UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

SOUTHERN DIVISION

VILMA GERMAINE-MCIVER, individually and as successor in interest to RYAN HALL, **Plaintiff,** **v.** **COUNTY OF ORANGE, et al.,** **Defendants.**	**Case No.: SACV 16-01201-CJC(GJSx)** **ORDER GRANTING IN PART AND DENYING IN PART DEFENDANT COUNTY OF ORANGE'S MOTION FOR SUMMARY JUDGMENT [Dkt. 124] AND GRANTING DEFENDANTS SHERIFF HUTCHENS AND KIM PEARSON'S MOTION FOR SUMMARY JUDGMENT [Dkt. 129]**

I. INTRODUCTION

This case arises from the tragic suicide of Ryan Hall while he was in custody and awaiting trial at Orange County Men's Central Jail in Santa Ana, California. Hall's mother, Plaintiff Vilma Germaine-McIver, brings this action on behalf of herself and her

son against Defendants County of Orange, Sandra Hutchens, Kim Pearson, and Does 1 through 10.[1] (Dkt. 1 [Complaint, hereinafter "Compl."].) Plaintiff asserts eight causes of action: (1) a § 1983 claim for substantive due process under the Fourteenth Amendment, (2) a § 1983 claim for deprivation of life without due process of law under the Fourteenth Amendment, (3) a § 1983 claim for failure to adequately train officers, (4) a § 1983 claim under *Monell*, (5) negligence, (6) violation of California Government Code § 845.6, (7) violations of the Americans with Disabilities Act ("ADA"), the Rehabilitation Act, and the Unruh Civil Rights Act, and (8) wrongful death. (*See generally* Compl.)

Before the Court are two motions for summary judgment, one brought by the County of Orange (the "County") and one brought by Sheriff Sandra Hutchens and Kim Pearson (collectively, the "Individual Defendants"). (Dkts. 124, 129.) For the following reasons, the County's motion is **GRANTED IN PART** and **DENIED IN PART**. The Individual Defendants' motion is **GRANTED**.

II. BACKGROUND

A. Hall's Detention and Suicide

On November 29, 2014, Hall was arrested by the Santa Ana Police Department for attempted murder and resisting arrest. (Dkt. 152 [County's Reply to Separate Statement of Uncontroverted Facts and Conclusions of Law, hereinafter "SF"] 1.) Hall was booked into the Orange County Jail, where he was medically assessed. (SF 2.) During booking, jail staff deemed Hall to be gravely disabled and a danger to others. (SF 4.) They assigned Hall to Module L of the Intake Release Center, which is the unit specifically

[1] The Complaint also names Mark Refowitz and Patrick Hall as defendants. The parties stipulated to dismiss the claims against Refowitz. (Dkt. 86.) The Complaint states that Patrick Hall, Ryan Hall's natural father, is named as a nominal defendant. (Compl. ¶ 6.)

designated to house seriously mentally ill inmates. (SF 3.) The next day, a nurse practitioner reevaluated Hall. (SF 5.) After this evaluation, Hall was cleared for regular housing and rehoused in the general population on December 1, 2014. (SF 7.)

Five days later, Hall obtained a razor blade. (SF 11, 100.) Hall cut himself along his arms and legs and from ear-to-ear across the front of his neck. (SF 100.) Hall then grabbed his face with his hands and began twisting his head from side to side, in an apparent attempt to break his own neck. (*Id.*) The responding deputies subdued Hall, gave him emergency medical treatment, and transported him to Western Medical Center in Santa Ana. (SF 12.)

The next day, while at the hospital, Hall struggled with the deputies who were guarding him. (SF 13.) Hall grabbed the handle of a deputy's gun and attempted to remove it from its holster. (SF 14.) Hall told the deputies, "I want to go to heaven, please shoot me, I want to die." (SF 101.) The deputies had to restrain Hall. (SF 14.) Hall was released from the hospital on December 18, 2014. (SF 15.)

Upon Hall's return to the jail, he was assigned to Module L's acute unit. (SF 15, 102.) In the acute unit, Hall was provided with only a safety gown and a mattress. (SF 15.) When questioned by a psychiatrist after his return, Hall denied suicidal intent. (SF 16.) However, the jail's medical records describe Hall as "paranoid," "delusional," "unpredictable," and "at high risk for self harm." (SF 139, 142.)

During the following months, mental health professionals periodically visited Hall, though Plaintiff disputes whether these visits were "regular." (SF 61, 81.) Dr. Nabi Latif was the psychiatrist assigned to the Module L units that housed Hall. (SF 116.) Hall remained in the acute unit until January 6, 2015, when Dr. Latif ordered him transferred to the chronic unit. (SF 150, 155.) Psychiatrists conduct a daily morning round to

interview inmates in the acute unit, but visit inmates in the chronic unit less frequently. (SF 128–29.) While in the chronic unit, Hall was also seen by Clinician Fetric Simbolon, a licensed psychiatric technician. (SF 156.) Clinician Simbolon made rounds within Hall's chronic unit once each week. (SF 157.)

The Sheriff's Department classified Hall as a "yellow bander," meaning he had either assaulted other inmates or assaulted the deputies. (SF 131.) Mental health staff are instructed that inmates with yellow bands cannot attend group therapy sessions. (SF 146.) Since Hall had a yellow band, he was not allowed to participate in group therapy. (SF 147.)

During visits with the mental health staff, Hall repeatedly requested to return to regular housing. (SF 165.) Hall said he did not like being isolated in Module L and thought he would be more social in regular housing. (SF 140, 167.) In early February, the mental health staff held a team meeting on the possibility of clearing Hall for regular housing. (SF 171.) The staff concluded that Hall remained "at high risk" and that regular housing would not be safe for him. (SF 172.)

Since Hall could not attend group therapy, his psychological care primarily consisted of visits from mental health staff. Between February 3 and March 10, Dr. Latif did not visit Hall, even though Hall remained at a high risk for committing suicide. (SF 174.) No other psychiatrists visited Hall during that time, but Hall was visited by Clinician Simbolon. (SF 173, 175.) There was no protocol for psychiatrists to arrange for doctors to cover for them when they were gone. (SF 209.) The jail also did not have any policy as to how often inmates in the chronic units should be seen or visited by a psychiatrist. (SF 177.)

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In February and March, Hall remained at high risk for committing suicide. (SF 178.) On February 10, Hall's attorney called the mental health staff, stating that Hall appeared religiously preoccupied during court. (SF 179.) Neither Dr. Latif nor Clinician Simbolon returned the attorney's call. (SF 180, 182.) On February 13, Hall refused to come to his cell door when Clinician Simbolon conducted rounds. (SF 183.) On February 27, Hall expressed distress to Clinician Simbolon about the isolation due to Hall's yellow band. (SF 184.) On March 5, Hall asked Clinician Simbolon for increased anxiety medication. (SF 185.) Clinician Simbolon discussed how to use coping skills like breathing exercises instead of increased medication. (*Id.*) Dr. Latif resumed seeing Hall on March 10. (SF 187.) On March 17, Dr. Latif found that Hall was "low functioning" and had "poor coping." (SF 191.) Dr. Latif did not make an effort to see Hall outside of his chronic care rounds. (SF 202.)

On April 6, 2015, records indicate that deputies conducted a safety check of Hall's cell between 6:45 and 6:50 a.m. (SF 18.) As required by state law, deputies conduct these safety checks every sixty minutes, which they log into an electronic system. (SF 77, 249.) At approximately 7:10 a.m., Hall left his cell for the dayroom, which is a common area inside Module L. (SF 19.) At approximately 7:13 a.m., Hall told Correctional Services Assistant ("CSA") Brandon Mello that he was finished in the dayroom. (SF 20, 254.) Neither CSA Mello nor the deputy in the guardroom watched Hall leave or enter his cell, even though Hall's cell was visible from the guardroom. (SF 254, 257.) Hall returned to his cell and CSA Mello remotely locked the door. (SF 20, 264.) At approximately 7:15 a.m., another inmate spoke to Hall for about a minute. (SF 21.) At 7:25 a.m., the inmate alerted staff to Hall's cell. (SF 219.) Several deputies, nurses, a psychiatrist, and other staff responded. (SF 22.) Hall was found elevated off the ground, with a bedsheet stuck in the door and tied around his neck. (SF 22, 212.) Hall did not have a pulse and was not breathing. (SF 23.) The staff initiated CPR until

paramedics arrived. (SF 24.) Emergency services transported Hall to Western Medical Center, where he died a few days later. (SF 26–27.)

