2007 WL 2734637 (C.A.9) (Appellate Brief)
United States Court of Appeals, Ninth Circuit.

Charla CONN, Dustin Conn, Plaintiff-Appellants,
v.
CITY OF RENO, Ryan Ashton, David Robertson, Defendants-Appellees.

No. 07-15572.
August 6, 2007.

District Court No. 3:05-cv-00595 HDM
Appeal from Grant of Summary Judgment
United States District Court District of Nevada United States District Judge Howard D. McKibben

Appellants' Opening Brief

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I. *STATEMENT OF JURISDICTION*

This appeal challenges a final decision by a district court in a federal question case. The basis for subject matter jurisdiction in the district court is 42 U.S.C. §1983 and the Fourteenth Amendment to the United States Constitution. The basis for jurisdiction in the Court of Appeals is 28 U.S.C. §1291.

II. *ISSUES PRESENTED FOR REVIEW*

(1) In wrapping the paddy wagon seatbelt straps around her neck and repeatedly threatening to kill herself if taken to jail on civil protective custody, did the decedent Brenda Clustka put transporting officers Robertson and Ashton on notice that she was at risk of self-harm?

(2) Were the officers entitled to ignore Clustka's suicidal gesture and threats because she was intoxicated?

(3) Did the lower court err in finding no deliberate indifference where the officers were motivated to keep silent regarding Clustka's suicidal gesture and threats because they had violated procedures - first, by failing to handcuff Clustka, and second, by continuing to drive after she unbelted her seatbelt - and providing notice of Clustka's conduct would have revealed their misconduct and exposed them to discipline?

(4) Did the lower court err in concluding it was sheer speculation that, had the officers taken Clustka to jail on a Legal 2000[1] - as their superiors said they should have done - she would have more likely than not been protected from committing suicide on April 28.

(5) Did the fact that Clustka was released from civil protective custody with no suicide precautions in place constitute an intervening event protecting the officers from liability where she committed suicide after being returned to jail the next day?

III. *STATEMENT OF THE CASE*

A. *Nature of the Case*

Suicide has long been known to be the number one cause of death in United States' jails.[2] Jail inmates are nine times as likely to commit suicide than free persons. The likelihood of suicide is known to be highest in the first fourteen days of confinement.[3] Washoe County Detention Facility is no exception. The suicide death of Brenda Jean Clustka in April 2005 was the second jail suicide within one month at the Washoe County jail and the fifth in little over a year.[4]

What makes Clustka's suicide especially senseless and disturbing is that the officers who transported her to jail less than 48 hours before on civil protective custody[5] intervened and stopped her from choking herself with a paddy wagon seatbelt. As the two officers struggled to remove the seatbelt from around her neck, Clustka begged them not to take her to the jail and screamed, "Kill me or I'll kill myself then." To any reasonable person, this suicide gesture and these suicide threats would indicate intent to harm herself. To defendants Robertson and Ashton, they did not count because she was intoxicated and suicide threats by intoxicated persons may be ignored.

The tragedy of this case is that, even though Clustka made her suicidal intent known to her transporting officers in no uncertain terms - for reasons of their own - they failed to take any steps to protect her. They had reason to keep silent. Had they reported her conduct, they would have also had to report how they violated seatbelt laws and handcuffing policies. Their interest in keeping silent trumped her need for suicide intervention. This is the essence of deliberate indifference.

Failing to report Clustka's suicide threats to the appropriate officials and failing to involuntarily commit her, the officers deprived her of a safety net designed to protect persons at risk of killing themselves. When the officers took Clustka into civil protective custody, the objective was to protect her against self-harm. She had committed no crime. She needed protection, and the officers knew this.

At the very least - according to police department policy - they were obliged to report what they witnessed so that those who encountered her would have known to take suicide precautions. They weren't free to just drop her off as though nothing had happened. They had an affirmative obligation to protect her. Instead of protecting her, they compounded the harm with their silence.

The officers could have protected Clustka by advising jail authorities of her threatened suicide. That would've triggered the jail's obligation to protect her until she would be determined no longer a threat to herself. The officers could have protected Clustka by taking her directly to Washoe Medical Center and reporting her suicide threat to emergency room physicians. That would've triggered the hospital's obligation to protect her until she was determined no longer at risk of suicide. Finally, the officers could have protected Clustka by reporting her suicide threats to their superior officers. That would have triggered the supervisors' obligation to take appropriate action to protect her. The officers did none of the above. By dropping her off at jail while withholding critical information that only they were privy to, it is submitted that, exhibiting deliberate indifference to Brenda Clustka's welfare and safety, these officers deprived her of life-saving alternatives.

B. *Course of Proceedings and Disposition in Court Below*

On November 3, 2005, plaintiff-appellants filed their Complaint in the United States District Court, District of Nevada (CR 2), followed on December 12, 2005, by their First Amended Complaint (CR 16, ER 1), which defendants answered on April 17, 2006 (CR 28, ER 13). On August 29, 2006, defendant-appellees filed a motion for summary judgment on all claims (CR 49), which plaintiff-appellants opposed on September 25, 2006, (CR 53-54), and to which defendant-appellees replied on October 13, 2006 (CR 58). On March 8, 2007, the district court granted defendant-appellees' motion and entered judgment against plaintiff-appellants (CR 62-63, ER 434-453). Notice of appeal was timely filed on April 3, 2007 (CR 66, ER 454).

IV. *STANDARD OF REVIEW*

The appellate court reviews a district court's grant of summary judgment de novo. *Pool v. Vanrheen,* 297 F.3d 899, 905 (9th Cir. 2002); see also *Delta Sav. Bank v. United States,* 265 F.3d 1017, 1021 (9th Cir. 2001).

V. *SUMMARY OF ARGUMENT*

There is no dispute that Clustka - while being transported to jail on civil protective custody, having committed no crime and bothered no person, with a mere .10 breathalyzer reading as she stood in a Reno residential neighborhood - attempted to choke herself with a seatbelt strap in the paddy wagon and screamed repeatedly, "Kill me or I'll kill myself then." There is no dispute that transporting officers Robertson and Ashton watched Clustka tightly wind the seatbelt around her neck through the paddy wagon surveillance camera and heard her repeated threats to kill herself. There is no dispute these officers were advised before putting her in the paddy wagon that she was mentally ill.

There is equally no dispute these officers knew that, according to policy, all suicide attempts must be reported. There is no dispute they knew that officers like themselves *do not have discretion* to fail to file reports on such matters to their superiors or notify jail staff. Finally, there is no dispute these officers *knew* they were violating RPD policies when they decided to transport Clustka without first handcuffing her and that they knew they were violating, not only department policies, but also state law when they continued driving after seeing Clustka remove her seatbelt and move about the paddy wagon.

Had the officers reported the choking incident, they would also have had to explain just how Clustka came to wind the seatbelt around her neck, how their failing to secure her contributed to the situation. They had good reason to maintain silence and avoid exposure to discipline at the price of Clustka's welfare. The lower court erred in finding as a matter of law that this conduct by the officers did not constitute deliberate indifference.

The officers argue they had no responsibility to report Clustka's suicide attempt and threats because she registered .10 on the breathalyzer and therefore was "intoxicated." They insist - contrary to all officials and common sense - that suicide gestures and threats by intoxicated persons "don't count" and they are free to ignore them. They assert she was trying to get their attention, she was being "manipulative," and she could not have succeeded in killing herself in the paddy wagon because she would have passed out and the seatbelt would have slackened. On this basis, they argue, they were justified in ignoring her suicide attempt and threats. The lower court erred in giving the officers' self-serving rationales full credence against the deposition testimony of jail health officials, jail and police personnel, and their own supervisor, who emphatically make clear the officers had were mandated to report suicidal gestures and threats even if made by an intoxicated person. There is much circumstantial evidence the officers knew exactly what they were doing. The question of their subjective intent is for a jury to decide.

