2007 WL 4266351 (C.A.9) (Appellate Brief)
United States Court of Appeals, Ninth Circuit.

Charla CONN; Dustin Conn; Estate of Brenda Clustka, Plaintiffs-Appellants,
v.
CITY OF RENO; Ryan Ashton; David Robertson, Defendants-Appellees.

No. 07-15572.
September 27, 2007.

District Court No. CV05-00595-HDM Nevada (Reno)
On Appeal from the United States District Court for the District of Nevada

**Appellees' Answering Brief**

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***i *TABLE OF CONTENTS***

***iii** *TABLE OF AUTHORITIES*

**CASES**

**Statutes**

## *1 1. STATEMENT OF JURISDICTION

Respondents agree with appellants' statement of jurisdiction.

## 2. STATEMENT OF ISSUES

1. Was summary judgment properly granted when an intoxicated, angry Brenda Clustka wrapped a seatbelt around her neck to cause police officers to stop the transport vehicle and asked the officers to kill her or she would kill herself just hours after a psychiatrist had determined Clustka was not at risk for suicide because she did not present an objective risk of suicide?

2. Was summary judgment properly granted because the officers with no knowledge of Clustka's prior suicide threats did not subjectively believe Clustka was suicidal based on their assessment of all the circumstances?

3. Was summary judgment properly granted because the officers' actions in not reporting the seatbelt incident did not cause Clustka's suicide two days later after she had been repeatedly evaluated by medical personnel who did not find her to be at risk for suicide, any report would not have been available to jail intake personnel and the jail already knew she had been on suicide watch the month before?

4. Were the individual defendants entitled to summary judgment because they were protected by qualified immunity?

***2** 5. Was summary judgment properly granted because plaintiffs failed to show that any custom or policy of the City caused any harm to Clustka?

## 3. STATEMENT OF THE CASE

### A. Nature of the Case

Police officers Ryan Ashton and David Robertson were called upon to make a routine transport of Brenda Clustka to jail for civil protective custody[1] ("CPC") because she was intoxicated and unable to care for herself. They had no knowledge of Clustka's prior threats to commit suicide. Their task was to safely transport an angry intoxicated woman to the jail owned and operated by Washoe County.

When Clustka saw they were headed to jail, she tried to get the officers to stop the vehicle by tapping on the camera in the rear compartment. When that failed, she wrapped the seatbelt around her neck causing the officers to stop. While they took her hands off the seatbelt, she shouted at them to kill her or she would kill herself. The officers did not believe she was suicidal based on all the circumstances and made no report of the incident. Clustka was taken to jail without further incident and safely released just a few hours later when she became sober.

Just hours before Clustka was taken into custody, she had been released from Nevada Mental Health Institute ("NMHI") by a psychiatrist who determined ***3** she was not at risk for suicide. She was subsequently medically cleared by emergency medical personnel at the scene. Within the next 24 hours after the officers delivered her to jail, Clustka was evaluated three times by medical personnel, none of whom found her to be at risk for suicide.

The next day Clustka was arrested on misdemeanor charges and taken to jail again. Clustka had been placed on suicide watch the second day of confinement the prior month when she was arrested on a misdemeanor charge. The jail did not put her on suicide watch this time. This time on the second day, Clustka committed suicide.

Even if the officers had made a report of the seatbelt incident, it would not have been available to jail personnel when she was subsequently jailed. No medical evaluation of Clustka would have been any different if a report had been made. The conduct of the officers did not cause Clustka's suicide. Plaintiffs' assertions of what would have occurred if the officers had acted differently are speculation unsupported by the evidence.

### B. Course of Proceedings Below

Defendants agree with plaintiffs' description of the course of proceedings in the district court. In granting summary judgment to defendants, the district court concluded that the evidence was insufficient to establish that: (1) the individual defendant police officers were deliberately indifferent to any serious medical need ***4** of Clustka; (2) any act of the defendants caused harm to Clustka; and (3) any custom or policy of the City caused harm to Clustka.

## 4. STANDARD OF REVIEW

A grant of summary judgment is reviewed de novo. *Moreau v. Air France*, 356 F.3d 942, 945 (9th Cir. 2004). Once the moving party presents evidence that would call for judgment as a matter of law at trial if left uncontroverted, the nonmoving party must show by specific facts the existence of a genuine issue for trial. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250 (1986). Summary judgment should be granted where the nonmoving party fails to offer evidence from which a reasonable jury could return a verdict in its favor. *Triton Energy Corporation v. Square D Company*, 68 F.3d 1216, 1221 (9th Cir. 1995).

A mere scintilla of evidence is not sufficient to find a genuine issue of material fact because a jury is permitted to draw only those inferences of which the evidence is reasonably susceptible. *British Airways Board v. Boeing Co.*, 585 F.2d 946, 952 (9th Cir. 1978). An inference as to another material fact in favor of the nonmoving party may be drawn only if it is rational or reasonable and otherwise permissible under the governing substantive law. *T. W. Electrical Service, Inc., v. Pacific Electrical Contractors Association*, 809 F.2d 626, 631 (9th Cir. 1987). Moreover, "[i]f the factual context makes the non-moving party's claim of a disputed fact implausible, then that party must come forward with more persuasive ***5** evidence that otherwise would be necessary to show there is a genuine issue for trial." *Blue Ridge Insurance Co. v. Stanewich*, 142 F.3d 1145, 1149 (9th Cir. 1998). Conclusory allegations unsupported by factual data cannot defeat a motion for summary judgment. *Taylor v. List*, 880 F.2d 1040, 1045 (9th Cir. 1989).

This court may affirm a grant of summary judgment on any ground supported by the record, even if not relied on by the district court. *United States v. Daniel, Mann, Johnson & Mendenhal*, 355 F.3d 1140, 1144 (9th Cir. 2004).

## 5. SUMMARY OF ARGUMENT

The Eighth Amendment, which applies to the States through the Due Process Clause of the Fourteenth Amendment, prohibits the infliction of cruel and unusual punishment on pretrial detainees. When the alleged deprivation is a claimed failure to address the serious medical needs of a detainee, plaintiffs must establish that a defendant was deliberately indifferent to the detainee's serious medical needs by showing (1) the alleged deprivation was objectively sufficiently serious; (2) defendant knew of and disregarded an excessive risk to the detainee's health; and (3) defendant's act or omission to act caused the injury. Plaintiffs failed to establish these elements.

Plaintiffs failed to show that defendants could be held liable on their claim of deliberate indifference. Clustka did not present such an objectively serious threat of suicide that her confinement without further action posed a substantial ***6** risk of serious harm. The officers reasonably thought they were dealing with an angry manipulative detainee. A seasoned psychiatrist found she did not present a risk of suicide just five hours earlier. Clustka made no attempt to harm herself during the detention initiated by defendants. Within hours of her release, an emergency room physician found no reason to consider her suicidal and the next day a jail nurse reached the same conclusion when Clustka was arrested on misdemeanor charges. Because Clustka was not objectively suicidal, defendants cannot be held liable.

Defendants considered all the circumstances of Clustka's conduct and did not subjectively think she was suicidal. Plaintiffs'

arguments are aimed only at trying to establish that defendants should have known she was suicidal even though they didn't think so. Plaintiffs' argument that the officers must have known of a suicidal risk and didn't report the incident because of potential discipline ignores the facts. Neither officer thought they had done anything wrong and were not concerned about potential discipline. Their sergeant was concerned only because they did not tell him of the incident.

Plaintiffs failed to show the act of not reporting the seatbelt incident caused the suicide. Plaintiffs' argument is based entirely on speculation unsupported by the evidence. No harm came to Clustka when she was jailed for CPC. If defendants had reported Clustka's conduct, no additional action would have been ***7** taken. CPC reports are not reviewed by nursing staff at the jail if the same person is later arrested on a misdemeanor charge. Medical evaluations are not based on prior reports and Clustka would not have been kept for any extended time period at any health facility even if she was suicidal. Clustka's condition was repeatedly assessed by medical professionals between the two confinements and never found to present a risk of suicide.

Even if the officers were found to have caused the suicide by deliberate indifference, they were entitled to qualified immunity. It was not clear to a reasonable officer that his conduct in not making a report under the specific circumstances was clearly unlawful.

There is also no basis for municipal liability. There was no policy or practice that caused Clustka's suicide.

## 6. FACTUAL DISCUSSION

### A. Clustka was repeatedly evaluated for suicide risk before April 25, 2005 and released within hours every time.

In the year prior to her death, Clustka became well known at Washoe County Detention Facility ("the jail") as a repeat misdemeanor offender. AOB, p.8. From May 17, 2004, through April 21, 2005, she was jailed on five occasions involving three charges of battery, two charges of petit larceny and two charges of driving under the influence. On each occasion she was taken to jail by RPD ***8** officers. There is no evidence of any unusual behavior by her during any of these incidents. ER23-27.