B. Module L

The Orange County jails house approximately 6,000 inmates at any given time and book approximately 60,000 inmates into custody each year. (SF 84.) There are currently 1,600 inmates in mental health treatment at the jail. (SF 242.) From 2011 to 2015, there were four in-custody suicides, including that of Hall, in the Orange County jail system. (SF 85.)

Module L is the designated unit for inmates with the most serious mental health issues, including inmates who are suicidal. (SF 31, 108.) Module L has six sectors, with sixteen cells in each sector. (SF 103.) Three sectors are designated as acute units and three sectors are designated as chronic units. (SF 105–06.) Patients in chronic units are monitored less closely than those in acute units. (SF 106.) Each sector has one "dayroom area" outside the cells. (SF 107.) Each shift, three deputies and one CSA are assigned to Module L. (SF 109.)

Orange County jail policy dictates that all Module L inmates have 24/7 access to mental health professionals, through a combination of on-site and on-call staff. (SF 32.) On-site coverage by a psychiatrist is available on weekdays from 7:30 a.m. to 5:30 p.m. (SF 32.) Inmates in Module L are assigned individual observation cells that are mostly floor-to-ceiling glass. (SF 33.) The open, semi-circular layout of Module L ensures that every cell is visible from the medical station and the guard station twenty-four hours per day. (SF 34.) This design allows a clear line of sight from the guard station into each cell. (SF 104.)

Two county agencies staff Module L. The Orange County's Sheriff Department ("OCSD") personnel are responsible for providing security, clothing, food, and other common necessities to the inmates. (SF 35.) The Orange County Health Care Agency ("HCA") provides medical and mental health services through the Correction Health Services team, which includes psychiatrists, nurse practitioners, nurses, mental health clinicians, and other mental health professionals. (SF 36, 38–39, 44.) HCA professionals train all deputies who work in the jails on how to identify potential mental health issues, including how to prevent suicide. (SF 63.) Deputies also receive laminated pocket-cards that summarize signs that indicate an inmate may be suicidal. (SF 64.) The OCSD personnel assigned to Module L receive an additional two hours of training from HCA every four months. (SF 65.)

Defendant Sheriff Sandra Hutchens is the Sheriff for Orange County. (Compl. ¶ 7.) Under Sheriff Hutchens' chain of command, the Jail Compliance and Training Team is responsible for drafting, updating, and maintaining OCSD's policies relating to Module L. (SF 47.) Module L policies include guidelines for training on conducting safety cell checks, recognizing signs that an inmate's mental health may be deteriorating, and recognizing signs that an inmate may be suicidal. (SF 50.) At all relevant times, OCSD had established policies regarding safety checks, medical program administration, housing assignments, safety cells, emergency responses to suicides, and medical observation cells. (SF 51.)

At the time of Hall's detention, Defendant Kim Pearson was Deputy Director of HCA and responsible for administrative oversight of the Correctional Health Services team. (SF 88.) At all relevant times, HCA had established policies regarding medical and mental health housing assignments, suicide precautions, suicide risk assessment, tracking of suicide interventions, crisis intervention plans, psychiatric and medical

evaluations, psychiatric coverage, and transfers from regular housing to acute mental housing, among other areas. (SF 52.)

III. LEGAL STANDARD

The Court may grant summary judgment on "each claim or defense—or the part of each claim or defense—on which summary judgment is sought." Fed. R. Civ. P. 56(a). Summary judgment is proper where the pleadings, the discovery and disclosure materials on file, and any affidavits show that "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." *Id.*; *see also Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). The party seeking summary judgment bears the initial burden of demonstrating the absence of a genuine issue of material fact. *Celotex Corp.*, 477 U.S. at 325. A factual issue is "genuine" when there is sufficient evidence such that a reasonable trier of fact could resolve the issue in the nonmovant's favor. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). A fact is "material" when its resolution might affect the outcome of the suit under the governing law, and is determined by looking to the substantive law. *Id.* "Factual disputes that are irrelevant or unnecessary will not be counted." *Id.* at 249.

Where the movant will bear the burden of proof on an issue at trial, the movant "must affirmatively demonstrate that no reasonable trier of fact could find other than for the moving party." *Soremekun v. Thrifty Payless, Inc.*, 509 F.3d 978, 984 (9th Cir. 2007). In contrast, where the nonmovant will have the burden of proof on an issue at trial, the moving party may discharge its burden of production by either (1) negating an essential element of the opposing party's claim or defense, *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 158–60 (1970), or (2) showing that there is an absence of evidence to support the nonmoving party's case, *Celotex Corp.*, 477 U.S. at 325. Once this burden is met, the party resisting the motion must set forth, by affidavit, or as otherwise provided under

Rule 56, "specific facts showing that there is a genuine issue for trial." *Anderson*, 477 U.S. at 256. A party opposing summary judgment must support its assertion that a material fact is genuinely disputed by (i) citing to materials in the record, (ii) showing the moving party's materials are inadequate to establish an absence of genuine dispute, or (iii) showing that the moving party lacks admissible evidence to support its factual position. Fed. R. Civ. P. 56(c)(1)(A)–(B). The opposing party may also object to the material cited by the movant on the basis that it "cannot be presented in a form that would be admissible in evidence." Fed. R. Civ. P. 56(c)(2). But the opposing party must show more than the "mere existence of a scintilla of evidence"; rather, "there must be evidence on which the jury could reasonably find for the [opposing party]." *Anderson*, 477 U.S. at 252.

In considering a motion for summary judgment, the court must examine all the evidence in the light most favorable to the nonmoving party, and draw all justifiable inferences in its favor. *Id.*; *United States v. Diebold, Inc.*, 369 U.S. 654, 655 (1962); *T.W. Elec. Serv., Inc. v. Pac. Elec. Contractors Ass'n*, 809 F.2d 626, 630–31 (9th Cir. 1987). The court does not make credibility determinations, nor does it weigh conflicting evidence. *Eastman Kodak Co. v. Image Tech. Servs., Inc.*, 504 U.S. 451, 456 (1992). But conclusory and speculative testimony in affidavits and moving papers is insufficient to raise triable issues of fact and defeat summary judgment. *Thornhill Pub. Co. v. GTE Corp.*, 594 F.2d 730, 738 (9th Cir. 1979). The evidence the parties present must be admissible. Fed. R. Civ. P. 56(c). "If the court does not grant all the relief requested by the motion, it may enter an order stating any material fact—including an item of damages or other relief—that is not genuinely in dispute and treating the fact as established in the case." Fed. R. Civ. P. 56(g).

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IV. DISCUSSION

Defendants move for summary judgment on all eight of Plaintiff's causes of action. The County moves for summary judgment on the third, fourth, fifth, seventh, and eighth causes of action. Individual Defendants move for summary judgment on the first, second, third, fifth, sixth, seventh, and eighth causes of action.

A. § 1983 Claims (First, Second, Third, and Fourth Causes of Action)

Plaintiff's first, second, third, and fourth causes of action seek recovery for violations of the Fourteenth Amendment under 42 U.S.C. § 1983. Plaintiff contends that Defendants violated Mr. Hall's Fourteenth Amendment due process rights by failing to ensure regular visits with psychiatrists and train officers to adequately monitor and supervise mentally ill inmates.

Under the Fourteenth Amendment, "a detainee may not be punished prior to an adjudication of guilt in accordance with the due process of law." *Bell v. Wolfish*, 441 U.S. 520, 535 (1979). Although the government may detain someone to ensure his presence at trial and may subject him to the restrictions and conditions of a detention facility, these conditions and restrictions may not amount to punishment or otherwise violate the Constitution. *Id.* at 536–37. Under certain circumstances, jail conditions may unconstitutionally punish pretrial detainees, such as where officers fail to protect an inmate, *Castro v. Cty. of Los Angeles*, 833 F.3d 1060, 1073 (9th Cir. 2016), or where jail officials deny medical care, *Gordon v. Cty. of Orange*, 888 F.3d 1118, 1122–25 (9th Cir. 2018).

