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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA
(San José Division)

DEVIN REGAL, E.R., a minor, and C.R., a minor, by and through their guardian ad litem, MICHAEL LEITCHMAN, individually and as successors in interest to FREDERICK INEA REGAL,

Plaintiffs,

v.

COUNTY OF SANTA CLARA, CONSUELO GARCIA, and DOES 2-10, in their individual capacities,

Defendants.

No. 22-CV-04321 BLF

DEFENDANT COUNTY OF SANTA CLARA AND CONSUELO GARCIA'S MOTION FOR SUMMARY JUDGMENT

Date: February 20, 2025
Time: 9:00 a.m.
Ctrm: 3, 5th Floor
Judge: The Honorable Beth Labson Freeman
Trial: June 16, 2025

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NOTICE OF MOTION

PLEASE TAKE NOTICE that on **February 20, 2025 at 9:00 a.m.** in **Courtroom 3, 5th Floor** of the above-titled Court, located at 280 South 1st Street, San José, CA 95113, Defendants County of Santa Clara ("County") and Consuelo Garcia will move the court pursuant to Federal Rule of Civil Procedure 56 for summary judgment in accordance with the Scheduling Order. ECF 38. Defendants request that the Court enter judgment in their favor because the undisputed evidence establishes that Plaintiffs' claims against Defendants fail as a matter of law. This motion is based on this Notice, the Memorandum, the declarations, and the entire record before the Court.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

Plaintiffs are the children of the late Frederick Regal, who died by suicide after hanging himself in his cell at the County jail. They bring constitutional claims for deliberate indifference against the County and Regal's jail therapist, Consuelo Garcia. Upon intake, another jail clinician deemed Regal a moderate suicide risk and placed him on the County's suicide watch protocol. Garcia saw him the next day. Based on her clinical assessment, she determined nothing had changed with Regal and kept him on the same protocol. He hanged himself hours later. Regal's suicide is indisputably tragic, but Garcia's care does not come close to satisfying the demanding deliberate indifference standard, which is commensurate with abandonment. Garcia is also entitled to qualified immunity, which protects all but the plainly incompetent, because no clearly established law put her on notice that her exercise of clinical judgment regarding Regal's level of suicidality was unconstitutional.

Plaintiffs also assert various municipal liability theories, largely based on speculation about how the County could have improved its jail suicide-prevention program. This conjecture fails to establish the requisite unconstitutional custom or practice. At bottom, Plaintiffs sue Defendants for not being able to do the impossible: definitively predict Regal's suicide. But Regal's death underscores that "[t]he operation of a correctional institution is at best an extraordinarily difficult undertaking." *Wolff v. McDonnell*, 418 U.S. 539, 566 (1974). As the undisputed evidence shows, it is not one the County shied away from.

II. FACTUAL BACKGROUND

A. Relevant County Agencies

The Santa Clara County Sheriff's Office Custody Bureau ("Custody") operates the fifth-largest jail system in the State, including the Main Jail facility in Downtown San José and Elmwood Correctional Complex ("Elmwood") in Milpitas. Duran ¶ 4.[1] Adult Custody Health Services ("ACHS"), a County department that employs various medical disciplines, provides healthcare to thousands of incarcerated individuals ("individuals") housed in the jails each year. Rodriguez ¶ 4.

B. The County's Suicide Prevention Program

1. The challenge of suicide prevention

Suicide is the leading cause of death in local jails nationwide. Kaftarian ¶ 9 (County's psychiatrist expert). Preventing suicide in its jails is a high priority for the County. Rodriguez ¶ 5; Duran ¶ 5. Custody and ACHS have long collaborated to implement a suicide-prevention program. *Id.* But it is a fundamentally agreed upon principle in mental health that there is no reliable way to predict suicide because there are many social, environmental, and psychological variables at play. Kaftarian ¶ 10. Between November 2017 and July 2020, the County jail system had an average daily population ranging from approximately 2,000 (at the height of COVID-19) to 3,600 individuals. Duran ¶ 4. During this same period, ACHS completed over 52,000 intake mental health consults, which included suicide-risk evaluations where needed. Rodriguez ¶ 6. Still, like other jails, the County regrettably cannot prevent all suicides; during that same period, there were four suicides before Regal's attempt on July 29, 2020. Perumattam Tr. at 107:6–110:8 & Ex. 5.

2. The legal backdrop for the County's suicide prevention program

The County has had a suicide prevention program for decades, which has evolved over the years, and the features of which are guided by community standards, applicable state standards, and, more recently, the terms of a 2019 federal consent decree. Rodriguez ¶ 5. Titles 15 and 24 of the California Code of Regulations establish minimum standards for local jail facilities, including for

[1] All "¶" citations refer to the accompanying declarations unless otherwise noted. "Tr." citations are to the deposition transcript excerpts attached to the accompanying Declaration of Aryn Paige Harris.

suicide prevention programs. Harris ¶ 13 & Exs. 11, 12. In 2020, Section 1030 of Title 15 had a generic requirement that the County establish suicide-prevention training, conduct intake screenings for suicidality, develop housing recommendations, address communication protocols among staff, implement suicide intervention policies and procedures, conduct data collection, and conduct a multi-disciplinary review of all suicides and suicide attempts. Rodriguez ¶ 5; *see also* Harris ¶ 13 & Ex. 11. Title 24 governed physical plant requirements for local jails but had no standards relating to retrofitting existing facilities for suicide hazards. Sivongxay ¶ 6; *see also* Harris ¶ 13 & Ex. 12. The California Board of State and Community Corrections ("BSCC") conducts biennial and targeted inspections of all California jail facilities to assess compliance with Titles 15 and 24, all of which the County passed in the years before the events of this case. Duran ¶ 13 & Ex. 2.

In 2015, the County Board of Supervisors voluntarily undertook a comprehensive self-evaluation of the jail's healthcare delivery system, including an analysis of its suicide-prevention program by a consultant named Lindsay Hayes. *Id.* ¶ 10. Hayes made recommendations for the County to improve its suicide-prevention program, Harris ¶ 16 & Ex. 19, based in part on his finding that the County had a "slightly higher" number of suicides than the nationwide average, *id.*, Ex. 19 at 613. Separately, in 2019, the County entered a federal consent decree in *Chavez et al. v. County of Santa Clara*, No. 15-cv-05277-RMI, a class action seeking broad injunctive relief related to the County's jail operations, including its suicide-prevention practices. *Id.* ¶ 16 & Exs. 20, 21. The consent decree has no deadlines for implementation of its remedial plan. *See id.*, Ex. 20 at 3–4 ¶ 12. The County's progress is also subject to the twice-yearly scrutiny of federal monitors, and the *Chavez* plaintiffs' counsel may seek judicial remedies if the County fails to progress toward substantial compliance. *Id.* at 4 ¶ 13; *id.* at 7 ¶¶ 28–29. The consent decree remains in effect until the County achieves substantial compliance for a year or longer. *Id.* at 7 ¶ 30. It also provides that "[n]either the fact of this Consent Decree nor any statement of claims contained herein shall be used in any other case, claim, or administrative proceedings[.]" *Id.* at 8 ¶ 33.

