

You are not your worst mistake

Vindicating the rights of those who die in police custody

By Denisse O. Gastélum

The manner in which a society treats its most vulnerable speaks directly to the values and morals of its people. Our "most vulnerable" can quite simply be summarized as those who do not have a voice because of their standing in life, their capabilities and limitations, and because of restrictions to their freedom. Defending the rights of our most vulnerable and ensuring that they *too* get to enjoy the inviolable right to life, liberty and pursuit of happiness *no matter* where they may find themselves – even in a correctional setting – is my life's work. And I wouldn't have it any other way.

About Jose

Let me tell you about Jose …

Jose came to this country at a very young age with his parents and five younger siblings. They came in search of one thing: The American Dream.

As the eldest son in a Mexican family, Jose took great pride in helping his parents provide for his siblings. He was a hard worker and was quite industrious in the restaurant business, working long days as a bus boy and a dishwasher. He was "muy alegre" (i.e., a very happy person) and an obedient and respectful son. Whenever his mother asked Jose to do chores around the house, he would simply respond, "si, mamá," and would carry out the chore with no complaints. Every mother's dream, indeed; though this dream would one day be taken from her.

On February 23, 2019, Jose committed suicide inside of his jail cell by tying a noose made from bedsheets around his neck, then attaching the noose to the ladder of his bunkbed. During the time that Jose was engaging in the act of asphyxiating himself, and more specifically

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during a 92-minute timespan, the custody staff failed to conduct a mandatory Title 15 welfare/safety check to ensure that Jose was safe and well.

Four years have passed since Jose's death, and still his father watches the front door every evening wishing and praying that the door opens, and he sees his eldest boy walk in. His mother too holds on to her memories of Jose. She fondly remembers Jose's response in the mornings when she would ask him what he wanted for breakfast: "huevos, pero sin cebolla." Like me, Jose loved his eggs in the morning but was *not* a fan of onions.

Before Jose passed away, family dinners were considered to be a sacred and necessary time for the family to come together and enjoy each other's company around the dinner table. Now, dinner is had *anywhere* but the dinner table. Some eat in the living room. Others eat in their bedroom. Jose's father prefers to eat dinner at work before he gets home because the thought of gathering for a family dinner with an empty chair is far too painful.

The family used to love Christmas. It was their favorite holiday and despite Jose's parents having very little money, they *always* made sure that a Christmas tree decorated their living room during the month of December. Since Jose's death, Christmas is no longer celebrated. Even the weekends are different now. Sundays were days for carne asadas (i.e., Mexican-style barbeques) and, of course, for family. Now, Sundays are spent at the cemetery.

Now that I have told you a little bit about Jose, let me explain some of the fundamental theories of liability pursued in the federal civil rights/wrongful death action arising from Jose's death, particularly those theories which focus on public-entity/private-medical-provider liability.

Fourteenth Amendment violations

Failure to protect from known risks of serious harm and failure to provide adequate mental health care

The Fourteenth Amendment requires that correctional facilities not be deliberately indifferent towards the detainees' safety and protection. (See *Gordon v. County of Orange* (9th Cir. 2018) 888 F.3d 1118.) As it pertains to detainees who suffer from medical conditions, including mental health issues such as suicidal ideations, the Fourteenth Amendment "ensures that states will provide not only for the medical needs of those in penal settings, but for anyone restricted by a state from obtaining medical care on his own." (*Gibson v. County of Washoe* (9th Cir. 2002) 290 F.3d 1175, 1188, n. 9.) "This duty to provide medical care encompasses detainees' psychiatric needs." (*Id*. at 1187.)

