No. 23-20502

United States Court of Appeals for the Fifth Circuit

KIMALETHA WYNN; JEANIQUE McGINNIS, as next friend of K.Y., R.Y., and M.Y., minors; VALENE HOSKINS, as next friend of M.Y.; CHRISTINA BLUEFIELD PICKETT, as next friend of C.Y.,

Plaintiffs – Appellants

VINCENT LEDAY; MELANIE YOUNG, as representative of the Estate of GWENETTA YOUNG; SHARONDA DONATTO, as next friend P.Y.; RESHAN GEORGE, as next friend M.Y.; PHYLLIS SMITH, as next friend C.Y.

Intervenor Plaintiffs - Appellants

v.

HARRIS COUNTY, TEXAS; SHERIFF ED GONZALEZ; PATRICIO LAU; ABRAHAM ROMERO; LEESA BROWN

Defendants - Appellees

Appeal from the United States District Court for the Southern District of Texas in Case No. 4:18-CV-4848, the Honorable Keith Ellison

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BRIEF OF APPELLEE HARRIS COUNTY, TEXAS

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Fifth Circuit Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

Appellants:	**Counsel for Appellants:**
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Harris County, Texas	Appeal Counsel: Seth Hopkins Harris County Attorney's Office Houston, Texas Trial Counsel: Rachel Fraser Suzanne Bradley Harris County Attorney's Office Houston, Texas
Dr. Patricio Lau	Appeal Counsel: Michelle Robberson Cooper & Scully, P.C. Dallas, Texas Frank Doyle Myers, Doyle Houston, Texas

/s/ Seth Hopkins
Attorney of record for Harris County, Texas

STATEMENT REGARDING ORAL ARGUMENT

Pursuant to Federal Rule of Appellate Procedure 34(a) and Fifth Circuit Rule 28.2.3, Appellee Harris County believes oral argument is unnecessary because the dispositive issues have been authoritatively decided, the facts and legal arguments are adequately presented in the briefs and record, and the decisional process would not be significantly aided by oral argument.

After 56 months of litigation, thorough discovery, and an 8,118-page record, the material facts in this case are well-established and undisputed. Appellants have no evidence to support the existence of an official custom or policy enacted with deliberate indifference that was the moving force behind any violation of Vincent Young's constitutional rights under *Monell v. Department of Social Services of City of New York*, 436 U.S. 658 (1978). This court recently, regularly, and authoritatively rules on *Monell* claims, and while the record is lengthy, the issues in this case are not complex or nuanced.

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RESPONSE TO STATEMENT OF THE ISSUES

Of the four issues identified by Appellants, only the third directly applies to Harris County. Harris County respectfully suggests that Appellants' third issue should be more precisely divided into two issues as follows:

Issue 3(a): Whether the district court correctly found that Harris County cannot be liable under *Monell v. Department of Social Services of City of New York*, 436 U.S. 658 (1978) when its physicians used their medical judgment to prescribe a Librium taper and Ativan to ease Vincent Young's Xanax addiction and anxiety after he successfully completed this protocol at least three times before.

Issue 3(b): Whether the district court correctly found that Harris County cannot be liable under *Monell v. Department of Social Services of City of New York*, 436 U.S. 658 (1978) when its policies followed all state laws, it trained staff to comply with these policies, and it followed the recommendations of licensed medical personnel in housing, treating, and supervising Vincent Young.

STATEMENT OF THE CASE

I.
FACTS

A. The Harris County Jail repeatedly screened Vincent Young for physical and mental illness and provided prompt medical attention.

On February 2, 2017, Vincent Young violated the conditions of his bail when his parole officer discovered he was a felon in possession of a firearm and he failed drug tests for opiates, marijuana, and benzodiazepine. ROA.3645. On February 7, Mr. Young was brought to the Harris County Jail, where medical and mental health personnel screened him for physical and psychological conditions requiring treatment. ROA.3517; ROA.6709-6780. None of his medical records from either the jail or local hospitals indicate he was ever diagnosed with any psychiatric disorder, prescribed any antipsychotic medication, or visited any community mental health centers. ROA.3650-3651.