3. <u>The status of COVID-19 in July 2020</u>

The COVID-19 pandemic added a layer of complexity to County jail operations in July 2020. By then, the County—along with the rest of the world—had been grappling with the deadly

pandemic for about four months, and COVID-19 numbers were becoming more dire. Rudman ¶¶ 7, 13–14. County public health leaders viewed COVID-19 as a severe threat to life and were making decisions on how to protect the public health from COVID-19 based on the little information they had about the virus. *Id.* ¶ 15. At that time, they did not know how the virus mutated, how the relevant isolation or quarantine periods would change as the virus mutated, or whether asymptomatic people could transmit the virus. *Id.* The risks were particularly urgent in congregate settings like jails, where the virus had a greater propensity for spread given the shared airspace and the multiple vectors through which the virus could enter a facility (*e.g.*, newly-booked arrestees, staff coming and going). *Id.* ¶ 17. In July 2020, there was no COVID-19 vaccine or treatment, and the availability of COVID-19 tests was not a given—all of which further exacerbated the challenges of controlling the virus among the incarcerated population and its personnel. *Id.* ¶¶ 16, 18.

4. The County employs highly trained staff to prevent suicides

ACHS employed trained and licensed psychiatrists, psychologists, and mental health clinicians who have masters-level or doctorate-level training to care for individuals in custody with mental health needs, including suicidal behavior. Rodriguez ¶ 6. Although the County's training program is not a legal issue in this case, ECF 75 at 15–16, ACHS and Custody received annual on-the-job training in suicide prevention, Rodriguez ¶ 6; Duran ¶ 5.

5. Intake screening and housing of suicidal individuals

At the time of the events giving rise to this case, the County actively screened individuals entering its jail system for potential suicide risks. It solicited information from the arresting agency about the arrestee's physical and mental health, as well as the arrest circumstances. Fernandes Tr. at 29:8–19. A trained registered nurse was required, under ACHS Policy 6.2.15, to screen all new arrivals for suicide risk. Rodriguez ¶ 7 & Ex. 1. Depending on the individual's responses (*e.g.*, history of mental illness, psychiatric hospitalization, criminal charges, statements), they could be referred to an ACHS mental health clinician, who would administer a suicide-risk evaluation ("SRE," also called a suicide risk assessment) developed with Hayes, the suicide-prevention consultant. *Id.*; Rodriguez Tr. at 82:15–21, 109:16–18. The SRE collected data on chronic and acute risk factors as well as protective factors. Rodriguez ¶ 7 & Ex. 1 at 1943–44 (SRE in use in

July 2020). The SRE also asked whether the individual "report[ed] a plan to kill him/herself" or a "desire to die," and prompted the administering clinician to exercise her or his clinical judgment and rate chronic and acute risk as low, medium, or high based on the relevant factors. *Id.* As part of the evaluation, the clinician was also expected to review the individual's medical records and the reason for the referral. *Id.*; Rodriguez Tr. at 109:24–110:4. The clinician would then determine what, if any, suicide-prevention measures were appropriate, including a referral to psychiatry, and communicate them to Custody. Rodriguez ¶ 7.

As for housing, Custody's Classification Unit is responsible for conducting a safety and security evaluation and placing individuals in the least restrictive setting necessary to ensure their own safety and the safety of staff, other individuals, and the public. Duran ¶ 6. An individual's housing assignment is "highly individualized" and requires "continual and ongoing assessment of that individual's needs," as determined based on their interview with Classification as well as "input from [Custody's] mental health and medical partners." Duran Tr. at 65:25–66:18.

In July 2020, Unit 8A of the Main Jail ("8A") was designated as a Lanterman-Petris-Short Act ("LPS") facility pursuant to pursuant to Cal. Welf. & Inst. Code § 5000 *et seq.*, which limited admission to individuals placed on a "5150 hold" because they were a danger to themselves or to others or gravely disabled. Rodriguez ¶ 8. The jail also designated several housing units as Special Management Units ("SMUs") for individuals with significant mental health needs. *Id.* While Classification generally made all decisions regarding where individuals were housed in the jails, only ACHS could authorize housing in 8A, the SMUs, or the jail's infirmary. *Id.*; Duran ¶ 6. Aside from that limited exception, it was Custody's responsibility to assign individual housing, including Unit 4B of the Main Jail ("4B"), which houses individuals who engage in serious acts of violence and pose high security threats. Duran ¶ 7. Due to the security risks, these individuals have limitations on their privileges, including out-of-cell time. *Id.*

COVID-19 also affected the County's jail housing system. In July 2020, ACHS had implemented a COVID-19 protocol for the County's jail facilities. Chyorny ¶¶ 5–6 & Ex. 1; Duran Tr. at 99:5–10, 103:20–104:2, 120:19–23, 122:1–124:17. As part of this protocol, new arrivals to the County's jail system who had no exposure to confirmed COVID-19 cases and who were

asymptomatic were isolated in "risk management units" ("RMUs") or a single room for 14 days ***before*** being housed per Classification's assignment. Chyorny ¶ 6. During this time, only two housing assignments could override the general requirement that new individuals begin their stay in the County jail in an RMU: 8A and the infirmary (*i.e.*, for individuals who required serious, ongoing medical care). Duran ¶ 9. While the RMU protocol required individuals to undergo an initial period of isolation to curb the spread of the infection, ACHS remained available to provide them mental health care services. Rodriguez ¶ 13; Duran ¶ 9.

6. Interventions available to ACHS mental health clinicians

In July 2020, ACHS mental health clinicians had a number of suicide-prevention interventions at its disposal that clinicians could deploy as needed based on their clinical judgment. Rodriguez ¶ 9. This case focuses on three: (a) placing an individual on suicide watch (including regular follow-up from ACHS and potentially a psychiatric referral); (b) removing his possessions and clothing to remove the risk of a ligature; and (c) housing (or re-housing) him in a suicide-resistant cell. For mental health clinicians working in suicide prevention in the jail setting, the interventions they choose not to use can be just as critical as the ones they do use, as such interventions often require an additional deprivation of liberty or privacy (*e.g.*, removal of clothing, administering 15-minute checks). Kaftarian ¶ 18. ACHS policies in July 2020 were meant to encourage mental health clinicians to use the least restrictive measure that would be effective for an individual given their circumstances. Rodriguez ¶ 9. Thus, Policy 6.2.15 set forth some, but not all, of the interventions that an ACHS clinician could use to treat a suicidal individual—but ACHS also expected that mental health clinicians would use their clinical judgment to individualize their treatment however necessary. *Id.*; Rodriguez Tr. at 39:18–25, 70:19–71:4.

a. Suicide watch (15-minute checks)

Suicide watch—also known as "15-minute checks"—was a multi-faceted intervention that kept suicidal individuals at various risk levels under regular observation. Rodriguez ¶ 10. Fifteen-minute checks could be used for individuals who were presenting with suicidal risk. *Id.* ¶ 10 & Ex. 2 at 1951. An ACHS clinician would initiate the checks, first speaking with the individual and then

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conducting an SRE to evaluate the level of risk. *Id.* ¶ 10. If indicated, the clinician would place an order for 15-minute checks. *Id.*

Once ordered by an ACHS clinician, it became Custody's responsibility to timely execute the 15-minute checks. Duran ¶ 15; Rodriguez ¶ 10; Duran Tr. at 81:14–20; Rodriguez Tr. at 40:9–18. The correctional deputies assigned to each housing unit were responsible for conducting and documenting the checks. Duran ¶ 15. While deputies were trained to stay within the policy requirements of conducting checks at least every 15 minutes, they were encouraged to incorporate some level of unpredictability and avoid completing the checks every quarter-hour on the dot. Coté Tr. at 109:14–110:12. During those checks, deputies walk up to an individual's cell door and look in long enough to observe signs of life—*e.g.*, the rise and fall of his chest, other movement, or a verbal response—and any "safety issues" in the cell. *Id.* at 92:9–93:12; 94:3–11. Deputies who observed anything "out of the ordinary" were required to report that information to ACHS. Duran Tr. at 81:21–83:10. If an individual on 15-minute checks requested to speak with ACHS, deputies were likewise expected to facilitate that. Coté Tr. at 69:12–70:4.