In addition, the lower court erred in finding as a matter of law that there was no causal relationship between the officers' conduct and Clustka's actual suicide less than 48 hours later. So finding, the court ignored that, when Robertson and Ashton took her into civil protective custody, they assumed an obligation to protect her from self-harm and that they failed that obligation by "leaving her out in the cold," that is, simply dropping her off at the jail without alerting anyone to the need to take suicide precautions.

Several options were available to save Clustka: First, consistent with their training,[6] the defendant officers could have taken her directly to a hospital under Nevada's Legal 2000 involuntary commitment procedure and reported what they saw and heard to emergency medical staff. Second, had they informed the jail, the jail would have had the option of refusing her, instituting a Legal 2000, and sending her to a hospital for assessment and treatment. Third, the jail would have had the option of admitting her and placing her under suicide watch until she was detoxified, then sending her to a hospital under a Legal 2000.

Any of these options would have assured suicide intervention by qualified medical and psychiatric staff until Clustka was determined to be not at risk of suicide. While Clustka was briefly evaluated medically at least twice following Robertson and Ashton's contact with her, *no one who evaluated her was apprised of her most recent suicide threats* because the officers told

no one. No one at the jail had any way to know of her suicide gestures and threats. How could the jail take necessary suicide precautions if Robertson and Ashton failed to alert anyone of the need to do so? As a result, Clustka was never assessed or treated for suicide risk. The lower court erred in refusing plaintiffs' substantial evidence of a different outcome and dismissing it as mere "speculation."

VI. *FACTS*

A. *Clustka Had a History of Suicidal Behavior*

Brenda Jean Clustka was well known at Washoe County Detention Facility as a repeat misdemeanor offender. She had a documented history of family troubles, alcohol and other drug dependence and suicide threats dating back several years (ER 22-27, 37). In addition, she was involuntarily committed on a Legal 2000 three times between September 2001, and April 2004 (ER 97-142). In each of these commitments, Clustka was held until she was determined no longer suicidal. Afterwards, she remained "suicide free" between eight and 24 months (ER 97-142).

Nearly a year after her 2004 commitment for attempted suicide, on March 19, 2005, Reno police - among them defendant Ashton - arrested Clustka for misdemeanor domestic battery after a dispute with her mother. Police documented several bruises and injuries to her head, which she insisted her brother inflicted (ER 29, 31). Adhering to procedures, they took her to the Washoe Medical Center ("WMC") for examination and treatment before taking her to jail. On March 20, jail authorities placed Clustka on suicide watch in the jail's infirmary after she made comments about "not being able to make it in jail." The jail kept her on suicide watch - with checks every 15 minutes - until it determined she was no longer a suicide risk (ER 36, 38-43).

B. *After Her Release from Jail, on April 25 Clustka Was Involuntarily Committed*

On April 21, Clustka was released from jail (ER 36). Meantime, Clustka's mother had applied for a temporary protective order ("TPO") that would require Clustka to stay away from her home and be accompanied by police when retrieving her belongings (ER 48).

On April 25 - the TPO had not yet been issued - Clustka and her mother had a verbal altercation in which Clustka threatened suicide overdose with an anxiety medication. Her mother called 911. Reno police responded and took Clustka to WMC to be evaluated for involuntary commitment to a mental health facility. The emergency department admitted her at about 9:30 a.m. She lied to emergency staff that she had never made any suicide threats or attempts when she clearly had repeated attempts on file. She escaped and officers were summoned to bring her back involuntarily. The hospital then transferred her to Northern Nevada Mental Health Institute ("NNMHI") on a Legal 2000 commitment where she was assessed for suicidal ideation. Clustka arrived at NNMHI at around 4:30 p.m. on April 25 and was held overnight on a suicide watch (ER 78-85, 133-142).

NNMHI conducted a thorough suicide assessment and, around 9:30 a.m. on April 26, released Clustka after she assured mental health staff she would "not attempt to harm herself," exhibited thoughts that were "logical and organized with no signs of psychosis," and demonstrated adequate judgment and insight "to meet basic needs and understand dependence" (ER 142). She was given back her anxiety medications and was advised to "return or call for future difficulties" (ER 85).

C. *Clustka's Condition Deteriorated Again After her Release from NNMHI*

The morning of April 26 after being released from NNMHI, Clustka took a turn for the worse. At around 11:00 a.m., her mother obtained the TPO and she realized she could not go home (ER 44). By around 2 p.m., Regional Emergency Medical Services Authority ("REMSA") responded to a 911 call from an passerby regarding a "psychiatric problem" Finding Clustka "supine" on the sidewalk, REMSA cleared her medically and, smelling alcohol on her breath, they called Reno police for a

civil protective custody (“CPC”) commitment (ER 425).

Reno police officers Robertson and Ashton were dispatched to the scene. Ashton recalled Clustka because he assisted in arresting her a month earlier. Clustka explained to Robertson and Ashton that she wanted assistance in retrieving her belongings-that she was aware of the TPO and wanted to comply. Though intoxicated, Clustka responded appropriately to the officers’ questions and carried on a conversation. She was not stumbling, falling down, fighting anyone or causing any disturbance (ER 218@59:1-4, 219@62:14-19, 220@67:14-24). The officers had discretion to take her on a CPC or leave her alone-they decided to take her to jail (ER 219@63:7-9). They conducted a wants and warrants check, which indicated precautions that Clustka abused drugs and alcohol, had a history of mental problems, and had violent tendencies (ER 47, 148:8-12). She was not yet served with the TPO and so was not violating it (ER 147-148, 158).

To gain Clustka’s cooperation and entice her into the paddy wagon, Robertson lied, promising, “Okay. We’ll go take you to pick up your stuff.” At his deposition, Robertson admitted he lied and had no intentions of taking her anywhere but jail (ER 149:7-10). Violating department policy and general orders, Robertson and Ashton chose not to handcuff her for the trip in the paddy wagon to jail. Robertson drove and Ashton was in the passenger seat (ER 148:12-20, 149:17-18, 182@14:10-22, 222@73:24-74:1, 239@141:3-9, 474-475).

D. ***On Seeing the Jail, Clustka Wrapped the Seatbelt Around Her Neck and Threatened to Kill Herself***

On the way to the jail, Ashton watched Clustka in the back of the paddy wagon through a video surveillance camera. He saw her undo her seatbelt, leave her seat, walk about the wagon several times and repeatedly knock at the camera with her hand. He asked Robertson if they shouldn’t stop. Though it was a known violation of seatbelt laws and department policy, Robertson decided not to stop and secure Clustka in her seat (ER 149:10-17, 185@25:11-15, 213@40:10-16, 214 @43:3-21).

When she sighted the jail out the paddy wagon window, Clustka became extremely agitated and distressed. She sat back down, grabbed the seatbelt straps and wrapped them tightly around her neck in what the officers admit was an attempt to *choke* herself (ER 149:13-151:1, 349-350, 359:3-7). This time, Ashton made Robertson stop the paddy wagon and the officers went to the back. It took both of them to unwind the seatbelt from around Clustka’s neck. They then placed her on the floorboard, placed her hands behind her back, handcuffed her with flexible handcuffs, and secured her in the seat. Clustka was screaming, “You lied to me. Just kill me. I’ll kill myself then” (ER 150:1-8, 195@66:7-10, 353:21-25, 363:10-15).