1. Mr. Young denied any suicidal thoughts or attempts and acknowledged that he knew how to request medical assistance.

During his February 7, 2017 intake examination, Young claimed to have back pain and be under the influence of marijuana. ROA.6710. He acknowledged taking Xanax (benzodiazepine), Norco (Vicodin), lisinopril, and marijuana. ROA.6710. He had long-standing high blood pressure and reported a history of anxiety and depression but was alert and responsive. ROA.6710. Most importantly, he denied

having any thoughts of suicide and denied having ever attempted suicide in the past. ROA.6711. Medical staff explained to Young how to request medical and mental health care while in jail, and Young verbalized his understanding.[1]

During his last incarceration at the Harris County Jail three months earlier, Young similarly reported no thoughts of suicide, suicide attempts, feelings of hopelessness, history of depression, concerns that his arrest would affect his job, position, spouse, or custody of his children, or history of receiving services for emotional or mental health problems. ROA.6711-6712. He also reported no disability or chronic illness, no history of drug or alcohol abuse, and no concern about having withdrawal symptoms while in jail. ROA.6711.

The Harris County Jail had medical records for Young dating to March 29, 2007. ROA.3651-3666. Each time he was brought to jail, Young was asked about any mental health problems, and nothing in any of these records indicated any risk of taking his life. See, e.g., ROA.3646; ROA.3651; ROA.3667; ROA.6961-7248.

[1] "Patient encouraged to submit SCR [Sick Call Request]/RTC PRN [Return To Clinic *Pro Re Nata* (as needed)] to access non emergent care in the medical and/or MHC [Mental Health Clinic]. Patient verbalizes understanding." ROA.6712.

2. During a February 8, 2017 follow-up medical exam, Mr. Young again denied suicidal thoughts, and although he showed no signs of drug withdrawal, he claimed to have a drug addiction and was prescribed medication to help with detoxification.

The following day, on February 8 at 8:21 a.m., Mr. Young was brought back to the jail medical clinic to recheck his blood pressure, address his back pain, and provide him with assistance going through detoxification. ROA.6713. He reported sporadically taking blood pressure medication,[2] using "1-2 blounts/day, [N]orco tabs daily…[X]anax 4 mg/day with last dose taken 2/6/17." ROA.6713. He reported a prior history of anxiety and again denied suicidal ideation or homicidal ideation.[3]

During this visit, medical staff saw no signs or symptoms of withdrawal for either benzodiazepines or opiates.[4] Nevertheless, out of an abundance of caution, the clinic still prescribed a "[L]ibrium taper" to ease his transition off of Xanax (benzodiazepine) and an "opiate taper" to ease his transition off of Norco (an opioid). ROA.6715. The jail clinic prescribed him chlordiazepoxide (Librium),

[2] "…currently on Lisinopril 20 mg daily and HCTZ 25 mg daily with last dose taking one week ago. Patient states he only takes medication 'when he needs it'." ROA.6713.

[3] "He denies SI [Suicidal Ideation]/HI [Homicidal Ideation]." ROA.6713.

[4] "Benzo abuse: reports taking Xanax 4 mg daily for anxiety. Last dose 2/5. No s/s [signs or symptoms] of withdrawl on exam. Opiate abuse: reports taking [N]orco 2 tablets daily (dose unknown). Last dose 2/5, no s/s [signs or symptoms] of withdrawl on exam." ROA.6715.

loperamide, promethazine, lisinopril, hydrochlorothiazide, clonidine, and acetaminophen.[5]

The clinic also ordered bloodwork and a chemistry profile and placed Young on a low-sodium diet. It ordered a follow-up in three days to monitor his detox ("f/u [follow-up] detox") ROA.6716. Within two hours, his blood pressure was stable, and he returned to general population with his prescription. ROA.6719.

3. During a February 10, 2017 follow-up medical exam, Mr. Young again denied suicidal thoughts, and when he mentioned having psychiatric problems when he was eight years old, staff again confirmed that he knew how to request mental health services.

On February 10, LPHA Lamonica Kinch[6] followed up to monitor Mr. Young's health and detoxification regimen. Young told Kinch that his mood was "kind of alright" but complained about anxiety and depression, and for the first (and only) time, reported that at age eight, he may have been in a psychiatric hospital "for unknown reasons."[7] He also claimed—for the first (and only) time—to have had a prescription by a "Dr. Lee" for Xanax since age 17.[8]

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[5] ROA.6715. This taper is consistent with medical standards in correctional settings. ROA.3651.