ACHS mental health clinicians would also complete daily check-ins with individuals on 15-minute checks, and individuals could ask to speak with ACHS at any time. Rodriguez Tr. at 48:9–12, 50:9–14. ACHS clinicians also had the option of ordering a psychiatry consult for individuals, which in July 2020 was expected to happen within seven days of the referral. Rodriguez ¶ 10; Rodriguez Tr. at 109:5–12. Clinicians were also trained to actively look for signs of improvement that would permit the discontinuation of 15-minute checks, given the relative invasiveness of that intervention. Rodriguez ¶ 10. To discontinue checks, clinicians were required to administer a new SRE. *Id.*; Rodriguez Tr. at 110:5–11. Clinicians who elected to maintain previously-ordered 15-minute checks, however, did not need to administer a new SRE. Rodriguez ¶ 10.

b. Removal of clothing or bedding

For certain suicidal individuals, mental health clinicians could restrict or remove certain possessions—including standard-issue clothing and bedsheets—to prevent them from fashioning a ligature. *Id.* ¶ 7 & Ex. 1 at 1939–40. When an individual's clothes and bedsheets were taken away, they were required to be provided with a Ferguson gown and Ferguson (safety) blanket. *Id.* ¶ 11.

Ferguson gowns and blankets are made of a heavy, bulky nylon that cannot be torn or rolled into a ligature. *Id.* While the Ferguson gown and blanket can be effective risk-reduction tools, they also tend to stigmatize individuals who wear them in the jail. *Id.*; *see also* Rodriguez Tr. at 94:6–14; Kaftarian ¶ 25.

The 2019 consent decree required the County to adjust its policies and practices and limit the use of Ferguson gowns to individuals at a "***high*** risk for suicide." Harris ¶ 16 & Ex. 21 at 19 (emphasis added). This was consistent with Hayes' recommendation that Ferguson gowns be used "only when a clinician believes that the inmate is at ***high*** risk for suicide by hanging, and not as a default or behavior management plan." *Id.*, Ex. 19 at 9 (emphasis added). In July 2020, Roberta Stellman, M.D., was the federal court-appointed monitor tracking the County's compliance with the suicide-prevention components of the consent decree. Rodriguez Tr. at 24:9–12. At the time, Dr. Stellman was working with the County on an overhaul of several of its suicide-prevention policies to align them with the remedial plan; until those revisions could be completed, she advised the County to change its practice to restrict the use of Ferguson gowns and blankets to high-risk individuals, who in the County system, are housed in 8A. *Id.* at 55:7–56:14, 65:22–66:7, 88:18–89:5 & Ex. 3 at 3197. Thus, on July 21, 2020, at the recommendation of Dr. Stellman, ACHS prohibited the use of Ferguson gowns and Ferguson blankets in outpatient settings—*i.e.*, anywhere outside of 8A—effective immediately. *Id.* at 52:19–25, 55:11–16. ACHS staff were notified of this change in subsequent days, culminating in an email to all mental health clinicians on July 23, 2020. *Id.* at 86:14–89:16 & Ex. 3 at 3196–98. This directive precluded ACHS clinicians from removing clothing and bedsheets for individuals outside of 8A, since removal of those items would require issuance of a Ferguson gown and blanket, contrary to the new directive issued at the federal monitor's recommendation. Rodriguez ¶ 11.

c. Suicide-resistant cells

Prior to the Court's entry of the consent decree, the County did not have any "suicide-resistant and protrusion-free cells." Sivongxay ¶ 5; *see also* Harris ¶ 16 & Ex. 21 at 19. At the time that the Main Jail and Elmwood were built, Title 24, which supplies minimum standards for design and construction of local detention facilities, did not require that local detention facilities in

California have suicide-resistant cells. Sivongxay ¶ 6. Likewise, in July 2020, the then-governing BSCC regulations did not require local detention facilities to retrofit its facilities to include suicide-resistant cells. *Id.*

Nevertheless, given its obligations under the consent decree, the County's Facilities and Fleet Department ("FAF") undertook the process of retrofitting its jails with suicide-resistant cells, which entailed extensive design, public bidding, permitting, and construction planning. *Id.* ¶¶ 7–11 & Ex. 1 (describing challenges and complexity of the project). In general, a suicide-resistant cell aims to remove anything that an individual can use to harm themselves. Sivongxay Tr. at 23:24–24:16. Removing just one or two hanging points is insufficient, as individuals can easily utilize any remaining anchor points. Duran ¶ 12 (describing the different ways individuals commit suicide); Sivongxay Tr. at 24:5–14, 25:7–24, 26:10–20, 28:17–29:7 & Ex. 2, 29:20–25, 30:4–10 (describing cell anchor points needing modification). The County used the design requirements recommended by Hayes for its retrofit, but certain of those requirements were inconsistent with certain code requirements. Sivongxay ¶ 14–15; Sivongxay Tr. at 49:17–25, 50:15–25 & Ex. 5. There were also challenges in designing the cells to also be compliant with the Americans with Disabilities Act ("ADA"). Sivongxay ¶ 15. Further, various suicide-resistant items recommended by Hayes (*e.g.*, smoke detector covers) were not available on the market. *Id.*

The logistics of starting the construction project were also complicated given that the jails at large remained open during construction. *Id.* ¶ 17. To start, FAF had to provide the names of all contracting staff to Custody staff for the purpose of conducting security checks. *Id.* Before FAF could begin construction, the housing unit had to be empty. *Id.* ¶ 13. Custody, for its part, would have to rehouse ***all*** of the individuals in the unit and redirect resources to provide security for the contractors. Duran ¶ 17. The pandemic further exacerbated this logistical complexity: the County was simultaneously implementing its COVID-19 housing protocol in the jails, which put a high demand on the same cell-style housing that is used to house individuals on suicide watch given that it required new arrivals to be quarantined and isolated for approximately two weeks, to the extent it was feasible. *Id.* ¶ 18; Chyorny ¶ 6. This left fewer options to house individuals displaced by construction. Duran ¶ 18. FAF also had difficulty obtaining materials and labor due to the COVID-

19 crisis. Sivongxay Tr. at 91:8–16; Sivongxay ¶ 20. Given these hurdles, FAF took whatever opportunities were available to retrofit suicide-resistant cells, prioritizing construction based on cell availability at the County's two jail facilities. Sivongxay Tr. at 67:20–68:6.

The County began construction pursuant to the consent decree in 8A and 4B. Duran ¶ 11; Sivongxay ¶¶ 12, 19. 8A is the type of high-risk environment where suicide-risk cells should be prioritized. *See* Kaftarian ¶ 19–23; Duran ¶ 11. As for 4B, the County selected that unit for efficiency, as there was already construction underway there, meaning there would be less individual displacement. Duran ¶ 11; Sivongxay ¶12. All told, by July 2020, the County had 12 suicide-resistant cells in the Main Jail—10 in 8A and two in 4B. Sivongxay Tr. at 52:15–25. During this timeframe, there were no suicide-resistant cells at Elmwood. Sivongxay ¶ 19 & Ex. 3. Thus, at the time Regal was in the County jail system, suicide-resistant cells were a treatment option for suicidal individuals who qualified for placement in 4B or 8A. Rodriguez ¶ 12. Only Classification, however—not ACHS—could assign individuals to 4B, which operated as a restrictive housing unit where only specific qualifying individuals could be housed per the terms of the consent decree. Duran ¶ 7 (describing criteria for the use of 4B); *see also* Duran Tr. at 54:1–18; Harris ¶ 16 & Ex. 21 at 37–38. Conversely, only ACHS clinicians could direct that an individual be housed in 8A—if they concluded he satisfied the stringent criteria for a 5150 hold. Rodriguez ¶ 12; Rodriguez Tr. at 73:9–17, 75:6–15, 81:16–25, 116:14–117:2.

