **must** be taken seriously. Dr. Caplan testified that a risk factor he considers in doing a suicide assessment is recent excessive drinking and/or drugs, which is a factor heightening the risk of suicide (Exh 15, 23:12-20). According to Dr. Caplan, **the fact of Clustka's intoxication "would have set off an alarm bell saying this person is at high risk of suicide**" (Exh 15, 25:4-9).

Singletary agreed that intoxication and emotional state are strongly related to suicide (Exh 7, 19:1-12), adding that the threats of an intoxicated person should be taken seriously (Exh 7, 19:20-20:7). RPD Deputy Chief Johns testified it is **not** the policy of the Reno Police Department to ignore threats of suicide by intoxicated persons or to consider such threats any "less serious" than those made by non-intoxicated persons (Exh 11, 47:21-48:4). Sgt. Evans testified that an officer transporting an intoxicated prisoner to jail **may not disregard** the intoxicated person's suicide threat. (Exh 12, 34:4--35:25). Lt. Perry testified it would be "against the rules" to disregard a suicide threat from an intoxicated person. (Exh 13, 27:9-14).

**E. The Failures of Robertson and Ashton Were in Violation of Policy**

**1. The Events of April 26, 2005**

On April 26, 2005 at approximately 2:00 p.m., Robertson and Ashton received a call from RPD dispatch concerning an intoxicated female (Exh 9, 35:9-18). When they arrived, Remsa was talking to Clustka – she had registered a .10 on the breathalyzer (Exh 9, 59:5-9). Remsa had temporarily detained Clustka (Exh 9, 61:9-22). Robertson introduced himself, telling Clustka that due to her level of intoxication she was going to jail.[3] Clustka, agitated, refused to go to jail and said she wanted to go "home" to gather her belongings (Exh 9, 37:24-38:11 & 38:20-23).[4]

**a. Clustka Is Not Bothering Anyone or Committing a Crime**

The officers testified that Brenda Clustka had not committed any crime on April 26th (Exh 9, 36:8-20). There were no complaints that she was "bothering" any persons (Exh 9, 71:8-10). She was not fighting with anyone of the street or causing any disturbance whatsoever (Exh 9, 62:14-18). To be taken to "civil protective custody" (CPC) – a non-criminal charge – a person must demonstrate some impairment. Robertson testified that Clustka's impairment was she had slurred speech, was unsteady on her feet, and had the aroma of intoxicants about her. On cross-examination, Robertson admitted: (1) it is not a violation of the law to be unsteady on one's feet (Exh 9, 65:20-25; 66:1-9); (2) it is not a violation to have the aroma of an intoxicating beverage on one's person (Exh 66:10-13); (3) it is not a violation to consume intoxicating beverages (Exh 64:20-22).

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[3] According to Ashton, needing CPC is not a crime (Exh 8, 40:21-26).

[4] Clustka, who lived with her children in the home of her mother, Donna Clustka, had earlier gotten into an argument with her mother who had taken out a Temporary Protection Order (TPO) against her. While not technically "served" with the TPO, she was aware of its existence and wanted the officers' help in gathering her belongings so as to avoid violating the TPO.

Whatever impairment Clustka had from intoxication, at .10, it had to be minor. Clustka was not falling down or stumbling, she was not lying on private property (Exh 9, 59:1-4; 66:6-9; Exh 8, 44:23-25). She could walk like "anyone else," carry on a conversation, and respond to questions. (Exh 9, 67:14-68:4; Exh 8, 43:5-6). She was not talking to herself or bothering anyone (Exh 8, 63:2-3; 63:23-64:2).

**b. The Officers Deliberately Lie to Gain Clustka's Cooperation**

Having decided to take the somewhat inebriated Clustka to jail, Robertson and Ashton believed they would have an easier time getting her into the transport vehicle if they lied to her about where they were taking her (Exh 8, 37:10 -14). Both admitted they lied, telling her they'd take her home when they knew they were taking her to jail (Exh 9, 39:4-17; Exh 8, 37:8-9). The decision to take Clustka to jail was made without even interviewing her (Exh 9, 63:16-64:2; Exh 8, 41:17-20).

**c. Realizing She Is Being Taken to Jail, Clustka Attempts Suicide**

Believing the officers were helping her go home to retrieve her belongings, Clustka was initially calm and cooperative. However, as the transport vehicle approached the jail, she realized that the officers had lied to her and became angry (Exh 8, 37:16-25; Exh 9, 58:8-9). She unbelted her seatbelt, got up, and began moving around. (Exh 9, 42:18-24). Ashton next saw Clustka with a seatbelt wrapped around her neck through the surveillance camera and observed she was appearing to "choke" herself. He communicated to Robertson, who was driving, that she was "trying to choke herself" (Exh 8, 65:2-7; Exh 16, Adm 2, 31, 35, 36, 39, 40, 41, 44, 45). Ashton admitted that he knew at that time that Clustka had a history of mental illness (Exh 8, 65:8-11; Exh 16, Adm 14, 16).

Robertson also recognized that Clustka was trying to choke herself (Exh 9, 119:8-15). Robertson stopped the paddy wagon. Both officers proceeded to grab Clustka's hands and, together, they removed the seatbelt from her neck by "going around her neck" to unwind it (Exh 8, 65:12-24; 66:4-10). Clustka angrily screamed at the officers: "You lied to me, I want to die, kill me, you lied to me" (Exh 9, 45:11-21; Exh 16, Adm 21; Exh 17, Adm 54). Again, as the paddy wagon proceeded to the jail, at the sally port, Clustka again screamed at Robertson that she wanted to die (Exh 9, 47:1-9).

**2. The Officers Do Nothing to Protect Clustka from Self-Harm**

Admitting it would have taken "five seconds" to inform jail staff that his detainee had attempted to kill herself during transport – Robertson said nothing (Exh 9, 48:1-9; Exh 17, Adm 55, 56). Clustka's

threatened suicide in the paddy wagon were so insignificant to him that he "didn't think about" relaying the information to anyone at the jail (Exh 9, 127:23-128:3). He wrote no report on Clustka's suicide attempt until after his supervisor ordered him to do so after she killed herself (Exh 9, 30:9-11; 33:13-16).

Robertson knew better. He testified that RPD policy mandates the reporting to a supervisor of any suicide attempt or threat (Exh 9, 133:1-19). He justified his failure to write a report, notify jail staff, or alert a supervisor by claiming he did not believe Clustka's wrapping of the seatbelt around her neck was a true suicide attempt – she was just "angry" (Exh 9, 49:7-20). Because Robertson perceived Clustka to be merely angry, he asserted, failing to notify jail staff, write a report, or inform a supervisor was appropriate (Exh 9, 129:13-18; 133:20-25). According to Robertson, if the same situation were to occur tomorrow, or at any time in the future, he would handle it "exactly" the same way (Exh 9, 133:20-25; 130:6-8).