Clustka was also repeatedly evaluated by medical professionals on a Legal 2000.[2] Clustka attempted suicide four times of which her mother was aware. When Clustka originally began talking about suicide in 1999, it was more just for attention. Her mother knew Clustka had a severe alcohol and prescription drug addiction, drinking about a fifth of vodka every day and taking Xanax on a daily basis "like its Pez candy". ER35.

On September 14, 2001, police brought Clustka to Washoe Medical Center ("WMC") when she threatened suicide by cutting her wrist with a piece of glass. Clustka was admitted at 7:00 a.m. at NMHI, evaluated by Dr. Caplan and discharged at 6:00 p.m. that same day with a recommendation for outpatient counseling. ER98-107. There is no evidence Clustka followed this recommendation.

On August 16, 2003, Clustka was brought to St. Mary's Hospital when she attempted suicide by cutting her wrist with a razor. She was transferred to NMHI on a Legal 2000 and discharged the next morning with instructions to follow-up with her primary care physician, Alcoholics Anonymous and clinical services. ***9** ER109-121. There is no evidence Clustka followed any of these recommendations.

On April 3, 2004, police brought Clustka to the emergency room at WMC after she had taken 20 tablets of Benadryl, drank ½ pints of Bacardi for the prior 3 days and stated she did not want to live. Although a psychiatrist recommended Clustka be admitted to NMHI, Clustka informed the social worker at WMC that if she was sent to NMHI she would lose the new job she was about to start. ER123-131. There is no evidence Clustka was transferred to NMHI or that she followed any discharge recommendations.

**B. The Jail Places Clustka On Suicide Watch On March 20, 2005.**

On March 19, 2005, RPD officers McQuattie and Pitsnogle were dispatched to Clustka's mother's home because after Clustka was told to leave, she pushed her 74 year old mother to the ground causing her to hit her head on the kitchen counter. Clustka's brother called 911. ER30-31.

Officers Hoyt and Ashton stood by at WMC with Clustka who had been driven there by her daughter. Clustka was treated and then arrested for domestic battery by McQuattie and Pitsnogle.[3] ER30-31.

***10** On March 20 the jail placed Clustka on a suicide watch after she made suicidal statements. No jail official applied for a Legal 2000 commitment to address any suicidal condition. Instead, Clustka was held at the jail until April 21. ER 36; 39-42; 169 @34:14-15.

**C. Clustka Is Found Not To Be Suicidal At 9:30 A.M. April 26.**

On the morning of April 25, 2005, Clustka was again taken to WMC for a psychiatric evaluation. Clustka's mother informed staff that Clustka had been combative, had a bottle of pills for anxiety (Xanax) and threatened to kill herself that morning.[4] ER133.

Clustka was evaluated by Dr. Gansert. He has transferred hundreds of patients to NMHI on a Legal 2000 over his 17 years as an emergency room physician. Every psychiatric evaluation he performs is based on its individual merit and according to the specific circumstances then present. He did not review any records from Clustka's prior visits to WMC in evaluating her. Dr. Gansert transferred Clustka to NMHI noting that Clustka had made suicidal threats with a plan and the means to carry it out. If Clutska had been brought in for another evaluation the very next day, Dr. Gansert could only speculate what his evaluation would have concluded. Clustka was taken to NMHI about 4:10 that afternoon. ***11** ER324@7:25- 8:1-20; ER325@10:5-6; 327@18:6 - 19: 1-11; ER133-134; ER141; ER136; ER324@6:11-23.

On arrival at NMHI Clustka was again evaluated by psychiatrist Dr. Caplan. Clustka was not found to be a suicide risk on arrival at NMHI but she was kept overnight for observation. When evaluating an intoxicated patient who has stated she wants to kill herself, Caplan agrees that one must look at all the circumstances surrounding that comment and analyze whether or not that statement was made because of the intoxication or whether she truly has that intention. When a person is intoxicated, her judgment is not as good and she could say something she would have no intention of doing if sober. ER91@2-8; ER419.

Clustka was discharged at 9:30 the morning of April 26. At the moment of discharge, Caplan judged Clustka not to be at risk for suicide. Although Caplan believed Clustka's Xanax abuse would be a risk to her safely, he returned that medication to her upon discharge. Clustka was instructed to follow-up with an alcohol treatment program and not to mix alcohol and medications. There is no evidence Clustka followed the discharge recommendations. ER91@108:2-22; ER81;ER 84.

Even when a patient arrives on a Legal 2000 with a specific threat of suicide, NMHI does not necessarily keep the patient for the full 72 hour period allowed by law. A patient is kept only until the patient is no longer deemed at risk for suicide. ***12** That determination is made by simply observing the patient and talking with her. ER88@80:18-25- 81:1-17.

**D. The Officers Properly Transport Clustka To Jail For CPC.**

Less than 5 hours after Clustka was determined not be at risk for suicide, a Regional Emergency Medical Services Authority ("REMSA") medical crew was dispatched on April 26, 2005 on a 911 call categorized as "Unknown Problem (Man Down)". On arrival, medical personnel found Clustka lying on the sidewalk and assessed her as requiring CPC. ER424-426.

Officers Robertson and Ashton were dispatched to assist REMSA. The officers were told by REMSA personnel that Clustka had been medically cleared and was being released to them for CPC. Robertson understood that REMSA performed a mental and physical evaluation of Clustka before releasing her. Ashton recognized Clustka but didn't recall where he had seen her

previously. ER182 @15:21-25 - 16:1; ER218@60:1-3; ER182@16:18-23.

Both officers thought Clustka was intoxicated. She had difficulty walking and was belligerent to the officers. She had slurred speech and red watery eyes. She gave a breath sample for alcohol which registered .10. The officers conducted a wants and warrants check which informed them Clustka had violent tendencies, abused drugs, was alcoholic and had unspecified mental health problems. ER181@10:1-25 - 11@1-2; ER218@58:6-25 - 59:5-9; ER219@64:8-12; ER47.

***13** The officers told Clustka they were taking her to jail for CPC. When Robertson asked her to get in the prisoner transport vehicle, Clustka objected and told him she wanted him to take her home to get her things. To get Clustka into the vehicle, Robertson told her he would take her home. Clustka then voluntarily climbed into the rear of the vehicle with the officers holding her arms so she wouldn't fall. When she got into the vehicle, she had become calm. ER221@69:5-25 - 70:1-3; ER194@64:8-12; ER188@37:3-7.

Clustka was not handcuffed in the vehicle, but was seatbelted in. Robertson believed handcuffing was not required and elected not to do so. Ashton had been an officer just five months and does not recall knowing whether he was required to do so at the time. Department policy leaves handcuffing to the discretion of the officer. ER239@143:2-4; ER182@14:18-24; ER289@88:18-23.

On the way to jail, Officer Ashton watched Clustka in the rear compartment through the surveillance camera. She became belligerent, uncooperative and angry when she saw she was being taken to jail. Her attitude changed back to what it had been before she entered the vehicle. Ashton saw her undo her seatbelt, crawl to the front of the compartment and place her fingers back and forth on the camera as if to get their attention. Ashton asked Robertson if they should stop to put her back in the seat. Robertson told him no because they were almost at the jail, but did say to watch her closely. Ashton felt that if they went back to try to put her in her seat ***14** an unnecessary confrontation would result. Their immediate supervisor would also have left her unbelted because of the proximity to the jail. Nevada state law did not require the City to use seat belts for passengers in the rear of the police transport vehicle.[5] ER149; ER183@20:3-5; ER185@26:12-25; ER188@38:21-25; ER188@40:8-14; ER214@42:18-43:2; ER290@90:4-12.

When Ashton saw Clustka wrapping a seatbelt around her neck, he told Robertson who stopped the vehicle. The officers went into the rear compartment where they found Clustka holding the seatbelt wrapped on her neck. Robertson recalls Clustka was angry and screaming, "You lied to me. I want to die, kill me, you lied to me." ER215@44-45.

The officers each took one of Clustka's clenched hands to get them off the seatbelt. Clustka did not resist their efforts. When they took Clustka's hands off the seatbelts, she fell to the floorboard of the vehicle. While the officers tried to put handcuffs on her, Ashton recalls Clustka telling them: "You lied to me. Just kill me. I'll just kill myself then." Clustka told them to kill her prior to saying she was going to kill herself. The officers then handcuffed her with flexible handcuffs for the duration of the remaining short ride to the jail. Clustka was angry when she ***15** arrived at jail. When the door of the vehicle was opened, Clustka screamed at them to kill her, beat her, and that she wanted to die. ER149-150; ER195@66:9-12 & 23-25 - 67:1; ER187 @34:15-17; ER228@100:23-25; ER229@101:1-5;ER215@46:25-47:3.