C. Regal's Arrest, Incarceration, and Death by Suicide

1. <u>Regal's arrest</u>

On July 28, 2020, around 8:25 a.m., officers from the San José Police Department were dispatched to Regal's residence, a warehouse at 1775 Monterey Road in San José, based on reports of a shooting in an occupied dwelling. Ortega Tr. at 18:13–17 & Ex. 1 at 1506. The investigating officer, Ramon Ortega, later reported that Regal had discharged two firearms around 54 times inside his residence. *Id.* Police arrested Regal on various firearm- and drug-related charges, including shooting into an inhabited dwelling and possession of a loaded firearm while under the influence. *Id.* Blood samples taken after Regal's arrest later confirmed Regal had cocaine, methamphetamine, and MDMA (ecstasy) in his system. Sobolesky Tr. at 19:17–20:2, 24:5–31:17 & Ex. C.

At the time of arrest, Ortega determined that Regal had no prior 5150 holds and did not meet the criteria for a 5150 hold. Ortega Tr. at 29:2–30:24 & Ex. 1 at 1515. He transported Regal to the Main Jail for intake and booking. *Id.* at 33:15–23. Ortega supervised the completion of the Agency Advisory Form pertaining to Regal, which noted that Regal was neither suicidal nor on any type of mental health hold, but was showing signs of "Alcohol or Drug Intoxication" and unspecified "Bizarre or Aggressive Behavior." *Id.* at 50:21–51:6 & Ex. 5, 53:1–54:22, 74:17–75:22.

2. Regal's intake assessments

Once at the Main Jail, Regal underwent two intake assessments. His nursing intake assessment acknowledged receipt of the Agency Advisory Form prepared by SJPD and stated that Regal was not "thinking of killing or hurting [him]self"; was not "acutely suicidal" or "on psychiatric legal hold"; had not attempted or considered suicide in the previous year; had never been "treated for mental or emotional problems"; and did not feel as if "there is nothing to look forward to in the immediate future." Rodriguez ¶ 13 & Ex. 3 at 1396. Regal then underwent a mental health intake assessment with Jason Pierce, an ACHS marriage and family therapist. *Id.* at 1398. In his assessment, Pierce listed the reason for the consult as a referral for a history of mood swings, depression, and current suicidal ideation. *Id.* at 1399. In his medical history, Pierce noted that Regal was divorced, had three children, and was currently unemployed. *Id.* at 1400. He also noted that Regal "denied being under the influence, but appeared to be detoxing." *Id.* at 1399–1400; *see also id.* at 1399 (chart review noting Regal's methamphetamine use). Regal told Pierce that he had no past suicide attempts, but "does think about it, and is currently thinking about it." *Id.* at 1400.

Pierce proceeded with a mental status examination, where he described Regal's mood as anxious and noted "passive SI [suicidal ideation]," but fair judgment and impulse control. *Id.* at 1401. He then administered the Hayes-approved SRE, noting several acute risk factors: Regal's suicidal ideation, a depressive episode, anxiety, substance abuse and/or intoxication, "Hopelessness/Helplessness," and the fact that he was within his first two weeks in jail. *Id.* at 1401–02. There were also several chronic risk factors: a "history of depressive or psychotic disorders," being older than 35, being male, and having a history of substance abuse. *Id.* at 1402. Countering these risk factors were Regal's "[s]ense of optimism" and "self efficacy." *Id.* Pierce also noted that

Regal had three children. *Id.* at 1400. Critically, Pierce noted that Regal did not report a plan to kill himself. *Id.* at 1402. Pierce accordingly deemed Regal a moderate suicide risk and ordered that he be housed in accordance with Classification's assignment and placed on 15-minute checks as a precaution. *Id.* at 1401, 1403. As part of his analysis, Pierce determined that Regal did not meet the criteria for a 5150 hold. Pierce ¶ 3.

3. Regal's housing assignment and 15-minute checks

Classification subsequently deemed Regal as medium-security and assigned him to Unit M5-D at Elmwood, which at the time was an RMU. Duran ¶ 14. Although Regal was a moderate suicide risk, he did not satisfy the criteria for a 5150 hold and thus was ineligible to be housed in the acute psychiatric unit known as 8A. Pierce ¶ 3; *see also* Rodriguez ¶ 8; Duran Tr. at 57:8–19. Nor did Regal satisfy the highly restrictive criteria for placement in 4B where individuals who met criteria for restrictive housing were held. Duran Tr. at 57:8–19, 118:20–24; *see also* Duran ¶ 14. And, because of the COVID-19 protocols in effect, Regal was required to spend his first 14 days in jail in an RMU, in this case without a cellmate, in an effort to contain the spread of COVID-19 in the congregate jail setting. *See* Chyorny ¶¶ 5–6; *see also* Rudman ¶¶ 17–18.

Elmwood houses low- and medium-security men. Duran Tr. at 76:9–12. M5-D is a "direct-supervision setting" (*i.e.*, cell-based living) in contrast to indirect-supervision settings, which are similar to "giant dorms" with bunk beds in an "open floor plan setting." *Id.* at 49:24–50:14. Most cells in direct-supervision settings have two bunks per cell (*i.e.*, an upper and lower bunk). *Id.* at 50:7–21; *see also* Coté Tr. at 40:25–41:13. Regal had to be housed in a direct-supervision (cell) setting for two reasons: he was housed in an RMU and he was on 15-minute checks. Duran ¶ 14; *see also* Chyorny ¶ 6. Individuals on 15-minute checks must be housed in direct-supervision settings because the indirect-supervision setting makes it difficult for correctional deputies to effectively track individuals given all of the movement and activity in those units. Duran ¶ 14; *see also* Duran Tr. at 79:4–23, 99:3–5.

The first of Regal's 15-minute checks was logged in Custody's observation record on July 28, 2020 at 4:45 p.m. Duran ¶ 15 & Ex. 3. Those checks continued, at varying intervals, until the following day. *Id.* Deputy Omar Cevallos' shift in M5-D began at 6:00 a.m. on July 29, 2020,

which is also when he took over conducting Regal's 15-minute checks. Cevallos Tr. at 56:12–58:1 & Ex. 1 at 1589. Throughout the day, Cevallos observed Regal sleeping, washing his face, and at times, talking to himself. *Id.* When Cevallos asked Regal how he was doing, Regal said he was fine. *Id.* At approximately 4:15 p.m., Cevallos conducted a 15-minute check on Regal, during which time Regal said "he could hear people shouting outside the building." *Id.* at 1590. Cevallos asked if Regal was doing well, and Regal replied he was fine. *Id.*

4. Regal's consultation with Garcia

On July 29, 2020, Defendant Consuelo Garcia, an ACHS licensed marriage and family therapist, was assigned to meet with Regal for his first daily check-in since being placed on 15-minute checks. Garcia Tr. at 53:13–16, 53:23–54:2, 54:13–20, 62:19–63:12. Prior to meeting with Regal, Garcia reviewed his medical record, including Pierce's progress note. *Id.* at 18:4–13; 21:6–12; *see also* Ballesteros ¶¶ 5–6 & Ex. 1 (audit trail showing materials reviewed by Garcia). Garcia was aware that Regal had told Pierce the day prior that he was feeling suicidal, which she took seriously. Garcia Tr. at 67:1–12, 68:2–10.