Ashton similarly testified that he hadn't bothered to think. When asked why he failed to report her conduct, he stated, "It never really crossed my mind" (Exh 8, 8:3-8; Exh 16, Adm 48, 50, 53-56). According to Ashton, Clustka's suicidal gestures were not "important enough" to report because they were – in his view – merely a manipulative attempt to get the officers' attention (Exh 8, 33:5-11; 70:1-3; 70:11-13). Unwavering, Ashton insisted that it was not a bona fide suicide attempt, the decision he made on April 26, 2005, to not inform jail staff was correct, and if the situation were to happen again he'd handle it exactly the same way (Exh 8, 33:12-13; 34:1-10; 34:24-35:7; Exh 16, Adm 46).

Neither Robertson nor Ashton received discipline for their failure to report Clustka's suicide attempt and threats on April 26, 2005 (Exh 16, Adm 57, 58; Exh 17, Adm 51-52).

**3. Failure to Report Suicide Attempt/Threats Violated Policy**

Defendants Robertson and Ashton stand alone in their insistence that they were correct in failing to notify anyone as to Clustka's conduct. Their RPD superiors and Washoe County officials strongly disagree. According to these others, Robertson and Ashton violated well-known policy and practice.

**a. Prison Health Services Director Gail Singletary**

Following Clustka's suicide – to protect against future policy violations by transporting officers – the Washoe County Detention Center implemented a new policy requiring all officers who transport detainees to the Washoe County jail to fill out a form indicating whether the detainee transported is or is not a "suicide risk." The forms are at the jail and, according to Singletary, all "users" of the jail "must" fill

out the form (Exh 7, 21:22-22:25; 23:21-25).

Singletary testified, all transporters to the jail must answer whether the detainee's conduct indicates they have mental health problems or are suicidal (Exh 7, 24:12-18). Singletary made crystal clear that, if a transporting officer sees either a suicidal gesture and/or hears a threat of suicide, that must be communicated to jail staff (Exh 7, 25:2-6). Singletary further testified that, if RPD officers transporting a detainee to jail see the detainee attempt to choke his or herself (as Robertson and Ashton did with Clustka), that too must be communicated to jail staff (Exh 7, 25:20-26:2).

"All law enforcement officers should be aware of the signs and symptoms of suicide to communicate it and help avert it," Singletary testified (Exh 7, 26:21-24). Singletary added that, when Robertson and Ashton arrived at the jail with Clustka, they should have let jail nurses know what they saw and heard (Exh 7, 53:4-11). They should have informed jail and medical staff of her conduct because there would have been an "opportunity to do a more complete evaluation" (Exh 7, 53: 13-20). The fact that Clustka had made a recent statement threatening suicide, made a recent gesture, and had a history of suicide were appropriate for an intake nurse to consider in deciding what to do with her (Exh 7, 57:6-10).

**b. Washoe County Lt. Milt Perry**

According to Lt. Perry, all deputies must take action and inform a supervisor. Deputies have no discretion to ignore a detainee's threat of suicide (Exh 13, 51:6-14). Perry testified the "threat to kill oneself" by any detainee should be taken seriously (Exh 13, 27:19-21). A deputy who has knowledge that a detainee has threatened suicide will generally take such information to medical staff and ask what to do (Exh 13, 43:3-6). Like Singletary, Perry was adamant that all communication between a transporting officer and jail staff regarding suicide must be documented and reported (Exh 13, 53:15-19). Before joining Washoe County Sheriff's Department, Perry was a RPD officer. He testified, from his training as a police officer, that, when he used to transport detainees to the jail who said they wanted to kill themselves, such information had to be reported to the jail staff (Exh 13, 71:1-10).

**c. RPD Deputy Chief James Johns**

Deputy Chief Johns testified that whenever a detainee states he or she wants to kill him or herself; that statement should reported to appropriate officials – it is never okay to ignore a suicide threat (Exh 11, 55:15-24). Johns added that, if Robertson and Ashton saw Clustka wrap the seatbelt around her neck and

heard her statements about wanting to kill herself, they should have told jail staff when they arrived at the jail (Exh 11, 39:13-19). Had he been transporting an intoxicated person to jail who said she wanted to kill herself and made a suicidal gesture, he would have done so (Exh 11, 35:9-19).

**d. RPD Sergeant David Evans**

Sgt. Evans refused to agree with his subordinates Robertson and Ashton that they have "discretion" to decide what suicide gestures and threats are legitimate and what are not. He testified that when an officer hears someone intends to kill him or herself, the officer **must** report it (Exh 12, 28:24-29:3). Evans would **not** advise officers under his control to disregard a detainee's threat of suicide (Exh 12, 29:25-30:15). Protecting people from self-harm is a custom and practice of the Reno Police Department (Exh 12, 41:13-20). According to Evans, had he been the transporting officer who heard Clustka say she wanted to kill herself, he would have told the jail staff – that would be an important fact to relate (Exh 12, 47:14-18; 48:6-8).

**4. Robertson and Ashton Admit They KNEW Policy, Custom, and Practice Mandated Them to Report a Detainee's Suicide Threats**

Ashton – simultaneously insisting he did the right thing – admitted he knew that supervisors want to know if a person being transported has said anything about harming his or herself (Exh 8, 61:10-11). He knew that suicide attempts should be reported and officers do not have discretion to ignore such conduct (Exh 8, 75: 15-20). Ashton admitted that reporting a suicide attempt is an important aspect of a police officer's purpose because it is helping people in need (Exh 8, 75:21-76:8).

Robertson similarly testified that, if he believes a prisoner may harm his or herself, he has a duty to alert others (Exh 9, 117:23-25). While it is RPD policy to notify a second officer of the means of the attempted harm, to notify a supervisor and to complete a written form, Robertson admitted he did "none of those things" (Exh 9, 119:17-24). According to RPD policy and Robertson's training, a threat of suicide must be reported at least to a supervisor (Exh 9, 133:1-19).

**5. Municipal Liability Is Based on City's Failure to Train its Officers on their Obligation to Report Suicide Gestures and Threats**

It is well-documented that suicide is **the leading cause** of death in U.S. jails (Exh 19). Clustka was the second inmate in 30 days to commit suicide at the Washoe County jail (Exh 20) and the fifth of six to die by suicide there between January 2004 and August 2005 (Exh 21, pp. 3-4). All witnesses in this

case testified unambiguously that transporting officers have a duty to protect persons at risk of suicide and a corresponding duty to report suicide attempts and threats by persons in their custody. Yet, the evidence is that City of Reno failed to train its officers on suicide prevention or what constitutes a "suicide attempt" or a "suicide threat." Deputy Chief Johns – a self-described policymaker – testified he doesn't know if RPD has a written policy on the reporting of suicide threats (Exh 11 , 40:25-41:9). To Johns' awareness, RPD has no suicide prevention policy (Exh 11, 41:13-15).

Sgt. Evans, Robertson and Ashton's supervisor, similarly testified he is not aware of any training given to RPD officers on how to distinguish when a person makes a serious suicide attempt or threat (Exh 12, 26:3-9). Additionally, he is unaware of any training on suicide prevention at RPD and has no recollection of any such training in the last ten years (Exh 12, 36:17-37:25). He has no recollection of ever receiving any suicide prevention training while at RPD (Exh 12, 38:3-14).