Here, Plaintiff contends the County and Individual Defendants violated Hall's due process rights by acting with objective deliberate indifference to Hall's serious medical

needs. Plaintiff faults the County's policies regarding the coverage of psychiatrists at the jail and deputies' monitoring of inmates. She also claims Pearson and Hutchens are liable as supervisors tasked with overseeing these policies.

1. Defendant County (Third and Fourth Causes of Action)

Plaintiff must satisfy the requirements of *Monell* and its progeny to impose liability on the County. *Mendiola-Martinez v. Arpaio*, 835 F.3d 1239, 1247 (9th Cir. 2016). Municipal liability under § 1983 may be based on (1) acts of "commission," where the government implements official policies or established customs that inflict constitutional injury, (2) acts of "omission," when those omissions amount to the local government's own official policy, or (3) the acts of or ratification by an official with final policymaking authority. *Clouthier v. Cty. of Contra Costa*, 591 F.3d 1232, 1249–50 (9th Cir. 2010), *overruled on other grounds by Castro*, 883 F.3d at 1070.

Here, Plaintiff bases her § 1983 claims on various acts of omission, due to the County's failure to properly train government employees or adopt reasonable policies to provide mental health care to pretrial detainees. Inadequate training "may serve as the basis for § 1983 liability only where the failure to train amounts to deliberate indifference to the rights of persons" with whom government employees come into contact. *City of Canton v. Harris*, 489 U.S. 378, 388 (1989). A municipality may also be liable when, with deliberate indifference, it "fails to adopt or implement policies when it is highly predictable that such inaction will result in constitutional violations." *Conn v. City of Reno*, 591 F.3d 1081, 1091 (9th Cir. 2010), *cert. granted, judgment vacated sub nom. City of Reno v. Conn*, 563 U.S. 915 (2010), *opinion reinstated*, 658 F.3d 897 (9th Cir. 2011). In other words, only where the omission "reflects a 'deliberate' or 'conscious' choice by a municipality . . . can a city be liable for such a failure under § 1983." *City of Canton*, 489 U.S. at 389. This high standard is met when the need for better policies or

training "is so obvious, and the inadequacy is so likely to result in the violation of constitutional rights, that the policymakers of the city can reasonably be said to have been deliberately indifferent to the need." *Id.* at 390.

Under *Monell*, a pretrial detainee must (1) show "a direct causal link between a municipal policy or custom and the alleged constitutional deprivation," and (2) "demonstrate that the custom or policy was adhered to with deliberate indifference to the constitutional rights of the jail's inhabitants." *Castro*, 833 F.3d at 1075–76 (internal quotation marks and alterations omitted). The deliberate indifference standard is an objective inquiry, "for the practical reason that government entities, unlike individuals, do not themselves have states of mind." *Castro*, 833 F.3d at 1076. Deliberate indifference may be found "[w]here a § 1983 plaintiff can establish that the facts available to city policymakers put them on actual or constructive notice that the particular omission is substantially certain to result in the violation of the constitutional rights of their citizens." *Id.* at 1076 (quoting *City of Canton*, 489 U.S. at 396).

Plaintiff asserts essentially two theories as to the County's liability under *Monell*: (a) the failure to provide medical care through the lack of policies to ensure inmates receive regular care from psychiatrists, and (b) the failure to prevent harm through the Sheriff's Department's practice of inadequately monitoring mentally ill inmates. (Dkt. 140 [Pl.'s Opp'n to County's MSJ] at 12–18.)

a. Regular Access to Psychiatric Care

The Fourteenth Amendment's due process clause guarantees that pretrial detainees receive constitutionally adequate medical and mental health care. *Conn*, 591 F.3d at 1094. The right to adequate medical care requires treatment of a "serious" medical need, which exists when "failure to treat the condition could result in further significant injury

or the unnecessary and wanton infliction of pain." *Id.* at 1095. "A heightened suicide risk or attempted suicide is a serious medical need." *Id.* Plaintiff argues that the County failed to provide medical care to address Hall's suicide risk through a custom where inmates were not regularly treated by a psychiatrist.

A "custom" is a "widespread practice that, although not authorized by written law or express municipal policy, is so permanent and well settled as to constitute a custom or usage with the force of law." *St. Louis v. Praprotnik*, 485 U.S. 112, 127 (1988) (internal quotation marks omitted). A municipal government may be liable as a result of a "governmental custom even though such a 'custom' has not received formal approval through the body's official decision-making channels." *Monell v. Dep't of Soc. Servs. of City of N.Y.*, 436 U.S. 658, 691 (1978). Nonetheless, "[l]iability for 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*, 99 F.3d 911, 918 (9th Cir. 1996).

Plaintiff contends the County had a custom and practice of failing to ensure adequate access to treatment by a psychiatrist. According to its policies, HCA was "responsible for determining adequate staffing levels and personnel requirements in order to provide necessary health care services to inmates." (Dkt. 141-13 Ex. 13.) Plaintiff offers evidence, however, that the County had a widespread practice whereby psychiatrists did not spend an adequate amount of time with inmates. Module L's senior psychiatrist, Dr. Farrell, testified he would spend as little as five minutes with patients in the acute unit. (Dkt. 144-2 Ex. 41 [Deposition of Peter Farrell, hereinafter "Farrell Dep."] at 42:8–10.) For inmates in the chronic unit, he would spend even less time on his weekly rounds. (*Id.* at 46:21–25.) These brief visits were also infrequent. Dr. Farrell and Dr. Latif both testified that HCA had no practice or policy to make sure that psychiatrists regularly saw inmates in the chronic units. (*Id.* at 142:21–143:14; Dkt. 144-

3 Ex. 42 [Deposition of Nabi Latif, hereinafter "Latif Dep."] at 96:1–13.) Most problematically, HCA had no way to account for a psychiatrist's absence. When a psychiatrist took leave, there was no policy to make sure that psychiatrist's patients still received care. (*Id.* at 123:4–25.) Dr. Latif simply assumed others would notice. (*Id.*) Accordingly, when Dr. Latif took a 5-week leave in February and March 2015, Hall went without psychiatric care, as did the other inmates in his unit and in units whenever a psychiatrist went on vacation. (*Id.*) From this evidence, a jury could reasonably conclude the County had a widespread practice of failing to ensure psychiatrists visited and spent enough time with inmates.

There is also a genuine dispute of material fact whether there was a direct causal link between the County's policies on the frequency and regularity of psychiatric visits and a deprivation of Hall's constitutional rights. The relevant constitutional right here is Hall's right to adequate medical care. Limited access to competent care by medical professionals, like psychiatrists, may implicate a pretrial detainee's right to adequate medical care. *See Cabrales v. Cty. of Los Angeles*, 864 F.2d 1454, 1461 (9th Cir. 1988), *cert. granted and opinion vacated*, 490 U.S. 1087 (1989), *reinstated*, 886 F.2d 235 (9th Cir. 1989) (affirming denial of summary judgment where psychiatric staff could spend only limited time with inmates, so it was more likely that psychological illness would go undiagnosed and untreated, and plaintiff submitted affidavits that medical understaffing contributed to decedent's suicide).

In opposition to the motion, Plaintiff submits an expert declaration by Dr. Debra Pinals, a board-certified psychiatrist with experience in correctional institutions.[2] (Dkt.

[2] Defendants object to Dr. Pinals' declaration as lacking foundation, speculative, unsupported by facts in the record, irrelevant, and containing improper conclusions of law and unsworn testimony. (Dkt. 148 [Defs.' Objections to Pl.'s Evidence] at 2, 11–15.) These objections are OVERRULED. Dr. Pinals' conclusions are properly based on her expertise as a psychiatrist and her review of the evidence in this case, including the jail's policies and Hall's medical records.