[6] An LPHA is a Licensed Practitioner of the Healing Arts, which is a designation created by Texas Occupations Code § 104.001, *et seq.*

[7] Young contradicted this during every other medical visit by stating he was never hospitalized for psychiatric reasons. ROA.3667.

[8] ROA.6725-6726. Young admitted to jail staff on September 11, 2011 that he illegally used Xanax (ROA.3653), and a positive drug test led to his arrest in 2017. This February 10, 2017 clinic note is the only time Young suggested he had a prescription for Xanax.

Young reaffirmed that he had no hallucinations, never attempted suicide, and had no current suicidal or homicidal ideations.[9] The clinic again educated Young on how to request mental health services and Young "verbalized understanding." ROA.6727.

During litigation, Appellants were never able to identify "Dr. Lee" or produce evidence to substantiate their claim that Young had a medical need for Xanax. Kimaletha Wynn, Young's wife, testified that Young's only prescription medication was for blood pressure, which he kept in a bathroom drawer. ROA.3618-3620. She never heard of a "Dr. Lee" and was not aware of Young regularly seeing any doctor. ROA. 3621-3622.

Ms. Wynn never heard her husband talk about being depressed, suicidal, or needing to take Xanax or any other medication for depression ROA.3623-3624. Young called his wife three or four times per day while in jail in February 2017 and Harris County produced recordings of each call. It is undisputed that Young never mentioned being depressed, suicidal, or needing Xanax or any other medication. ROA.3627-3628; ROA.3441-3449.

[9] ROA.6725. ("PT denied current AVH [auditory or visual hallucinations] . . . PT denied past suicide attempt. PT denied current SI [Suicidal Ideation]/HI [Homicidal Ideation].")

Similarly, Young's father admitted in requests for admissions that he knew his son took Xanax but had no knowledge of any "Dr. Lee," any medical need or mental health condition to justify needing Xanax, any prescription or pharmacy that might have legally dispensed Xanax to Young, or any psychiatric hospitalizations as a child. ROA.3614; ROA. 3648-3649; ROA.5801-5802.

4. Although Mr. Young never reported any suicidal thoughts, on February 12, a Harris County detention officer acted on a tip and referred Mr. Young for mental health screening.

On February 12 at 12:20 a.m., Young was housed in general population when he asked to speak with Detention Officer Levant Dogan. Officer Dogan asked Young what was bothering him, but Young did not answer and returned to his cell. ROA.6783.

Ten minutes later, Marlon Weatherspoon, another detainee,[10] approached Officer Dogan and said Young "was normal" at bedtime a few hours earlier, but that he had just overheard him make a comment suggesting he might be suicidal. ROA.3430. Officer Dogan took the initiative to move Young to a special cell and refer him for psychiatric screening. ROA.3518; ROA.6781; ROA.6783. Both Officer Dogan and a second set of officers tried to talk to Young, but he "never said

[10] While the words "detainee" and "inmate" are used interchangeably in the record, most people in the Harris County Jail are pretrial detainees, rather than convicted inmates. For purposes of this case, there is no legal distinction.

anything" about being suicidal. ROA.3430. Still, Officer Dogan completed the referral paperwork, and the second set of officers transferred Young to a holdover cell to be screened by a mental health officer.[11]

5. Medical professionals did not find Mr. Young to be a suicide risk, but they took him to the emergency room because they were concerned he may be having a stroke, seizure, or withdrawal.

On February 12 at 7:15 a.m., mental health staff arrived to talk to Mr. Young and found him:

> …laying on the floor of the elevator lobby holding cell, speaking to another inmate… When I asked the FCC officer to open the door Inmate Young closed his eyes and pretended to snore. I shook Inmate Young several times to get his attention, he continued to lay there and make noises as if he were asleep. I told Inmate Young that if he would not speak with me, I would conclude my interview and turn in his Referral [for mental health services].

