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GLENN, U.S. DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

BY: **MYN** DEPUTY

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

ROCHELLE NISHIMOTO, individually
and as Successor in Interest to Jason
Nishimoto,

Plaintiff,

v.

COUNTY OF SAN DIEGO; Does 1-100,
Defendants.

Case No.: 3:16-cv-01974-BEN-JMA

**ORDER DENYING DEFENDANT'S
MOTION TO DISMISS FIRST
AMENDED COMPLAINT**

Before this Court is Defendant's Motion to Dismiss Plaintiff's First Amended
Complaint. (Docket No. 11.) The motion is fully briefed. The Court finds the Motion
suitable for determination on the papers without oral argument, pursuant to Civil Local
Rule 7.1.d.1. For the reasons set for below, Defendant's motion is **DENIED**.

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1 **BACKGROUND^{1,2}**

2 Decedent Jason Nishimoto (“Jason”) was a troubled man who was diagnosed with
3 schizoaffective disorder when he was eighteen years old. At the time of his death, Jason
4 was forty-four years old. Despite his diagnosis, Jason independently managed his
5 medical care and held gainful employment. Prior to the subject incident, he had no
6 criminal history and had shown himself to be a high-functioning paranoid schizophrenic.

7 Approximately five months prior to his death, Jason became overwhelmed by the
8 side effects of his medication. However, he continued to take his medication to control
9 his paranoid delusions and the active hallucinations that accompanied his schizophrenia.
10 On May 27, 2015, Jason had a conversation with his mother, Plaintiff and Successor in
11 Interest Rochelle Nishimoto (“Rochelle”), which resulted in Rochelle taking Jason to Tri-
12 City Medical Center (“Tri-City”) to be placed in a 5150 Hold for his suicidal ideations.
13 Jason’s medical history showed he had a history of self-harm attempts, and Tri-City
14 admitted him under a 5150 Hold “for danger to self and others.”

15 On July 5, 2015, Jason attempted suicide by intentionally overdosing on one of his
16 prescriptions. Jason then told Rochelle what he had done, and Rochelle and her other
17 son, Adrian, called 911. Jason was taken to Tri-City and placed on another 5150 Hold
18 for his suicidal ideations. While in Tri-City’s care, Jason tried to hang himself, but
19 psychiatric professionals intervened.

20 On August 19, 2015, Jason again attempted to commit suicide by overdosing on
21 one of his medications. Rochelle immediately called 911, and Jason was taken back to
22 Tri-City and admitted on a 5150 Hold for his suicidal ideations. This time, his
23 commitment was extended to fourteen days.

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26 ¹ The factual allegations are drawn from the First Amended Complaint (“FAC”). (Docket
27 No. 10.) The Court is not making findings of fact.

28 ² Plaintiff’s FAC contains largely the same allegations as her initial Complaint.
Therefore, the Court repeats the overview of facts from its November 4, 2016 Order
(Docket No. 9), and new allegations will be discussed where relevant to its analysis.

1 On September 25, 2015, Jason made a third suicide attempt, again overdosing on
2 one of his medications. This time, when Rochelle and Adrian attempted to intervene,
3 Jason was resistant, and there was a physical altercation between Jason and Adrian.
4 Adrian called 911, and when the sheriffs arrived, Adrian informed them of Jason's
5 schizophrenia and contemporaneous suicide attempt. Adrian also advised the sheriffs of
6 Jason's history of mental illness and prior suicide attempts.

7 The sheriffs arrested Jason for assault despite Adrian's representation that he
8 would not press charges. Jason was taken to Tri-City, who released him back to the
9 sheriffs' custody less than an hour later. Jason was then transported to the Vista
10 Detention Facility ("VDF").

11 Rochelle first learned that Jason was incarcerated at VDF the following day, when
12 she received a phone call from a VDF psychiatric nurse. The nurse advised Rochelle that
13 she had attempted to evaluate Jason, but was unsuccessful because he was too disoriented
14 and could not answer her questions. The nurse stated her belief that Jason was
15 schizophrenic and requested information about his medications.

16 Rochelle informed the nurse of Jason's illness and medication needs, and that he
17 had several recent suicide attempts. Rochelle also informed the nurse that Jason had
18 attempted suicide moments before he was arrested. The nurse told Rochelle that she
19 would expedite his psychiatric evaluation to September 27, 2015, but did not think his
20 medication would be approved because it was too expensive.

21 While Jason was held at VDF, he did not receive his medications. He was housed
22 in an "Ad-Seg" cell, which is not an observation or safety cell. The day after Rochelle's
23 phone call with the VDF nurse, Jason was found hanging from an air vent with a noose
24 made from his bed sheet.

25 If Jason had been housed in a safety cell, he would have been monitored every 15-
26 30 minutes, and would have been monitored by a mental health professional at least
27 daily. Additionally, safety cells do not contain fixtures, bedding, and clothing, which
28 serve to prevent opportunity and means for suicide attempts.