136 [Declaration of Dr. Debra A. Pinals, hereinafter "Pinals Decl."].) According to Dr. Pinals, the "bare bones treatment" that Hall received from psychiatrists at the jail "likely caused a deterioration of his already fragile mental state and likely led to his suicide in April 2016." (*Id.* ¶ 17.) Inadequacies in treatment include the "haphazard" way that jail psychiatrists prescribed medications and Dr. Latif's failure to present Hall's case to his supervisor at any point or comprehensively review Hall's treatment. (*Id.* ¶¶ 8–9.) Hall had only five to ten minutes each week to talk with Clinician Simbolon or Dr. Latif, and he did not speak with a psychiatrist for roughly half of his weeks in jail. (*Id.* ¶ 13.) Dr. Pinals connects these deficiencies to the County's failure to establish systemic treatment planning and implement policies to ensure regular care. (*Id.* ¶¶ 14–16.) In particular, Dr. Pinals highlights HCA's failure to supervise or review psychiatrists' clinical work in order to ensure adequate assessment, monitoring, and treatment of mental illness. (*Id.* ¶ 22.) A reasonable jury could conclude these policies were the "moving force" behind the deprivation of Hall's constitutional right to adequate medical care.[3] *See Polk Cty. v. Dodson*, 454 U.S. 312, 326 (1981) (quoting *Monell*, 436 U.S. at 694).

In addition, there is a genuine dispute of material fact whether the County failed to oversee psychiatrists in a way that reflects objective deliberate indifference to Hall's

[3] Plaintiff contends several other practices rise to the level of custom, but there is no evidence of any causal connection between these practices and a deprivation of Hall's constitutional rights. *Cf. Castro*, 833 F.3d at 1075; *City of Canton*, 489 U.S. at 385. According to Plaintiff, it was a common custom for psychiatrists to cut and paste notes into the patient's medical file rather than make a weekly independent write-up about the patient. (SF 170.) However, merely copying and pasting medical records does not deprive an inmate of constitutionally adequate medical care. Similarly, although Plaintiff suggests the County had a widespread policy of discouraging deputies from discussing problems with inmates during safety checks, there is no causal link between this practice and depriving Hall's right to constitutionally adequate medical care. At the hearing, Plaintiff introduced a new theory that the County faces *Monell* liability under § 1983 for its "yellow band" policy. The record lacks evidence to support this claim. First, there is no "direct causal link" between the "yellow band" policy and a deprivation of the constitutional right to adequate medical care. There is no constitutional right to group therapy. Second, there is no evidence that the County acted with objective deliberate indifference. Plaintiff had a yellow band because he had acted violently in the past. The "yellow band" policy was reasonable to protect the deputies and other inmates from harm.

constitutional rights. In 2014, the Department of Justice ("DOJ") informed the County about the results of its investigation into the Orange County jails.[4] The DOJ identified "systemic deficiencies" related to the provision of medical care. (Dkt. 141 Ex. 32 [Letter from Jonathan M. Smith to Michael B. Giancola & Sandra Hutchens on March 4, 2014, hereinafter "DOJ Letter"] at 1.) In particular, the DOJ expressed concern over "[a] limited array of mental health treatment and housing options [that] results in an over-reliance on unsafe segregation and more restrictive interventions." (*Id.* at 2.) The DOJ stated "the County needs to evaluate Jail housing and treatment programs for prisoners with mental illness, and adopt a more integrated therapeutic model." (*Id.* at 8.) The letter from the DOJ also indicated that "Jail documentation is unclear as to whether staff are consistently increasing the frequency of rounds in areas used to house prisoners with mental illness." (*Id.* at 8 n.11.) In response to this letter, the County stated that "[a]ll mentally ill inmates . . . have access to and are on a designated case management list to be treated and managed by mental health staff." (Dkt. 141 Ex. 35 [Letter from Sandra Hutchens to Jonathan Smith on June 5, 2014, hereinafter "Hutchens Letter"] at 8.)[5]

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[4] Defendants make a number of objections to the DOJ's 2014 letter. (Dkt. 150 [County's Reply to Pl.'s Opp'n to MSJ] at 12–13; Defs.' Objections to Pl.'s Evidence at 2–3.) First, they argue the letter is inadmissible hearsay. The Court disagrees. Plaintiff offers the 2014 letter not for the truth of the matter asserted, but to prove that the County was on notice that its policies were "substantially certain to result in the violation of the constitutional rights of their citizens." *Cf. Castro*, 833 F.3d at 1076. In any event, even if the 2014 letter is offered for its truth, Federal Rule of Evidence 803(8) provides a hearsay exception for public records if the record sets out factual findings from a legally-authorized investigation in a civil case. Fed. R. Evid. 803(8). Defendants argue this exception does not apply because the 2014 letter states that the DOJ intends to conclude its investigation "without the need for formal findings." (Dkt. 141 Ex. 32 at 1.) Even if the DOJ does not make *formal findings*, however, it still makes a number of *factual findings*. Second, the Court overrules Defendants' objection that the letter's stated "areas of concern" lack foundation, as the letter describes how the DOJ inspected the jails and reviewed policies. Lastly, Defendants' complaints that Plaintiff mischaracterizes the letter's contents go to weight, not admissibility.

[5] The County objects to the Hutchens letter on the grounds of hearsay, relevance, and a lack of foundation. (Defs.' Objections to Pl.'s Evidence at 1.) These objections are OVERRULED. Hutchens wrote the letter in her capacity as Sheriff of Orange County, so the letter is a statement by an opposing party. Fed. R. Evid. 801(d)(2). The letter is relevant to whether the Defendants acted with objective deliberate indifference. Since Hutchens oversees the County's jails, there is proper foundation for her knowledge about the jails' operations and policies.

There is a genuine dispute of material fact whether the County was on notice that its policies were substantially likely to deprive inmates of their constitutional rights.

The foregoing genuine disputes of material fact preclude the Court from granting the County's motion for summary judgment. Accordingly, the County's motion for summary judgment is **DENIED** to the extent Plaintiff asserts a *Monell* claim against the County based on the failure to implement policies to ensure mentally ill patients had regular access to psychiatrists.

b. Failure to Monitor

Jail policies that fail to prevent harm may amount to punishment, in violation of pretrial detainees' Fourteenth Amendment rights, where these policies constitute deliberate indifference. *See Castro*, 833 F.3d at 1075–77; *see also Farmer v. Brennan*, 511 U.S. 825, 833–34 (1994) (discussing the duty of prison officials to protect prisoners from harm). Plaintiff claims that the Sheriff's Department, in practice, failed to train deputies to adequately monitor mentally ill inmates in order to prevent suicides. Plaintiff emphasizes two practices in particular. First, inmates in Module L were allowed to "self lockdown" when they returned from the dayroom to their cell, meaning that inmates shut their own cell door which then automatically locked. (SF 264.) OCSD had no requirement that personnel visually inspect the cell—rather than use the intercom—to confirm that the inmate had returned to his cell. (*Id.*) Second, OCSD monitored mentally ill inmates every sixty minutes, rather than every half hour. (SF 276.) Plaintiff has presented sufficient evidence to infer these were widespread policies. A jury could also conclude that these policies were causally related to OCSD's failure to prevent Hall's suicide. If CSA Mello had visually inspected Hall when he returned from the dayroom, CSA Mello would have seen that Hall was attempting to hang himself by sticking his sheet in the door. And since the jail staff had last checked Hall at 6:45 a.m., a 30-minute

safety check could have occurred at 7:15 a.m., just after Hall began attempting suicide at approximately 7:13 a.m. (SF 18, 232–35, 267, 336.)

It is disputed whether the County adhered to these policies in a way that constitutes deliberate indifference to a pretrial detainee's constitutional rights. An inmate like Hall, who had two prior suicide attempts, was at high risk for suicide. (SF 142, 172, 174, 178.) From 2011 to 2015, there were four in-custody suicides, including that of Hall. (SF 85.) Inmates had previously stuck bed sheets in their doors, including during one suicide. (SF 262, 299; Ex. 141 Ex. 46 [Deposition of Brian Snow, hereinafter "Snow Dep."] at 45:25–46:15.) Plaintiff provides evidence that hourly safety checks were also problematic. In 2014, the DOJ recommended that staff on segregation units conduct rounds at least every half hour, but OCSD had not yet increased the frequency of safety checks in 2015. (SF 274.) A reasonable jury could find that the County was on notice that these practices would likely deprive constitutional rights and acted with deliberate indifference by continuing to employ them. To the extent Plaintiff asserts a *Monell* claim based on OCSD policies regarding the monitoring of inmates with mental illness, the County's motion for summary judgment is **DENIED**.