To prevail on a claim of deliberate indifference, a plaintiff must demonstrate that (1) he had a serious medical need, (2) the official was deliberately indifferent to that need, and (3) this indifference caused him harm. (*Jett v. Penner* (9th Cir. 2006) 439 F.3d 1091, 1096.) A serious medical need is one which, without treatment, "could result in further significant injury or the unnecessary and wanton infliction of pain." (*Colwell v. Bannister* (9th Cir. 2014) 763 F.3d 1060, 1066.) "Indications that a plaintiff has a serious medical need include '[t]he existence of an injury that a reasonable doctor or patient would find important and worthy of comment or treatment; the presence of a medical condition that significantly affects an individual's daily activities; or the existence of chronic and substantial pain.'" (*Ibid.*)

"An inmate exhibiting symptoms of psychosis has established a serious medical need for purposes of the objective prong of a deliberate indifference claim." (*Padilla v. Beard* (E.D. Cal. Jan. 27, 2017) No. 2:14-cv-1118 KJM-CKD, 2017 U.S. Dist. LEXIS 11851 at *45-46; *Coleman v. Wilson* (E.D. Cal. 1995 912) F. Supp. 1282, 1321 [defendants exhibited deliberate indifference to inmates' psychotic condition by placing them in segregated housing]; see also, *Fricano v. Lane City* (D. Ore. June 8, 2018) No. 6:16-cv-01339-MC, 2018 U.S. Dist. LEXIS 96521 at *21, n. 4 ["Mr. Fricano's serious medical need was his psychosis"].) "A heightened suicide risk or an attempted suicide is [also] a serious medical need." (*Conn v. City of Reno* (9th Cir. 2010) 591 F.3d 1081.)

A pretrial detainee must show the defendant officials were *objectively* deliberately indifferent to that serious medical need. (*Gordon, supra*, 888 F.3d at 1124-25.) To demonstrate *objective* deliberate indifference, a pretrial detainee must show: "(1) [t]he defendant made an intentional decision with respect to the conditions under which the plaintiff was confined; (2) [t]hose conditions put the plaintiff at substantial risk of suffering serious harm; (3) [t]he defendant did not take reasonable available measures to abate that risk, even though a reasonable officer in the circumstances would have appreciated the high degree of risk involved – making the consequences of the defendant's conduct obvious; and (4) [b]y not taking such measures, the defendant caused the plaintiff's injuries. (*Ibid.*)

While my focus in Jose's case was the *objective* deliberate-indifference standard under the Fourteenth Amendment because of his classification as a pretrial detainee, it is important to note that a different and more stringent standard applies to "post-conviction prisoners" under the Eighth Amendment. "A prison official cannot be found liable under the Cruel and Unusual Punishment Clause for denying an inmate humane conditions of confinement unless the official knows of and disregards an excessive risk to inmate health or safety; the official must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and he must also draw the inference." (*Castro v. County of Los Angeles* (9th Cir. 2016) 833 F.3d 1060, 1068.)

In other words, you must show that the prison official *knew* of and disregard-

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ed an excessive risk to the victim's safety. Not an impossible feat, of course, but noteworthy for those who do not practice civil rights.

OK, back to Jose's case…

"With respect to the third element, the defendant's conduct must be objectively unreasonable, a test that will necessarily 'turn[ ] on the facts and circumstances of each particular case.'" (*Castro*, *supra*, 833 F.3d at 1071.) The "'mere lack of due care by a state official' does not deprive an individual of life, liberty, or property under the Fourteenth Amendment." (*Ibid.*) Thus, the plaintiff must "prove more than negligence but less than subjective intent – something akin to reckless disregard." (*Ibid.*)

Deliberate indifference may be shown where prison officials or practitioners "deny, delay, or intentionally interfere with medical treatment." (*Hutchinson v. United States* (9th Cir. 1988) 838 F.2d 390, 394.) Deliberate indifference can also be proven by the failure to medically screen a new jail inmate with serious medical needs. (*Gibson*, *supra*, 290 F.3d at 1189-93.) "Access to the medical staff has no meaning if the medical staff is not competent to deal with the prisoners' problems. The medical staff must be competent to examine prisoners and diagnose illnesses." (*Hoptowit v. Ray* (9th Cir. 1982) 682 F.2d 1237, 1253.)