E. ***Officers Robertson and Ashton Dropped Clustka off at the Jail Without Informing Anyone What Had Happened***

Robertson and Ashton continued to transport Clustka to the jail, this time in handcuffs and seatbelted. On arriving at the sally port, Clustka again screamed she wanted to die (ER 215@46:25-47:9). The officers told Central Control that they had an uncooperative and “disoriented” female but were silent on what had happened (ER 150:6-12).

Ashton asked senior officer Robertson if they shouldn’t report the suicide threats but they decided not to (ER 151:9-13). They had reason not to report what had happened: Had they reported it, they would have had to explain why Clustka was not handcuffed and not secured in a seatbelt in violation of department policy and state law (ER 182@14:10-22, 222@73:24-74:1, 239@141:3-9, 149:10-17, 185@25:11-15, 213@40:10-16, 214@43:3-21). The officers maintain they did not believe it was a serious suicide attempt, that Clustka knew they were watching her on video surveillance and that the seatbelt would have lost tension after she passed out-so she would not actually have died (ER 151). The officers also maintain that, because Clustka was inebriated, her suicidal gestures and threats “didn’t count” (ER 230@107:5-11, 193@56:17-24). This rationale and reasoning was denounced by their supervisors and jail staff, who insist that all suicide gestures and threats must be reported (pp. 15-17 *infra).*

F. ***The Officers Were Authorized to Involuntarily Commit Clustka***

NRS § 433A.115 specifically 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 intoxicated* (ER 246). 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" (ER 247, 399-400).

RPD Deputy Chief James Johns, a self-identified policymaker, testified that a "Legal 2000" occurs when an officer is dealing with an individual who demonstrates a potential threat to self (ER 252@5:16-17, 262@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" (ER 262@46:18-47:3). Even persons accused of heinous crimes may be taken to the hospital on a Legal 2000 before beginning their incarceration (ER 262@47:6-13). Washoe County Sheriff's Lt. Milt Perry agreed, stating that instead of booking such persons, officers may take them directly to the hospital on a Legal 2000 (ER 312@55:8-56:2). Generally, if officers bring someone to the jail who has made suicidal statements, the jail has them take the person directly to the hospital (ER 314@63:21-24). If an intoxicated person who has threatened suicide is taken in on CPC, typically, when they're no longer legally intoxicated, the jail does a Legal 2000 and takes the person to the hospital for involuntary commitment (ER 314@62:10-24).

Similarly, Robertson and Ashton's supervisor, Sgt. Evans testified that officers conduct Legal 2000 holds when someone threatens to harm his or herself (ER 273@21:8-13). If an officer is confronted with someone who threatens to kill herself, the officer has several options available to protect the person, including taking her to a medical facility to be assessed and evaluated (ER 278@41:21-42:14). "If she's making statements about killing herself we're going to make sure that she is taken to a safe place" (ER 273 @ 22:19-21). According to Evans, someone with medical training is in a better position to evaluate such a person than a police officer (ER 274@25:7-26:2).

G. *The Evening of April 26, With No Suicide Precautions in Place, Clustka Was Released from CPC then Returned to Jail the Next Day*

On arriving at the jail, Clustka was given a standard CPC evaluation, which meant only checking her vital signs and general appearance, including signs of withdrawal. The nurse did not evaluate her for suicide risk because the nurse had *no notice* of her suicide threats. Moreover, the jail is *not allowed* to medically treat persons in CPC (ER 171@44:2-12, 428-429). Clustka was released from CPC in the late evening of April 26 with no suicide precautions in place and was served with the TPO (ER 428-431).

Following her release, Clustka could not return home due to the TPO. She was picked up again near midnight on April 26 on another CPC by officers who knew *nothing* of her earlier suicide gesture and threats. This second time the jail refused her because she was not sufficiently intoxicated and the officers took her to the emergency room where she was briefly examined and released after refusing medical treatment. Knowing nothing of the suicide threats she had made earlier in the day, the physicians did not do any suicide assessment or send her to NNMHI on a Legal 2000 (ER 432-433). After being released from the hospital, Clustka attempted again to return home to retrieve her personal belongings (ER 51-52).

About noon on April 27, Clustka's brother called the police, who arrested Clustka for misdemeanor violation of the TPO and transported her to jail (ER 52). Clustka was placed in HU3, a medical housing unit, due to her mental health history (including the jail suicide watch one month earlier), anxiety disorder, and substance abuse. In the initial medical screening, Clustka was asked if she had ever "considered or attempted suicide" - this was all the suicide screening she received. She lied, denying she ever had done so. There was no sense of urgency, as the jail had *no notice* of Clustka's recent history of suicidal gestures and threats and she was neither placed on suicide watch nor referred to the hospital on a Legal 2000 (ER 53-58, 36).

H. *On April 28, with no Suicide Precautions in Place, Clustka Killed Herself*

At 8 a.m. on April 28, Clustka was removed from her cell for a video arraignment on the TPO violation (ER 61). With no

suicide precautions in place - she was left alone with no monitoring for over half an hour - Clustka hung herself in her bunk bed with a sheet, having tied a knotted bed sheet around her neck and to the top bunk while lying in the bottom bunk. At about 9:17 a.m., jail officials found her dead (ER 62). Death was found to be caused by "Asphyxia by hanging/suicide" (ER 37).

A short time after, defendant Ashton arrived at the jail with another transport and was told about Clustka's suicide. Ashton confessed to the sheriff's deputy accompanying him that he had transported her to the jail on a CPC the day before and that she was not handcuffed and "tried to hang herself in the wagon." He then remarked he would be writing a report and his "sergeant will be pissed." He did not elaborate further (ER 74).

I. *The Officers Violated Well-Known Policy in Failing to Respond to Clustka's Suicide Gesture and Threats*

Robertson and Ashton stand alone in their insistence that they were correct in failing to notify anyone as to what happened or take her to the hospital on a Legal 2000. Their superiors and all other officials strongly disagree. According to these others, Robertson and Ashton violated well-known policy and practice in failing to report Clustka's suicide attempt and threats.

1. *Prison Health Services Director Gail Singletary*

"All law enforcement officers should be aware of the signs and symptoms of suicide to communicate it and help avert it," Singletary testified (ER 167 @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 (ER 174@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" (ER 174@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 action to take (ER 175@57:6-10).

Following Clustka's suicide - to avoid future policy violations by transporting officers - the Washoe County Detention Center implemented a new policy requiring all transporting officers to fill out a form indicating whether the detainee 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 (ER 166@21:19-22:23, 166@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 (ER 166@24:10-25). If a transporting officer sees either a suicidal gesture and/or hears a threat of suicide, that *must be* communicated to jail staff (167@25:2-6). In addition, if RPD officers transporting a detainee see the detainee attempt to choke his or herself (as Robertson and Ashton did with Clustka), that too *must be* communicated to jail staff (ER 167@25:20-26:7).

2. *Washoe County Lt. Milt Perry*

According to Lt. Perry, deputies have no discretion to ignore a detainee's suicide threat (ER 311@51:6-14). Perry testified the "threat to kill oneself" by any detainee should be taken seriously (ER 305@27:19-21). A deputy who has learned that a detainee has threatened suicide will generally take such information to medical staff and ask what to do (ER 309@43:3-6). Perry acknowledged that all communication between a transporting officer and jail staff regarding suicide *must be* documented and reported (ER 312@53:15-19). Before joining the sheriff's department, Perry was an RPD officer. He testified, from his training as an RPD 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 (ER 316@71:1-10).

3. *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 (ER 264@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 (ER 260@39:13-19). In their place, he would have told jail staff what he had observed (ER 259@35:9-19).