Over his 18 years of experience, Officer Robertson had many prisoners, drunk and sober, state they wanted to kill themselves. Robertson believed, just as do Drs. Gansert and Caplan, that a determination of whether an individual is a threat to harm herself depends on an assessment of all the circumstances presented, including whether the person is intoxicated. Based on his assessment of all the circumstances, Roberston did not believe Clustka's wrapping the seatbelt around her neck was an attempt to harm herself. He thought this conduct resulted from her anger at being taken to jail and was an attempt to manipulate the situation. ER231@111:20-25 -112:1-2; ER216@49:7-25; ER216@ 50:1-25;ER216@51:1-14.

Officer Ashton understands there are procedures to follow if he believes a detainee is a danger to harm herself. That decision is made based on the observations he makes. He believes intoxication is a factor when assessing credibility. Determining whether a statement by an intoxicated individual that she intends to kill herself is actually a suicide threat depends on all the circumstances presented. Because of the need to assess all the factors, he cannot make an ***16** absolute statement that a suicide threat from an intoxicated individual may be disregarded. ER190@45:22-25 - 46:1; ER191@49:9-15; ER193@58:1-16.

With respect to Clustka's specific situation, Ashton did not view her acts as a suicide threat. Clustka knew the officers were watching her through the camera. Even if she passed out from the wrapped seatbelt, she would have lost all tension on the belt when she did pass out and could not have killed herself. Ashton didn't think Clustka's conduct in the transport vehicle was a joke, but he didn't think it was a suicide attempt. Clustka had been trying to get their attention the entire duration of the trip and he saw her conduct as just a further attempt to get their attention. ER149, 151; ER186@31: 15-24.

When the officers and Clustka arrived at jail, the incident was not reported to jail personnel. Ashton had been sworn in as a police officer just four months earlier and never had anything like that occur to him. It never crossed his mind to inform jail personnel or write a report of what occurred. Roberston also didn't think about informing jail personnel of what occurred. ER215@47:1-3; ER152; ER182@15:4-5; ER235@127:19-25 - 128:1-3; ER196@70:4-21.

Dr. Caplan testified that if Clustka had a blood alcohol level of .10 on April 26, she could not have been admitted for evaluation at NMHI until she detoxed. Keeping Clustka at the CPC facility at the jail until she sobered up was an appropriate measure to take. The officers could not initiate a Legal 2000 because ***17** of her intoxication. If the nursing staff at jail determined Clustka was suicidal, they could have sent her to the emergency room for evaluation and the medical personnel there could have decided whether to send her to NMHI. ER 422@154-155; ER338@32:18-25 - 33:1-6.

### E. The Officers Committed No Disciplinary Offense.

The immediate supervisor of the officers, Sergeant Evans, learned of the incident the next day. Sergeant Evans thought the officers did not have the option of taking Clustka to a medical facility for evaluation because she was grossly intoxicated and needed to be placed in a secure facility to sober up. Evans told both officers that because of the unusualness of the situation, he wanted to be informed of that kind of an occurrence. Although it was discretionary on the officers' part as to whether to handcuff the intoxicated Clustka, he would personally have handcuffed her because of the report of violent tendencies. If Evans had been in the transport vehicle that day and saw Clustka walking around in the back of the van, he may well have also continued on to the jail without stopping to reseatbelt her if they were close enough. ER286@75:5-17; ER288@84 - 92; ER289@89:18-23.

If an officer is transporting a detainee to jail and the detainee says "I want to kill myself, Evans believes the officer involved should explore the situation by trying to determine how serious that person is by assessing whether the person had ***18** a plan and the means to carry it out. The primary concern of the officer in that situation should be to try to determine if the individual is presently trying to commit suicide. The question of which officials an officer might inform of that conduct would be in the officer's discretion and depend on the circumstances. Sergeant Evans is not aware of any policy that requires a transporting officer in the situation to inform jail staff of what occurred. It is undisputed that neither officer was disciplined for their actions. ER278@43:1 - 44:23; ER279@46:25 - 47:12.

### F. Clustka Is Medically Evaluated At Jail, Not Found To Be Suicidal And Released Without Incident.

Clustka arrived at jail about 3:45 p.m. on April 26. Upon arrival the standard processing for a CPC is to medically assess the individual including her mental health. Clustka denied any medical injuries and was assessed as only mildly anxious, properly oriented and not recommended for transfer to the hospital upon release. ER428-430; ER315@66:5-25 - 67:1.

Gail Singletary has been employed by Prison Health Services ("PHS") as the Health Services Administrator at the jail since May 2000. PHS has a contract with Washoe County to provide medical services to the jail. Singletary has been a registered nurse since 1978 with a background primarily in psychiatric nursing from working in hospitals for the criminally insane and adult acute psychiatric facilities. ER162@6:7-25 -7:1-21.

***19** When asked whether the officers should have let the nursing staff know of the seatbelt incident and what value this information could have been to the nurses, Singletary responded that, "They would have an opportunity to do a more complete evaluation of the person's mental status, which would have been difficult given the intoxicated state." In any event, a statement of suicide is only one factor considered in assessing risk. ER173@52:19 - ER 174@53:20; ER171 @41:8-16.

As of 3:45 p.m. Clustka's blood alcohol level was still at .10. By 8:00 p.m., her level had dropped to .032 and she was released. While at the jail during her confinement for CPC, there is no evidence Clustka made any statement or gesture indicating any intention to kill herself. ER428, 430.

**G. Clustka Is Evaluated At WMC, Not Found To Be Suicidal And Discharged.**

Following her release, Clustka could not return to her mother's home because her mother had obtained a temporary protective order that required Clustka to stay away from the home. Clustka was picked up in the late evening on April 26 for CPC by police officers who initially took her to the jail which refused her admission because she was not intoxicated on ethanol. Not knowing what else to do, police brought Clustka to the emergency room at WMC. ER44; AOB, p.14; ER432.

Clustka had twice been evaluated at the WMC emergency room before 2005. On April 25, 2005, Clustka was evaluated there and sent to NMHI by Dr. ***20** Gansert. There is no evidence that Dr. Sanders, the emergency room physician on duty April 26 and 27, reviewed any records that pertained to Clustka's prior evaluations. Although the emergency room physician apparently conducted the usual thorough evaluation, he reported no basis for making any referral to NMHI and discharged Clustka.[6] ER432.

**H. Clustka Is Arrested On A Misdemeanor Charge, Not Found to Be Suicidal And Assigned To The Mental Health Unit.**

Just before noon on April 27, RPD Officer Fox was dispatched to Clustka's mother's home on a report of an individual violating a temporary protective order. Fox met with Clustka's brother who was escorting Clustka out of the house. Fox confirmed the issuance of the protective order and took Clustka to jail for violating it. ER51.

At the jail, Clustka was medically screened by the PHS nurse. When an inmate is admitted on a criminal charge, the nursing staff can access that person's history to see whether she was previously placed on a suicide watch at the jail. The nurse can look at the medical file maintained by the jail for that person and review her history. Those records are kept by the jail for two years. If an inmate is behaving normally when she comes in, but has a history of a suicide problem at the ***21** jail, it would be helpful for the nursing and jail staff to know that. ER168@30:16-24; @31:1-7; @32:2-20.

Although medical records for an inmate previously jailed in connection with a criminal charge are available to the nursing staff, information related to a prior confinement for CPC status are typically not accessed by the nurse when someone is subsequently arrested and brought to jail. Specifically, for Clustka who was brought in on CPC the prior day, unless the same nurse was working intake when Clustka was brought in for CPC and had knowledge of the reported conduct and was also working the next day when Clustka was evaluated, there would be no way for the second nurse to know about the prior CPC information.[7] And even if the nurse on the subsequent occasion knew of the prior conduct, at the most that information would have provided a "heads-up". Even if the screening nurse knew an individual had made a suicidal threat the day before, that information would not have been sufficient to make an absolute determination regarding placement. A variety of variables would come into play in assessing the individual including the fact she was intoxicated when the threat was made. ER174@54:18 - 55:9.

***22** Clustka made no suicidal comments when screened. However, because of Clustka's anxiety disorder, substance abuse and mental health history (including the jail suicide watch a month earlier), Clustka was placed in Housing Unit 3 ("HU3"), the mental health unit at the jail. HU3 is where an inmate who is too psychotic or needs a more supportive environment is placed. HU3 does not contain the suicide watch cells which are typically maintained in the jail infirmary. Despite the availability of records that revealed the prior suicide watch Clustka had been placed on, an evaluation by the psychiatric nurse was delayed until April 28. ER36; AOB, p.15; ER58; ER315@67:19-25.

**I. Clustka Commits Suicide.**

On the morning of April 28, Clustka left HU3 for her arraignment. Clustka acted confused and asked why she was being housed in HU3. She seemed tired but in a good mood upon reaching the video courtroom. However, after pleading not guilty, Clustka appeared upset. She blamed the police for everything that had happened to her. As Clustka neared her cell, she told the deputies she wanted to call a local attorney to get her out of jail. She was told she could make a call later and became upset as she was placed in her cell.[8] Clustka was returned to her cell at 8:35. ER36, 60, 61.