Robertson similarly testified he received no training on dealing with potentially suicidal prisoners (Exh 9, 98:2-4). The only training Robertson received was on handling the mentally ill, amounting to 15 to 20 minutes, and he could not recall when he received this training in his 17-year career (Exh 9, 113:16-114:7). He has no recollection of anyone who trained him on how to identify potentially suicidal prisoners (Exh 9, 124:1-8). Like Robertson, Ashton testified that, while he thought he ought to have been trained, he has no recollection of being trained by anyone while at RPD on what is or is not a genuine suicide attempt or how to deal with potentially suicidal prisoners (Exh 8, 32:12-15 & 62:13-18).

**6. Knowing Robertson Was a Deficient Officer and Without Remedial Training, City Made Him Responsible to Transport Persons in Custody and to Mentor New Officer Ashton**

(Please see Supplemental Opposition, filed under seal pursuant to protective order, Dkt 37.)

**F. Had Clustka Been Sent to an Appropriate Medical Facility, She Would Have Been Thoroughly Examined by Psychiatric Professionals**

**1. Had Robertson and Ashton Reported Clustka's Suicidal Attempt and Threats, Several Options Were Available to Protect Her**

Singletary explained the critical importance of communicating suicide threats and attempts to jail staff: First, the more information given to jail medical staff about potential suicide risk the better job medical staff can do to avert suicide (Exh 7, 14:11-15); second, if officers who transport a detainee to jail and see a suicidal gesture or hear a suicidal threat and do not inform jail staff – that omission can affect

the kind of care the person receives (Exh 7, 14:16-25; 15:1-3); third, the majority of all suicide victims communicate an intent to commit suicide prior to doing it (Exh 7, 20:21-25; 21:1-7); fourth – and most important – **it is jail policy to refuse admittance of suicidal persons** and to direct deputies to send such persons to hospitals (Exh 7, 47:1-8; 48:3-12). Jail staff and PHS nurses can request that someone, even someone in civil protective custody, be taken to a hospital for a Legal 2000 if they suspect the person is suicidal (Exh 7, 51:14-25). **Accordingly, had Robertson and Ashton reported Clustka's suicide gesture and threats, ample precedent exists for refusing Clustka at the jail and taking her directly to a medical facility.**

Washoe County Sheriff's Department Lt. Perry similarly testified that, had CPC jail staff known of Clustka's suicide attempt and threats, several options were available to protect her: First, despite Clustka's intoxication, Officers Robertson and Ashton could have applied for a Legal 2000 and taken her directly to a hospital (Exh 13, 65:3-9). Second, had the correctional deputies or staff known of her suicide attempt and threats, they could have placed her on a Legal 2000, the jail could have kept her under suicide watch, and a jail psychiatrist would have examined her, certainly a mental health professional (Exh 13, 83:11-84:3). Third, on releasing Clustka from CPC, the jail could have sent her to the hospital on a Legal 2000 (Exh 13, 56:3-24). In other words, when a person "sobers up" and drops below the standard for holding him or her in CPC, correctional staff are free to commence a Legal 2000 and send the person to a hospital to address the risk of suicide (Exh 13, 62:10-16). Any of those options could have resulted in a successful intervention.

**2. Had Clustka Been Taken to an "Appropriate Medical Facility" She Would Not Have Been Released Until Psychiatric Professionals Determined Her to Be No Longer a Danger to Herself**

**a. Dr. Gansert Testified to the Care Clustka Would Have Received**

WMC emergency physician, Dr. Guy Gansert testified that generally, the police **do take** a person who has threatened suicide to the emergency department (Exh 14, 5:16-20). At WMC, both suicide attempts and suicide threats are taken very seriously (Exh 14, 12:21-13:2). Upon arrival at the emergency department, the person is assessed for risk of suicide (Exh 14, 5:21-23). Emergency staff does a thorough medical screen - they take the person's history, they ask a battery of questions, and they find out why the person was brought into the emergency room (Exh 14, 5:24-6:10).

An "alert team" assists the emergency physician in evaluating the person for suicide risk, who carefully records all the information obtained (Exh 14, 7:5-14). After the emergency team finishes its evaluation, if the team feels the patient needs to be placed under a Legal 2000, the patient will be transferred to a psychiatric facility, generally NMHI (Exh 14, 7:24-8:4; 8:9-20). On average, persons at risk of suicide are held six to eight hours at WMC before transfer to NMHI (Exh 14, 22:24-23:6).

Based on Dr. Gansert's 17 years experience making referrals to NMHI, he believes they do a "thorough job evaluating patients at risk of suicide" (Exh 14, 8: 16-20, 9:10-13). They would give "appropriate intervention" to Brenda Clustka or persons at risk of suicide (Exh 14, 14-18). Dr. Gansert personally evaluated and transferred Clustka to NMHI on the 25th of April and was satisfied that he did the best thing for her as he was "confident that she would get good care" there (Exh 14, 9:19-25). Had Clustka been returned to the emergency care department on April 26 after her repeat suicide attempt, Dr. Gansert would have thoroughly evaluated her for risk of suicide (Exh 14, 18:6-12), and, if he believed that she was at risk of suicide, he would have "no hesitancy" to transfer her to NMHI (Exh 14, 10:1-6).

According to state statute, a patient may be kept against their will for up to 72 hours without a court order if medical professionals deem it necessary to protect them from self harm (Exh 14, 10:7-14). If a patient has medical issues or needs detoxification, the patient is kept at WMC until the medical issues are resolved or the patient is no longer intoxicated, and if that patient is still at risk of suicide, then it's appropriate to transfer the patient to NMHI (Exh 14, 12:9-19).

**b. Psychiatrist Dr. Caplan Testified to the Treatment Clustka Would Have Received at NMHI to Protect Her from Suicide**

NMHI provides mental health services for persons at risk of suicide (Exh 15, 5:10-13). It provides full service for persons with mental illness and suicide issues (Exh 15, 5:18-20). Patients are admitted to NMHI after a thorough assessment, complete with evaluations by social workers and nurses in addition to a psychiatrist. (Exh 15, 7:18-8:21). Also, when a patient is brought in for suicide risk, Dr. Caplan, NMHI's psychiatrist, personally does a psychiatric evaluation as an integral part of the suicide assessment, then diagnoses the patient (Exh 15, 10:7-21). Dr. Caplan testified he has a "duty to examine thoroughly and diagnose a person who is brought in for being a suicide risk (Exh 15, 10:18-21).

The social worker completes a "Locus Adult Assessment" as part of the determination of what care is needed for the patient (Exh 15, 11:2-12:1). In addition, the nurse does an individualized

treatment plan for a person identified at risk of su icide (Exh 15, 12:6-9). The treatment plan identifies goals, interventions and conditions for discharge (Exh 15, 12:10-18). Careful progress notes are kept (Exh 15, 13:13-16). As part of th e treatment plan for someone who comes in for risk of suicide, NMHI keeps the patient on observation, at leas t every 15 minutes, which observations are carefully recorded (E xh 15, 12:19-13:12). In sum, NMHI takes a wide array of ap proaches to protect a person from suicide (Exh 15, 14:4-6). Dr. Caplan testified to how it is important to pay attention to when someone makes a suicide gesture (Exh 15, 14:7-9). It is important to get someone who makes a suicide gesture to medical or mental health help, frequently both (Exh 15, 14:16-15:2).