4. *RPD Sergeant David Evans*

Sgt. Evans disagreed with his subordinates Robertson and Ashton that they have "discretion" to decide which suicide gestures and threats are legitimate and which are not. He testified that, when an officer hears someone intends to kill him or herself, the officer *must* report it (ER 274@28:24-275@29:6). Evans would *not* advise officers under his control to disregard a detainee who says, "I want to kill myself" (ER 275@29:25-30:15). 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 (ER 279@47:14-18, 279@48:6-8).

J. *Robertson and Ashton Admit They KNEW They Were Required 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 (ER 194@61:10-11). He knew that suicide attempts should be reported and officers do not have discretion to ignore them (ER 197 @75:15-20). Additionally, Ashton admitted that reporting a suicide attempt is important because a police officers' job entails helping people in need (ER 197 @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 (ER 233@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" (ER 233@119:17-24, 237@133:1-19).

K. *RPD Failed 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 (ER 385). Clustka was the second inmate in 30 days to commit suicide at the Washoe County jail and the fifth of six to die by suicide between January 2004 and August 2005 (ER 392, 395-396). All witnesses in this case testified 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, policymaker Johns testified he doesn't know if RPD has a written policy on the reporting of suicide threats (ER 260@40:25-261@41:9). To Johns' awareness, the department has no suicide prevention policy (ER 261 @41:13-15).

Sgt. Evans, Robertson and Ashton's supervisor, similarly testified he is not aware of any training given to officers on how to distinguish when a person makes a serious suicide attempt or threat (ER 274@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. He has no recollection of ever receiving any suicide prevention training while at RPD (ER 276@36:17-277 @37:25).

Robertson similarly testified he received no training on dealing with potentially suicidal prisoners (ER 228@98:2-4). The only training Robertson received was on handling the mentally ill, totaling 15 to 20 minutes, and he could not recall when he received this training in his 17-year career or who trained him on how to identify potentially suicidal prisoners (ER 234@121:23-122:3, 234@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 (ER 186@32:12-15, 194@62:13-18).

L. *Several Options Were Available to Protect Clustka*

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

Singletary testified to the 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 (ER 164@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 (ER 164 @14:16-15:3); third, the majority of all suicide victims communicate an intent to commit suicide prior to doing it (ER 165@20:21-21:7); fourth - and most important - *it is jail policy to refuse admittance of suicidal persons* and to direct deputies to send such persons to hospitals (ER 172@47:1-8; 48:3-12). Jail staff and nurses can request that persons in civil protective custody be taken to a hospital for a Legal 2000 if they suspect the person is suicidal (ER 173@51:14-25). Jail medical staff are *not allowed* to medically treat persons in civil protective custody because they are technically not under arrest (ER 171 @44:2-5).

According to Perry, had CPC jail staff known of Clustka's suicide attempt and threats, several options were available to protect her: First, despite Clustka's intoxication, Robertson and Ashton could have applied for a Legal 2000 and taken her directly to a hospital (ER 315@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 (ER319@83:11-84:3). Third, on releasing Clustka from CPC, the jail could have sent her to the hospital on a Legal 2000 (ER 312@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 would commence a Legal 2000 and send the person to a hospital to address the risk of suicide (ER 314@62:10-16).

2. *Had Clustka Been Taken to a "Medical Facility," She Would Have Been Held Until She Was No Longer at Risk*

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

Washoe Medical Center emergency physician, Dr. Guy Gansert testified that the police *"typically take"* a person who threatens suicide to the emergency department (ER 323@5:16-20). At WMC, both suicide attempts and suicide threats are taken very seriously (ER 325@12:21-13:2). On arrival at the emergency department, the person is assessed for risk of suicide (ER 323@5:21-23). Emergency staff perform 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 to the emergency room (ER 323@5:24-3246: 10).

An "alert team" assists the emergency physician in evaluating the person for suicide risk and carefully records all the information obtained (ER 324@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 is transferred to a psychiatric facility, generally NNMHI (ER 324@7:24-8:20). On average, WMC holds such persons six to eight hours before transferring them to NNMHI (ER 328 @22:24-23:6).

Based on Dr. Gansert's 17 years experience making referrals to NNMHI, they do a "thorough job evaluating patients at risk of suicide" (ER 324@8:16-20, 324 @9:10-13). They would have given "appropriate intervention" (ER 324@9:14-18). Gansert personally evaluated and transferred Clustka to NNMHI on April 25 and was satisfied that he did what was best for her and was "confident that she would get good care" there (ER 324@9:19-25). Had Clustka been returned to the emergency room on April 26 after her repeat suicide attempt, Gansert would have thoroughly evaluated her for suicide risk (ER 327@18:6-12), and, if he believed that she was at risk, he would have had "no hesitancy" in transferring her to NNMHI (ER 325@10:1-6).

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

Dr. Caplan, NNMHI's psychiatrist, testified 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" (ER 337@29:4-7). NNMHI provides full mental health services for persons with suicide issues (ER 331@5:10-20). Patients are admitted to NNMHI after a thorough assessment, complete with evaluations by social workers and nurses in addition to a psychiatrist (ER 332@7:18-8:21). Caplan personally does a

psychiatric evaluation as an integral part of the suicide assessment and diagnoses the patient (ER 333@10:7-21). It is his "duty" to examine thoroughly and diagnose persons brought in for suicide risk (ER 333 @10:18-21). The social worker completes a "Locus Adult Assessment" as part of the assessment (ER 333@11:2-12:1) and the nurse does an individualized treatment plan, which identifies goals, interventions and conditions for discharge (ER 333@12:6-18). Careful progress notes are kept (ER 333@13:13-16).

As part of the treatment plan, NNMHI maintains the patient on observation - at least every 15 minutes - which is carefully recorded (ER 333@12:19-13:12). NNMHI takes a wide array of approaches to protect persons from suicide (ER 334 @14:4-6). Had Clustka been taken to NNMHI, she would have been kept overnight, carefully assessed, closely monitored, and nurses and social workers would have interacted with her to remove suicidal thoughts and to address her psychological/psychiatric issues (ER 336@25:25-26:10). Caplan testified to how important it is to pay attention to when someone makes a suicide gesture and to get that person to medical or mental health help, frequently both (ER 334@14:7-9, 334@14:16-15:2).

NNMHI will not discharge a person who it believes remains a suicide risk (ER 334@15:9-12). If its staff believe a person is at suicide risk, they can keep that person up to 72 hours to protect him or her (ER 334@15:16-19). In addition, there are options for keeping the person longer by petitioning the court and obtaining a court order (ER 334@15:24-16:2). With a court order, NNMHI can keep a patient at risk of suicide up to six months and can petition the court for even more time (ER 334@16:4-11). It can keep that person indefinitely until the risk is no longer significant (ER 334@16:14-18).

According to psychiatrist Caplan - both a treating physician and expert witness - "most people" who are suicidal *want to be saved* (ER 335@20:12-16). For the vast majority, there is an opportunity to intervene successfully (ER 335@21:21-25). Most suicides can be prevented (ER 335@22:4-7). The fact that Clustka "improved rapidly while receiving appropriate intervention and care on April 25, signified someone who would want to be saved (ER 335@20:17-21:1).

Had Clustka been returned to NNMHI following her second suicide incident within two days, she would have been thoroughly evaluated (ER 336@24:19-23). The fact of her intoxication would have set off an "alarm bell" that she was at high risk (ER 336@25:4-9). In addition, the fact of her Xanax abuse - also documented the day before - would have set off another alarm bell (ER 336 @25:10-13). The fact that she had a documented history of suicide attempts would have set off even more alarm bells (ER 336@25:19-24).