2. Individual Defendants (First, Second, and Third Causes of Action)

The Ninth Circuit applies an "objective deliberate indifference standard" to a pretrial detainee's Fourteenth Amendment claims against individual defendants for a failure to protect from harm or provide adequate medical care. *Gordon v. Cty. of Orange*, 888 F.3d 1118, 1124–45 (9th Cir. 2018) (citing *Castro*, 833 F.3d at 1070). To succeed on a medical care or failure-to-protect claim, a plaintiff must prove:

> (i) the defendant made an intentional decision with respect to the conditions under which the plaintiff was confined; (ii) those conditions put the plaintiff

> at substantial risk of suffering serious harm; (iii) the defendant did not take reasonable available measures to abate that risk, even though a reasonable official in the circumstances would have appreciated the high degree of risk involved—making the consequences of the defendant's conduct obvious; and (iv) by not taking such measures, the defendant caused the plaintiff's injuries.

Id. at 1125. The first part of the inquiry requires that the defendant's conduct be intentional, rather than an accident. *Castro*, 833 F.3d at 1070. For instance, if the claim relates to inadequate monitoring of the cell, the question is whether the officer chose the monitoring practice, rather than having just suffered an accident or sudden illness that made him unable to monitor the cell. *Id.* The latter part of the inquiry, however, is "purely objective," asking whether "there [was] a substantial risk of harm to the plaintiff that could have been eliminated through reasonable and available measures that the officer did not take, thus causing the injury that the plaintiff suffered." *Id.* A pretrial detainee does not need to prove that the officer had actual awareness of the risk. *Id.* at 1071. Rather, the pretrial detainee must "prove more than negligence but less than subjective intent—something akin to reckless disregard." *Id.* at 1071.

A supervisor may be held liable under § 1983 "if there exists either (1) his or her personal involvement in the constitutional deprivation, or (2) a sufficient causal connection between the supervisor's wrongful conduct and the constitutional violation." *Starr v. Baca*, 652 F.3d 1202, 1207 (9th Cir. 2011) (quoting *Hansen v. Black*, 885 F.2d 642, 646 (9th Cir. 1989)). There is a sufficient causal connection if the supervisor set in motion a series of acts by others or knowingly refused to terminate a series of acts by others and the supervisor knew or reasonably should have known this would cause others to inflict a constitutional injury. *Starr*, 652 F.3d at 1207–08.

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a. Pearson

Plaintiff argues that lapses in the availability of medical care in Module L, under Pearson's authority, put Hall at a substantial risk of suffering harm. Plaintiff's focuses on several deficiencies in Hall's care under Pearson's supervision: the lack of access to a psychiatrist for five weeks, HCA staff's failure to address Hall's complaints about isolation, the failure to conduct more frequent follow-ups than weekly rounds, and the practice of copying and pasting notes when updating medical records. Plaintiff also argues that Pearson's lax supervision of psychiatrists, as director of the Correctional Health Services team, created a substantial risk of serious harm. Pearson had few policies in place to oversee the psychiatrists or ensure pretrial detainees received needed psychiatric care. There were only sporadic chart reviews and no way to review how frequently a patient was seen. (SF 177; Latif Dep. at 96:4–13.) There was no protocol for psychiatrists to arrange for people to cover their patient responsibilities when they were gone. (SF 209.) Accordingly, when Dr. Latif did not visit Hall for five weeks, no psychiatrist visited Hall. (SF 175.) There is a genuine dispute of material fact as to whether these conditions created a substantial risk of serious harm.

Plaintiff also presents sufficient evidence that Pearson may be held liable as a supervisor for her involvement. Pearson was deputy director of HCA and responsible for oversight of the Correctional Health Services division. (SF 280–81.) She had authority to suggest and review policy changes. (SF 282.) Pearson was also personally involved in reviewing the findings of the DOJ investigation and drafting portions of the County's response. (SF 284.)

There is a genuine dispute of material fact as to whether Pearson acted with objective deliberate indifference, such that she failed to take reasonable steps to abate the risk that inmates, like Hall, would suffer harm. The 2014 DOJ letter specifically found

that "the County needs to evaluate jail housing and treatment programs for prisoners with mental illness, and adopt a more integrated therapeutic model." (DOJ Letter at 8.) The letter also found that the jail's provision of "therapeutic treatment only to those most acutely ill individuals . . . means that therapeutic treatment may not reach prisoners who may be quite ill, but are not the most obviously in need of mental health care. This type of deficiency is thus similar to the broader problem of an inadequate chronic care system." (*Id.*) In response to the DOJ's findings, Pearson testified that the management team did not "need to change" their policies related to the limited array of mental health treatment. (Dkt. 141 Ex. 44 [Deposition of Kimberly Pearson] at 52:16–53:5, 53:15–24, 56:9–22, 71:5–19.) A reasonable juror could find that Pearson acted with objective deliberate indifference.

b. Sheriff Hutchens

Plaintiff argues that OCSD's failure, under the leadership of Sheriff Hutchens, to implement 30-minute safety checks or observe inmates performing "self lockdowns" put Hall at a substantial risk of serious harm. Plaintiff also argues that deficiencies in the Module L's door locking mechanisms, whereby an inmate could stick a sheet in the door, created a substantial risk to suicidal inmates. Hall had two prior suicide attempts and continued to exhibit signs that his mental condition was deteriorating. (SF 142, 172, 178.) Despite this risk, CSA Mello did not look at Hall—nor was he required to—when Hall returned to his cell. (SF 264; Dkt. 141 Ex. 43 [Deposition of Brandon Mello] at 60:16–61:5.) A reasonable jury could conclude these decisions, made under Hutchens' chain of command, created a substantial risk of serious harm for mentally ill inmates.

It is also disputed whether Sheriff Hutchens acted with objective deliberative indifference in instituting these policies at the jail. In 2014, the DOJ recommended that OCSD implement safety checks every half hour. (DOJ Letter at 9.) Sheriff Hutchens

responded that she would implement the recommendation, (Hutchens Letter at 5), so a reasonable jury could conclude that Sheriff Hutchens was on notice and should have taken measures to abate the risk. OCSD deputies were also aware that inmates could manipulate the cell doors to get objects like sheets in the door. (Snow Dep. at 45:25–46:15.) A jury could find that a reasonable official, faced with such risk, would require and train deputies to physically check doors to make sure they were locked.

c. Qualified Immunity

Although there remain factual disputes whether the Individual Defendants violated Hall's constitutional rights, Plaintiff's suit may still be barred under the doctrine of qualified immunity. Qualified immunity shields public employees from civil liability under 42 U.S.C. § 1983 if "their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known." *Harlow v. Fitzgerald*, 457 U.S. 800, 818 (1982). To determine whether a public employee is entitled to qualified immunity, a court must evaluate two independent questions: (1) whether the employee's conduct violated a constitutional right, and (2) whether that right was clearly established at the time of the incident. *Pearson v. Callahan*, 555 U.S. 223, 232 (2009). As discussed above, there is sufficient evidence for a jury to conclude that Pearson's and Sheriff Hutchens' conduct violated a constitutional right.

"To be clearly established, a right must be sufficiently clear that *every* reasonable official would have understood that *what he is doing* violates that right." *Hamby v. Hammond*, 821 F.3d 1085, 1090 (9th Cir. 2016) (quoting *Taylor v. Barkes*, 135 S. Ct. 2042, 2044) (2015)) (per curiam) (emphasis in *Hamby*). "Although a plaintiff need not find 'a case directly on point, existing precedent must have placed the . . . constitutional question beyond debate.'" *Hamby*, 821 F.3d at 1091 (quoting *Ashcroft v. Al-Kidd*, 563 U.S. 731, 741 (2001)). The Court must make its inquiry "in light the specific context of

the case, not as a broad general proposition." *Mullenix v. Luna*, 136 S. Ct. 305, 308 (2015) (quoting *Malley v. Briggs*, 475 U.S. 335, 341 (1986)).

Plaintiff asserts that Hall had a constitutional right to adequate medical care. To this broad general proposition, the Court agrees. *See Brown v. Plata*, 563 U.S. 493, 410-11 (2011) ("A prison that deprives prisoners of basic sustenance, including adequate medical care, is incompatible with the concept of human dignity and has no place in civilized society.") But in determining whether the Individual Defendants are entitled to qualified immunity, the Court must look to the particular circumstances of this case and "not . . . define clearly established law at a high level of generality." *City & Cty. of S.F. v. Sheehan*, 135 S. Ct. 1765, 1775–76 (2015); *see also Hamby*, 821 F.3d at 1095 (plaintiff need not find case with identical facts, but the further afield existing precedent lies the more likely that official's acts fall within vast zone of conduct that is constitutional). This is not a case where Pearson and Hutchens outright denied Hall medical care.