NMHI does not discharge a person who it believes remains a suicide risk (Exh 15, 15:9-12). If NMHI believes a person is at risk of suicide, it can keep that person up to 72 hours to protect him or her prior to petitioning the Court (Exh 15, 15:16-19). If NMHI be lieves the person continues to be at risk of suicide after the 72 hours expires, there are options for keeping the person longer by petitioning the court and obtaining a court order (Exh 15, 15:24-16:2). Based on a single court order, NMHI can keep a patient up to six months if it is believed that person continues to be a suicide risk (Exh 15, 16:4-8). Even at six months, it's not a forced discharg e because NMHI can petition another court order (E xh 15, 16:4-11). NMHI has the option to keep that person indefinitely until it is believed th at the person is no longer at significant risk of suicide (Exh 15, 16:14-18).

According to Dr. Caplan, "most people" who are suicidal want to be saved (Exh 15, 20:12-16). For the vast majority of people who make suicide attempts, there is an opportunity to do intervention to protect the person from suicide (Exh 15, 21:21-25). In those cases most suicides can be prevented by appropriate and caring intervention (Exh 15, 22:4-7).

The fact that Clustka "improved rapidly while receiving appropriate intervention and care on the 25th" of April, was a sign of a person w ho would want to be saved (E xh 15, 20:17-21:1). Had she been returned to NMHI b ased on a seco nd suicide incident in two days, she would have been thoroughly evaluated for risk of suicide (Exh 15, 24:19-23). The fact of her intoxication would have set off an "alarm bell" indicating to Dr. Caplan that she was at high risk of suicide (Exh 15, 25:4-9). The fact of her Xanax abuse, which was also documented the day before, would also have set off an alarm bell (Exh 15, 25:10-13). The fact that sh e had a documented history of suicide attempts would set off additional alarm bells (Exh 15, 25:19-24). Finally, the fact that she had been adm itted to NMHI just one day before and kept

overnight on suicide observation, would have set off "very serious alarm bells that this woman was at high risk of suicide" (Exh 15, 25:19-24). Dr. Caplan testified that "**it would have been critical to get Brenda Clustka to mental health care had she made a repeat suicide threat and attempt on April 26th** (Exh 15:29:4-7).

Had Robertson and Ashton reported Clustka's suicidal conduct to jail staff or taken her directly to a medical facility on April 26th, at the very least she would have had another psychiatric evaluation, another whole multi-disciplinary admission assessment, and another whole mental health examination. Had Brenda Clustka been returned to NMHI on April 26, many professionals, a social worker, a nurse and Dr. Caplan, a psychiatrist, would have given her appropriate treatment for suicide risk and worked to protect her from suicide (Exh 15, 27:19- 28:3). A nurse would have done a whole treatment plan, she would have been kept overnight and observed very carefully and nurses and social workers would have interacted with her to remove suicidal thoughts and to address her psychological/psychiatric issues (Exh 15, 25:25-26:10). A "whole safety net of precautions" would have protected Clustka from suicide had she been returned to NMHI on April 26th (Exh 15, 27:24-28:1).

## III. DEFENDANTS ROBERTSON AND ASHTON EXHIBITED DELIBERATE INDIFFERENCE TO CLUSTKA'S SAFETY BY FAILING TO TAKE REASONABLE MEASURES IN RESPONSE TO HER KNOWN RISK OF SUICIDE

The tragedy of this case is that Clustka made her condition known in no uncertain terms to the officers who transported her to jail. She tried to kill herself in their presence and made threats of future harm. Rather than report her suicidal conduct on the way to jail, Robertson and Ashton chose to keep mum with the predictable result that the jail would not take extra precautions to protect her,

Clustka was a pretrial detainee when she committed suicide. The Fourteenth Amendment, rather than the Eighth Amendment, applies to pretrial detainees, but as a pretrial detainee Clustka, was entitled to the same protections against deliberate indifference to her basic needs as are available to convicted prisoners under the Eighth Amendment. *Cavalieri v. Shepard,* 321 F.3d 616, 620 (7th Cir. 2003). Under both the Eighth and Fourteenth Amendments, a plaintiff has the burden of showing that (1) the harm to the plaintiff was objectively serious; and (2) that the official was deliberately indifferent to her health or safety. *Farmer v. Brennan*, 511 U.S. 825, 833 (1994). "A detainee establishes a § 1983 claim by demonstrating that the defendants were aware of a substantial risk of serious injury to the detainee but

nevertheless failed to take appropriate steps to protect [her] from a known danger." *Payne v. Churchich,* 161 F.3d 1030, 1041 (7th Cir. 1998); see also *Gibson v. County of Washoe,* 290 F.3d 1175, 1194 (9th Cir. 2002). "The very notion of deliberate 'indifference' connotes a regime where neglect of detainees' medical and psychological needs proves a constitutional violation." *Cabrales v. County of L.A.,* 864 F.2d 1454, 1461 (9th Cir. 1988), *vacated,* 490 U.S. 1087 (1989), and *reinstated,* 886 F.2d 235 (9th Cir. 1989).

**A. Plaintiff Easily Meets All the Elements of a Fourteenth Amendment Claim for Deliberate Indifference to Suicide Risk**

Several circuits have developed a framework for courts to follow when analyzing such claims. While there are variations in how the tests are framed, they incorporate the same elements. For example, The Third Circuit requires a plaintiff in a jail suicide case to establish the following elements:

> (1) the detainee had a "particular vulnerability to suicide," (2) the custodial officer or officers knew or should have known of that vulnerability, and (3) those officers "acted with reckless indifference" to the detainee's particular vulnerability.

*Colburn,* 946 F.3d at 1023 (quoted with approval in *Woloszyn v. County of Lawrence,* 396 F.3d 314, 319 (3rd Cir. 2005)).[5] The Eleventh Circuit sets forth a similar test:

> To establish a defendant's deliberate indifference, the plaintiff has to show that the defendant had (1) subjective knowledge of a risk of serious harm [and] (2) disregarded. . .that risk; (3) by conduct that is more than mere negligence.

*Cook ex rel. Estate of Tessier v. Sheriff of Monroe County, Fla.,* 402 F.3d 1092, 1115 (11th Cir. 2005) (quoted with approval in *Snow v. City of Citronelle, Ala.,* 420 F.3d 1262, 1268 (11th Cir. 2005)). Finally, the Eighth Circuit uses slightly different language to articulate the same test:

> To prevail on her deliberate indifference claim, [the plaintiff] must show: (1) appellants knew [the decedent] presented a substantial suicide risk; and (2) appellants failed to respond reasonably to that risk. *Coleman v. Parkman,* 349 F.3d 534, 538 (8th Cir. 2003).