Finally, the fact that Clustka was admitted to NNMHI just one day before and held overnight on suicide observation would have set off "very serious alarm bells that this woman was at high risk of suicide" (ER 336@25:19-24). According to Dr. Caplan, *"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*" (ER 337@29:4-7). A "whole safety net of precautions" existed to protect Clustka from suicide had she been returned to NNMHI after threatening suicide in the paddy wagon on April 26 (ER 337@28:17-21).

VII. *ARGUMENT*

A. *Deliberate Indifference to Suicide Threats*

Clustka was a detainee after Officers Robertson and Ashton took her into civil protective custody. The Fourteenth Amendment due process clause - rather than the Eighth Amendment - applies to protect such persons. Under the Eighth Amendment, prison officials must take reasonable measures to guarantee inmate safety, which means addressing serious physical and mental health needs. See *Farmer v. Brennan,* 511 U.S. 825, 833 (1994); *Hoptowit v. Ray,* 682 F.2d 1237, 1253 (9th Cir. 1982).

In the Ninth Circuit, the test for deliberate indifference has two parts: First, the plaintiff must show a "serious medical need" by demonstrating that "failure to treat a prisoner's condition could result in further significant injury or the 'unnecessary and wanton infliction of pain.' " Second, the plaintiff must show the defendant's response to the need was deliberately indifferent. *Jett v. Penner,* 439 F.3d 1091, 1096 (9th Cir. 2006) (citations omitted).

> This second prong - defendant's response to the need was deliberately indifferent - is satisfied by showing (a) a purposeful act or failure to respond to a prisoner's pain or possible medical need and (b) harm caused by the indifference.

Id. While an inadvertent or negligent failure alone is insufficient to state a claim, indifference may be shown where officials "deny, delay, or intentionally interfere with medical treatment." *Id.* As is often repeated, the deliberate indifference standard requires more than a finding of negligence but less than a showing of intentional harm-but rather a "subjective recklessness." *Farmer,* 511 U.S. at 840; see also, *Cavalieri v. Shepard,* 321 F.3d 616, 621 (7th Cir. 2003). "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), *reinstated,* 886 F.2d 235 (9th Cir. 1989).

1. ***The Lower Court Erred in Failing to Find Clustka's Suicide Threats Showed a "Serious Medical Need"***

Under the Ninth Circuit test for deliberate indifference, the first question is whether there was a serious medical need, in this case, for Clustka to have her threat of suicide addressed. Otherwise stated, was there a "substantial risk of serious harm" from the officers' ignoring her suicide threats? See *Farmer,* 511 U.S. at 828.

As observed by one court, the meaning of "substantial risk" is "neither static nor rigid, but instead depends on the nature of the potential harm. In other words, the more serious a possible injury, the lower the threshold for showing that the risk is substantial." *Mombourquette v. Amundson,* 469 F. Supp, 2d 624, 637 (W.D. Wis. 2007) (citations omitted).

Indisputably, Clustka had a "serious medical need" to have her suicide threats addressed. The lower court erred in deferring decision on the point. In deciding the officers were not deliberately indifferent, the court never acknowledged that it was Clustka's life that was at stake.

The officers saw Clustka injured in a particular fashion that demanded life-saving intervention. To properly address the problem, the medical providers who interacted with Clustka at the jail needed to know the critical information that Clustka had recently threatened suicide. Without this information, they could not take the necessary measures to save her life, and the officers decided to withhold it. Had the officers witnessed her being bitten by a rattlesnake and the medical providers been advised that a rattlesnake had bitten her, they would have known to give her appropriate antidotes. Otherwise precious opportunity for appropriate intervention would be lost and her life would be at stake. Clustka's suicide threat is no different: Had the medical providers been advised she was threatening suicide, they would have known to take suicide precautions. No one who examined Clustka after her interactions with Robertson and Ashton had the critical information that would have "set off alarm bells" that suicide precautions were necessary. Precious opportunity for appropriate intervention was lost and Clustka died as a result.

2. ***The Lower Court Erred in Finding as a Matter of Law that the Officers Were Not Deliberately Indifferent***

a. ***Whether the Officers Purposefully Failed to Respond Is a Jury Question***

1. ***Issue of Fact Over Awareness of Risk***

Under *Farmer,* 511 U.S. at 837, a plaintiff must prove not only that the defendants knew facts that would *allow* drawing an inference of substantial risk of harm, but also that the defendants *actually* drew the inference. See also, *Toguchi v. Chung,* 391 F.3d 1051, 1057 (9th Cir. 2004). 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." *Farmer,* 511 U.S. at 842. Knowledge may be inferred if a risk is obvious. *Id.*

While it is not a violation if an official should have been aware of the risk but was not, *Toguchi,* 391 F.3d at 1057, the official may not immunize himself from liability simply by averring he was unaware. Circumstantial evidence may be used to persuade the factfinder that the official was subjectively aware of the risk, despite his protestations to the contrary. *Farmer,* 511 U.S. at 842. Further, while the official is not liable for obvious risks of which he was unaware, the obviousness of a risk may constitute evidence that he was in fact aware of the danger presented. *Farmer,* 511 U.S. at 842. An obvious risk is one that a reasonable person would realize. *Id.*

Who would admit to deliberate indifference? No one of course. Because the defendants' state of mind is a question of fact worthy of probing inquiry, it is a matter generally reserved for a jury. In this case, Robertson and Ashton argue that, because Clustka was intoxicated, they were justified in ignoring her conduct and her suicide threats. Despite their protestations, there is substantial circumstantial evidence indicating they knew exactly what they were doing. Viewed in a light favoring plaintiffs - as is required - such evidence is sufficient for a reasonable jury to conclude that they were aware of the risk they were courting that Clustka would attempt to harm herself again. The lower court erred in simply crediting Robertson and Ashton's expected denials.

(a) ***Witnessed Attempt at Self Harm***

Robertson and Ashton admitted they observed Clustka wrap the seatbelt around her neck in an "attempt to choke herself" - what they could see was an attempt at self-harm. Robertson further admitted he did not think she was joking, and Ashton agreed (ER 235@128:4-5, 286@31:22-24).

By itself, the officers' awareness of Clustka's choking attempt is sufficient to create a jury question on the issue of awareness. In several published appellate cases addressing jail suicide, courts have found that, when the evidence was that the defendants were aware of recent suicide attempts, it would be improper to grant summary judgment or judgment as a matter of law on the question whether the defendants were aware of a substantial risk of serious harm. See e.g., *Cabrales,* 864 F.2d at 1456, 1461; *Woodward v. Correctional Medical Services of Illinois,* 368 F.3d 917, 924, 928 (7th Cir. 2004); *Cavalieri,* 321 F.3d at 621-22; *Hall v. Ryan,* 957 F.2d 402, 405 (7th Cir. 1992); *Snow v. City of Citronelle,* 420 F.3d 1262, 1270 (11th Cir. 2005) (attempted to cut wrist one month earlier); *Turney v. Waterbury,* 375 F.3d 756, 760 (8th Cir. 2004) (previous suicide attempt at another facility); *Colburn v. Upper Darby Township,* 838 F.2d 663, 669 (3d Cir. 1988).

(b) ***Additional Known Factors: Record of Mental Illness, Violent Tendencies, Emotional Dysfunction and Substance Abuse***

Although the suicide threats alone ought to be sufficient, several additional factors point to the officers' awareness of Clustka's vulnerability to suicide:

First, when the Robertson and Ashton unwrapped the seatbelt from around Clustka's neck, she threatened suicide. Her communication was unambiguous-as in "I'll kill myself"-and the officers plainly got the message. Nor did Clustka take back her words by averring she was "just joking." Instead, as Robertson acknowledged, she repeated she "wanted to die" when he dropped her off at the jail. In *Coleman v. Parkman,* 349 F.3d 534, 539 (8th Cir. 2003), the appellate court found an issue of fact over deliberate indifference where the officials were made aware of the inmate's recent threat to kill himself in the jail.