ROA.6781. While Appellants state in their Brief that Young was found "unresponsive…while awaiting a psych referral" (Appellants' Brief at 6), Mental Health Officer Harold Layton explained at deposition that he described Young as unresponsive because he would not speak to him and that Young's eyes were open and he was awake. If Young had been unconscious, Officer Layton testified he would have used the word "unconscious." ROA.7851.

[11] ROA.6786-6788. Appellants complain that it took several hours until the morning shift for medical staff to see Young. Appellants' Brief at 5-6 & 36-37. However, there is no evidence that Young was harmed by this wait in the holding cell.

Further, while Appellants complain that "there was *nothing* passed on to the incoming shift of detention officers regarding Young's reportedly being suicidal or his referral for a psychiatric evaluation" (Appellants' Brief at 6), that is also not true.[12] Officer Dogan completed psychiatric referral paperwork and moved Young from general population to the holding cell so he could be seen by medical personnel. That referral was passed on, and Young was provided medical treatment.

Young was brought from the holding cell to the clinic where he was found to be in moderate respiratory distress and spontaneously opening and closing his eyes. ROA.3518; ROA.6732-6735. His blood pressure was high, and the clinic transferred him to Ben Taub Hospital to make sure he was not having a stroke (CVA), new onset seizure, or withdrawal symptoms. ROA.6732-6733; ROA.3660.

6. Ben Taub Hospital conducted numerous tests, stabilized Mr. Young's blood pressure, and discharged him to jail the same day.

Ben Taub Hospital found Young to be confused and disoriented, and he demanded to be released with "a pain pill" despite not complaining of any pain. ROA.3966. Despite his mild and temporary confusion, the hospital's physicians saw

[12] Appellants cite ROA.6789-6793, which is a statement by former Detention Officer Abraham Romero. Romero never saw Young on February 12 and could not have testified about what happened that day.

no evidence of depression, distress, hallucinations, memory loss, or agitation, and Mr. Young was awake, alert, and oriented to place, year, and name.[13]

Hospital physicians conducted a CT scan of Young's head, an EKG, chest x-rays, and blood and urine tests that found a high white blood count (Leukocytosis) that the doctors dismissed as likely being Young's baseline. ROA.3961-3962; ROA.3966; ROA.3973-3974; ROA.3987-3988. He also tested positive for benzodiazepine and cannabinoids. ROA.3971. There is no indication that hospital staff believed Young was suicidal. ROA.3650; ROA.3660; ROA.6736.

7. Medical staff admitted Mr. Young to the infirmary and monitored him closely while he underwent detoxification.

To ensure continuity of care, the jail clinic required the hospital to contemporaneously send Young's medical records, laboratory and radiological tests, and other materials. ROA.6734. Based on the hospital's findings, Dr. Patricio Lau restarted Young's blood pressure medication, continued the drug taper, and monitored his blood pressure in two-hour intervals. ROA.6736-6740.

Rather than release him into the general population, medical staff housed Young in the infirmary so they could more closely monitor him as he detoxified. On

[13] ROA.3963-3966. Dr. Joseph Penn notes that confusion and delirium during withdrawal is a temporary condition and "not a type of a chronic psychotic disorder." ROA.3651.

February 12 at 10:59 p.m., Dr. Lau noted: "Pt likely to be withdrawing, will increase to Librium protocol and admit to infirmary." ROA.3518; ROA.6740-6741.

On February 13 at 9:30 a.m., Registered Nurse Kennikqua Thompson noted Young was "ambulatory, and able to make needs known." He was "slightly drowsy" and discussed his medical history but "denies any other significant medical complaints at this time." ROA.6757. Still, medical staff wanted to schedule a psychiatric evaluation once he completed his detox treatment. ROA.6757-6758.