1 the municipality adopted a policy that amounts to “deliberate indifference to the rights of
2 the person with whom the [untrained employees] come into contact.” *Id.*

3 “Deliberate indifference” is characterized as a “stringent standard of fault requiring
4 proof that a municipal actor disregarded a known or obvious consequence of his action.”
5 *Connick*, 563 U.S. at 61 (quoting *Board of Comm’rs of Bryan Cnty. v. Brown*, 520 U.S.
6 397, 410 (1997)). For example, a city may be deemed deliberately indifferent if its
7 policymakers choose to retain a program which they have actual or constructive notice
8 that one of their training programs causes city employees to violate citizens’
9 constitutional rights. *See id.* On the other hand, a “city’s ‘policy of inaction’ in light of
10 notice that its program will cause constitutional violations ‘is the functional equivalent’
11 of a decision by the city itself to violate the Constitution.” *Id.* at 61-62 (quoting *City of*
12 *Canton v. Harris*, 489 U.S. 378, 389 (1989) (O’Connor, J., concurring in part and
13 dissenting in part)). When bringing a Section 1983 failure to train claim, “[a] pattern of
14 similar constitutional violations is ‘ordinarily necessary’ to demonstrate deliberate
15 indifference.” *Connick, supra*, 563 U.S. at 62 (citing *Bryan Cnty., supra*, 520 U.S. at
16 409).

17 As Defendant points out and Plaintiff acknowledges, the Court previously found
18 Plaintiff’s initial Complaint lacked specific factual allegations of a pattern of similar
19 constitutional violations that Defendant was aware of other suicides occurring under
20 similar circumstances as Jason’s suicide. In Plaintiff’s FAC, there are new allegations
21 that two years prior to Jason’s September 2015 death, “there were at least six (6) suicides,
22 associated with inmates suffering from mental health conditions, each preceded by
23 obvious triggers and/or warning signs, either directly from the inmate or their family, that
24 were blatantly ignored” by the County’s employees at multiple San Diego County
25 detention facilities. (FAC ¶ 108.) The FAC describes the six suicides as follows:

- 26 1) In or around February 2013, Robert Lubsen was detained in a San Marcos
27 campus holding cell, where he attempted to hang himself with his shoelaces.
28 (FAC ¶ 77.) Campus police observed and intervened. (*Id.*) The following

1 day, Mr. Lubsen was transferred to VDF, where intake noted he had ligature
2 marks around his neck. (*Id.*) VDF also “received a tip that [Mr. Lubsen]
3 was a risk to himself,” but County sheriffs “determined the tip was not
4 credible.” (*Id.*) Mr. Lubsen subsequently committed suicide. (*Id.*)

- 5 2) During a security check, County deputies discovered Jose Sierra hanging
6 from a bed sheet. (*Id.* ¶ 102.) During the previous security check, the
7 deputies observed an “unauthorized laundry line affixed to the top bunk in
8 Sierra’s cell, and failed to take corrective action per Sheriff’s Policies [sic] &
9 Procedures.” (*Id.*) The deputies “failed to remove the unauthorized laundry
10 line or confront Sierra to direct its removal, actions which may have
11 prevented Sierra from carrying out the suicide at that time.” (*Id.*)
- 12 3) On April 28, 2013, Anna Wade was found “hanging in her cell.” (*Id.* ¶ 103.)
13 A County deputy “violated policy and procedure by logging a security check
14 that did not actually happen.” Deputies are supposed to make hourly checks,
15 but “two hours passed between when Wade was last seen alive and when she
16 was found hanging in her cell.” (*Id.*)
- 17 4) Hector Lleras, a schizophrenic, separately advised a Central Jail nurse and
18 deputy that he was going to kill himself. (*Id.* ¶ 104.) “[H]e was put in a
19 safety cell, and released 24 hours later. Almost hours after that, he was
20 found hanging in his . . . cell.” (*Id.*)
- 21 5) In 2014, Christopher Carroll, a mentally ill homeless man, was placed in Ad-
22 Seg because he was unable to get along with other inmates. (*Id.* ¶ 105.) He
23 “scrawled a suicide note on his cell walls in blood” and “[p]rior to hanging
24 himself, he urinated on the floor and stuck feces and food to the ceiling of
25 his cell.” (*Id.*) He was never transferred from the Ad-Seg cell. (*Id.*)
- 26 6) Jonathan Thomas, a paranoid schizophrenic, had made multiple suicide
27 attempts at Atascadero State Hospital. (*Id.* ¶ 106.) Additionally, in 2008, he
28 jumped from a second tier while he was held at George Bailey. (*Id.*) The