Second, the officers were aware, from the wants and warrants check, that Clustka had a history of mental problems. Ashton had personal awareness of her mental illness and substance abuse from having arrested her the previous month (ER 147-148). Further, it occurred to Robertson that she was "seriously mentally ill" (ER 235@128:6-9).

Third, both officers noted that Clustka was disoriented and intoxicated. According to Dr. Caplan, this factor alone ought to have sounded "alarm bells" for suicide risk given her verbalized suicide threat.

Fourth, the officers knew that Clustka's mother had just obtained a TPO against her, prohibiting her from returning to the home they shared. Clustka had a new problem of being unable to retrieve her belongings. This extra mental stress coupled with her suicide gesture and threats were sufficient to put the officers on notice to take her seriously.

Fifth, the officers were aware that Clustka continued to face all the stressors that contributed to her substance abuse and disoriented condition, including dysfunctional family relations, loss of home, and betrayal by the officers who had lied to her in promising to help her obtain her belongings.

There is no dispute that the officers saw Clustka attempt to choke herself and heard her threaten suicide in a context where several known factors indicated her vulnerability to suicide. It was error for the lower court to insist as a matter of law that they had no awareness.

(c) *The Lower Court Erred in Finding No Dispute over Officers' "Unawareness"*

Ashton admitted that, if an officer is transporting a person who is "about to harm themselves," the person should be taken to a medical facility (ER 190 @45:22-46:23). Robertson too admitted that someone who has mental illness and indicates intent to engage in self-harm should be checked out by a "qualified professional" (ER 225@85:12-19, 229@102:11-103:6). 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 (ER 225@86:20-87:4).

Notwithstanding the officers' admissions the lower court found persuasive the their several arguments why they were free to ignore Clustka's attempt at choking herself and suicide threats: First, that they did not have to believe her because she was angry and intoxicated; second, that she was attempting to manipulate them and get their attention; third, that she could not have succeeded in killing herself because the seatbelt would have slackened after she passed out; fourth, that she had sufficient breath to scream that she wanted to kill herself when the officers unwrapped the seatbelt from around her neck. These arguments may be worthy of presentation to a jury, but, in summary judgment proceedings, they serve at best to show a factual dispute.

(1) *Suicide Threats by Intoxicated Persons Must Be Taken Seriously*

First, Robertson asserted that suicidal threats by an intoxicated person "don't count" and Ashton agreed (ER 230@106:23-107:11, 193@58:17-24). These averments by the officers that they were free to ignore Clustka's suicide threats because she was intoxicated fly in the face of everything known about suicide risk. All officials who testified in this case flatly contradict the officer defendants - their supervisor Sgt. Evans, RPD Deputy Chief Johns, jail health administrator Singletary, Washoe County Lt. Perry, and psychiatrist Dr. Caplan. The testimony of these other officials is powerful circumstantial evidence of the knowledge and awareness prevalent in the department and so may be imputed to the defendants.

Sgt. Evans testified that an officer transporting an intoxicated prisoner to jail *may not disregard* the intoxicated person's suicide threat (ER 276@33:25-35:25). Deputy Chief Johns confirmed it is *not* the policy of the RPD to ignore threats of suicide by intoxicated persons or consider such threats any "less serious" than those of non-intoxicated persons (ER 262@47:21-48:4). Additionally, jail health administrator Singletary testified that the threats of an intoxicated person should be taken seriously, adding that intoxication and emotional state are strongly related to suicide (ER 165@18:24-19:12, 165 @19:20-20:7). Lt. Perry testified it would be "against the rules" to disregard a suicide threat from an intoxicated person. (ER 305@27:9-11). Psychiatrist Caplan testified that recent excessive drinking and/or drugs, heightens the risk of suicide and ought to set off alarm bells (ER 336@23:12-20). Finally, Thomas Rosazza, expert witness in custodial care, testified that testimony by the officers 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 (ER 371).

There is abundant case precedent finding the existence of a jury issue over deliberate indifference where officers ignore suicide threats by intoxicated detainees. For example, in *Coleman v. Parkman,* during a pre-arrest investigation, witnesses

told the arresting officer that the intoxicated detainee needed mental help, had been doing "crazy things," was at risk of harming himself or others, and threatened to kill himself if jailed. *Coleman,* 349 F.3d at 536, 539. After receiving this information, the officer testified, he concluded the detainee was drunk and *not at risk of suicide.* He said nothing to jail officials about the warnings he had received. Lacking notice of the detainee's suicide risk, the jail placed him in a "drunk tank" containing the usual prison items, including a bed sheet, and - like Clustka - the detainee hung himself with the sheet. *Id.* On appeal, the court found that a factfinder could infer the officers actually knew the detainee presented a substantial suicide risk. *Id.* at 539. It emphasized that these issues of credibility cannot be resolved in summary proceedings but rather require trial. *Id.*

Similarly, in *Snow v. City of Citronelle,* the custodial officer - like the defendants in this case - maintained he did not personally view the detainee as a suicide risk. The detainee in question was arrested for DUI following an automobile accident. The officer testified that, had he regarded her a suicide risk, he would have taken steps to protect her from harming herself. Like the officers transporting Clustka, the officer saw her as a drunk and not suicidal; so he failed to take precautions or report information conveyed to him about an earlier suicide attempt. After the officer went off shift - with no suicide precautions in place - the detainee hung herself. *Snow,* 420 F.3d at 1270. The appellate court found that the officer's subjective belief as to whether the detainee was a suicide risk was a matter of dispute properly addressed at trial.

(2) *Manipulativeness and Attention-Seeking*

In this case, the lower court also found persuasive the assertion that the officers believed Clustka was simply trying to "get their attention" and "manipulate" them into not taking her to jail. As one district court persuasively explained, in a case such as this, the question whether a detainee was being "manipulative" is "close to irrelevant:"

The important question is this: did plaintiff pose a serious risk of harm to herself? Defendants point to nothing in the record suggesting that [the jail nurse] believed a person who harms herself for "manipulative" reasons is less likely to make another attempt. Defendants' own training materials confirm what common sense would already suggest: "The more attempts a person has made the greater the likelihood that the person will eventually die from suicide. *This is true even of inmates who made several attempts that seem to be attempts at manipulation of jail staff.*"

Mombourquette, 469 F. Supp. at 663 (emphasis in original). As in *Mombourquette,* Clustka demonstrated to the officers that she was capable of hurting herself when she wound the seatbelt around her neck and shouted she wanted to kill herself. Further, the officers knew there were aggravating factors--that she was mentally unstable, had a history of substance abuse, had a history of violence, was dysfunctional, and had family problems that prevented her from returning home or even gathering her belongings. "It matters little why she did these things, that is, whether she actually wanted to kill herself or was just seeking to use these attempts to seek some secondary gain." *Id.* As she attempted to harm herself before their eyes, she was likely to do it again. See *id.*

(3) *Ineffectiveness at Killing Herself*

In addition, the lower court cited the officers' argument that Clustka could not have succeeded in killing herself in the paddy wagon. Recognizing that Clustka "tried to choke herself," Ashton averred he did not see it as a serious threat because "she would have lost all tension on the seatbelt once she... after she passed out." The lower court ignored how the sheer admission that Clustka would have passed out demonstrates awareness of serious attempt at self-harm. There is no legal precedent for the proposition that custodial officers are free to disregard suicide attempts and threats where the detainee couldn't have succeeded in completing the suicide. To the contrary, according to RPD training documents, officers are trained that a "small non life threatening" attempt at self-harm accompanied by a statement about "wanting to die" do meet the criteria for a Legal 2000 involuntary commitment (ER 412).