**1. Clustka's Suicide Attempt on the Way to Jail Demonstrated a Substantial Risk of Serious Harm to the Officers Who Witnessed It**

Clustka demonstrated her "particular vulnerability to suicide" with her suicidal gesture and threats on the way to jail. Robertson and Ashton knew Clustka was at substantial risk of serious harm because

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[5] In *Woloszyn*, the appellate court upheld the lower court's dismissal of the case based on the fact that the officers had no knowledge of the decedent's risk of suicide. There was no evidence on record in that case that the decedent had a particular vulnerability to suicide. He did not attempt suicide in the presence of any officers, and he did not threaten suicide. *Woloszyn*, 396 F3d at 321-22. This case is distinguished from *Woloszyn*, because Officers Robertson and Ashton had knowledge of Clustka's suicide gesture and threats.

they personally witnessed it. Despite both the attempt and threats, Robertson and Ashton decided to not do an incident report and decided to not report the information to jail staff. Their conduct is the **extreme** epitome of deliberate indifference.

Reviewing the lower court's grant of summary judgment in *Snow*, the Eleventh Circuit found an issue of fact over deliberate indifference where an officer who supervised the detainee's detention in the holding area of the jail and went off shift without placing the detainee on suicide watch or reporting information he had learned suggesting that the detainee had suicidal tendencies. Specifically, the officer had learned from a previous jailor that, "sometime in the last month," the detainee tried to cut her wrist while in custody and given a lot of trouble. The officer further told the detainee's family that he thought she might be suicidal but **did not share his belief with jail staff**. After the officer went off shift – with no suicide watch in place – the detainee hung herself. *Snow,* 420 F.3d at 1270.

Similarly, in the instant case, there was a strong risk that Clustka would attempt suicide at the jail given her suicide attempt on the way to jail.[6] Officers Robertson and Ashton had two options available to them at that point in time: One, they could have taken Clustka directly to the hospital on a Legal 2000, where emergency room staff would have kept her until she was no longer intoxicated, and, after performing a thorough assessment and if she remained suicidal, would have transferred her to a mental health hospital to for psychiatric assessment and treatment. She would have been kept in the mental health hospital until psychiatric professionals would have deemed her no longer a threat to herself. Two, they could have taken her to the jail and reported her suicide attempt and threats to jail staff. The jail would then have had several alternatives available to protect Clustka from self-harm. It could have refused her at the door based suicide risk and sent her to the hospital on a Legal 2000. It could have flagged her as a potential suicide risk, placed her on suicide watch, and given her medical and mental health treatment until she was determined to no longer be at risk of self harm. Finally, three, the jail could have kept her in

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[6] The defendants assert that Ms. Clustka was at low risk of harming herself "at the time she was in the custody of Robertson and Ashton. This is not true. The evidence shows that, the day before, Clustka was taken to WMC on a Legal 2000 for threatening to kill herself and transferred to NMHI for overnight observation and treatment. She was released approximately five hours before Robertson and Ashton encountered her. During the five hours between Clustka's release from the Legal 2000 and her encounter with Officers Robertson and Ashton, her condition deteriorated to the point the officers determined that a civil protective custody was necessary. Furthermore, the officers admit that their own conduct – in lying to Clustka that they were taking her home to retrieve her belongings when they were really taking her to jail – precipitated Clustka's suicide attempt and threats in the paddy wagon.

civil protective custody on suicide watch with evaluation by a mental health professional until she was no longer intoxicated, then send her to the hospital on a Legal 2000.

In *Cavalieri,* the detainee who later committed suicide said he was fine when the officer spoke with him over the phone and was calm when interviewed. However, the Seventh Circuit found a triable issue over whether the officer was aware that the detainee presented a suicide risk where the plaintiff's facts indicated that the mother and girlfriend had told the officer that the detainee threatened suicide if taken to jail. *Calvalieri,* 321 F.3d at 621. Because the officer failed to pass the warnings of a suicide risk to jail authorities, the appellate court affirmed the lower court's denial of qualified immunity to the officer. This too would be a different case had Robertson and Ashton not personally witnessed Clustka's suicidal threats and gestures. They cannot legitimately deny awareness of her suicide risk and their requirement to respond in reasonable fashion by alerting jail authorities.

**2. Once on Notice that Clustka Was at Risk for Suicide, Officers Robertson and Ashton Were Required at the Very Least to Report It to Jail Authorities**

Once an official knows of a detainee's suicide risk, the Fourteenth Amendment requires the official to take reasonable measures to abate the risk. E.g., *Coleman,* 349 F.3d at 538. Because Robertson and Ashton failed in their duty to report Clustka's suicide attempt, jail authorities who dealt with her were not alerted to the need to address her suicide threats. They did not know to refuse her in civil protective custody and send her directly to the hospital for suicide assessment and treatment.

Based on the facts as presented, and the testimony of the officers themselves, there can be no doubt that these officers made a deliberate decision to do nothing to protect Clustka from making good on her suicide threats. They did not take her to the hospital on a Legal 2000, they did not tell the jail booking authorities of her suicide attempt, and they did write an incident report on her suicide attempt. Jail officials were deprived of the ability to conduct necessary suicide assessment and referral.

**B. At Best, Defendants Show a "Question of Fact"**

Defendants assert that plaintiff cannot show deliberate indifference because the officers "thought that Clustka was just acting out because she was drunk" (Def. Br. p. 7:11-12). However, this is a question for a factfinder to determine on review of the evidence to be developed in this case. It cannot be resolved via a motion for summary judgment where there are specific facts indicating the defendants' awareness of both a suicide attempt and a suicide threat while on route to the jail. According to Thomas A. Rosazza,

expert witness in custodial care, any testimony that suicide statements by an intoxicated person are not to be taken seriously "is callous, contrary to industry precepts, and contrary to RPD practices regarding the care, custody and protection of potentially suicidal persons (Exh 18, 4).

In *Snow*, Officer Chennault – like the defendants in this case – maintained he did not personally view the detainee as a suicide risk. Chennault testified that, had he regarded her as a suicide risk, he would have taken actions to protect her from harming herself. *Snow,* 420 F.3d at 1270. Given the plaintiff's facts that a prior jailer had told Chennault about the detainee's earlier suicide attempt and he discussed with family members his belief that she was a suicide risk, the court recognized that the officer's subjective belief was a matter of dispute, an issue properly addressed at trial.

In *Coleman,* during a pre-arrest investigation, interviewees told the officer that the detainee needed mental help, had been doing "crazy things," was at risk of harming himself or others, and would kill himself if jailed. *Coleman,* 349 F.3d at 536, 539. After receiving this information, the officer testified, he concluded that the detainee was not at risk of suicide and said nothing to jail officials about the warnings he had received. Lacking notice of the detainee's suicide risk, the jail placed the intoxicated detainee in a "drunk tank" containing the usual prison items, including a bed sheet, and – like Clustka – the detainee used the sheet to hang himself. *Id.* On review, the Eighth Circuit found that, taking the facts in the light most favorable to the plaintiff, they support an inference that the officers actually knew the detainee presented a substantial suicide risk. *Id.* at 539. The court emphasized that these issues of credibility cannot be resolved in summary proceedings but rather require trial. *Id.*

Similarly, in *Cavalieri v. Shepard,* the defendant officer asserted he did not believe the detainee was at risk of suicide in justification of his failure to tell jail officials about warnings he had been given. Lacking notice of a need to take suicide precautions, the jail put the detainee in a holding cell that had a telephone where he hung himself using the telephone cord. *Cavalieri,* 321 F.3d at 620. The court found that the officer was responsible to pass information including suicide risks to the jail facility, that it would have been an easy thing for him to do. *Id.* at 622-623 (citing *Farmer,* 511 U.S. at 831 and *Viero v. Bufano,* 901 F. Supp. 1387, 1394 (N.D. Ill. 1995) (adequate measures include communicating likely suicide risk to transferee correctional facility) (emphasis added)).