Ten minutes later, at 9:40 a.m., Young reported to medical staff that he had a history of anxiety and depression, but no history of psychiatric hospitalizations, no suicidal ideations, no history of suicidal behavior, was not hearing voices, did not want to hurt himself, and did not want to hurt others. He declined any psychiatric evaluation and said he understood how to request psychiatric help.[14]

At 11:45 a.m., Registered Nurse Thompson again checked on Young. She found him to be ambulatory and able to make his needs known. He again denied suicidal ideations, homicidal ideations, auditory hallucinations, or visual

[14] ROA.6761-6762. ("Pt denies SI [Suicidal Ideation], HI [Homicidal Ideation], AH [Auditory Hallucinations], or VH [Visual Hallucinations] at this time. . . Pt declines psych eval at this time. Pt advised to SCR [Sick Call Request]/RTC [Return to Clinic]/notify nursing staff for any pscyh concerns. Pt verbalized understanding.") See also, ROA.3665.

hallucinations. He again confirmed that he understood how to request assistance for any psychological concerns. ROA.6762; ROA.3665.

At 3:28 p.m., Medical Assistant Bora Yskollari took Young's vital signs and found him to be calm. ROA.3416. She understood that Young was housed in the infirmary "because he was detoxing off of some type of substance," and that while detainees who are detoxing are normally placed with others in a larger cell, Young had been "placed inside a single person cell do [sic] to his behavioral issues"[15]

At 3:37 p.m., Licensed Vocational Nurse Charles Ruhamya again checked on Young and found no changes in his psychological status. His blood pressure had improved to 105/63. ROA.3665.

Video evidence shows that Young was fed at 3:39 p.m. ROA.3461. At 4:03 p.m., Dr. Gaston Casillas, a physician, signed a progress note finding that Young's clinical status had not changed. ROA.3665. At 4:49 p.m., Licensed Vocational Nurse Kadiana Lee-Walker screened Young and found no new clinical issues. ROA.3665. Video footage shows that a nurse had contact with Young at 5:11 p.m. ROA.3461.

[15] ROA.3416. Young had a long history of violence during previous incarcerations at the Harris County Jail. He fought with a peer, barricaded himself in his cell, refused to obey orders, and engaged in assaultive behavior which required him to be placed in administrative segregation to protect inmates and staff. ROA.3645; ROA.3651. When medical staff tried to take his history during a 2007 incarceration, he "became combative and noted to be banging on the door." ROA.3651. While incarcerated in 2014, Young "took someone else's Thorazine," was often non-compliant with his medication, and refused health services. ROA.3652. Although Young was violent toward others, there was never any indication that he was at risk of harming himself.

8. While medical staff monitored Mr. Young's physical and mental condition, detention officers independently checked on him every 25 minutes.

Medical staff were not the only people checking on Mr. Young. The Texas Commission on Law Enforcement requires jails to observe detainees every 60 minutes, or every 30 minutes when detainees are "known to be assaultive, potentially suicidal, mentally ill, or who have demonstrated bizarre behavior." Tex. Adm. Code § 275.1.

Out of an abundance of caution, jail staff placed Young into this classification. Harris County's standards are higher than the state standards, and detainees in the clinic must be checked every 25 minutes. ROA.3341. To ensure these standards are met, detention officers supplement medical staff's observations by conducting their own independent observations. They must contemporaneously sign a log at the end of the hallway verifying the exact time they started and ended each round. ROA.3341. This is promulgated as Policy 220—Inmate Observation:

> **II. Policy**
>
> It is the policy of the Harris County Sheriff's Office to establish procedures of accountability for its staff to ensure the safety and security of any inmate in the custody of the Sheriff. It is essential that related records be accurately completed, and serve as a reliable record of Department activity.
>
> **III. Procedure**
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> B. Observation of Separation Cells

1. All inmates either classified or temporarily housed in any separation cell or detoxification cell shall have detailed records kept of their daily activities.

2. Inmates housed or placed in a separation or detoxification cell shall be observed at irregular intervals not to exceed every twenty-five (25) minutes. Inmates shall not be allowed to prevent staff members from observing the interior of the cell by any means, to include obscuring the window(s), doors, or other observation areas with paper, cardboard, clothing, etc.

3. Documentation shall be made on the applicable form.

4. Note: All rounds shall be made in varying routes in order to maintain an irregular schedule and lessen predictability.

5. Criminal Justice Command Form CJCF-219a – Daily Observation Log shall be used to document all observations of inmates housed in separation cells or detoxification cells.