***23** At 8:42 a security check was logged on the shift activity log. At 9:15, another deputy called Clustka over the intercom for tier time with no response from Clustka. At 9:17, it was discovered Clustka had committed suicide by hanging herself by a bed sheet tied around her neck and upper bunk. ER 36.

## 7. LEGAL DISCUSSION

### A. The applicable legal principles.

The premise of plaintiffs' argument is that Ashton and Robertson caused Clustka's death because they did not inform County jail employees of the seatbelt incident or take her to the hospital for evaluation on April 26. Plaintiffs allege that defendants had a constitutional obligation to protect Clustka from killing herself and that by choosing not to take these actions, breached that duty.

The Eighth Amendment, which applies to the States through the Due Process Clause of the Fourteenth Amendment, prohibits the infliction of "cruel and unusual punishments" on those convicted of crimes. *Wilson v. Seiter*, 501 U.S. 294, 296-297 (1991). To be cruel and unusual punishment forbidden by the Eighth Amendment, conduct that does not purport to be punishment must involve more than ordinary lack of due care for the prisoner's interests or safety. *Whitley v. Albers*, 475 U.S. 312, 319 (1986). The Supreme Court's cases mandate inquiry ***24** into the official's state of mind when it is claimed that the official has inflicted cruel and unusual punishment. *Wilson v. Seiter*, supra, at 299. "The source of the intent requirement is the Eighth Amendment itself which bans only cruel and unusual punishment." *Id*. at 300 (emphasis in original). "The infliction of punishment is a deliberate act intended to chastise or deter." Id.(quoting with approval *Duckworth v. Franzen*, 780 F.2d 645, 652 (7th Cir. 1985), cert. denied, 479 U.S. 816 (1986)). "The thread common to all [Eighth Amendment prison cases] is that 'punishment' has been deliberately administered for a penal or disciplinary purpose." *Id*. (quoting 481 F.2d 1028, 1032 (2nd Cir. 1973), cert. denied sub nom. *John v. Johnson*, 414 U.S. 1033 (1973).

In *Estelle v. Gamble*, 429 U.S. 97 (1976), the Supreme Court first acknowledged that the Eighth Amendement could be applied to some deprivations that were not specifically part of a formal sentence but were suffered during imprisonment. In that case, however, the Court rejected the claim that prison doctors had inflicted cruel and unusual punishment by inadequately attending to the inmate's medical needs because he failed to establish they possessed a sufficiently culpable state of mind. *Wilson, supra* at 297. Because the Court had previously established that only the "unnecessary and wanton infliction of pain" implicates the Eighth Amendment, a prisoner advancing such a claim must, at minimum, allege "deliberate indifference" to an inmate's "serious" medical needs. ***25** *Id*. (quoting *Estelle*, at 429 U.S. at 104). It is only such indifference that can violate the Eighth Amendment; allegations of inadvertent failure to provide adequate medical care simply fail to establish the requisite culpable state of mind. *Id*. Thus, when the claim involves an alleged failure to meet a prisoner's medical needs, it is "obduracy and wantonness, not inadvertence or error in good faith" that characterizes the conduct prohibited by the Cruel and Unusual Punishments Clause. *Whitley v. Alters, supra*, at 319.

The obligation to take reasonable measures to address inmate safety includes addressing serious physical and mental health needs. *Hoptowit v. Ray*, 682 F.2d 1237, 1253 (9th Cir. 1982). The rights of a pre-trial detainee arise under the Fourteenth Amendment Due Process Clause. *Frost v. Agnos*, 152 F.3d 1124, 1128 (9th Cir. 1998). Because pretrial detainees' rights under the Fourteenth Amendment are comparable to prisoners' rights under the Eighth Amendment the same standards are applied to both claims. *Id*.

To state a claim under the 8th and 14th Amendments, plaintiffs must establish three elements: (1) the alleged deprivation was objectively sufficiently serious; (2) the individual defendants were "deliberately indifferent" to Clustka's health and safety; and (3) the harm was caused by the indifference. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994); *Jett v. Penner*, 439 F.3d

1091, 1096. (9th Cir. 2006).

***26 B. The officers did not subject Clustka to a substantial risk of serious harm.**

For a claim based on a failure to prevent harm to a detainee, it must be shown she has been incarcerated under conditions posing a substantial risk of serious harm. *Farmer v. Brennan*, 511 U.S. 825, 834 (1994). When the claim is that a serious medical need was not addressed, it must be demonstrated that the failure to treat the condition could result in further significant injury or the unnecessary and wanton infliction of pain. *Jett v. Penner*, 439 F.3d 1091, 1096. (9th Cir. 2006). Indicia of a serious medical need include (1) the existence of an injury that a reasonable doctor would find important and worthy of comment or treatment, (2) the presence of a medical condition that significantly affects an individual's daily activities, and (3) the existence of chronic or substantial pain. *Doty v. County of Lassen*, 37 F.3d 540, 546 (9th Cir. 1994).

Plaintiffs failed to establish that Clustka presented such an objectively serious threat of suicide that incarcerating her without reporting her conduct to jail personnel or taking her to the hospital subjected her to a substantial risk of serious harm. The officers were faced with an intoxicated woman who did not want to be taken to jail. REMSA personnel had performed a mental and physical evaluation and released her for transport for CPC. The only experience either officer had with Clustka was Ashton's observations of her while she was treated for injuries before being arrested on a domestic battery charge more than a month earlier. The only ***27** other information the officers had was Clustka possessed violent tendencies, abused drugs and alcohol and had unspecified mental health problems. Clustka was placed in the van for transport to jail with no objective reason to believe she was suicidal.

When Clustka realized she was headed to jail instead of to her home, she tapped on the camera to get the officers to stop the van. When that didn't work, she wrapped the seatbelt around her neck and the officers stopped the van. Her actions were reasonably understood to be nothing more than an attempt to manipulate the situation. When she told the officers to kill her or she would kill herself, the officers had no more reason to believe Clustka would kill herself than she did that the officers would actually kill her.

Robertson had repeatedly heard many sober and intoxicated detainees threaten to kill themselves over the years when being taken to jail. Both officers understood that intoxication is a factor to consider when assessing credibility, but also considered all the circumstances presented. Their assessment of the situation is supported by Dr. Caplan's testimony that intoxication changes a person's state of mind and judgment to the point that an intoxicated person might say something she doesn't really mean such as I'm going to kill myself if I don't get my way. The judgment of an intoxicated person is simply not as good as someone who is not ***28** intoxicated. The officers reasonably believed Clustka's actions occurred because she was angry and was attempting to manipulate that situation.

Not only did the facts available to the officers fail to indicate that Clustka presented an objectively serious threat of suicide, the remaining facts also did not support such a finding. First, Dr. Caplan judged Clustka not to be a risk of suicide just hours before Ashton and Robertson transported Clustka. Second, the REMSA medical personnel found no basis for concluding that Clustka presented a risk of suicide and released her to the police officers for transport to jail. Third, no determination was made that Clustka was at risk for suicide when evaluated by the intake nurse upon her arrival at the jail. Fourth, Clustka made no threat of suicide while confined at the jail for CPC. Fifth, Clustka was hot found to be a suicide risk by the emergency room doctor at WMC just hours after her release from CPC detention.

While it is apparent that suicide itself is an objectively serious harm, the question presented with respect to the first factor is whether plaintiffs have shown that Clustka presented an objective "serious medical need" at the time that the defendants chose not to take additional action. The fact that Clustka ultimately took her own life two days later does not establish this requirement. Rather, it was plaintiffs' burden to show that Clustka presented an objective serious medical need at the time when defendants are accused of not taking appropriate action.

***29** In addition to the foregoing factors, none of the indicia of a serious medical need identified in *Doty, supra*, are present here. There is no evidence that Clustka's acts, without reference to her prior medical history, would be worthy of comment or treatment by any reasonable doctor or that she had a medical condition that significantly affected her daily activities. There is also no evidence that either chronic or substantial pain was involved with Clustka's actions.

Plaintiffs' argument on this point is based on the assumption that Clustka actually tried to commit suicide and ignores the need to make an objective assessment of the situation based on all the circumstances presented. Plaintiffs' approach puts the cart before the horse in the analysis. The real question presented is whether Clustka had an objective serious medical need while being transported to jail without having the information that Clustka would commit suicide two days later. The facts available at the time of the incident demonstrate that Clustka did not then have an objective serious medical need.

Plaintiffs' attempt to analogize to a situation where one is bitten by a rattlesnake does not provide support for their position. It is obvious the officers were not presented with a situation involving an injury inflicted by an outside agent under circumstances where death could immediately result. The choice under the circumstances plaintiffs describe is simple. The choice made by the officers under the circumstances presented to them was far more involved.