Garcia met with Regal at approximately 11:47 a.m. in the unit's interview room, a short walk away from Regal's cell. *Id.* at 123:16–25, 145:16–146:9, 146:24–147:3, 147:19–148:6 & Ex. 2; Duran ¶ 16 & Ex. 4 at CCO_REGAL_1836 at 11:45:45 (showing deputy unlocking cell door and Regal departing unit around 11:47:27 a.m.).[2] According to Garcia's progress note, Regal was still experiencing suicidal ideation, telling her, "Yes I'm suicidal," "I'm depressed," and "personal things are going on in my life." *Id.* at 12:6–8, 117:7–11 & Ex. 1 at 1404. Like Pierce, Garcia conducted a mental status examination and noted that Regal's appearance was groomed, his behavior was "[w]ithout disturbance," his thought content was not psychotic, and his judgment and impulse

[2] Garcia's progress note identifies the time of her meeting with Regal as July 29, 2020 at 3:21 p.m. Garcia Tr. at 12:6–8, 117:7–11 & Ex. 1 at 1404. This erroneous timestamp automatically populated. *Id.* at 117:20–118:20. At 5:21 p.m. that same day, Garcia emailed her manager to clarify that she had met with Regal "at approximately between 11:30-12:15 pm today (7/29/20)." *Id.* at 145:16–146:9, 146:24–147:3, 147:19–148:6 & Ex. 2.

control was fair. *Id.* Garcia noted that Regal was anxious and "[d]ysthymic" (*i.e.*, had a "low mood"). *Id.*; *see also id.* at 161:14–23. In her assessment, Garcia noted that Regal "reports feeling suicidal, denies having a plan at this time." Garcia Tr. at 12:6–8, 117:7–11 & Ex. 1 at 1404. Regal told Garcia about "personal stressors including relationship troubles," and that he was "feeling depressed" and "using substances . . . to cope/manage unwanted feelings." *Id.* He also told Garcia that he had three children, who he saw "frequently" and were "his motivation." *Id.* Garcia concluded that while Regal "presents anxious and in distress," he "does not meet criteria for 5150 hold at this time." *Id.*

Garcia concluded that Regal was experiencing "vague suicidal ideation" and remained a moderate suicide risk. *Id.* Based on her understanding of ACHS policy at the time, she understood that she had three options at her disposal to treat Regal: discontinue the checks, maintain the checks, or place Regal on a 5150 hold. *Id.* at 76:24–78:9. She believed Regal was still a suicide risk, such that discontinuing checks would be inappropriate. *Id.* at 12:6–8, 36:16–18, 36:23–37:2, 39:11–15, 117:7–11 & Ex. 1 at 1404. She also concluded that Regal did not qualify for a 5150 hold. *Id.* at 80:24–81:9; *see also id.* at 12:6–8, 117:7–11 & Ex. 1 at 1404. Given that Regal had also told Pierce that he was feeling suicidal the day before, that Regal's mental condition had not otherwise deteriorated as far as Garcia could tell, and that Regal continued to deny having a plan, Garcia exercised her clinical judgment to maintain his 15-minute checks. *Id.* at 36:23–37:2, 37:22–25, 68:23–69:3, 69:7–13; Garcia ¶¶ 3–4. Indeed, Garcia understood maintaining the 15-minute checks to be the only tool at her disposal for which Regal qualified that would reduce his risk of suicide. Garcia Tr. at 81:10–19, 129:2–14. She also made a note stating that she placed an order for a consult to psychiatry. *Id.* at 12:6–8, 69:24–70:4, 71:5–11, 117:7–11 & Ex. 1 at 1404.[3]

5. Regal's hanging and death

On July 29, 2020 at approximately 4:30 p.m., Cevallos approached Regal's cell for a 15-minute check. Cevallos Tr. at 56:12–58:1 & Ex. 1 at 1590. During the previous hours, he logged

[3] A later review determined that Garcia "recommended" a psychiatry referral in the medical record but did not actually place the order prior to Regal's hanging on July 29, 2020. Rodriguez ¶ 14.

checks at 4:16 p.m., 4:00 p.m., 3:45 p.m., 3:31 p.m., 3:15 p.m., 3:01 p.m., 2:45 p.m., 2:30 p.m., 2:16 p.m., 2:02 p.m., 1:50 p.m., 1:32 p.m., 1:15 p.m., and 12:58 p.m. Duran ¶ 15 & Ex. 3. Through Regal's door, Cevallos observed Regal hanging from his neck by his bedsheet tied to the top bunk. Cevallos Tr. at 56:12–58:1 & Ex. 1 at 1590. Cevallos and others cut Regal down and began CPR and chest compressions. *Id.* at 1590–91. At around 4:51, Regal was transported from Elmwood to Santa Clara Valley Medical Center. *Id.* Regal remained on life support at the hospital until August 5, 2020, when his life support was removed and he died. ECF 52 ¶¶ 35–36.

III. LEGAL STANDARD

Parties are entitled to summary judgment when they show "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *see also Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). Once the moving parties satisfy their initial burden of "proving the absence of a genuine issue of material fact," that burden "then shifts to the non-moving party to designate specific facts demonstrating the existence of genuine issues for trial." *In re Oracle Corp. Sec. Litig.*, 627 F.3d 376, 387 (9th Cir. 2010). Where the non-moving parties' "evidence is merely colorable, or is not significantly probative, summary judgment may be granted." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 249–50 (1986) (cleaned up). To defeat a summary judgment motion, "[t]here must be enough doubt for a 'reasonable trier of fact' to find for the plaintiffs[.]" *Corales v. Bennett*, 576 F.3d 554, 562 (9th Cir. 2009).

IV. ARGUMENT

A. Plaintiffs' Deliberate Indifference Claim Against Garcia Fails

1. Garcia was not deliberately indifferent to Regal's suicidality

"Demonstrating deliberate indifference requires a substantial showing." *Fraihat v. U.S. Immigration & Customs Enfc't*, 16 F.4th 613, 636 (9th Cir. 2021). To prove that a defendant was deliberately indifferent to a pretrial detainee's serious medical need under the Fourteenth Amendment, a plaintiff must show: (i) the defendant made an "intentional decision" with respect to the plaintiff's conditions of confinement, which (ii) "put the plaintiff at substantial risk of suffering serious harm"; and (iii) the defendant "did not take reasonable available measures to abate that risk," even though the consequences of doing so were "obvious" as "a reasonable official in the

circumstances would have appreciated the high degree of risk involved"; thus (iv) causing the plaintiff's injuries. *Gordon v. Cnty. of Orange*, 888 F.3d 1118, 1125 (9th Cir. 2018) ("*Gordon I*").

As to elements (i) and (ii), the only "intentional decision" that Plaintiffs could attack is Garcia's decision to keep Regal on 15-minute checks, which they contend put Regal "at substantial risk of serious harm" given his suicidality. *See Doty v. Cnty. of Lassen*, 37 F.3d 540, 546 (9th Cir. 1994). Element (iii) is objective and turns on the facts and circumstances of each particular case. *Gordon I*, 888 F.3d at 1125. It is akin to a "reckless disregard" standard—which is a "formidable one," as "neither mere lack of due care, nor an inadvertent failure to provide adequate medical care, nor even medical malpractice, without more, is sufficient to meet this standard." *Fraihat*, 16 F.4th at 636 (citing authorities) (cleaned up). Rather, "[i]n cases involving choices between alternative courses of treatment, plaintiff must show that the course of treatment the doctors chose was medically unacceptable under the circumstances and that they chose this course in conscious disregard of an excessive risk to plaintiff's health." *Gordon v. Cnty. of Orange*, 6 F.4th 961, 970 (9th Cir. 2021) ("*Gordon II*") (cleaned up).