6. Documented Observations
   a. The "Start" field shall be legibly printed to indicate the time the round began.
      i. The interval between round "Start" times shall not exceed 25 minutes.
      ii. The first round of the shift shall be made within 10 minutes after shift change.
      iii. The last round of the watch shall be made no sooner than 10 minutes prior to the shift ending.

   b. The "End" field shall be *legibly* printed to indicate the time the round ended.

   c. The employee shall legibly print their Employee Identification Number (EIN) in the designated field.

> d. On the back of the form CJCF-219a in the "Comment" section, staff members shall not[e] any unusual or significant events observe[d]/found during the round and explain in **detail** if a round was late (fight, medical emergency, etc.)
>
> e. If a round is completed late, the employee must notify his/her on-duty supervisor. The supervisor shall initial the comment section regarding the late round.
>
> f. On the back of form CJCF-219a, staff members assigned to the respective area shall sign the form for their respective watch indicating the information is true and accurate to the best of their knowledge.

ROA.3345-3346.

During the second shift on February 13, 2017, former Officer Abraham Romero was assigned to watch Young. He was properly trained and knew he was "required to conduct visual checks every twenty-five (25) minutes and then document them on the Observation Log (Round Sheet) which is attach[ed] at the end of the hallway." ROA.3353. The logs show that Romero checked on Young at 2 p.m., 2:25 p.m., 2:50 p.m., 3:15 p.m., 3:40 p.m., 4:05 p.m., 4:30 p.m., 4:55 p.m., 5:20 p.m., 5:45 p.m., and 6:10 p.m. ROA.3348.

B. Mr. Young unexpectedly committed suicide.

At 7:10 p.m., Romero found that Young had propped his bed on its side and hanged himself. Romero, Officer Bertram, and several medical staff tried to save Young's life and called for emergency services. ROA.6772; ROA.6777-6778. Young was brought to St. Joseph's Hospital and pronounced dead. ROA.3517.

No one saw or heard anything unusual coming from Young's cell. Detainee Jesse Jones could see Young through the gap below the door. He "did not hear any movement of the lowrider [bed] from inside Young's cell" to indicate that Young was moving his bed into a position to hang himself. ROA.3420. Jones witnessed Harris County Jail staff responding to Young's suicide and stated: "I was surprised to see how well the personnel performed when they responded and reacted to this style of incident. I thought the responding personnel were efficient and effectively handled this incident in a professional manner." ROA.3420.

Detainee Frederico Sanz-Lopez said he may have heard the bed being moved but did not think it was out of the ordinary and "could have mistaken the noise for something else. I feel the staff members were quick to respond to this type of incident." ROA.3420.

C. The Harris County Sheriff's Office thoroughly investigated the incident, fired former Officer Abraham Romero, reported him to the state as being dishonorably discharged, and referred him to the District Attorney's Office for criminal prosecution.

The Harris County Sheriff's Office conducted a thorough Internal Affairs investigation and found that while staff interacted with Young at least seven times between 1:50 p.m. until he was found dead at 7:10 p.m. (ROA.3465), former Officer Romero's logs were not accurate, and he missed checking on Young for 44 minutes longer than allowed by state regulations. Appellants' Brief at 10; ROA.3465. Romero claims he got distracted around 6:09 p.m. escorting a detainee to the clinic and working with Medical Assistant Bora Yskollari, but there are unexplained gaps in his time.[16] Romero was fired, reported to the Texas Commission on Law Enforcement as being dishonorably discharged, and referred to the District Attorney's Office for criminal prosecution. ROA.3341-3347.

The 77-page Internal Affairs Report summarized the Incident Report and 10 supplements related to Young's death,[17] logs documenting how, when, and by whom Young was monitored,[18] 51 phone calls Young made from the jail between February

[16] ROA.3354. Yskollari confirmed that Romero was with her and then left when she completed her rounds. She assumed he was completing his own observation rounds. ROA.3416.

[17] ROA.3395-3402

[18] ROA.3403-3404; ROA.3436-3437

7 and February 11, 2017,[19] Houston fire and police department reports,[20] photographs,[21] and the Autopsy Report.[22] Investigators also reviewed Young's housing classification records (ROA.3435) and Romero's employment history and background. ROA.3410.