***30** This Court has held that, under circumstances far more egregious than those presented here, where officers reasonably believe an inmate's comments about committing suicide are merely a joke, there is no basis for finding deliberate indifference. In *Estate of Cartwright v. City of Concord*, 856 F.2d 1437 (9th Cir. 1988), a pretrial detainee committed suicide in his cell after speaking of committing suicide while in jail. However, because the jail personnel reasonably believed he was continuing the joke his companion had started earlier in the evening and no other statements gave them reason to believe he needed preventative care, the individual defendants were not held liable for not taking additional precautions. Although neither officer considered Clustka's acts to be a "joke", there was also no objective basis for concluding she had a serious medical need. Plaintiffs failed to establish the first required element of the claim.

**C. Defendants Were Not Deliberately Indifferent To Clustka's Health Or Safety.**

The second requirement follows from the principle that only the unnecessary and wanton infliction of pain implicates the Eighth Amendment. *Farmer*, supra, at 834. To violate the Cruel and Unusual Punishments Clause, the official must be shown to have a sufficiently culpable state of mind that amounts to deliberate indifference to the detainee's health or safety. *Id*. An official cannot be held liable unless he knew of and disregarded an excessive risk to the detainee's health or safety. *Id* at 837. The official must be both (1) aware of facts from which the ***31** inference could be drawn that a substantial risk of serious harm exists and (2) actually draw that inference. *Id; Toguchi v. Chung*, 391 F.3d 1051, 1057 (9th Cir. 2004). If an official should have been aware of the risk but was not, no violation has been established no matter how severe the risk. *Toguchi*, at 1057. This subjective approach focuses only on what a defendant's mental attitude actually was. *Id*. Mere negligence in diagnosing or treating a medical condition does not violate a prisoner's constitutional rights. *Id*. In a jail suicide case, deliberate indifference requires that the defendant disregard a strong likelihood rather than a mere possibility that the self-infliction of harm will occur. *Snow v. City of Citronelle*, 420 F.3d 1262, 1268 (11th Cir. 2005); *Cook ex rel. Estate of Tessier v. Sheriff of Monroe County, Fla.*, 402 F.3d 1092, 1115 (11th Cir. 2005). The undisputed facts of this case are insufficient to meet these standards.

Plaintiffs were required to present sufficient evidence that would allow a trier of fact to conclude the officers knew Clustka was suicidal. The officers testified they did not believe Clustka was actually trying to harm herself in the back of the transport vehicle on April 26 because of the following facts:

1. Clustka attempted to get their attention the entire duration of the trip, even getting out of her seat and tapping on the camera in the rear of the vehicle to get their attention, but they did not stop in response to those efforts.

***32** 2. Clustka became angry when she saw she was being taken to jail rather than home as she had been told. Clustka put the seatbelt around her neck only when she saw she was not going home and the prior attempts to get the officers to stop the vehicle had failed.

3. Clustka knew the officers were watching her when she put the seatbelt around her neck.

4. Clustka was intoxicated. Both officers believed intoxication is a factor when assessing credibility.

5. Clustka told them to kill her before she said she was going to kill herself.

6. There was no indication from any other conduct by Clustka that she was suicidal.

7. Clustka lacked the means to commit suicide. Even if she had managed to pass out from the seatbelt, she would have lost all tension on the belt and could not have killed herself.

8. Clustka was angry when she arrived at jail.

9. Both officers reached the conclusion that Clustka was not trying to harm herself based on the totality of the circumstances.

Plaintiffs produced no evidence that either officer actually knew Clustka was at substantial risk of serious harm. Instead, they argue only that the circumstances ***33** support an inference that they were negligent in diagnosing her condition and that the officers were motivated by their own self interest in not taking further action to inform others of Clustka's conduct.

Plaintiffs contend that the following factors point to the officers awareness of Clustka's vulnerability to suicide: (1) the words stated by Clustka, (2) the officers' supposed awareness of Clustka's history of mental problems, (3) Clustka's disorientation and intoxication, (4) knowledge that Clustka's mother had obtained a temporary protective order against her, and (5) knowledge that Clustka continued to face stressors that contributed to her substance abuse and disoriented condition. AOB, p.29-30. The facts referenced by plaintiffs do not provide evidence of actual knowledge.

First, the fact that officers saw Clustka wrap the belt around her neck did not mean they knew she wanted to kill herself. The officers knew her actions were an attempt to get them to stop the vehicle and that she could not commit suicide.[9] All the cases cited by plaintiff at page 29 involved knowledge of an undisputable attempt at suicide that is not present here.

Second, the words spoken by Clustka did not mean the "officers plainly got ***34** the message" that she actually intended to kill herself. As discussed at length above, the officers had ample reason to conclude she did not intend to do so and did not believe she intended to do so. Plaintiffs' assertion that Clustka's failure to say she was just joking should have lead the officers to conclude she was suicidal is a misguided attempt to characterize a complex situation as something a child could resolve. That was clearly not the situation presented to the officers.[10]

Plaintiffs' citation to *Coleman v. Parkman*, 349 F.3d 534 (8th Cir. 2003), does not support plaintiffs' position. In Coleman, the arresting officer was told by several people the day before and of Coleman's arrest that he would kill himself if jailed. When Coleman was arrested, the person with Coleman told the officer Coleman had threatened suicide. After Coleman was arrested, he told the same officer he had contemplated suicide the day before. The same officer told the jailer Coleman was a suicide risk. *Id*. at 536. Under these facts, the court found a factual issue as to whether the arresting officer and jailer knew Coleman presented a substantial suicide risk. The facts known to the two officers here do not approach the level of knowledge held by the officers in Coleman.

Third, the officers had no reason to know Clustka was suicidal because the ***35** warrants check stated Clustka had a history of mental problems. There is no evidence that knowledge of a history of unspecified mental problems must or even should lead one to conclude the individual is suicidal.

Plaintiffs also claim that Ashton had personal awareness of Clustka's mental illness and substance abuse from having arrested her the prior month and that Robertson thought she was seriously mentally ill. Plaintiffs have misstated the evidence. It is undisputed that the only role Ashton played in the March 19 incident was to stand by at WMC while Clustka received medical treatment for the physical injuries she sustained. ER 30-31. And the only reason Robertson thought Clustka "might be seriously mentally ill" was because she was intoxicated. ER 235 @128:12-16. Neither fact establishes sufficient evidence to demonstrate a genuine issue of fact regarding either officers' state of mind.

Fourth, the officers did not know Clustka was suicidal because she was disoriented and intoxicated. Plaintiffs contend the officers knew she was suicidal because Dr. Caplan, the examining psychiatrist at NMHI, testified that disorientation and intoxication should set off "alarm bells" for an increased suicide risk for Clustka.[11] But Dr. Caplan was actually asked, *knowing* he had evaluated ***36** Clustka for being at risk of suicide on April 26, if he would consider her intoxication and substance abuse if she was returned the next day based on a second suicide attempt in assessing her suicide risk. ER 336

@23:12-16. It is obvious in the context of his testimony that he was not saying that the mere fact of intoxication or substance abuse by any individual is an indication the person is at risk of suicide. There is no basis in the record for attributing the experience Dr. Caplan had with Clustka to the two officers.

Fifth, the officers' knowledge that Clustka's mother had obtained a temporary protective order against her did not mean the officers knew Clustka was suicidal. Plaintiffs contend this knowledge was "sufficient to put the officers on notice to take her seriously." AOB, p.30. The issue though is not whether the officers took Clustka seriously, but whether they knew Clustka was at substantial risk of serious harm. The fact that a protective order was issued does not present a genuine issue of material fact. There is no evidence that indicates any officer should conclude that one is at risk of committing suicide because of a protective order.

Sixth, the officers had no personal knowledge of Clustka's history and didn't know if any stressors she faced would make her suicidal. The fact that the officers were not psychologists, who may take years to assess the causes of a person's troubles, does not mean they thought Claustka was suicidal.

***37** In addition to the foregoing factors, plaintiff also contend the officers knew they had violated department policies regarding the handcuffing and seat belting of prisoners in the transport vehicle and failed to report Clustka's conduct because they were concerned they would be disciplined if they did.[12] The record does not support this argument.

Ashton thought not reseatbelting Clustka was against policy and state law, but would take the same action again because he thought it would cause an unnecessary confrontation if he did. Robertson thought it was also against policy and state law if he is "not mistaken." With respect to handcuffing, Robertson did not believe policy required handcuffing. Ashton didn't know at the time if policy required handcuffing although he didn't think she should have been cuffed. 185@25:4-25;@26:12-25;ER213@40:6-16;ER213@143:2-4;ER182 @14:18-24.

Sergeant Evans was the immediate supervisor of both officers. He agreed it was discretionary on the officers' part as to whether to handcuff an intoxicated person and he may well have also continued on to the jail without stopping to reseatbelt Clustka. No discipline was imposed against either officer for any claimed violation of law or policy. Given the fact that no injury occurred to Clustka from ***38** any failure to initially handcuff her or to re-seatbelt her, there is simply no basis for inferring that either officer failed to report Clustka's conduct because of any fear of discipline. ER 286@75:5-17; 288 @84-92.