Theories of *Monell* liability

To establish municipal liability under *Monell v. Dep't of Soc. Servs. of City of New York* (1978) 436 U.S. 658, a plaintiff must prove: "(1) that [the plaintiff] possessed a constitutional right of which she was deprived; (2) that the municipality had a policy; (3) that this policy amounts to deliberate indifference to the plaintiff's constitutional right; and, (4) that the policy is the moving force behind the constitutional violation." (*Dougherty v. City of Covina* (9th Cir, 2011) 654 F.3d 892, 900.) The policy "need only cause the constitutional violation; it need not be unconstitutional per se." (*Chew v. Gates* (9th Cir. 1994) 27 F.3d 1432, 1444.)

Recognized paths to *Monell* liability include: (1) an unconstitutional custom or policy behind the violation of rights; (2) a deliberately indifferent omission, such as a failure to train or failure to have a needed policy, and (3) a final policymaker's involvement in or ratification of the conduct underlying the violation of rights. (*Clouthier v. County of Contra Costa* (9th Cir. 2010) 591 F.3d 1232, 1249-1250.)

A government policy is "a deliberate choice to follow a course of action . . . by the official or officials responsible for establishing final policy with respect to the subject matter in question." (*Pembaur v. City of Cincinnati* (1986) 475 U.S. 469, 483.) A local government "may [also] be liable if it has a 'policy of inaction and such inaction amounts to a failure to protect constitutional rights.'" (*Lee v. City of Los Angeles* (9th Cir. 2001) 250 F.3d 668, 681.) However, "[l]iability for improper custom may not be predicated on isolated or sporadic incidents; it must be founded upon practices of sufficient duration, frequency and consistency that the conduct has become a traditional method of carrying out policy." (*Trevino v. Gates* (9th Cir. 1996) 99 F.3d 911, 918; see also *Oyenik v. Corizon Health Inc.* (9th Cir. 2017) 696 F.App'x 792, 794 ["There is no case law indicating that a custom cannot be inferred from a pattern of behavior toward a single individual"].)

A local government's failure to train its employees may also create section 1983 liability when the "failure to train amounts to deliberate indifference to the rights of persons with whom the [employees] come into contact." (*City of Canton v. Harris* (1989) 489 U.S. 378, 388.) "The issue is whether the training program is adequate and, if it is not, whether such inadequate training can justifiably be said to represent municipal policy." (*Long v. County of Los Angeles* (9th Cir. 2006) 442 F.3d 1178, 1186.) "To allege a failure to train, a plaintiff must include sufficient facts to support a reasonable inference (1) of a constitutional violation; (2) of a municipal training policy that amounts to a deliberate indifference to constitutional rights; and (3) that the constitutional injury would not have resulted if the municipality properly trained their [sic] employees." (*Benavidez v. County of San Diego* (9th Cir. 2021) 993 F.3d 1134, 1153-54.) "A pattern of similar constitutional violations by untrained employees is 'ordinarily necessary' to demonstrate deliberate indifference for purposes of failure to train." (*Connick v. Thompson* (2011) 563 U.S. 51, 62.) However, a plaintiff can "prov[e] a failure-to-train claim without showing a pattern of constitutional violations 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*, *supra*, 442 F.3d at 1186; see also *Bd. of Cnty. Comm'rs v. Brown* (1997) 520 U.S. 397, 409 ["The likelihood that the situation will recur and the predictability that an officer lacking specific tools to handle that situation will violate citizens' rights could justify a finding that policymakers' decision not to train the officer reflected 'deliberate indifference' to the obvious consequence of the policymakers' choice – namely, a violation of a specific constitutional or statutory right"].)