(4) *Breath to Scream*

Finally, the lower court was persuaded that the officers were justified in ignoring Clustka's suicide risk because she had sufficient breath to scream at them when they unwound the seatbelt from around her neck. This too misses the mark. First, it needs mention that, contrary to the court's findings, there is no evidence that the officers believed Clustka's suicide attempt and threats were not serious because she had sufficient breath to scream. Similarly unsupported is the assertion that the officers observed no bruises on Clustka's neck after the unwinding the seatbelt from around it. These are fictions created for purposes of argument and are not grounded in the officers' testimony or in any document before the court.

Even Clustka's screaming and lack of bruises had been observed as significant by the officers, it still cannot be denied that in attempting to choke herself and threatening to kill herself, Clustka communicated suicidal thoughts and the officers saw and heard her. Suicide was obviously on her mind. She had taken steps-however effective or ineffective-to kill herself and, in no uncertain terms, communicated her intent: "Kill me. Or I'll kill myself then." How clear must a cry for help be before officers are constitutionally required to act?

2. *The Lower Court Erred in Finding the Officers' Knowing Violations of Policies Did not Give Rise to Constitutional Liability*

a. *The Officers Were Motivated to Hide their Wrongdoing*

Robertson and Ashton further admit to knowingly violating Nevada traffic laws in continuing to transport Clustka in their paddy wagon after she removed her seatbelt. Finally, they admit to knowingly violating department policy in failing to handcuff Clustka before transporting her. While they have testified that their reason for failing to report Clustka's suicide attempt and threats was because they did not believe she was serious, there can be no denial that they had good reason to keep silent to avoid having to reveal their violations to their superiors. Better to sweep the matter under the rug and avoid censure and potential discipline.

Later, on learning of Clustka's suicide, Ashton confessed to another officer that he had transported her to the jail on a CPC the day before, that she was not handcuffed and "tried to hang herself in the wagon," and that his "sergeant will be pissed" when he finds out (ER 74).

The lower court was wrong to find that these officers' knowing violations may not give rise to constitutional liability under circumstances in this case. The issue is *not* whether these violations of department policy and state law amounted to a constitutional violation, which was the issue in the cases relied upon by the court, *Case v. Kitsap County Sheriff's Dep't,* 249 F.3d 921, 929-30 (9th Cir. 2001) et al. Here, the issue is entirely different. It addresses, not the violations per se, but the officers' *motivation* to keep silent.

In violating seatbelt laws and handcuffing policies, the officers created a situation where Clustka was not restrained from moving about the paddy wagon and using the seatbelt in an attempt to choke herself. The fact that these officers recognized at the time what they had done is highly probative circumstantial evidence of their deliberate indifference. The officers had a strong motive - avoiding discipline - to withhold Clustka's suicide gesture and threats from their superiors and jail staff. If they had mentioned her conduct as they should have, they would have had to reveal their failure to follow procedures. See *Mombourquette,* 469 F. Supp. 2d at 635-36. The lower court erred in overlooking this probative evidence that Robertson and Ashton were motivated to hide their wrongdoing at the price of Clustka's welfare and safety.

b. *Harm--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 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)).

In its decision, the lower court found as a matter of law no causal relationship between the officers' failure to protect Clustka and her suicide less than 48 hours later. It noted that she did not commit suicide during her six hours in CPC, medical providers "evaluated" her at least twice, she received "substantial" intervening medical attention, and she made an "independent decision to return to her mother's house and violate the TPO." Finally, it found that, had the officers reported Clustka's attempted choking and suicide threats, the course of events would not have been any different, that plaintiffs' assertion that several options were available to protect her "relies entirely on speculation" (ER 447:21-448:17). The court erred in making these findings.

(1) *Plaintiffs Set Forth a Causal Relationship Between the Deprivation and the Harm*

Plaintiffs set forth in detail exactly what Robertson and Ashton did and failed to do with the harm that resulted. 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 of the choking incident and her threats.

Had Robertson and Ashton taken Clustka to the emergency room on a Legal 2000 after she both attempted and threatened suicide in the paddy wagon - either at the jail's direction or on their own - it is not speculative that 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 transfer to a mental health hospital for further suicide assessment and treatment. Finally, the jail could have kept Clustka on civil protective custody - addressed her suicide issues then and there - and, on releasing her at the end of detoxification, sent her to the hospital on a Legal 2000 (See pp. 19-23 *supra).* As a result of Robertson and Ashton's deliberate decision to keep silent, Clustka was deprived of these several avenues of protection.

(a) *Under Any Scenario, Clustka Would Have Been Flagged as a Suicide Risk*

Under any of these options, Clustka would have been red-flagged as a potential suicide risk. Had she been sent to the hospital on a Legal 2000, her mental health history would have been flagged and carefully scrutinized, and she would have been held involuntarily until she was determined to be no longer at risk of suicide. Based on the testimony received in this case, it is extremely likely - not speculative - that hospital staff would have sent her to NNMHI and she would have remained there for days because of her earlier suicide attempt *one day* before her interaction with the defendant officers.

Robertson and Ashton set in motion the constitutional deprivation when they failed to report Clustka's known vulnerability to suicide. They took her into civil protective custody but failed to protect her from self-harm. The jail is forbidden from giving medical treatment to persons in civil protective custody and so would likely have rejected her at the door or placed her on suicide watch and sent her to the hospital on a Legal 2000 when releasing her from CPC. This is not mere speculation. The procedure for doing this was fully explained by jail health director Singletary.

Robertson and Ashton were responsible for the fact that the jail did not implement suicide precautions or send her to the hospital on a Legal 2000. But for their decision to not report her suicidal gesture and threats, precautions would have been taken to protect her from suicide. Accordingly, Robertson and Ashton's decision to keep silent contributed to Clustka's ultimate death by suicide. 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) *The Court Erred in Finding Plaintiffs' Showing on Causation Is "Speculation"*

The court further erred in finding that plaintiffs' showing on causation rests on pure "speculation." No one can deny that nearly every case that comes to trial has some propensity for speculation and no guarantees. It is never possible to say exactly what would have, could have happened for certain in any one case. All that may be shown in cases such as this is what may likely have happened - what is more probable than not - given appropriate intervention.

That is why trial is necessary. In a trial, one can ask the jury, is it more reasonable than not to conclude based on the testimony of Lt. Evans, Nurse Singletary, Dr. Gansert and Dr. Caplan that protections would have been in place to protect Clustka had Robertson and Ashton only reported what they witnessed. All plaintiffs are asking is that the jury be allowed to decide what would have been the most credible outcome had the officers informed authorities about the choking incident and suicide threats.

One thing is clear: all these forms of intervention were *available* for Brenda Clustka and they are *designed* to protect people like her from killing themselves after they threaten to do so. She had been taken in on Legal 2000s before, and they had been successful in protecting her against self-harm in the past. As Dr. Caplan testified, her rapid improvement in previous commitments indicated she was someone who would have wanted to be saved (ER 335@20:17-21:1). Clustka had two teen-aged children-plaintiffs--to live for. Medical records show how she felt that relationship was "very close" (ER 127). Had she been given appropriate care - for example, sent for intervention to NNMHI - she likely would have resisted the lure of suicide. She just needed the appropriate authorities to be told of her risk of self-harm. She needed Robertson and Ashton to put the proper authorities on notice of what they saw and heard. While all these interventions are designed specifically to ensure that she would not kill herself, she was deprived of any of them.