Plaintiffs failed to show there was sufficient evidence to raise a genuine issue of material fact regarding the officers' knowledge of a substantial risk of serious harm to Clustka. The district court properly granted summary judgment.

### D. Plaintiffs Failed To Show The Officers' Acts Were A Cause In Fact Of Clustka's Suicide.

Even if plaintiffs were able to establish the two elements of a deliberate indifference claim, they failed to show the officers caused any harm to Clustka by their conduct. In order to maintain their claim, plaintiffs must show the defendants' alleged deliberate indifference caused the harm in question. *Jett v. Penner*, supra, at 1096.

The requirement of establishing causation under a section 1983 claim is not unique to Eighth Amendment claims. In any section 1983 claim, the plaintiff must show the defendants deprived him of a right. *Arnold v. International Business Machines Corp.*, 637 F.2d 1350, 1355 (9th Cir. 1981). The statute creates liability for any person who "subjects, or causes to be subjected" particular persons to the deprivation of a constitutional right. *Id*. A person "subjects" another to the deprivation of such a right if he does an affirmative act, participates in another's affirmative acts, or omits to perform an act which he is legally required to do that ***39** causes the deprivation. *Johnson v. Duffy*, 588 F.2d 740, 743 (9th Cir. 1978). A person "causes" a deprivation not only by directly participating in the deprivation but also by 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. *Id*. A defendant's conduct is a cause of an event if the event would not have occurred but for that conduct; conversely, the defendant's conduct is not a cause of an event if the event would have occurred without it. *White v. Roper*, 901 F.2d 1501, 1505 (9th Cir. 1990); W. Prosser & W. Keaton, *The Law of Torts*, sec. 41, at 266 (5th ed. 1984) ("Prosser").

It is undisputed that the harm at issue is Clustka's suicide. Plaintiffs advance three theories as to how the officers' conduct caused this harm:
1. The officers could have taken Clustka to a hospital under a Legal 2000 procedure and reported what they saw and heard to emergency room staff;

2. The officers could have informed jail personnel who would have had the option of refusing her and sending her to a hospital for assessment and treatment; or

3. The jail had the option of admitting her and placing her under a suicide watch until she was detoxified and then sending her to a hospital under a Legal 2000.

***40** Plaintiffs contend that under any of these options, Clustka would have been assured suicide intervention by qualified medical staff until she was determined not to be at risk of suicide. AOB, p.7. Plaintiffs' arguments are not supported by the evidence and amount to mere speculation as to what might have occurred if any one of these courses of action had been pursued.

**(1) Choosing Not To Initiate A Legal 2000 Commitment Did Not Cause Clustka's Suicide.**

Plaintiffs initially contend the officers could have taken Clustka to a hospital under a Legal 2000 procedure and reported what they saw and heard to emergency room staff.[13] But plaintiffs' theory under this scenario does not stop here. Plaintiffs also contend that if this occurred, Clustka's mental health history would have been flagged and carefully scrutinized by emergency room personnel who would then have transferred her to NMHI where she would have remained for days and presumably never have committed suicide. AOB, p.39. Plaintiffs' contentions are not supported by the evidence and amount to mere speculation.

Whenever an individual is brought to WMC, a new evaluation is performed. Each encounter with an individual is evaluated based solely on its merit as to whether a patient needs to be placed under a Legal 2000 and transferred to a psychiatric facility. The mere fact that a patient was found to require psychiatric ***41** treatment for suicidal ideation on day one and was returned for evaluation the very next day for a repeat suicide threat or attempt would not change this approach; the same evaluation process based solely on the merits of the circumstances presented on the second day would be performed anew. Thus, Dr. Gansert who evaluated Clustka on April 25 and found her to be suicidal testified that he could only speculate on what action he might have taken with Clustka if he had evaluated her on April 26 even with the additional information of a repeat suicide attempt and threat. The claim that Clustka would have been referred to a psychiatric facility if she had been taken by the officers to the emergency room on a new claim of attempted suicide is pure speculation. Nobody knows what conclusion an evaluation would have reached at the emergency room. ER324@7:25 -8:4; ER325@10:1-6; ER327@18:6-25 -19:1-11.

The record of Clustka's evaluations performed at emergency rooms other than on April 25, 2005, does not support plaintiffs' theory. On September 14, 2001, and on August 16, 2003, Clustka was evaluated in an emergency room and transferred to NMHI. On April 3, 2004, although a psychiatrist recommended that Clustka be admitted to NMHI, Clustka informed the social worker at WMC that if she was sent to NMHI she would lose her new job. There is no evidence Clustka was transferred to any psychiatric facility from the hospital. And on April 26, ***42** 2005, the parties agree that Clustka was not transferred to any psychiatric facility after evaluation at WMC.

There is also no basis for the assertion that Clustka's mental health history would have been flagged and carefully scrutinized by emergency room personnel if she had been taken for evaluation to the emergency room by the officers on April 26. There is no evidence any evaluation of Clustka performed prior to 2005 was ever reviewed by medical staff in any subsequent evaluation. Dr. Gansert did not review any such document on April 25, 2005. There is no evidence the emergency room doctor reviewed any health history on April 27 even though Clustka had been referred to NMHI from that same emergency room just two days earlier. Plaintiffs' assertion that Clustka's mental health history would have been flagged and carefully scrutinized by emergency room personnel if she had been taken for evaluation on April 26 is also pure speculation.

There is also no evidence to support plaintiffs' claim that if Clustka had been transferred to NMHI on April 26, she would have remained there for days. On September 14, 2001, Clustka was kept at NMHI for less than 12 hours. On August 17, 2003, she was kept for one day. On April 25, 2005, Clustka was kept 17 hours. Even though the statutes allow a patient to be kept for up to 72 hours without a court order, the undisputed evidence is that a patient admitted at NMHI on a Legal 2000 is kept only until the physician determines she is no longer at risk for ***43** suicide. ER88@80:18 -81:7. Plaintiffs' assertion that Clustka would have been kept at NMHI for days on April 26 is not supported by the evidence and is pure speculation.[14]

The undisputed evidence is that medical intervention for one contemplating suicide does not "cure" an individual from entertaining similar thoughts in the future. Plaintiffs contend that had Clustka been given appropriate care such as being sent to NMHI for intervention, "she likely would have resisted the lure of suicide." AOB, p.41. There is no evidence to support this assertion. NMHI keeps a potentially suicidal patient only until the medical staff concludes the patient is no longer at risk of committing suicide. NMHI cannot provide a cure for a person with suicidal thoughts and doesn't even provide ongoing treatment for a suicidal patient. For example, although Clustka's potential intoxication was viewed as a risk to her future safety, NMHI does not provide substance abuse treatment. Instead, typically the patient is referred to substance abuse treatment and all NMHI does is "hope" the patient attends. Although Clustka was assessed on April 25 as requiring "medically monitored residential services," there is no evidence that ***44** Clustka obtained that level of care or that she had any plan for doing so. ER90@105:15 - ER90@106:9; ER138.

The records for the treatment Clustka received for suicidal ideations prior to April 25, 2005, demonstrate that none of the medical facilities where she was evaluated provided ongoing treatment of any underlying cause of suicidal ideation. Instead, these facilities simply kept her until she was determined to no longer be a high risk of immediate suicide and left any ongoing treatment up to Clustka to obtain. In September 2001, Clustka tried to cut her wrist with a piece of glass because she was depressed. Increased suicide risk factors included substance abuse, poor insight and an unresponsive family. The only action taken by NMHI to address any of these factors was to prescribe medication and refer her to counseling and group therapy. In August 2003, Clustka again tried to kill herself after overdosing on an over the counter medication and drinking tequila because she was upset. NMHI discharged her with instructions to follow up with her primary care physician, alcoholics anonymous and clinical services if needed. ER101, 103, 104, 106, 107, 110, 118, 120.

Plaintiffs' argument that Clustka would not have killed herself if she had been taken to the hospital on April 26 has no support in the evidence and is just additional speculation. Even if a Legal 2000 had been initiated, it is speculative to conclude that Clustka would have been admitted to NMHI at all. If she had been, ***45** she would have been kept only until she no longer presented an immediate risk of suicide. NMHI's role was only to keep her until she no longer presented an immediate risk of suicide and provide a discharge treatment plan for her to follow on her own. Upon discharge Clustka would have been able to access the same substances that lead her to attempt suicide previously. The record is replete with Clustka's attempts to commit suicide and the evidence suggests she would have tried again no matter what action was taken.