Plaintiffs cannot establish element (iii). The following facts are undisputed: on July 29, 2020, Garcia met with Regal for his requisite, at-least daily check-in with ACHS. Before their meeting, Garcia reviewed the sparse medical records regarding Regal that were available to her. She knew Pierce had concluded the previous day that Regal was a moderate suicide risk; upon meeting with Regal, she concluded nothing had changed since then. Like Pierce, Garcia concluded that Regal had suicidal ideations but did not have a plan and therefore did not qualify for a 5150 hold. Regal also told Garcia about his three children, whom she viewed as a significant protective factor. Based on her assessment, and Regal's ongoing "vague suicidal ideation," she exercised her clinical judgment to conclude that maintaining the checks was the only appropriate clinical choice. Far from indifferent, Garcia's decision was well within the standard of care, Kaftarian ¶¶ 28–31, and thus not "medically unacceptable," *Gordon II*, 6 F.4th at 970. Nor is there any evidence that Garcia made her decision "in conscious disregard of an excessive risk to" Regal's health. *Id.*

Post-*Gordon I* caselaw applying the pretrial-detainee deliberate indifference standard to a clinician in the custodial context at the summary judgment stage is relatively sparse, but still

underscores that Plaintiffs' claim fails here. In *Shidler v. County of San Bernadino*, the family of an individual who died by suicide in his jail cell sued a mental health nurse they contended had conducted an inadequate suicide risk assessment. No. 5:19-CV-00503-AB (SHKx), 2022 WL 2255309, at *7–8 (C.D. Cal. Mar. 7, 2022). The court granted the nurse summary judgment, notwithstanding the plaintiffs' assertions that she did not complete the evaluation or failed to ask certain questions, and emphasized that the nurse had "kept Decedent on suicide watch." *Id.* at *7. Here, Plaintiffs have no evidence that Garcia's evaluation was somehow incomplete. In *Sandoval v. County of San Diego*, an arrestee—unbeknownst to arresting deputies—swallowed "several hundred times the typical recreational dose" of methamphetamine. 985 F.3d 657, 662 (9th Cir. 2021). A jail nurse was alerted that the arrestee was "sweating, tired, disoriented," and had him placed in a "sobering tank"—and then ignored him for the last six hours of his shift, neglecting to "relay any information about [the arrestee] to the nurses who replaced him." *Id.* at 669–70 (denying nurse's summary judgment motion). In another case, an injured individual sued jail medical staffers after he sought treatment, only to have staff laugh at him, take away his wheelchair, refuse to examine him, and handcuff him to a gurney. *Voskanyan v. McDonnell*, No. 2:15-CV-06259 MWF (KES), 2021 WL 1235032, at *1, 4, 11–13 (C.D. Cal. Feb. 10, 2021), *report & recommendation adopted*, 2021 WL 1235030 (C.D. Cal. Mar. 10, 2021) (denying staffers' summary judgment motion). Garcia, in contrast to the defendants in *Sandoval* and *Voskanyan*, did not abandon Regal to the perils of jail life. Plaintiffs simply disagree with the manner in which she exercised her clinical judgment.

2. <u>Garcia is entitled to qualified immunity in any event</u>

Plaintiffs asserting § 1983 claims against overcome qualified immunity only when they "demonstrate that (1) a federal right has been violated and (2) the right was clearly established at the time of the violation." *Horton by Horton v. City of Santa Maria*, 915 F.3d 592, 599 (9th Cir. 2019). "A clearly established right is one that is sufficiently clear that every reasonable official would have understood that what [she] is doing violates that right." *Id.* "The burden is on Plaintiffs to make the showing that 'the right's contours were sufficiently definite that any reasonable official in the defendant's shoes would have understood that [she] was violating it.'" *Hart v. City of Redwood City*, 99 F.4th 543, 555 (9th Cir. 2024) (cleaned up); *see also Evans v. Skolnik*, 997 F.3d 1060,

1066–67 (9th Cir. 2021) (caselaw in qualified immunity analysis must be "binding precedent").

To defeat qualified immunity, Plaintiffs must show that at the time of Garcia's assessment of Regal, it was clearly established under Supreme Court or Ninth Circuit caselaw that any reasonable jail therapist would have understood that it was unconstitutional for Garcia to maintain an individual deemed to be a moderate suicide risk on existing suicide precautions (*e.g.*, 15-minute checks and mental health follow-ups). *See Hart*, 99 F.4th at 555. But no Supreme Court case law clearly establishes the level of care that a jail clinician must provide a suicidal individual. As the Court expressly stated in 2015: "No decision of this Court establishes a right to the proper implementation of adequate suicide prevention protocols. No decision of this Court even discusses suicide screening or prevention protocols." *Taylor v. Barkes*, 575 U.S. 822, 826 (2015) (per curiam). No United States Supreme Court decision has done so since. Likewise, the Ninth Circuit has never "establish[ed] any clearly established right to a certain level of suicide prevention protocol." *Germaine-McIver v. Cnty. of Orange*, No. SACV 16-01201-CJC(GJSx), 2018 WL 6258896, at *11 (C.D. Cal. Oct. 31, 2018) (examining Ninth Circuit precedent). In *Clouthier v. County of Contra Costa*—a pre-*Gordon I* case—the Ninth Circuit reversed a grant of qualified immunity to a jail mental health worker treating a pretrial detainee "whose suicidality had been described to her by a fellow mental health professional as 'the real deal,'" noting that "a reasonable mental health professional could not have thought it was lawful to remove key suicide prevention measures put in place by a prior Mental Health staff member." 591 F.3d 1232, 1245 (9th Cir. 2010), *overruled on other grounds by Castro v. Cnty. of L.A.*, 833 F.3d 1060, 1070 (9th Cir. 2016). But that case involved the unjustified removal of preventive measures, not the sufficiency of those measures. The other Ninth Circuit cases pertaining to suicide prevention in the custodial setting focus on correctional officers, not mental health providers. *Conn v. City of Reno*, 591 F.3d 1081, 1901–93 & 1102 (9th Cir. 2010), *vacated* 563 U.S. 915 (2011), *reinstated in part*, 658 F.3d 897 (9th Cir. 2011) (denying qualified immunity to transporting officers who failed to report arrestee's suicidal behavior to jail personnel); *NeSmith v. Olsen*, 808 F. App'x 442, 445 (9th Cir. 2020) (same for deputies who observed a rope hanging in cell the night before individual's suicide but took no action). Setting aside that cases involving ***correctional deputies*** could not put a ***jail therapist*** "on fair notice that her

conduct was unlawful," *Kisela v. Hughes*, 584 U.S. 100, 104 (2018), Garcia's conduct was nothing like that of the officials in *Conn* or *NeSmith*. Because no clearly established law governed the situation faced by Garcia, she is entitled to qualified immunity.

B. Plaintiffs' Derivative Claim for Familial Loss Fails

A failure to establish deliberate indifference precludes a finding of conduct that "shocks the conscience," the more demanding standard applicable to familial-loss claims. *See Lemire v. Cal. Dep't of Corr. & Rehab.*, 726 F.3d 1062, 1075 (9th Cir. 2013); *Hernandez v. Cnty. of Santa Clara*, No. 19-cv-07888-EJD, 2020 WL 3101041, at *5 (N.D. Cal. June 11, 2020). Garcia is accordingly entitled to summary judgment on Plaintiffs' familial-loss claim for the reasons set forth above.