Just so, the instant case raises issues that cannot be resolved in summary proceedings. See also, *Estate of Olivas v. City and County of Denver,* 929 F. Supp. 1329, 1336 (D.Col. 1996) (finding the

question whether a suicide threat presented a "specific risk" that the detainee would kill himself or that the defendant was deliberately indifferent when he assumed the contrary was a jury question). According to the facts as presented, Officers Robertson and Ashton could not have mistaken the seriousness of Clustka's suicide attempt and threats.

**C. Nevada's Legal 2000 Law Specifically Provides for the Involuntary Commitment of Mentally Ill Persons Who Are Intoxicated**

For purposes of involuntary commitment, NRS § 433A.115 defines a "mentally ill person" as a person who presents a

> clear and present danger of harm to himself or others, but does not include any person in whom that capacity is diminished by. . . intoxication. . ., **unless** a mental illness that can be diagnosed is also present which contributes to the diminished capacity of the person.

One way a person demonstrates a clear and present dangers of harm is if, "as a result of mental illness," the person has "attempted to or threatened to commit suicide or committed acts in furtherance of a threat to commit suicide" and there exists a reasonable possibility the person will do so unless admitted to a mental health facility. NRS § 433A.115(2)(b) (Exh 10; Exh 24).

Thus, if a person is mentally ill and attempts or threatens suicide – there is no dispute that Clustka was mentally ill or that Robertson and Ashton were notified that Clustka was mentally ill – a Legal 2000 involuntary commitment is appropriate, no matter if the person is also intoxicated. Expert witness Rosazza, concluded that, under the circumstances presented a Legal 2000 would have been appropriate:

> Had Officers Robertson and Ashton reported Ms Clutska's actions and statements to CPC personnel such information would have been important to CPC personnel whether to accept her at the facility, reject her for medical and/or psychiatric referral, or accept her and assess whether or not she should be committed for a "Legal 2000" (Exh 18, 4).

He further concluded:

> Officers Ashton and Robertson had sufficient justification to exercise a Legal 2000 commitment for Ms. Clutska given her attempted suicide, her threats of suicide, her belligerence, their knowledge that she was mentally ill, and her being distraught. Had such been done her current suicide attempt and threats would have been addressed by competent mental health professionals (Exh 18, 4-5).

**D. It Is Classic Deliberate Indifference Where Police Officers Witness a Detainee Attempt to Kill Herself, Fail to Respond Reasonably and Decide to Not Report It**

It is classic deliberate indifference where police officers witness a detainee attempting to kill herself as well as hear a suicide threat and determine to warn no one and do nothing about it. See *Snow,*

420 F.3d at 1270. Although the hurdle of showing deliberate indifference is a "high hurdle for a plaintiff," the plaintiff "need not show that a prison official acted or failed to act believing that harm actually would befall an inmate; it is enough that the official acted or failed to act despite his knowledge of a substantial risk of serious harm." *Cavalieri,* 321 F.3d at 622 (quoting *Farmer,* 511 U.S. at 842). Thus, plaintiff is not required to show that Robertson and Ashton actually believed Clustka would succeed in killing herself in jail. It is sufficient to establish deliberate indifference if plaintiff can later prove that they failed to act despite their knowledge of Clustka's suicide attempt and threats on her way to jail. Acts of omission, namely Robertson and Ashton's failure to report their knowledge of Clustka's conduct, constitutes "the predicate for a finding of liability" on their part. *Cabrales,* 864 F.2d at 1461 (finding that an omission in the form of medical understaffing at the jail directly contributed to the decedent's suicide).[7]

Viewing plaintiff's facts in the light most favorable to her – as this Court must do – the Court must deny defendants' summary judgment motion on the question of deliberate indifference. Given defendants' knowledge of Clustka's suicide attempt and her threat to kill herself if taken to jail, there is no way this Court could find that plaintiff can prove no set of facts to support a finding of deliberate indifference on defendants' part. See *Morley v. Walker*, 175 F.3d 756, 759 (9th Cir. 1999).

## IV. A FAIR READING OF PLAINTIFF'S FACTS SHOWS THAT DEFENDANTS' DELIBERATE INDIFFERENCE PROXIMATELY CAUSED THE DEPRIVATION OF CLUSTKA'S EIGHTH AMENDMENT RIGHT

### A. Plaintiff Shows an Issue of Fact over Causation Because Robertson and Ashton Set in Motion the Constitutional Deprivation

Section 1983 imposes liability upon those who "subject[] or cause[] to be subjected, any citizen of the United States. . .to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws. . . ." 42 U.S.C. § 1983. This includes the setting in motion a series of acts by others which the actor knows or reasonably should know would cause others to inflict the constitutional injury. *Springer v. Seaman,* 821 F.2d 871, 879 (1st Cir. 1987 (quoting *Soto v. City of Sacramento,* 567 F. Supp. 662, 673-74 (E.D. Cal. 1983) and *Johnson v. Duffy*, 588 F2d 740, 743-44 (9th Cir. 1978) (emphasis added)).

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[7] The defendants argue that Officers Robertson and Ashton took appropriate steps to protect Clustka. To the contrary, the officers admit that that they did nothing to report Clustka's suicide attempt and threats. They further admit that it is their duty according to Reno Police Department policy to report all suicide attempts and threats.

Defendants assert in their motion for summary judgment that plaintiffs cannot show a "causal connection" between Clustka's suicide attempt and threats on the way to jail and her suicide in jail less than 48 hours later. They assert that, even if defendants Robertson and Ashton had reported Clustka's suicide attempt and threat, the jail would have done nothing different and would not have prevented her from killing herself on being rearrested. Defendants are wrong. Causation is very much present and the brief period of Clustka's release is not an intervening event that breaks the causal chain.

Plaintiff has set forth in great detail exactly what Robertson and Ashton did and failed to do and the harm that resulted. Had Robertson and Ashton transported Clustka to the hospital emergency room on a Legal 2000 after she both attempted and threatened suicide in the paddy wagon, she would have been carefully watched and thoroughly assessed and transferred to a mental health hospital where she would have been kept as long as was needed. Had Robertson and Ashton informed jail authorities of Clustka's suicide attempt and threats, the jail would have had the option of refusing her at the door and sending her directly to the hospital for detoxification, suicide assessment, and likely transferred to a mental health hospital for further suicide assessment and treatment. Finally, the jail could have kept Clustka on civil protective custody – addressed her suicidal issues then and there – and, on releasing her at the end of detoxification, sent her to the hospital on a Legal 2000. As a result of Robertson and Ashton's deliberate decision to keep mum, Clustka was deprived of these several avenues of protection.