(2) *The Factors Cited by the Lower Court Do Not Defeat Causation*

The lower court based its holding as to causation on certain factors, none of which defeat causation as a matter of law:

(a) *Timing Does Not Defeat Causation*

First, as to the fact that Clustka did not kill herself during her six-hour CPD but rather 48 hours later when again in custody, the case law includes several examples where causation is found for suicides committed so long as a month after the threat is made. See, e.g., *Cabrales,* 864 F.2d at 1457 (suicide "gesture" two weeks earlier); *Snow,* 420 F.3d at 1270 (one month earlier); *Turney,* 375 F.3d at 760 (previous attempt at another facility). What is critical in all of these cases is that the custodial officers knew about suicide gestures or threats and failed to take reasonable measures to protect the inmates from killing themselves, whether the suicides took place hours or months later. Having set in motion the constitutional deprivation, the defendant officers rendered themselves potentially liable no matter when the suicide actually occurred.

(b) *Medical Intervention Does Not Defeat Causation*

Second, as to the court's observation that Clustka was "evaluated" at least twice after the incident in the paddy wagon and received "substantial" medical intervention, it omits the essential fact that *none* of the medical providers were privy to what happened in the paddy wagon. None of them knew about her suicidal gesture and threats. None of them knew that she had threatened to kill herself. It did not matter how many times medical providers in the two short days between her civil protective custody on April 26 and her suicide on April 28. *No one* in position to help Clustka had the benefit of this critical information.

Had the officers simply dropped Clustka off at the jail after finding out she was bitten by a rattlesnake, the consequences would be the same. As with a rattlesnake bite, the officers knew Clustka had a problem-the threat from which demanded immediate life-saving intervention. Just as to properly treat a rattlesnake bite, the medical providers would have needed critical information so they would know to give her the proper antidote, a statement by Robertson and Ashton that Clustka was simply "disoriented" would not cue the medical providers into her specific risk of harm-suicide.

Had the medical providers in this case been told that Clustka was threatening suicide, they would have known to take suicide precautions. Suicide precautions are the antidote that would have saved her. No one who examined Clustka after her interactions with Robertson and Ashton had the critical information that would have "set off alarm bells" that suicide precautions were necessary. Moreover, review of the record shows that the "intervention" Clustka received was minimal. At

best she was asked if she had a history of wanting to commit suicide, which (as is typical in these cases) she denied. At no time was she thoroughly assessed for risk of suicide or given the battery of tests she would have received had she been taken to the hospital for suicide assessment and treatment.

(c) *The TPO Arrest Does Not Defeat Causation*

Third, as to the fact that Clustka violated the TPO and was rearrested, that was foreseeable given the officers' deliberate indifference to her plight. In *Cabrales,* another jail suicide case, the inmate who made a suicide gesture while in isolation was released into the general population after being determined not suicidal. He became involved in a fight and was "sentenced" to ten days in disciplinary isolation, whereupon he committed suicide. The Ninth Circuit *rejected* the defendants' argument that there was no proximate causation between the failure to take suicide precautions and the inmate's ultimate suicide. It found the defendants' conduct was the "moving force" behind the suicide. *Cabrales,* 864 F.2d at 1461. It did not matter that the "intervening event" was the inmate's involvement in a fight, which landed him in isolation. Just so, in this case the lower court erred in failing to reject the defendants' argument that there was no causal connection.

Similarly, in another case alleging deliberate indifference to safety, the inmate alleged that a sergeant caused him injury by assigning him to share a cell with a known violent cellmate. Rather than enter the cell, the inmate ran and was beaten by jail guards. The Ninth Circuit rejected the lower court's reasoning that the inmate's running constituted an intervening cause of his injury at the hands of third parties. It found that the inmate's running was a foreseeable consequence of the assignment. The inmate had two alternatives: either enter the cell and risk being injured by the cellmate or run and risk being injured by the guards. Since his running was a foreseeable consequence of the order to enter the cell, the intervening act of his running did not break the change of causation. See *White,* 901 F.2d at 1505.

Just so, in this matter, it was foreseeable that the officers' failure to alert jail staff and medical providers of Clustka's suicidal gesture and threats would cause her not to receive necessary and appropriate care required to prevent suicide. Robertson and Ashton set in motion a series of events that foreseeably ended in Clustka's jail suicide. Her death was caused by the fact that no suicide precautions were taken, either by the jail or by the hospital on a Legal 2000--and none were taken because Robertson and Ashton failed to alert them to the need. 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-given its not being informed about her suicide threats. It was likewise reasonably foreseeable that - in the absence of suicide intervention - Clustka 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. Her "decision" to violate the TPO was no more independent than the inmate's "decision" in *Cabrales* to become involved in a fight and land in isolation. It was a predictable consequence of her disturbed and distressed condition. Clustka would likely not have been released into the streets had the jail been put on notice of her suicide attempt. She would likely have been *kept* under suicide watch at jail, then sent to the hospital on a Legal 2000 or *rejected* at the jail and sent to the hospital on a Legal 2000. Either way, she would likely have been safe.

B. *The Lower Court Erred In Finding Qualified Immunity*

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.

1. *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, Officers Robertson and Ashton violated Brenda Clustka's right to be free of deliberate indifference to her known risk of harm.

2. *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 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,* 946 F.3d at 1023.

C. *The Lower Court Erred in Finding No Municipal Liability*

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.

1. *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.

2. *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, Nevada law on Legal 2000 is extremely protective of persons at risk of suicide and RPD witnesses all acknowledged their strong duty to protect persons to make suicide attempts and threats. However, as they also consistently 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.

3. *The Known Deficient Robertson*

Another way to establish municipal liability is to show how RPD 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). RPD knew well Robertson's several deficiencies in judgment, knowledge of laws, policy and procedure, reporting, and other violations repeatedly referenced in documents submitted under seal (See ER 473-538). RPD had an obligation to take remedial measures to correct his blatant errors in judgment. Instead of meeting its obligation, RPD 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 there fore a basis for municipal liability." *Skiby v. City of New York,* 109 F.R.D. 58, 65 (E.D.N.Y. 1985). RPD 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. RPD's knowing failure to rein in this deficient officer created constitutional time bomb and Clustka, at high risk of suicide, was its predictable victim.

4. *Failing to Discipline*

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. Reno's worse than inadequate response to these officers known violations gives a strong message: So far as Reno 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 reverse the lower court's grant of summary judgment to the defendants and to remand this case for trial.

STATEMENT OF RELATED CASES

Plaintiff-Appellants are aware of no related cases pending before the court.

Footnotes

[1] Legal 2000 is Nevada's emergency admission procedure whereby mentally ill persons deemed a danger to themselves or others may be involuntarily committed to a mental health facility for up to 72 hours. See NRS §433A.115 (ER 246).

[2] Goss et al., "Characteristics of Suicide Attempts in a Large Urban Jail System with an Established Suicide Prevention Program," *Jail Suicide/Mental Health Update,* Vol. 11, No. 3, pp. 1-6 (Fall 2002) (ER 385).

[3] *Jutzi-Johnson v. U.S.A.,* 263 F.3d 753, 757 (7th Cir. 2001) (citing Hayes et al., "National Study of Jail Suicides: Seven years Later" (National Center on Institutions and Alternatives, Feb. 1988)).

[4] Reno Gazette Journal, "Inmate, 43, Reportedly Hangs Herself in Jail" (Crime & Courts, April 30, 2003) (ER 392).

[5] Clustka was reportedly drunk in public with a blood alcohol of .10. There is no dispute that she was bothering no persons and breaking no laws.

[6] See ER 412-13.

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