Plaintiff's fundamental claim here is that Pearson and Hutchens failed to implement certain *policies* that would have prevented Hall's suicide, either through more regular psychiatric care or increased monitoring. The right to proper suicide prevention protocols is not clearly established. In *Taylor v. Barkes*, the Supreme Court granted qualified immunity to officials who failed to properly implement adequate suicide prevention protocols, such as intake screening. 135 S. Ct. at 2045. Writing in June 2015, just after the relevant time period in this case, the Supreme Court noted: "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." *Id.* at 2044.

The Ninth Circuit has also not clearly established any right to a certain standard of suicide prevention protocols. The Ninth Circuit has held "that the Eighth Amendment

protects against deliberate indifference to a detainee's serious risk of suicide." *Conn*, 591 F.3d at 1102. But this right refers to the obligation of particular government actors not to act with deliberate indifference to a particular inmate's suicidal ideations. *See Conn*, 591 F.3d at 1102 (officers not entitled to qualified immunity where detainee threatened suicide en route to jail and officers failed to report incident to those responsible for her custody and safety); *Clouthier*, 591 F.3d at 1245 (mental health professional not entitled to qualified immunity where she removed key suicide prevention measures put in place by another mental health staff member, even though she thought the pretrial detainee was still not "out of the woods"). It "does not clearly establish a broader duty for government entities to implement a suicide prevention policy that meets certain unspecified standards." *NeSmith v. Cty. of San Diego*, 2016 WL 4515857, at *7 (S.D. Cal. Jan. 27, 2016) (granting qualified immunity to sheriff because a failure to implement a superior suicide policy did not violate clearly established law).

A closer look at Ninth Circuit precedent on suicide prevention policies—and their complicated procedural history—fails to establish any clearly established right to a certain level of suicide prevention protocol. In *Cabrales v. County of Los Angeles*, the Ninth Circuit held that understaffing of a jail, where medical staff could only spend minutes with each inmate per month, may amount to a policy or custom of deliberate indifference to pretrial detainees' medical and psychological needs. 864 F.2d 1454, 1461 (9th Cir. 1988), *cert. granted and opinion vacated*, 490 U.S. 1087 (1989), *reinstated*, 886 F.2d 235 (9th Cir. 1989). The possibility that understaffing may violate pretrial detainees' rights, however, does not create a *clearly established right* to have more than weekly visits with mental health staff, as Plaintiff claims here.

More recently, the Ninth Circuit in *Conn* held that a "failure to adopt and implement policies on suicide prevention" may amount to deliberate indifference. 591 F.3d at 1104. On the denial of rehearing en banc, however, seven Circuit Judges

published a dissent that sharply questioned *Conn*'s holding and cited a number of cases in other circuits in which courts had rejected claims based on suicide prevention policies. *Conn*, 591 F.3d at 1087 (Kozinski, J., dissenting from denial of rehearing en banc) ("The measures taken by the city . . . went far beyond anything the Constitution could conceivably require. . . . [According to the panel,] the city is obliged to run its suicide prevention program in whatever manner unelected federal judges think best. This is precisely the kind of micromanagement of local law enforcement that the Supreme Court has instructed us to avoid."). And on remand, the Ninth Circuit vacated the portion of its opinion addressing the failure to implement suicide prevention policies. *Conn*, 658 F.3d at 897. *Cabrales* and *Conn* fail to develop any right "in such a concrete and factually defined context to make it obvious to all reasonable government actors, in the [Individual Defendants'] place, that what [they are] doing violates federal law." *Shafer v. Cty. of Santa Barbara*, 868 F.3d 1110, 1117 (9th Cir. 2017); *cf. Taylor*, 135 S. Ct. at 2045 (rejecting the Third Circuit's finding that there was a clearly established right to suicide prevention protocols based on Third Circuit precedent, as these cases "did not identify any minimum screening procedures or prevention protocols that facilities must use").

Since there was no clearly established right to proper suicide prevention protocols, both Pearson and Sheriff Hutchens are entitled to qualified immunity. Plaintiff challenges the quality of mental health treatment within Module L, but there is no clearly established right to a particular level of treatment. Although Hall had a clearly established right to adequate medical care, this right does not necessarily require regular access to a psychiatrist, as opposed to other mental health professionals. Accordingly, Pearson is entitled to qualified immunity. Similarly, Sheriff Hutchens is also entitled to qualified immunity. There is no clearly established right to the proper implementation of suicide prevention protocols, such as safety checks every thirty minutes or supervised lockdowns. The existing precedent is not "sufficiently clear that *every* reasonable official

would have understood" that these policies violated the Constitution. *Hamby*, 821 F.3d at 1090; *see also Taylor*, 135 S. Ct. at 2044.

Accordingly, the Individual Defendants' motion for summary judgment on the § 1983 claims is **GRANTED**. Pearson and Sheriff Hutchens are entitled to qualified immunity.

B. ADA and Rehabilitation Act (Seventh Cause of Action)

Plaintiff asserts a claim under the ADA and Rehabilitation Act against the County and Pearson.[6] Since these two "statutes provide identical 'remedies, procedures and rights,'" the Court analyzes them together.[7] *See Vos v. City of Newport Beach*, 892 F.3d 1024, 1036 (9th Cir. 2018) (quoting *Hainze v. Richards*, 207 F.3d 795, 799 (5th Cir. 2000)). Title II of the ADA bars a public entity from excluding an eligible disabled individual from "participation in a public entity's services, programs, or activities." *Sheehan v. City & Cty. of S.F.*, 743 F.3d 1211, 1232 (9th Cir. 2014), *reversed in part on other grounds*, 135 S. Ct. 1765 (2016). To state a claim under Title II of the ADA, a plaintiff generally must show: (1) he is an individual with a disability, (2) he is otherwise qualified to participate in or receive the benefit of a public entity's services, programs, or activities, (3) he was either excluded from participation in or denied the benefits of the public entity's services, programs, or activities, or was otherwise discriminated against by the public entity, and (4) such exclusion, denial of benefits, or discrimination was by reason of his disability. *Vos*, 892 F.3d at 1036 (quoting *Sheehan*, 743 F.3d at 1232). In order to seek monetary relief, Plaintiff must prove intentional discrimination by the "deliberate indifference" standard. *Duvall v. Cty. of Kitsap*, 260 F.3d 1124, 1138 (9th

[6] Plaintiff has withdrawn her parallel state law claim under the Unruh Act, California Civil Code § 51. (Pl.'s Opp'n to County's MSJ at 22 n.11.)

[7] The Rehabilitation Act's only additional requirement is that the defendant is a recipient of federal funding. This is undisputed. (*See* Pl.'s Opp'n to County's MSJ at 19 n.6.)

Cir. 2001). "Deliberate indifference requires both knowledge that a harm to a federally protected right is substantially likely, and a failure to act upon . . . the likelihood." *Id.* at 1139. This standard is not met "where a duty to act may simply have been overlooked," but rather "a failure to act must be a result of conduct that is more than negligent." *Id.*

Plaintiff contends the County violated the ADA by excluding her son from participating in group therapy because of his disability and by failing to provide him with reasonable alternative therapies or with a comprehensive treatment plan. (Pl.'s Opp'n to County's MSJ at 19.) The County diagnosed Hall with a depressive disorder and treated him for depression. (SF 123.) Hall was placed on "yellow band" status after he assaulted deputies while in the hospital on December 7, 2014. (SF 131, 134.) Since Hall was on yellow band status, jail staff excluded Hall from group therapy. (SF 147.) Plaintiff asserts that Hall repeatedly told jail staff how he felt "isolated" and lonely due to his yellow band status. (SF 140, 238.)

The plain language of the ADA prohibits the exclusion of an individual with a disability "*by reason of such disability*." 42 U.S.C. § 12132 (emphasis added). Here, Hall was excluded from group therapy because of his "yellow band" status—in other words, because Hall had acted violently, not because he had a depressive disorder. In *Simmons v. Navajo County*, the Ninth Circuit rejected an ADA claim based on a suicidal inmate's exclusion from outdoor recreation. 609 F.3d 1011, 1021–22 (9th Cir. 2010). *Simmons* held that a jail does not deny an inmate services based on a disability if the inmate is denied access based on a policy restricting the activities of inmates on suicide watch. *Id.* Similarly, Hall's exclusion from group therapy was based on a policy restricting the activities of inmates who had a history of violence. He was not excluded based on his depression.