The officers' failure to report Clustka's paddy wagon suicide attempt had natural and foreseeable consequences. Had defendants not failed to report Clustka's suicide attempt to jail staff, according to Singletary and Lt. Perry, Clustka would have either been rejected at the door and sent to the hospital for suicide assessment ant treatment or she would have been immediately placed on suicide watch, with the result that on release from CPC, she would have been sent to the hospital on a Legal 2000 if deemed by jail medical professionals to remain at risk of killing herself. Clustka would have been red-flagged as a potential suicide risk. Her mental health history would have been flagged and carefully scrutinized, which would have further alerted jail staff to her history of suicide attempts and the need to protect her from killing herself. Jail personnel would have seen how she had been previously placed on suicide watch due to suicidal ideation. Jail staff would have made inquiries and discovered that only a day before, she was on a suicide hold at the local hospital. Even without the benefit of further research – simply given notice

of Clustka's suicide attempt on the way to jail – jail staff would have known to monitor her and to address her suicide issues before releasing her.

Robertson and Ashton set in motion the constitutional deprivation when they failed to report Clustka's known vulnerability to suicide. They were responsible for the fact that the jail did not implement suicide precautions or send her to the hospital on a Legal 2000. Their conduct led to the constitutional deprivation that resulted in Clustka's death. But for their failure to report Clustka's suicide attempt, jail authorities would have set in motion standard procedures to protect her from killing herself. Accordingly, Robertson and Ashton's failure to report the suicide attempt was at least one of the actual causes of Clustka's ultimate injury. See *White v. Roper*, 901 F.2d 1501, 1505 (9th Cir. 1990) (citing W. Prosser and W. Keeton, *The Law of Torts* § 41, at 266 (5th ed. 1984)).

**B. Nor Does the Short Time of Release Constitute a Superceding Intervening Cause That Would Relieve Officers Robertson and Ashton from Liability**

"Once it is established that the defendant's conduct has in fact been one of the causes of the plaintiff's injury, there remains the question whether the defendant should be legally responsible for the injury." *Id.* (quoting Prosser & Keeton, § 42, at 272-73). This question is generally referred to as one of proximate cause. The evidence is that Robertson and Ashton transported Clustka to jail on April 26, 2005, she remained there until that night, when she was released with no place to go. The next morning, April 27, 2006, she returned to her mother's home in another misguided attempt to retrieve her belongings and again was arrested. The jail **did not know on April 26, 2006, to refuse Clustka at the door and send her to the hospital on a Legal 2000 or even to place her on suicide watch** because Robertson and Ashton had failed to notify anyone the day earlier of her suicide attempt and threats. Lacking that critical information – the jail medical staff certainly did not know to place her on suicide watch the next day when she was arrested again.

The question for the Court to determine is what was "reasonably foreseeable" to the officers at the time they delivered Clustka to jail without informing jail personnel of her suicide attempt. "The courts are quite generally agreed that [foreseeable] intervening causes. . .will not supersede the defendant's responsibility." *Id.* (quoting Prosser & Keeton, § 44, at 303-04). Courts look to the original foreseeable risk that the defendants created. *Id.* (citations omitted).

In *White*, a § 1983 case alleging deliberate indifference to the plaintiff's safety, the plaintiff inmate alleged that the defendant sergeant caused him to be injured by assigning him to share a cell with a known violent cellmate. Rather than enter the cell, the plaintiff ran and was beaten by jail guards. The court found that the plaintiff's running constituted an intervening cause of his injury at the hands of third parties, but that his running was a foreseeable consequence of the sergeant's assigning him to room with a known dangerous cellmate. The inmate had two alternatives: either enter the cell and risk being injured by the cellmate or run away and risk being injured by the jail guards. Since his running was a foreseeable consequence of the order that he enter the cell with a known violent cellmate, the intervening act of his running did not break the change of causation. Overturning summary judgment on the plaintiff's claim of deliberate indifference against the sergeant, the court concluded that there was a genuine issue of fact over actual and proximate cause.

Similarly in the instant case, Robertson and Ashton set in motion a series of events that foreseeably ended in Clustka's successful jail suicide. Clustka's suicide was a foreseeable consequence of failing to inform jail authorities of Clustka's suicide attempt. Her death was caused by jail authorities failing to take suicide precautions that they would have otherwise taken. The fact that Clustka was released and rearrested within a matter of hours does nothing to change the calculus. It was reasonably foreseeable that Clustka would be released without the jail's doing anything to protect her from self-harm. It was likewise reasonably foreseeable that – in the absence of professional intervention to address her suicidal ideation – she would find herself back in jail, given the TPO, given Clustka's unmet need to retrieve her belongings from her mother's home, and given her extremely distraught condition.

The release and near immediate rearrest cannot be viewed as an intervening cause of Clustka's jail suicide because Clustka would likely not have been released into the streets had the jail been put on notice of her suicide attempt. She would have been kept under suicide watch at jail, or they would have sent her to the hospital on a Legal 2000.

The fact that, when Clustka was rearrested, no protections were in place to protect her from killing herself is what enabled her to succeed in killing herself. No protections were in place because Robinson and Ashton did not alert jail authorities to her recent suicide attempt. In other words, the chain of causation leads back to Robertson and Ashton. The intervening event of Clustka's short release from jail played no superceding role in the events that unfolded as a result of their misconduct.

A "defendant will not be relieved of liability by an intervening cause that was reasonably foreseeable, even if the intervening force may have 'directly' caused the harm. An 'unforeseen and abnormal' intervention on the other hand, 'breaks the chain of causality,' thus shielding the defendant from liability." *Gutierrez-Rodriguez v. Soto,* 882 F.2d 553, 561 (1st Cir. 1989). There was nothing "unforeseen" or "abnormal" in the fact that Clustka was released from jail and rearrested within a day. It was as foreseeable as the fact that she would later kill herself in jail if not protected from self-harm. For these reasons, plaintiff's allegations are well sufficient to support causation, both actual and proximate.

## V. QUALIFIED IMMUNITY IS NOT AVAILABLE TO DEFENDANTS ROBERTSON AND ASHTON

Qualified immunity shields an officer from suit when the officer makes a decision that, even if constitutionally deficient, reasonably misapprehends the law governing the circumstances he confronted. *Brosseau v. Haugen,* 543 U.S. 194, 599 (2005) (citing *Saucier v. Katz,* 533 U.S. 194, 201 (2001)). The focus is on whether the officer had fair notice his conduct was unlawful. Accordingly, reasonableness is judged against the backdrop of the law at the time of the conduct. *Id.* "The contours of the right must be sufficiently clear that a reasonable official would understand that what he is doing violates that right." *Id.* (quoting *Saucier,* 533 U.S. at 201-02). Courts take a two-step approach to resolving this question. First the court must determine whether Robertson and Ashton violated the plaintiffs' constitutional rights. *Saucier*, 533 U.S. at 201-02. If the answer is in the affirmative, the analysis proceeds to determine whether that right was clearly established at the time.