Monell violations and correctional facilities

Local municipalities, including county jails, have a duty to provide inmates constitutionally adequate healthcare, whether it contracts out its health care responsibilities or provides them itself. (See *West v. Atkins* (1988) 487 U.S. 42, 55-56.) Often, counties hire private medical corporations to provide medical and mental health services to the inmates housed in their jails. Under these types of circumstances, both the local municipality *and* the private medical corporation can be held liable for constitutional violations. (See *West v. Atkins*, 487 U.S. 42, 54-56 (1988) [holding that an independent contractor performing medical services for prisoners may be subject to the Monell standard for

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liability under 42 U.S.C. § 1983 to the same extent as a government entity]; see also *West*, *supra*, 487 U.S. at 55-56 ["[c]ontracting out prison medical care does not relieve the State of its constitutional duty to provide adequate medical treatment to those in its custody, and it does not deprive the State's prisoners of the means to vindicate their Eighth Amendment rights"].)

So, what does this mean in terms of liability? A county cannot shift responsibility to care for its inmates' medical needs to the private medical corporation because "if this were the basis for delimiting § 1983 liability, the state will be free to contract out all services which it is constitutionally obligated to provide and leave its citizens with no means for vindication of those rights, whose protection has been delegated to 'private' actors, when they have been denied." (*Id.* at 56, n. 14; see also *Pollard v. GEO Group, Inc.* (9th Cir. 2010) 629 F.3d 843, 856 ["*West* makes clear that '[c]ontracting out' care '*does not* relieve' the government of its 'constitutional duty' to provide adequate care or 'deprive inmates of the means to vindicate their Eight Amendment rights.'"]; *Armstrong v. Schwarzenegger* (9th Cir. 2010) 622 F. 3d 1058, 1074 [the state "cannot avoid its obligations under federal law by contracting with a third party to perform its functions. The rights of individuals are not so ethereal nor so easily avoided"].)

Thus, the local municipality remains responsible to provide constitutional levels of medical and psychiatric care to its inmates regardless of whether it has hired a private medical company to provide such services. And the private medical company, too, remains responsible. You now have *two* theories of liability against *two* entities – one being a public entity and the other being a private corporation.

Monell violations attributable to staffing

"In order to comply with their duty not to engage in acts evidencing deliberate indifference to inmates' medical and psychiatric needs, jails must provide medical staff who are 'competent to deal with prisoners' problems.'" (*Gibson*, *supra*, 290 F.3d at 1187.) Reliance on trained medical professionals does not absolve the County of its responsibility to provide adequately trained and competent medical staff. (*Long v. County of Los Angeles* (9th Cir. 2006) 442 F.3d 1178, 1187.)

In Jose's case, he was incarcerated at the county jail for four months prior to his death. During those four months, Jose *himself* pled with both the medical and custody staff, requesting psychiatric help. One of the psych slips that Jose submitted to the custody/medical staff stated the following: *"I need help with sleeping and with the voices I hear in my head … they don't let me sleep and I don't eat much. Outside I was getting some medication for the voices and it helped. I was able to sleep and the voices will go away."*

For almost two months, Jose was denied psychiatric help due to staffing issues at the jail. The medical staffing issues were due, in part, to the medical services agreement that was entered into by the county and the private medical corporation. Because the county was "too cheap," the medical services agreement did not provide enough funding for psychiatric services at the county jail.

There also existed custody-staffing shortages during the time period that Jose's mental health deteriorated. The end result of these staffing issues being countless cancellations of psychiatric appointments for Jose, despite Jose's own pleas for psychiatric help and his fellow inmates also requesting that Jose be seen by medical staff because of the alarming behavior he was engaging in, which included making nooses in his jail cell; seemingly appearing to try to jump off the second tier of housing modules; praying naked in the middle of his cell; wiping feces with his own bare hands from his bottom; and starving himself to the point where he lost 20 pounds in a matter of weeks. Indeed, these staffing deficiencies had life-ending consequences for Jose.