1 Central Jail had knowledge of each of these incidents. (*Id.*) In 2014, Mr.
2 Thomas was transferred from Atascadero to Central Jail for a routine
3 commitment hearing, and housed him on a second tier cell. (*Id.*) “Days
4 later Mr. Thomas jumped from the second tier sustaining severe injuries.”
5 (*Id.*)

6 7) In February 2004, Kristopher NeSmith hung himself from his general
7 population cell. He had severe mental and personality disorders, and had
8 made previous suicide attempts while in custody. (*Id.* ¶ 106.) An hour
9 before he was found dead in his cell, a County deputy “saw a noose hanging
10 from NeSmith’s light fixture. Instead of taking proactive measures, the
11 deputy said, ‘NeSmith, what are you trying to do? Kill yourself? Take that
12 thing down!’” (*Id.*)

13 In addition, Plaintiff alleges that prior to Jason’s death, the Citizens Law
14 Enforcement Review Board (“CLERB”), an independent oversight body, “has twice
15 found that San Diego County sheriffs’ deputies violated policy and procedure in instances
16 of inmate suicides.” (*Id.* ¶ 101.) The first instance was Mr. Sierra, and the second was
17 Ms. Wade, discussed above.

18 Defendant attempts to revive its prior argument that Plaintiff is required to allege a
19 pattern of *adjudicated* constitutional violations to maintain a municipal federal rights
20 claim. Relying on *Connick*, Defendant re-asserts that the pattern of constitutional
21 violations must be based on “adjudicated fact,” lest the Court “inevitably be engulfed by
22 having to conduct trials within trials to ascertain whether in each instance a constitutional
23 violation occurred[.]” (Def.’s Mot. to Dismiss, Docket No. 11-1 at 8.) The Court is not
24 persuaded that *Connick* supports Defendant’s assertion.

25 In *Connick*, the Supreme Court found the respondent did not establish a pattern of
26 constitutional violations because the *Brady* violations he identified were dissimilar to the
27 *Brady* violation he suffered. *Connick, supra*, 563 U.S. 62-63. In its discussion, the
28 Supreme Court noted that the respondent had “every incentive at trial to establish a

1 pattern of similar violations, given that the jury instruction allowed the jury to find
2 deliberate indifference based on, among other things, *prosecutors' 'history of*
3 *mishandling' similar situations.*” *Id.* at 63 n. 7 (internal citation omitted) (emphasis
4 added). Notably, the *Connick* Court did not use the term “adjudication” and accepted the
5 petitioner’s concession that a *Brady* violation occurred against the respondent. *Id.* at 57
6 n. 3. Moreover, the *Connick* Court appears to have contemplated that the respondent
7 could have established the pattern with evidence of un-adjudicated “mishandling” of
8 “similar situations.” *Id.* at 63 n. 7.

9 In short, the reasoning and language in *Connick* contradicts the conclusion
10 Defendant asks this Court to draw. The Court remains unconvinced by Defendant’s
11 arguments as to this issue, and incorporates by reference its reasoning in its November 4,
12 2016 Order finding Plaintiff need not allege the existence of specific verdicts against
13 Defendant for constitutional violations in order to maintain her action. (Docket No. 9.)

14 Finally, Defendant contends that the above incidents are not similar enough “to
15 establish allege [sic] occurrence of a pattern of similar constitutional violations
16 attributable to a common program deficiency, common circumstances, or common jail
17 personnel.” (Def.’s Mot. to Dismiss, Docket No. 11-1 at 5.) To support its contentions,
18 Defendant points to the fact that the FAC does not allege that the suicides occurred at the
19 same facility, and that the individual inmates committed suicide under dissimilar
20 circumstances. However, Defendant’s position ignores the crux of Plaintiff’s FAC,
21 which is that there is a systemic deficiency in the manner in which the County addresses
22 inmates exhibiting suicidal ideations, and this deficiency amounts to the adoption of a
23 policy deliberately indifferent to inmates’ rights. The new allegations regarding other
24 inmate suicides both at VDF and other County-operated facilities supports this claim.

25 In addition, Defendant’s arguments focus heavily on Plaintiff’s failure to provide
26 proof of her allegations of similar suicides. But Plaintiff is not required to prove her
27 allegations to survive a 12(b)(6) motion to dismiss. Rather, a plaintiff need only plead
28 factual allegations which, taken as true, indicate a plausible claim for relief. *See Fed. R.*


1 Civ. P. 12(b)(6); *Twombly*, 550 U.S. at 556–57. The Court finds Plaintiff has met her
2 burden. Accordingly, Defendant’s Motion to Dismiss as to this claim is **DENIED**.

3 **CONCLUSION**

4 For the reasons stated above, the Court **DENIES** Defendant’s Motion to Dismiss
5 the Second, Third, and Fourth Claims for Relief in Plaintiff’s First Amended Complaint.

6 **IT IS SO ORDERED.**

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8 DATED: June 20, 2017

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10 HON. ROGER T. BENITEZ
11 United States District Judge
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