C. The County Is Entitled to Summary Judgment on Plaintiffs' *Monell* Claim

1. Overview of *Monell* framework and Plaintiffs' theories

"While local governments may be sued under § 1983, they cannot be held vicariously liable for their employees' constitutional violations." *Gravelet–Blondin v. Shelton*, 728 F.3d 1086, 1096 (9th Cir. 2013). To sustain their municipal liability claim, Plaintiffs must show that the action that caused Regal's constitutional injury was part of an "official municipal policy of some nature." *Monell v. Dep't of Soc. Servs. of City of N.Y.*, 436 U.S. 658, 691–92 (1978). They must establish that: (1) Plaintiffs had a constitutional right of which they were deprived; (2) the municipality had a policy; (3) the policy amounts to deliberate indifference to their constitutional right; and (4) the policy is the moving force behind the constitutional violation. *Gordon II*, 6 F.4th at 973. A plaintiff can satisfy *Monell*'s policy requirement by showing the government acted pursuant to an express official policy, the government maintained a longstanding practice or custom, or the act was ratified by an official with policy-making authority. *Id*. at 973–74. Official nonfeasance can constitute a *Monell* violation when the municipality, in effect, "has a policy of inaction and such inaction amounts to a failure to protect constitutional rights." *Berry v. Baca*, 379 F.3d 764, 767 (9th Cir. 2004). Where, as here, plaintiffs allege inaction by the entity, they must first show "that [the] policy amounts to deliberate indifference to the plaintiff's constitutional right." *Tsao v. Desert Palace, Inc.*, 698 F.3d 1128, 1143 (9th Cir. 2012) (cleaned up). This requires a showing that the County

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"was on actual or constructive notice that its omission would likely result in a constitutional violation." *Id*. at 1145 (citations omitted).

2. Plaintiffs cannot establish a constitutional violation

As an initial and dispositive matter, Plaintiffs' *Monell* claim fails because they have not established that Regal suffered a "constitutional deprivation." *Castro*, 833 F.3d at 1075. As established above in Section IV.A and B, Garcia did not treat Regal with deliberate indifference and thus did not violate his constitutional rights, a prerequisite for a *Monell* claim. *See Williams v. City of Sparks*, 112 F.4th 635, 646 (9th Cir. 2024) (reversing denial of summary judgment on *Monell* claims given failure to establish constitutional violation by individual defendants).

Plaintiffs' *Monell* claims are based on perceived deficiencies in the County's suicide-prevention program—namely, its failure to conduct staggered 15-minute checks, to install suicide-resistant cells, or to remove clothing and bedsheets for moderately suicidal individuals. As another court has recognized, "[i]t is deceivingly inviting to take a suicide in a custodial setting, *ipso facto*, as conclusive proof of deliberate indifference"—but evaluation of the preventive measures put in place "cannot be made from *ex post facto* perspective." *Rellergert by Rellergert v. Cape Girardeau Cnty., Mo.*, 924 F.2d 794, 796 (8th Cir. 1991). Plaintiffs attempt such an *ex post facto* analysis here. It is undisputed that the County has a suicide-prevention program, which provides for training, intake screening, communication protocols between Custody and ACHS, housing options, numerous suicide-prevention measures, and various quality-improvement measures coupled with multi-disciplinary review. Rodriguez ¶ 5; Duran ¶ 5.

Under the only known legal standards pertaining to the adequacy of a suicide prevention program—Titles 15 and 24—the County's program was legally compliant. Duran ¶ 13 & Ex. 2. There is no other established legal metric dictating what constitutes an "adequate" suicide-prevention program. To the contrary, the Supreme Court and Ninth Circuit have made clear that there is no clearly established constitutional right under § 1983 to any particular level of suicide-prevention care in the first place. *See Taylor*, 575 U.S. at 826; *Germaine-McIver*, 2018 WL 6258896, at *11. Courts addressing the contours of a suicide-prevention program have generally required a showing of deliberate indifference to known risks, *see, e.g., Estate of Abdollahi v. Cnty. of*

Sacramento, 405 F.Supp.2d 1194, 1205–06 (E.D. Cal. 2005) (denying summary judgment to county given evidence it ignored known risks relating to heroin detoxication protocols), rather than mandating specific suicide prevention protocols, which is what Plaintiffs seek to do here. Notably, Plaintiffs succeed in underscoring how difficult this work was, given their list of purportedly reasonable, alternative measures the County could have taken to abate the constitutional harm—none of which are relevant, as the possibility of an alternative measure does not itself establish that the County's actions were unconstitutional, and none of which are feasible. *See* Harris ¶ 15 & Ex. 16 at 11–22 (Plaintiffs' list of alternative proposals); *but see* Duran ¶¶ 12, 15, 19–20; Sivongxay ¶¶ 13, 20; Rodriguez ¶ 15 (explaining deficiencies in Plaintiffs' proposed alternative measures).

Because Garcia was not deliberately indifferent, and given that Plaintiffs' remaining theories seek to mandate specific features of a suicide prevention program, Plaintiffs cannot establish a constitutional violation and the *Monell* analysis should end here.

3. <u>Plaintiffs cannot establish that County policy was the moving force behind the alleged constitutional violation</u>

a. Single bunks do not alleviate suicide risk

Plaintiffs first cite the lack of an option, under ACHS Policy 6.2.15, to house a moderately suicidal individual in a cell with a single (*i.e.*, non-double-bunk) bed, positing that this would "prevent inmates from using the upper bunk as an anchor point for hanging, the most common anchor point." *See* Harris ¶ 15 & Ex. 16 at 16. Because Plaintiffs allege the absence of a policy, they must show the County was on actual or constructive notice that allowing moderately suicidal individuals to remain in cells with upper bunks would lead to a constitutional violation. *Tsao*, 698 F.3d at 1145. But there were no known legal standards in place at the time that required modification to the physical plant as part of a suicide-prevention program. Further, Plaintiffs cannot establish this omission would lead to a constitutional violation here (or in any case) because even Hayes—the suicide prevention consultant on whom Plaintiffs rely—noted that single bunks would not address the alleged harm: "[w]hile it is more common for ligatures to be affixed to air vents and window bars (or grates), all cell fixtures should be scrutinized, since bed frames/holes, shelves with clothing hooks, sprinkler heads, door hinge/knobs, towel racks, water faucet lips, and light fixtures

have been used as anchoring devices in hanging attempts." Harris ¶ 16 & Ex. 19 at 15. Plaintiffs' focus on bunkbeds as the primary hanging point is myopic and ignores the reality of suicide in jails. This half-measure would not have mitigated the risk, and Plaintiffs cannot establish that the County was on notice that bunkbeds would lead to a constitutional violation. *Tsao*, 698 F.3d at 1145.

b. The construction and use of suicide-resistant cells

Plaintiffs also allege the County did not have enough suicide-resistant cells and further attack the County's policy and practice of limiting the use of suicide-resistant cells to individuals who are deemed "high risk," as outlined in ACHS Policy 6.2.5. *See* Harris ¶ 15 & Ex. 16 at 12–13.

As to the lack of suicide-prevention cells, the County was not on notice that failure to construct (or limiting the use) of suicide-resistant cells was deliberately indifferent. *Tsao*, 698 F.3d at 1145. As noted above, there is no legal requirement to retrofit for suicide-resistant cells. Sivongxay ¶ 6. The County agreed to do so as part of the *Chavez* consent decree, as ***one*** way to improve its suicide-prevention program—but the absence of this feature does not equate to a *Monell* violation. *See U.S. v. S. Fla. Water Mgmt. Dist.*, No. 88-1886-CIV, 2011 WL 4591946, at *12 (S.D. Fla. Sept. 30, 2011) (consent decrees are "designed to succeed, not to punish"). At the time of Regal's death, the County was in the midst of the difficult and extensive process of renovating the jails to implement ADA improvements, suicide-resistant cells, and other safety measures. Sivongxay ¶ 11 & Ex. 1 (Gantt chart). In July 2020, construction of suicide-resistant cells had been in progress since before the entry of the consent decree the previous year, the suicide resistance cells were completed in only two locations: 8A and 4B. *Id.* ¶ 12–13, 19 & Ex. 3. There were no such cells completed at Elmwood at that time because the County had reasonably elected to begin construction in the most acute space (8A) and where construction was already taking place (4B). *Id.* ¶ 12; Duran ¶ 11. It was legally impermissible to house Regal in 8A because he did not meet the criteria for a 5150 hold. Rodriguez ¶¶ 8, 15; Kaftarian ¶ 31. And it was legally impermissible to house Regal in 4B because that housing location is very restrictive, and he had a right to be housed in the least restrictive setting. Duran ¶¶ 6–7, 14.