Investigators interviewed and summarized statements by three registered nurses,[23] 10 licensed vocational nurses,[24] and three medical assistants[25] who were working in the clinic on February 13. Investigators further interviewed eight detention officers,[26] two sergeants[27] three detainees,[28] and the bail bond agent responsible for Mr. Young's bond. ROA.3414-3415.

Investigators watched 84 hours of video to create a timeline of Young's physical movements from February 10 at 9:47 a.m. until the Internal Affairs Division investigators arrived on February 13 at 9:46 p.m. ROA.3450-3462. They created a second timeline of Young's interactions with medical services between February 7

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[19] ROA.3441-3449.

[20] ROA.3437-3438.

[21] ROA.3409-3410.

[22] ROA.3462-3463.

[23] ROA.3404; ROA.3405; ROA.3407; ROA.3417-3418.

[24] ROA.3405-3408.

[25] ROA.3405; ROA.3406; ROA.3415-3417.

[26] ROA.3411-3412; ROA.3419; ROA.3421-3436.

[27] ROA.3412-3414; ROA.3435.

[28] ROA.3419-3420; ROA.3429.

and the completion of his autopsy on February 14. ROA.3466-3472. These were compared and checked by outside agencies such as the Texas Rangers to verify that the video matched the records. ROA.3463.

Harris County cooperated with investigations from the Texas Attorney General (ROA.3429), United States Department of Justice (ROA.3440-3441), Federal Bureau of Investigations (ROA.3463), Harris County Institute of Forensic Sciences (HCIFS) (ROA.3441), Texas Rangers (ROA.3463-3466), and Harris County District Attorney's Office. ROA.3466.

On February 24, 2017—only 11 days after Romero was 44 minutes late checking on Young, the Sheriff's Disciplinary Review Board sent him a 17-page letter firing him for failing to conduct visual checks of each cell to ensure the detainees were secure and well every 25 minutes and then accurately documenting the start and end time in daily observation logs. As noted, he was also referred for criminal prosecution and reported to the Texas Commission on Law Enforcement as being dishonorably discharged. ROA.3341-3347.

D. The Texas Rangers independently investigated Mr. Young's death and found no violation of state law or standards, except for Officer Romero's 44-minute lapse in checking on Mr. Young.

Texas Ranger James Wilkins reviewed the most recent Harris County Jail inspections conducted by the Texas Commission on Jail Standards, including an inspection on February 21, 2017, and conducted an independent investigation that found no violation of state law or standards, except for Romero's 44-minute lapse in checking on Mr. Young. ROA.3465. Ranger Wilkins also concluded that "the investigation conducted by the Harris County Sheriff's Office adhered to accepted law enforcement principles and investigative techniques." ROA. 3465.

II.
PROCEDURAL HISTORY

Plaintiffs-Appellants Kimaletha Wynn and Jeanique McGinnis, as next friend of K.Y., R.Y., and M.Y., minors, filed suit against Harris County, Texas on December 30, 2018. ROA.38-46. On February 13, 2019, Appellants filed a First Amended Complaint.[29] On May 13, 2019, Appellants filed a Second Amended Complaint.[30] On January 19, 2021, Appellants filed their live pleading—a Fourth

[29] ROA.152-179. Harris County moved to dismiss based on the putative plaintiffs' failure to show standing and capacity to sue under the Texas Survival Statutes and Texas Wrongful Death Statutes. ROA.198-224.

[30] ROA.310-319. Harris County again moved to dismiss. ROA.607-612.

Amended Complaint—which named Harris County, Abraham Romero,[31] Leesa Brown, Lamonica Kinch, Dr. Patricio Lau, Harris Center for Mental Health and IDD, and Ed Gonzalez as defendants.[32]

On January 28, 2021, Appellees moved to dismiss.[33] The District Court dismissed all claims against Harris County except those under *Monell v. Department of Social Services*, 436 U.S. 658 (1978) for failure to monitor and understaffing. ROA.1708-1709; ROA.1718; ROA.3289.

On September 1, 2022, Appellees moved for summary judgment.[34] Harris County and Sheriff Ed Gonzalez argued that Appellants failed to create a genuine issue of material fact that Harris County met all applicable state standards for staffing and medical care and there was no policy promulgated with deliberate indifference that violated Young's constitutional rights.[35]

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[31] Plaintiffs sued—but never served—former Officer Romero, and the district court dismissed him.