Monell violations attributable to failure to train

A plaintiff can prove a "failure-to-train" claim against a municipality "without showing a pattern of constitutional violations 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*, *supra*, 442 F.3d at 1186.)

Suicide-prevention training is critical in the correctional profession. Both the custody and medical staff should receive structured and scheduled training in order to understand the basic principles of suicidal ideations and what types of behavior they should look for when observing the inmate population. In Jose's case, the evidence revealed that the custody and medical staff were either not trained at all regarding suicide prevention or were not *meaningfully* trained on the subject matter.

Throughout Jose's incarceration, he was never placed on suicide watch, despite the fact that he acted in a manner that deeply concerned fellow inmates. No fewer than three inmates were so concerned for Jose that they spoke with the custody staff about his behavior in an effort to get him the help he needed – again, the alarming behavior included starvation, attempts to jump of the second floor, and a noose being found in Jose's cell prior to his actual suicide.

There can be no greater or clearer sign of suicidality than fashioning the means to kill oneself by tying an actual noose. Yet, this did not lead to suicide watch or immediate mental health care for Jose. Ultimately, Jose's suicide was a "highly predictable consequence of [the County's] failure to equip [correctional] officers with specific tools to handle" suicide risk in a correctional facility. (See *Brown*, *supra*, 520 U.S. at 409.)

Monell violations attributable to welfare checks

A plaintiff can also establish the County's liability by "'demonstrating that

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… the constitutional tort was the result of a longstanding practice or custom which constitutes the standard operating procedure of the local government entity.'" (*Price v. Sery* (9th Cir. 2008) 513 F.3d 962, 966.)

Gordon II held that "pre-trial detainees do have a right to direct-view safety checks sufficient to determine whether their presentation indicates the need for medical treatment." (*Gordon v. County of Orange* ("*Gordon II*") (9th Cir. 2021) 6 F.4th 961, 973.) The Court also noted a district court case explaining how inadequate safety checks can set in motion constitutional violations. (*Id*., at n. 6.) California correctional facilities are governed by the Title 15 Minimum Standards for Local Detention Facilities. One of the most important standards that is impressed upon correctional facilities is the requirement that at a minimum, custody staff must perform the welfare/safety checks every 60 minutes. Notably, there are heightened standards for administrative segregation (i.e., every 30 minutes) and safety cells (i.e., every 15 minutes).

During the relevant time period leading up to Jose's suicide, and more specifically during the 11-hour period on February 22, 2019 and into February 23, 2019, there were ten instances that far exceeded the 60-minute window required by Title 15. The times documented indicate the following 102 minutes, 97 minutes, 102 minutes, 95 minutes, 101 minutes, 98 minutes, 101 minutes, 102 minutes, 144 minutes, and 92 minutes. During the immediate time period that Jose was found hanging, 92 minutes had elapsed between Jose's last welfare check at 2:33 a.m. and when he was found hanging at 4:00 a.m. This check exceeded the allotted 60-minute mandate as directed by the State of California by 32 minutes.

The county continued to engage in this practice even two months after Jose's suicide. On April 28, 2019, a sampling of safety checks at the county was reviewed by the Board of State and Community Corrections, which showed that the safety checks throughout the county jail were still not being routinely completed within the required 60-minute time frame of this regulation. Notably, the public can request copies of the BSCC's inspections and audits at m www.bscc.ca.gov.

In Jose's case, the argument was made that the county's customary failure to conduct welfare checks every 60 minutes not only violated Title 15 and the county's own policies, but it also set in motion constitutional violations. More specifically, this apparent county practice not to comply with the mandatory Title 15 welfare checks led to the involved custody staff ignoring their duties to Jose without fear of accountability. Had Jose been in an appropriate cell (i.e., suicide watch/safety cell) under *constant* observation – or had he been transferred to a hospital or mental health facility – he would have received the life-saving care he needed, and Jose would still be here with us today.



Gastélum

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