Plaintiff argues the Ninth Circuit's decisions in *Mark H.* and *Sheehan* suggest that a valid ADA claim does not require that a disability motivate the exclusion. *Mark H.* involved educational accommodations provided to students with autism. *Mark H. v. Hamamoto*, 620 F.3d 1090, 192–93 (9th Cir. 2010). *Sheehan* involved accommodations to persons with mental illness during arrest. 743 F.3d at 1232–33. Neither case abrogated the ADA claim requirement that "such exclusion, denial of benefits or discrimination was by reason of [his] disability." *Sheehan*, 743 F.3d at 1232; *see also Mark H.*, 620 F.3d at 1098 ("[B]ecause of their autism, [the students] could not access the benefits of a public education without receiving autism-specific services.").

In any case, Hall still received psychiatric care, despite his yellow band status. Plaintiff's ADA claim focuses on how the treatment of Hall's disability was deficient, as the County failed to provide Hall with more than a weekly check-in with a therapist and an occasional visit from a psychiatrist. But allegedly insufficient treatment for a disability does not amount to a denial of service based on a disability. *Simmons*, 609 F.3d at 1022. Even though Plaintiff was excluded from group therapy, he still received care through visits by Clinician Simbolon and Dr. Latif. Plaintiff's ADA claim fails. The Defendants' motions for summary judgment on the ADA and Rehabilitation Act claim are **GRANTED**.[8]

C. State Law Claims

Defendants also move for summary judgment on Plaintiff's state law claims: the fifth cause of action (negligence), sixth cause of action (violation of California Government Code § 845.6), and eighth cause of action (wrongful death).

[8] Since the Court resolves Plaintiff's ADA claim on the merits, it does not reach Pearson's argument that it would be redundant for her to be sued under the ADA in her official capacity.

1. Individual Defendants' Immunity Under California Government Code §§ 820.2 & 820.8

The Individual Defendants argue they are entitled to immunity against Plaintiff's state law claims under sections 820.2 and 820.8 of the California Government Code. Under § 820.2, "a public employee is not liable for an injury resulting from his act or omission where the act or omission was the result of the exercise of the discretion vested in him, whether or not such discretion be abused." Cal. Gov't Code § 820.2. Courts construe § 820.2 narrowly. *Johnson v. State*, 69 Cal. 2d 782, 787–90 (1968). "[A]lthough a basic policy decision . . . may be discretionary and hence warrant governmental immunity, subsequent ministerial actions in the implementation of that basic decision must still face case-by-case adjudication on the question of negligence." *Id.* at 797. Officials receive immunity for "deliberate and considered policy decisions, in which a conscious balancing of risks and advantages took place." *Caldwell v. Montoya*, 10 Cal. 4th 972, 981 (1995).

The Individual Defendants are entitled to immunity under § 820.2. Both Individual Defendants are policymakers. Plaintiff challenges only the Individual Defendants' discretionary decisions: general decisions regarding Module L's administration, Pearson's oversight of psychiatrists, and Sheriff Hutchens' failure to adopt more stringent inmate monitoring policies. Plaintiff does not point to any regulations or laws that made it mandatory for the Individual Defendants to administer the jail's medical care and custodial arrangements under the alternatives asserted by Plaintiff. *Cf. Estate of Abdollahi v. Cty. of Sacramento*, 405 F. Supp. 2d 1194, 1213 (E.D. Cal. 2005) (denying § 820.2 immunity where the sheriff failed to implement state building regulations for jails). Plaintiff argues the Individual Defendants had no discretion to ignore the ADA. (Dkt. 138 [Pl.'s Opp'n to Individual Defs.' MSJ] at 25.) But the decisions on which she bases her state law claims are not related to the ADA in

any way. The decisions are entirely discretionary, involving county-wide decisions made by Hutchens and Pearson on how to staff, administer, and run the jail. (*See* Compl. ¶¶ 76–83, 95–99.) The Individual Defendants are entitled to immunity for the decisions they made as policymakers. *Accord George v. Sonoma Cty. Sheriff's Dep't*, 2010 WL 4117381, at *26 (N.D. Cal. Oct. 19, 2010) (granting § 820.2 immunity to sheriff for the creation of jail policies relating to inmate medical care).

The Individual Defendants also contend they are entitled to immunity under California Government Code § 820.8, which provides "a public employee is not liable for an injury caused by the act or omission of another person." A public employee may be liable, however, "for injury proximately caused by his own negligent or wrongful act or omission." Cal. Gov't Code § 820.8. Since the provision limits liability to injuries stemming from the employee's *own* actions, a supervisor is not liable for the acts of subordinates. Legislative Committee Comments to Cal. Gov't Code § 820.8 ("This section nullifies the holdings of a few old cases that some public officers are vicariously liable for the torts of their subordinates."); *see also Weaver v. State*, 63 Cal. App. 4th 188, 202–03 (finding CHP Commissioner was not vicariously liable for acts of his subordinates).

The Complaint contains no allegations that the Individuals Defendants were personally involved in Hall's care. Nor does Plaintiff present any such evidence. The Individual Defendants cannot be liable for any acts or omissions of their subordinates, such as any failure by deputies or HCA staff to immediately seek medical care in response to Hall's suicide attempt. *See* Cal. Gov't Code § 820.8. Plaintiffs' only other theories of liability are based on the Individual Defendants' discretionary decisions, which are subject to immunity under § 820.2. Accordingly, the Individual Defendants' motion for summary judgment on Plaintiff's state law claims is **GRANTED**.

2. California's Claim Requirement

The County argues that Plaintiff's fifth cause of action (negligence) is barred by the estate's failure to file a government tort claim.[9] (Dkt. 124 [County's MSJ] at 23.) Where, as here, a claimant seeks to maintain a personal injury or wrongful death lawsuit against a public entity, the claimant or a person acting on his or her behalf must first present a claim to the public entity. Cal. Gov't Code § 911.2. California Government Code § 910 lists the information required in such a claim, including the name and address of the claimant and a description of the event that gave rise to the injury. *Id.* § 910. Only after a claim is presented to and rejected by the public entity may the claimant bring suit. *Id.* § 945.4; *see Nguyen v. Los Angeles Cty. Harbor/UCLA Med. Ctr.*, 8 Cal. App. 4th 729, 732 (1992), *modified* (Sept. 4, 1992). If the claimant sues, he or she may not bring any causes of action that were not included in the claim to the public entity. *Nguyen*, 8 Cal. App. 4th at 732.

"In comparing claim and complaint, we are mindful that so long as the policies of the claims statutes are effectuated, the statutes should be given a liberal construction to permit full adjudication on the merits." *Stockett v. Ass'n of Cal. Water Agencies Joint Powers Ins. Auth.*, 34 Cal. 4th 441, 449 (1974) (citations and quotations omitted). "[A] claim need not contain the detail and specificity required of a pleading." *Id.* at 446. The purpose of the claim requirement is "to provide the public entity sufficient information to enable it to adequately investigate claims and to settle them, if appropriate, without the expense of litigation." *Id.* (quoting *City of San Jose v. Superior Court,* 12 Cal. 3d 447, 455 (1974)). "As the purpose of the claim is to give the government entity notice sufficient for it to investigate and evaluate the claim, not to eliminate meritorious actions,

[9] The County also argued that the estate's failure to file a government tort claim barred Plaintiff's seventh cause of action under California Civil Code § 51. (County's MSJ at 23.) Plaintiff has since withdrawn that claim. (Pl.'s Opp'n to County's MSJ at 22 n.11.)

the claims statute should not be applied to snare the unwary where its purpose has been satisfied." *Id*. (citations and quotations omitted).