Plaintiffs further argue that ACHS Policy 6.2.15 inappropriately allocated these cells to individuals that were deemed a "high suicide risk," "once [such cells] have been constructed."

Rodriguez ¶ 7 & Ex. 1 at 1940. That policy language is immaterial here because those cells only existed in locations where Regal could not legally be housed. Rodriguez ¶¶ 8, 12; Duran ¶¶ 7, 14. Even if policy limitations relating to an individual's suicide risk level were material, it would not establish that the County was on actual or constructive notice that such a limitation was deliberatively indifferent. Finally, notwithstanding the significant public policy problems inherent in punishing public entities who voluntarily agree to implement remedial measures to prevent potential constitutional violations in the future, this *Monell* theory is essentially an attempt to hold the County liable for being "out of compliance" with the consent decree—but "a remedial court decree does not provide a right secured by the Constitution or laws of the United States, the violation of which is a necessary element of a § 1983 claim." *Garcia v. Stewart*, No. C 06-6735 MMC (PR), 2009 WL 688887, at *7 (N.D. Cal. Mar. 16, 2009) (citing authorities); *S. Fla. Water Mgmt. Dist.*, 2011 WL 4591946, at *12. For that reason, Plaintiffs' second *Monell* theory fails.

c. The use of staggered welfare checks

Plaintiffs next contend that staggered checks are "critical to suicide prevention" because "they prevent suicidal inmates from timing their suicides based on the regularity and predictability of checks, and so ensure less time for suicidal inmates to prepare nooses and asphyxiate." Harris ¶ 15 & Ex. 16 at 17. Plaintiffs point to the lack of a requirement, pursuant to DOC Policy 12.05, to require correctional deputies to "stagger" their 15-minute checks for individuals on suicide watch. Harris ¶ 15 & Ex. 16 at 16–17. The policy provides that for individuals on suicide watch, correctional staff "shall immediately complete a Med/Psych Referral form and document welfare checks ***at least*** every fifteen (15) minutes on an Inmate Observation Record." Duran ¶ 5 & Ex. 1 at 2010 (emphasis added). In Plaintiffs' view, DOC Policy 12.05 is constitutionally deficient because "[c]hecks occurring at regular intervals of 15-minutes [sic] apart are so ineffective as to be deliberately indifferent to the substantial risk inmates would hang themselves in their cells[.]" *Id.*

No case has held that failure to stagger 15-minute checks is deliberately indifferent. Nothing in Title 15 requires that jail staff conduct "staggered" 15-minute checks, either. And there is no universally accepted clinical definition of "staggered checks" in the suicide-prevention context, Kaftarian ¶ 24, making it difficult to know what, exactly, Plaintiffs contend the County should have

done. Plaintiffs cite a single reference by Hayes to staggered checks, in which he suggests that checks should take place every 10 minutes—but Hayes does not actually describe what it means to stagger them. *See* Harris ¶ 15 & Ex. 16 at 17 (citing Hayes' language). Presumably, the goal of staggering is to be unpredictable, which is a difficult feat given the short time interval. As far as the County's practice, correctional deputies are required to complete 15-minute checks ***at least*** every 15 minutes, which effectively accomplishes the nebulous concept of staggering. Regardless, the County's custom and practice in this regard was not the "moving force" behind constitutional harm because, in Regal's case, his 15-minute checks ***were*** staggered, insofar as they did not happen exactly every 15 minutes and were thus less regular and/or predictable. *See* Duran ¶ 15 & Ex. 3 (observation log showing staggered checks in the hours before Cevallos' discovery of Regal).

d. The use of Ferguson gowns and blankets

Last, Plaintiffs contend that "[b]y restricting the use of Ferguson gowns and safety blankets to only Unit 8A of the Main Jail . . . the County's policies prohibited the use of these suicide prevention measures for inmates at a moderate suicide risk, like Mr. Regal . . . and left moderately suicidal inmates like Mr. Regal with bedsheets, the most obvious and most-used ligature[.]" Harris ¶ 15 & Ex. 16 at 20. Plaintiffs mischaracterize the County's policy. ACHS Policy 6.4.3 provides that Ferguson gowns "should not be used in general population," and that if an individual is determined to be "at high risk for self-harm" or to need a Ferguson gown, he should be placed on a 5150 hold and rehoused in 8A. Rodriguez ¶ 10 & Ex. 2 at 1951. In July 2020, days before Regal's arrival at Elmwood, the federal monitor for the consent decree advised the County to restrict the use of Ferguson gowns ***and*** blankets to individuals in 8A, where the highest-risk patients reside. Rodriguez Tr. at 55:7–56:14, 65:22–66:7, 88:18–89:5. The monitor's rationale for removing both was that if, in the clinician's judgment, bedsheets posed a risk, their clothing did too. Rodriguez ¶ 15.

To prevail on this theory, Plaintiffs must prove this policy decision was unconstitutional on its face. *See Monell*, 436 U.S. at 660–61 (involving city policy compelling pregnant employees to take unpaid leaves of absence before such leaves were medically required). It is not. Furthermore, Plaintiffs cannot, as they must, demonstrate that the County was "on actual or constructive notice that the particular omission[s were] substantially certain to result in the violation of the constitutional

rights of [its] citizens." *Castro*, 833 F.3d at 1076 (emphasis removed). To the contrary, the County followed the advice of the federal monitor, and ACHS Policy 6.4.3 is consistent with the consent decree requirements, which ***required*** the County to limit the use of Ferguson gowns to individuals at a "***high*** risk for suicide." Harris ¶ 16 & Ex. 21 at 19 (emphasis added). Given that bedding and clothing both present a suicide risk, it is logical that the clinical justification for their removal would be treated equally. Limiting the removal of an individual's clothing and bedding to those deemed a high risk is also consistent with standards for mental health care to patients in the community for when this is legally acceptable, as such measures are drastic and tend to stigmatize individuals and make them less likely to trust mental health staff. Kaftarian ¶¶ 22–23, 25 (explaining community standards and legal restrictions for using these precautions on patients in the community); *see also* Rodriguez ¶¶ 11, 15.

Plaintiffs also fail to establish that the County's policy decision was the "moving force" behind the alleged constitutional violation. *Gordon II*, 6 F.4th at 973. Even in 8A, not all high-risk patients have their clothing or bedding removed. Rodriguez ¶ 11. Given Pierce's determination—and Garcia's concurrence—that Regal was moderately suicidal, Regal was not eligible for the removal of his clothing or blanket because that was only an option for high-risk patients. And even if Regal had qualified for a Ferguson gown/blanket, it does not mean Garcia would have taken such measures, as this extreme measure is not standard even for high-risk patients. *See id.*

V. CONCLUSION

Frederick Regal's suicide is a tragedy—but it was not the result of deliberate indifference on the part of Consuelo Garcia or the County of Santa Clara. Defendants respectfully request that the Court grant their motion for summary judgment.

Respectfully submitted,

Dated: October 18, 2024

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