**(2) The Act Of Not Informing Jail Personnel Of Clustka's Conduct Did Not Cause Her Suicide.**

There is also no basis in the evidence for concluding that Clustka would not have committed suicide if the officers had informed jail personnel of the seatbelt incident. Plaintiffs argue that if the officers had done so, jail personnel either could have refused admittance to Clustka and sent her to the hospital on a Legal 2000 or placed her on a suicide watch. The first assertion has already been addressed. Likewise, any attempt to predict how jail personnel would have dealt with Clustka if they had been given this information is speculative. While at the jail during her confinement for CPC, there is no evidence Clustka threatened to kill herself. There is no evidence Clustka made any gesture indicating any intention to kill herself. In fact, the undisputed evidence is that Clustka did not attempt to harm herself in any way while confined for CPC on April 26. Because no harm came to Clustka while confined for CPC, the lack of a report about the seatbelt incident ***46** caused no harm to her during the only confinement initiated by Ashton and Robertson.

If the officers had informed jail personnel of Clustka's conduct, there is also no basis for concluding that Clustka's suicide two days later would have been prevented because jail personnel would not have had access to the information associated with her CPC confinement. As discussed above, although medical records for an inmate previously jailed in connection with a criminal charge are available to the nursing staff, information related to a prior confinement for CPC status are typically not accessed by the nurse when someone is subsequently arrested and brought to the jail. Unless the same intake nurse working

when Clustka was brought in for CPC was also working the next day when Clustka was evaluated, there would be no way for a second nurse to know about the prior CPC information. Even if the screening nurse knew that an individual had made a suicidal gesture and threats the day before, that information would not have been sufficient to make a determination regarding placement. A variety of variables would have come into play in assessing the individual including the fact that she was intoxicated when the gesture and threats were made. There is no basis for concluding that not reporting Clustka's conduct to jail personnel affected anything they did when Clustka was admitted to jail on April 27.

***47** Even without the additional information from the officers on April 26, the jail already had sufficient information to allow it to determine appropriate precautions for Clustka during her confinement that began on April 27. The jail was aware she had been on a suicide watch there less than a month before. Clustka was placed in Housing Unit 3, the mental health unit, because of her anxiety disorder, substance abuse and mental health history, including the jail suicide watch a month earlier, and a psychiatric evaluation was scheduled for her. Even though all this information was taken into account in determining her placement, Clustka was still not placed on a suicide watch. And even with all this information, the deputy who escorted her back to her cell just prior to when she committed suicide failed to report her disturbing conduct he witnessed. There is simply no basis for finding that even if the additional information from April 26 had been available that Clustka's suicide would have been prevented.

The fact that Clustka sustained no harm during the time she was confined as a result of defendants' actions and only after she was confined on different charges the next day also shows the lack of causation. The cases that plaintiffs cite do not support their position and are not analogous to the facts presented here. In *Cabrales v. County of Los Angeles*, 864 F.2d 1454 (9th Cir. 1988), plaintiff claimed that the county and its employees at the jail were deliberately indifferent to her son's medical needs and should be held liable in damages for his suicide. On ***48** December 16, 1983, the decedent attempted to commit suicide in his jail cell but was saved by two deputies. The decedent was subsequently examined by a psychiatrist who determined the suicide attempt was simply a gesture undertaken to get out of his housing assignment On January 3, 1984, while in jail continuously from the prior incident, the decedent committed suicide. Summary judgment was granted to the psychiatrist. At trial, the plaintiff succeeded only on her claim that the county maintained a policy or custom of deliberate indifference to the safety and medical needs of inmates. No individual was held liable for causing the subsequent suicide.

In *Snow v. City of Citronelle*, 420 F.3d 1262 (11th Cir. 2005), summary judgment in favor of Officer Chennault was reversed. Although he told the decedent's parents the decedent was suicidal, Chennault placed the decedent in a cell knowing she should be checked every 15 minutes and that items that could be used to harm herself should be removed without taking either action. The decedent killed herself the next morning while continuously confined. Understandably, no issue of causation was raised. In *Turney v. Waterbury*, 375 F.3d 756 (8th Cir. 2004), summary judgment for the sheriff was reversed because although he knew the decedent had tried to kill himself three days earlier and had violently resisted efforts to stop him, the sheriff still placed him directly in a regular cell where he ***49** committed suicide just hours later. Again, no issue of causation was raised. None of these cases are similar to the circumstances of this case.

The record does not provide a basis for finding the existence of a genuine issue of material fact regarding actual causation. Accordingly, summary judgment was properly granted.

### E. Plaintiffs Failed To Show The Officers' Acts Were The Proximate Cause Of Clustka's Suicide.

The officers' acts were not only not a cause in fact of her suicide, they were also not the proximate cause of her death. The causation requirement is not satisfied by a mere showing of causation in fact. *Arnold*, at 1355. Rather, the plaintiff must establish proximate or legal causation. *Id*. The problem of proximate cause is "one of the policy as to imposing legal responsibility." *Hunley v. Ace Maritime Corp.*, 927 F.2d 493, 497 (9th Cir. 1991) (quoting *Prosser*, sec.44 at 301). Conduct is not the proximate cause of an injury if another cause intervenes and supersedes the actor's liability for the subsequent events. *White v. Roper*, supra, at 1506. Whether an intervening cause superseded the defendant's liability for the results of his own conduct depends on what was reasonably foreseeable at the time. *Id*.

Plaintiffs contend that once the individual officers became aware of Clustka's conduct in the transport vehicle and did not immediately report it, they "rendered themselves potentially liable no matter when the suicide actually ***50** occurred." AOB, p.42.[15] The prospect of unlimited liability asserted by plaintiffs is exactly why the proper application of proximate cause is

crucial.

The undisputed evidence is that, regardless of a patient's history of suicidal threats or attempts, the determination of whether one presents an immediate danger of suicide is based upon the current situation of the patient. Dr. Gansert testified that every psychiatric evaluation he performs on a patient is based on its individual merit and according to the specific circumstances presented for that evaluation. Thus, he could only speculate on what action he might have taken with Clustka if he had evaluated her on April 26 even with the additional information of a repeat suicide attempt and threat. When Dr. Caplan was asked whether Clustka was a risk of suicide when he discharged her on April 26, his response was that, "At that moment in time she was judged not to be a risk." ER91@108:16-19. He believed that her suicide two days later occurred because her state of mind and possibly her situation, including the fact of incarceration, had changed. ER91@108:20 - 109:25.

Clustka received several medical evaluations after she was removed from the transport vehicle on April 26: (1) she was evaluated by the nurse at the jail when she was detained for CPC on April 26; (2) she was evaluated by a physician ***51** at WMC and (3) she was given a full evaluation by the intake nurse at the jail on April 27. None of the evaluators concluded Clustka was suicidal at any one of these points in time.

The undisputed evidence is that Clustka was suicidal only at specific times and for limited time periods. None of these medical professionals found Clustka to be suicidal and the only reasonable conclusion that can be drawn is that she was not suicidal at those times of evaluation. If Clustka was suicidal the entire time between the seatbelt incident and when she committed suicide, the failures of the medical professionals to properly diagnose her were superseding causes of her suicide that were not foreseeable to the officers. If she was not suicidal at the time of those evaluations, the officers could not reasonably foresee that choosing not to report the seatbelt incident could result in Clustka's suicide two days during a separate confinement. Even if actual causation was established, a finding that their mere failure to report a claimed suicide attempt in the transport vehicle makes them responsible for any suicide attempt by Clustka no matter when or where it occurs would exceed all bounds established by the principle of proximate cause.

The circumstances under which Clustka was confined were also very different on April 26 from those on 27. On April 26, Clustka was told she was simply being taken in for CPC, a confinement that lasts only until the prisoner becomes sober, and she was held only a few hours. On April 27 however, she was ***52** booked on a misdemeanor charge of violating a protective order. The last time she had been booked on a misdemeanor charge in March, 2005, she was held for over a month and was placed on suicide watch her second day of confinement. When she was booked on the misdemeanor charge on April 27, she committed suicide the second day. Dr. Caplan's view that Clustka's suicide two days later occurred because her state of mind and possibly her situation, including the fact of incarceration, had changed bears considerable weight. The policy as to imposing legal responsibility cannot lead to the conclusion that defendants are the proximate cause of Clustka's death under these circumstances.

**F. The Individual Defendants Are Entitled To Qualified Immunity.**

If the grant of summary judgment is upheld, there is no reason to address the issue of whether the individual officers are entitled to qualified immunity for their actions. A court required to rule upon the qualified immunity issue must consider, then, this threshold question: Taken in the light most favorable to the party asserting the injury, do the facts alleged show the officer's conduct violated a constitutional right? *Saucier v. Katz*, 533 U.S. 194, 201, (U.S., 2001). If no constitutional right would have been violated were the allegations established, there is no necessity for further inquiries concerning qualified immunity. *Id*. On the other hand, if a violation could be made out on a favorable view of the parties' submissions, the next, sequential step is to ask whether the right was clearly ***53** established. *Id*. This inquiry must be undertaken in light of the specific context of the case, not as a broad general proposition. *Id*. The relevant, dispositive inquiry in determining whether a right is clearly established is whether it would be clear to a reasonable officer that his conduct was unlawful in the situation he confronted. *Id*. at 202. If the law did not put the officer on notice that his conduct would be clearly unlawful, summary judgment based on qualified immunity is appropriate. *Id*.