### A. Robertson and Ashton Violated Clustka's Right to Be Free of Deliberate Indifference to a Demonstrated Risk of Suicide

For all the reasons previously addressed, Reno defendants Robertson and Ashton violated Brenda Clustka's right to be free of deliberate indifference to her known risk of harm.

### B. The Law Protecting Pretrial Detainees from Deliberate Indifference to Suicide Risk Is Well-Established

The second prong of the two-step qualified immunity inquiry asks whether it would have been clear to a reasonable officer that his alleged conduct was unlawful. See *Saucier,* 533 U.S. at 202. The conduct of Robertson and Ashton at the time they observed Brenda Clustka attempt to choke herself in the paddy wagon and heard her threaten suicide and took no steps to protect her is what is at issue in this case. Accordingly, the law at that time is the guide. *Id.*

The law of deliberate indifference in the context of jail suicides is well-established. Several courts, including the Ninth Circuit, have made clear that at the time of the incidents alleged, Clustka had a clearly established constitutional right to be free from an officer's deliberate indifference to her potential suicide. *Cavalieri,* 321 F.3d at 623; *Cabrales*, 864 F.2d 1454 (jail suicide case decided in 1988). "A particular vulnerability to suicide represents a serious medical need." *Colburn v. Upper Darby Township*, 946 F.3d 1017, 1023 (3rd Cir. 1991).

## VI. CITY OF RENO MAY BE HELD LIABLE FOR THE WRONGS DONE TO CLUSTKA BASED ON FAILURE TO TRAIN, CUSTOM AND POLICY

Municipalities are "persons" under 42 U.S.C. § 1983 and thus they may be liable for causing a constitutional deprivation. *Monell v. Department of Social Services*, 436 U.S. 658, 690 (1978). A municipality may be sued when execution of a governmental policy or custom inflicts the injury. *Id.* A policy is "a deliberate choice to follow a course of action. . .made from among various alternatives by the official or officials responsible for establishing final policy with respect to the subject matter in question." *Fairley v. Luman*, 281 F.3d 913, 918 (9th Cir. 2002) (per curiam). "A policy can be one of action or inaction." *Long v. County of Los Angeles*, 442 F.3d 1178, 1185 (9th Cir. 2006). To impose liability against a municipality for its failure to act, a plaintiff must show: (1) that a city employee violated the plaintiff's constitutional rights; (2) that the city has customs or policies that amount to deliberate indifference; and (3) that these customs or policies were the moving force behind the employee's violation of constitutional rights. *Id.* (citing *Gibson v. County of Washoe*, 290 F.3d 1175, 1193-94 (9th Cir. 2002).

For all the reasons addressed in the preceding portions of this brief, Robertson and Ashton violated Brenda Clustka's right to be free of deliberate indifference to a demonstrated risk of suicide.

### A. Failing to Train

"A municipality's failure to train an employee who has caused a constitutional violation can be the basis for § 1983 liability where the failure to train amounts to deliberate indifference to the rights of persons with whom the employee comes into contact." *Long*, 442 F.3d at 1186. A plaintiff might succeed in proving a failure to train claim where "a violation of federal rights may be a highly predictable consequence of a failure to equip law enforcement officers with specific tools to handle recurring situations." *Id.*

It is a well-known, well-documented fact that suicide is the number one cause of death in U.S. jails. All the witnesses who testified acknowledged the importance of an officers' obligation to protect persons at risk of suicide. Nonetheless, RPD fails to offer any suicide prevention training to its officers. None of the witnesses who testified could recall any specific policies at RPD on suicide prevention or any training on how to recognize when a person is custody is suicidal and what action to take to protect that person. Robertson testified that, in his 17-year career with RPD he received maybe 15 to 20 minutes training on mental illness.

**B. Failing to Implement Policies**

The Ninth Circuit "consistently has found that a [municipality]'s lack of affirmative policies or procedures to guide employees can amount to deliberate indifference, even when the [municipality] has other general policies in place." *Long*, 442 F.3d at 1189. The Ninth Circuit explained:

> In *Gibson*, a mentally ill detainee died while in the custody of the county jail. The decedent's wife sued the county, alleging that it had acted with deliberate indifference to her husband's mental illness. The district court granted summary judgment in favor of the county. On appeal, this court reversed and remanded, finding that the county's policy – which precluded a medical evaluation for an incoming detainee who was uncooperative, combative, or intoxicated – **failed adequately to instruct the nurse on duty how to act upon medical information**, including information from prescription medications, which she obtained from the detainee. The court held that a jury could find that the omission was sufficiently likely to result in the violation of the detainee's right to medical care that the county was deliberately indifferent to those needs. *Id.* (citing *Gibson*, 290 F.3d at 1195).

Similarly, state law on Legal 2000 is extremely protective of persons at risk of suicide and City of Reno witnesses all testified their strong duty to protect persons to make suicide attempts and threats. However, as all RPD witnesses testified RPD has no policies addressing suicide prevention and has not trained its officers on their duty how to act when handling potentially suicidal persons.

**C. Charging the Known Deficient Robertson with Responsibility to Protect the Public**

Another way to establish municipal liability is to show how City was aware of similar misconduct in the past, but failed to take reasonable precautions against future violations, and that this failure, at least in part, led to the injury. *Bielevicz v. Bubinon*, 915 F.2d 845, 851 (3rd Cir. 1990). City knew well Officer Robertson's deficiencies in judgment, knowledge of laws, policy and procedure, reporting, and other violations referenced in documents filed under seal herewith. City had an obligation to take remedial measures to correct his blatant errors in judgment. Instead of meeting its obligation, City did nothing.

Robinson was never suspended, never had his pay docked, and was never required to attend additional training. "Tolerance of unconstitutional conduct is tantamount to encouragement of such conduct and is therefore a basis for municipal liability." *Skiby v. City of New York,* 109 F.R.D. 58, 65 (E.D.N.Y. 1985). City knowingly let Robinson "slip through the cracks" over his seventeen-year career and placed him in a position involving high interaction with the public and exercise of discretion transporting people to the jail while mentoring a new officer. RP D's knowing failure to rein in this deficient officer created constitutional time bomb and Clustka, at high risk of suicide, was its predictable victim.

**D. Failing to Discipline Robertson and Ashton for Violations of Policy**

The Ninth Circuit has held that post-event evidence is admissible for proving the existence of a municipal defendant's policy or custom and may be highly probative of that inquiry. *Henry v. County of Shasta,* 132 F.3d 512, 520 (9th Cir. 1997). It is undisputed that both Robertson and Ashton were found to have violated RPD policies and procedures in their failure to report Clustka's suicide attempt and threats. It is similarly undisputed that neither officer received any discipline for this extraordinary violation. City's worse than inadequate response to these officers known violations gives a strong message: So far as City is concerned, that what happened to Clustka as a result of the officers' indifference just didn't matter.

## VII. CONCLUSION

For reasons stated, plaintiffs ask this Court to deny defendants' motion for summary judgment.

Dated this 25th day of September 2006.

/s/ Diane K. Vaillancourt
TERRI KEYSER-COOPER
DIANE K. VAILLANCOURT