On September 29, 2015, Plaintiff presented a claim to Defendant County of Orange, describing the damages she was seeking for her son Ryan Hall's death "as a result of a completed suicide attempt on or about April 7, 2015 while in custody in the Orange County Jail." (Dkt. 128-29 Ex. S [Claim for Damages] at 1.) The claim states that the County failed to accommodate Hall's mental illness and failed to provide appropriate medical care during Hall's custody. (*Id.* at 2.) The claim expressly refers to Hall's "wrongful death" and states that the County is liable pursuant to "42 U.S.C. § 1983 and various state-law statutory and common law theories." (*Id.*)

Defendants maintain that Plaintiff's claim is not adequate. They do not dispute that Plaintiff can bring a claim in her individual capacity because she submitted a claim. But, Defendants argue, Plaintiff is precluded from bringing a claim on her son's behalf because she did not file a separate form for Hall.

Defendants' argument is unavailing. What matters is not that one form be submitted by each injured party, but rather that the forms submitted contain "sufficient information to enable [the Defendants] to adequately investigate claims." *Stockett*, 34 Cal. 4th at 446. The form submitted here contained sufficient information to enable the County to investigate the claims asserted in this action. It notified the County of the act (failure to provide medical care) that caused the claimed injuries, which included wrongful death. The notice explicitly mentions the County's failure to accommodate and provide medical care while in custody, which are survival claims brought as successor in interest. *Cf. Nelson v. Cty. of Los Angeles*, 113 Cal. App. 4th 783, 797 (2003) (finding claim requirement was not met where claim filed by mother described damages as only for "the loss of a son," with no mention of damage before her son's death).

3. Negligence (Fifth Cause of Action) and Wrongful Death (Eighth Cause of Action)

Plaintiff's remaining state law claims against the County are for negligence and wrongful death. Plaintiff's wrongful death claim is derivative of her negligence claim. (*See* Compl. ¶¶ 95–99.) To establish a claim for negligence, a plaintiff must establish: (1) the defendant had a legal duty to use due care, (2) the defendant breached such duty, and (3) the breach was the proximate or legal cause of the resulting injury. *Ladd v. Cty. of San Mateo*, 12 Cal. 4th 913, 917 (1996). Jail and prison guards owe detainees a duty of care to protect them from foreseeable harm. *See Giraldo v. Dep't of Corr. & Rehabs.*, 168 Cal. App. 4th 231, 245–47, 250 (2008).

Sections 844.6 and 845.6 of the California Government Code limit the County's liability to prisoners, like Hall.[10] Under § 844.6, "a public entity is not liable for . . . [a]n injury proximate caused by any prisoner [or] [a]n injury to any prisoner," except as provided by § 845.6. Cal. Gov't Code § 844.6(a). Section 845.6 carves out a "narrow exception" to this immunity. *See Castaneda v. Dep't of Corr. & Rehab.*, 212 Cal. App. 4th 1051, 1070 (2013). Under § 845.6, a public entity may be liable for a prisoner's injuries if "the employee [acting within the scope of his employment] knows or has reason to know that the prisoner is in need of immediate medical care and he fails to take reasonable action to summon such medical care." Cal. Gov't Code § 845.6. Accordingly, the County can be liable for common law negligence if a jail employee knew or had reason to know that Hall was in need of immediate medical care and failed to take reasonable action to summon such medical care. *See id.*

[10] The County also raises an immunity argument under California Government Code § 855.6. (County's Reply at 21–23.) Since the County raised this argument for the first time in its Reply, the Court does not address this issue.

The County has only a limited duty to provide prisoners medical care. Liability of public entities under § 845.6 is restricted "to serious and obvious medical conditions requiring immediate care" where the public entity "intentionally or unjustifiably fails to furnish immediate medical care." *Watson v. State*, 21 Cal. App. 4th 836, 841–42 (1993). "The duty to provide medical care to prisoners is limited to . . . cases where there is *actual or constructive knowledge* that the prisoner is in need of immediate medical care and fail to summon such care." *Lucas v. Cty. of Los Angeles*, 47 Cal. App. 4th 277, 288 (1996) (internal citations and quotation marks removed).

Here, Plaintiff argues that the County breached this duty when the deputies failed to timely respond to Hall's suicide attempt. The undisputed facts point otherwise. For there to be liability, the public entity must know or have "reason to know that the prisoner is in need of immediate care." Cal. Gov't Code § 845.6. Plaintiff argues that the deputies knew that Hall was at risk for suicide and should have been watching him more frequently. (Pl.'s Opp'n to County's MSJ at 23.) Plaintiff also argues there was a clear line of sight from the guard station to Hall's cell, so it was possible for the deputies to see Hall hanging himself. (*Id.*) But there is no evidence that the deputies knew or had reason to know that Hall was committing suicide at that particular moment. On April 3, Hall told Clinician Simbolon that he wanted to return to regular housing and requested dayroom time with other people. (SF 216.) Clinician Simbolon found Hall's thought to be illogical at that time. (SF 217.) Besides this interaction with the therapist three days earlier, Plaintiff offers no evidence that Hall's suicidal condition required immediate medical care on the day in question. Plaintiff also cites no authority for the proposition that a suicide attempt creates a duty to protect in perpetuity. After another inmate alerted jail staff to the suicide attempt, it is undisputed that the staff responded immediately. (SF 20, 22, 219, 254.) This response came roughly 12 minutes after the staff last communicated with Hall. (*Id.*) Moreover, to the extent Hall needed mental health care for his persisting suicidal state, Hall was under psychiatric care at the time of his suicide

and remained housed in Module L, the designated housing for mentally ill inmates. Section 845.6 does not impose a duty to monitor the quality of care provided. *See Watson*, 21 Cal. App. 4th at 843. Rather, § 845.6 simply creates a duty to "summon" care, an "obligation to help that does extend to 'furnishing, monitoring, follow-up, or subsequent care for the same condition' for which care was originally summoned." *Estate of Pradad ex rel. Prasad v. Cty. of Sutter*, 958 F. Supp. 2d 1101, 1117 (E.D. Cal. 2013) (quoting *Castaneda*, 212 Cal. App. 4th at 1074).

Plaintiff's negligence claim also fails for lack of causation. A failure to summon immediate medical care is not the proximate cause of Hall's death. In *Lucas v. City of Long Beach*, a juvenile inmate committed suicide while in custody, after an officer failed to conduct the required hourly safety checks for almost three hours. 60 Cal. App. 3d 341, 345 (1976). The jury found in favor of the decedent's mother on her wrongful death claim against the city. The state appellate court overturned the jury verdict, holding that the juvenile's suicide was a superseding cause of harm. *Id.* at 351 ("The intentional act of a third person is a superseding cause of harm and relieves the original actor of liability unless such act was reasonably foreseeable or the failure to foresee such act was a factor in the original negligence."). Similar to *Lucas*, Hall's suicide is the superseding cause of harm. The cause of death was Hall's suicide attempt, not the jail's failure to provide immediate medical care. Hall spoke with jail personnel and other inmates less than thirty minutes before his suicide attempt. There is no evidence that Hall indicated a desire to take his own life at that time.

Accordingly, the County's motion for summary judgment on the negligence claim is **GRANTED**. Since Plaintiff's wrongful death claim depends on a viable claim for negligence, the Court also **GRANTS** the County's motion for summary judgment on the wrongful death claim.

V. CONCLUSION

For the foregoing reasons, the Individual Defendants' motion for summary judgment is **GRANTED** and the County's motion for summary judgment is **GRANTED IN PART** and **DENIED IN PART**.[11] The Court grants summary judgment in favor of the Individual Defendants to all claims against them. The Court grants summary judgment to the County on the ADA and Rehabilitation Act, negligence, and wrongful death claims. The Court denies summary judgment on Plaintiff's *Monell* claims against the County, to the extent the claims are based on HCA's coverage of psychiatrists at the jail and OCSD's failure to implement half-hour safety checks and supervise self lockdowns.

DATED: October 31, 2018

CORMAC J. CARNEY
UNITED STATES DISTRICT JUDGE

[11] Plaintiff's request for judicial notice is DENIED AS MOOT, as the Court did not need to rely on these documents. (*See* Dkt. 139.) Except as otherwise discussed, Defendants' objections to Plaintiff's evidence are MOOT, since the Court did not rely on this evidence. (*See* Dkt. 148.) The Court DENIES Plaintiff's request for further discovery under Federal Rule of Civil Procedure 56(d). There is not good cause for further discovery. The Court has extended the discovery cut off on three occasions, (Dkts. 35, 54, 85), and Judge Standish has recommended that this Court not reopen discovery, (*see* Dkt. 146).