The concern of the immunity inquiry is to acknowledge that reasonable mistakes can be made as to the legal constraints on particular police conduct. *Id*. at 205. It is sometimes difficult for an officer to determine how the relevant legal doctrine will apply to the factual situation the officer confronts. An officer might correctly perceive all the relevant facts but have a

mistaken understanding as to whether a particular course of conduct is legal in those circumstances. If the officer's mistake as to what the law requires is reasonable, however, the officer is entitled to the immunity defense. *Id*. The question is what the officer reasonably understood his powers and responsibilities to be, when he acted, under clearly established standards. *Id*. at 208.

The application of these principles here must lead to the conclusion that the individual officers were entitled to qualified immunity. As discussed at length above, the circumstances under which the officers were acting provided reasonable ***54** grounds for them to conclude that the actions they were taking did not violate Clustka's constitutional rights. Neither officer was aware of any prior suicide attempt by Clustka and the facts indicated they had an angry intoxicated subject who did not want to go to jail like any other detainee who was willing to try to manipulate the situation to avoid doing so. They knew she would be released from custody when she sobered up and had no idea she would be arrested and again confined at the jail on a new criminal charge. Plaintiffs have not identified a clearly established rule applicable to the circumstances presented that the officers disregarded. Accordingly, the individual officers were entitled to qualified immunity.

**G. There Is No Basis For Municipal Liability.**

A municipality may be held liable only where it inflicts an injury; it may not be held liable under a respondeat superior theory. *Monell v. Dep't of Social Services of City of N.Y.*, 436 U.S. 658, 691 (1978). *Gibson v. County of Washoe*, 290 F.3d 1175, 1185 (9th Cir. 2002). Liability may be established by what the municipality does or by what it fails to do; that is, there may be direct liability or liability by omission. *Id*. at 1186. Plaintiffs do not contend the City directly violated Clustka's constitutional rights. Therefore, the City can be held liable only if there is a legally cognizable basis for imposing liability against it for a failure to act.

***55** To impose liability against a city for a claimed failure to act, plaintiffs must show that a (1) City employee violated Clustka's rights; (2) the City has customs or policies that amount to deliberate indifference; and (3) these policies were the "moving force" behind the employee's violation of Clustka's constitutional rights. *Id*. at 1193-94. As discussed above, plaintiffs failed to show that either of the individual defendant officers violated Clustka's constitutional rights. Therefore, there is no basis for imposing liability against the City. However, even if the first element was satisfied, plaintiffs have failed to show that the remaining elements have been satisfied.

There is no basis for imposing liability against the City on any of the four theories asserted by plaintiffs. Plaintiffs rely on the theory that a failure to train may serve as a basis for recovery 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. *Long v. County of Los Angeles*, 442 F.3d 1178, 1186 (9th Cir. 2006). The availability of that theory depends upon a showing of the likelihood that the situation will recur and the predictability that an officer lacking specific tools to handle that situation will violate citizens' rights. Id.

Plaintiffs have failed to show that the type of situation encountered by the officers here is one that is likely to recur. Plaintiffs produced no evidence that any member of the City's police force has ever encountered any situation like that ***56** presented by Clustka on April 26, 2005. The City has a policy regarding civil protective custody detentions that was in existence at the time of the incident. ER 399. Plaintiffs contend that it is well-known that suicide is the number one cause of death in U.S. jails and that therefore, the City's officers should be trained in suicide prevention. But plaintiffs ignore the fact that the City does not own or operate the jail. Furthermore, if Clustka was attempting to kill herself in the transport vehicle, the officers kept her from doing so. Therefore, is no basis for finding that the lack of specific training on how to deal with the kind of situation presented by Clustka caused her suicide to occur.

There is also no basis for finding that a failure to have a policy that specifically addresses suicide prevention caused a constitutional deprivation. Plaintiffs quote extensively from *Long* with respect to this theory but failed to include the very next sentence from that decision that follows the language quoted: "When policymakers know that their medical staff members will encounter those with urgent mental health needs yet fail to provide for the identification of those needs, it is obvious that a constitutional violation could occur." *Long, supra*, at 1189 (quoting *Gibson, supra*, at 1196). However, Dr. Caplan testified that Clustka could not have been taken to NMHI while intoxicated and that taking her to jail in order to detox her was a proper way to address Clustka's needs at the time. The City also already has a policy regarding the transport of

mentally ill. ER401. As ***57** shown by the action of City police officers in bringing Clustka to WMC after she was released from CPC custody on April 26 when the jail refused her admittance, the officers did what they could do to obtain treatment for her. It was the physician on duty who saw no need for further treatment to be provided to Clustka. Thus, there is no basis for claiming that the lack of a specific policy caused Clustka's suicide.

There is no basis for plaintiffs' assertion that the City was aware of similar conduct by Officer Robertson in the past and failed to take reasonable precautions against similar behavior in the future. There is nothing in any of the material submitted by plaintiffs' from Robertson's personnel file or other documents that contain any indication that he had ever engaged in conduct that could ever be considered as providing grounds for a claim of deliberate indifference with respect to any member of the public.

Finally, there is also no basis for the claim that the City is liable for a claimed failure to discipline either of the officers involved. The evidence does not establish a basis for disciplining either officer.

## *58 8. CONCLUSION

For the foregoing reasons, defendants request that the judgment of the district court be affirmed.

RESPECTFULLY SUBMITTED this *21st* day of September, 2007.

Footnotes

1 Reno Police Department ("RPD") procedures direct, pursuant to NRS 458.270, officers to take intoxicated persons who cannot care for themselves to the detoxification center at the Washoe County Jail ("jail"). ER399-400; ER248.

2 *See* Appellants' Opening Brief ("AOB"), p. 2, note 1, for an explanation of a Legal 2000.

3 Plaintiffs state that Clustka was transported to WMC by Reno Police and arrested by Officer Ashton. AOB, p.8. Neither assertion is accurate. ER 30-31.

4 A person taking a substantial amount of Xanax could mirror an intoxicated state. ER418@40:6-8.

5 NRS 484.641(1)(b) provides: 1.It is unlawful to drive a passenger car manufactured after: (b) January 1, 1970, on a highway, unless it is equipped with a lap-type safety belt assembly for each permanent seating position for passengers. This requirement does not apply to the rear seats of vehicles operated by a police department or sheriff's office.

6 Although plaintiffs claim Clustka was only "briefly" examined by the emergency room physician, the report states, "Time seen: Hours". ER432. There is no other evidence in the record which indicates the length of the evaluation. Plaintiffs agree WMC "emergency staff performs a thorough medical screen." AOB, p.21.

7 It is undisputed that the nurse who performed the intake assessment of Clustka on April 26 in connection with her confinement for CPC was *not* the same nurse who performed Clustka's intake assessment on April 27 when arrested on the criminal charge. ER 428-429; 56-58.

8 The report describing this conduct was not written until nearly eight hours later and there is no evidence the deputy informed any medical or supervisory personnel prior to Clustka's death of what occurred despite Clustka's recent placement on a suicide watch and a psychiatric exam scheduled for later that day. ER61.

9 Plaintiffs argue that the fact that Clustka could not kill herself by wrapping a seatbelt around her neck is irrelevant. Dr. Gansert's diagnosis that Clustka was suicidal was based on the fact that she had a plan to commit suicide and the ability to carry it out. ER141. The fact that Clustka could not carry out any alleged plan is clearly relevant.

10 Plaintiffs contend there is no evidence the officers considered the fact that Clustka had enough breath to scream at them when they removed the seatbelt or that they observed no bruises on her. It is undisputed that the officers considered all the circumstances in assessing whether Clustka was attempting to harm herself and the intake nurse saw no sign of any injury.

[11] Plaintiffs repeatedly use the term "alarm bells" throughout their opening brief as though this phrase has some accepted meaning to the officers. The use of the term originated in a question asked by plaintiffs attorney of Dr. Caplan. ER336@25:48. No witness ever used that term.

[12] Plaintiffs expressly admit they do not assert that a claimed violation of policy amounts to a constitutional violation. AOB, p.36.

[13] It is undisputed that the officers would not have been able to take Clustka directly to NMHI because of her intoxication. ER92@150:5-12.

[14] Dr. Caplan did not personally know the average length of stay of involuntarily admitted patients at NMHI, but did not dispute the average length of stay is three weeks. However, it is apparent from the context that this time period was with reference to all such patients, and not specifically those at risk for suicide for whom no court order of confinement had been obtained. ER332@6-7.

[15] It is undisputed that Clustka's own family had specific knowledge of her history of suicidal threats and attempts. There is no evidence they ever informed anyone at the jail of these facts.

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