[32] ROA.1375-1410. There is not a Third Amended Complaint in the record. See ROA.1375 at fn. 1.

[33] Harris County and Sheriff Ed Gonzalez's motions are at ROA.1412-1421. The Harris Center for Mental Health and IDD and Lamonica Kinch's motions are at ROA.1422-1435. Leesa Brown's motion is at ROA.1436-1443. Dr. Patricio Lau's motion is at ROA.1444-1454.

[34] Sheriff Ed Gonzalez's motion is at ROA.2543-3279. Harris County's motion is at ROA.3280-4838. Dr. Patricio Lau's motion is at ROA.4986-5294.

[35] Harris County's summary judgment record includes its brief (ROA.3280-3315), 24 exhibits (ROA.3316-4838), and a hard drive containing the second part of Exhibit 7. (625 files Bates labeled HC\YOUNG 150-161; HC\YOUNG 565-747; and HC\YOUNG 4765-5196.) ROA.5295-5297.

On October 12, 2022, Appellants responded to the motions for summary judgment. ROA.6253-6675. On October 17, 2022, they filed corrected responses. ROA.7311-7754. Harris County replied on November 21, 2022. ROA.7773-7864. Harris County also objected to Exhibits 6, 10, 11, 12A, 12B, and 15 of Appellants' response[36] and moved to strike or limit the testimony of economist Dr. Kenneth Lehrer[37] and social worker Harvey Norris. ROA.4867-4985; ROA.5298-5304. Response at ROA.5382-5441 and Reply at ROA.5540-5545. (Response to Motion to Strike Harvey Norris at ROA.5338-5381 and Reply at ROA.5546-5615).

On August 11, 2023, the District Court heard oral argument and granted the motions for summary judgment. ROA.8011-8082. On October 13, 2023, Appellants and Intervenor Appellants filed notices of appeal. ROA.7983-7985. In their brief, they concede that they are only appealing summary judgment as to Harris County and Dr. Lau. Appellants' Brief at 3. Appellees Leesa Brown and Sheriff Ed Gonzalez filed notices advising the Court that they will not be filing briefs.

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[36] ROA.7865-7874. Harris County objected to: (1) the affidavit of Young's sister because she was not disclosed as a witness, (2) a hearsay statement from Inmate Guerra falsely alleging Young was killed by guards, (3) a chart of jail suicides created by a lawyer that is unauthenticated hearsay and irrelevant to *Monell* because it lacks detail and is outside the relevant time period, (3) an unauthenticated letter from another attorney who was not disclosed regarding his opinion about jail staffing, (5) unauthenticated hearsay news articles printed off the internet about events that occurred five years after Young's death, (6) the hearsay opinion of a union leader about jail conditions, and (7) a hearsay news story about a police union lawsuit (that has since been dismissed). Harris County incorporates these objections into its Brief.

[37] This motion was filed at ROA.4841-4866 and a supplemental exhibit filed at ROA.5443-5539.

SUMMARY OF THE ARGUMENT

Vincent Young's death is tragic, but Harris County is not legally responsible. The district court granted summary judgment because there are no genuine issues of material fact that would allow Appellants to proceed under 42 U.S.C. § 1983 and *Monell v. Department of Social Services of City of New York*, 436 U.S. 658 (1978).

First, Harris County did not violate Young's constitutional right to medical care and protection from suicide on February 13, 2017, because no Harris County employee was aware that Young was suicidal. *Estate of Bonilla by & through Bonilla v. Orange County, Texas*, 982 F.3d 298, 304 (5th Cir. 2020). Young had just been medically cleared by two sets of physicians and was housed in the infirmary with 25-minute observations (ROA.3650) and a button he could press if he needed anything. ROA.7855-7856. The physicians who cleared Young relied on the fact that he had never attempted suicide before, denied being suicidal, and was clinically stable. ROA.3666. He was being treated for anxiety and undergoing detoxification for a Xanax addiction using the same medications that worked for him three times over the prior 10 years. ROA.3651-3654.

Second, Appellants failed to identify an official policy adopted with deliberate indifference by Sheriff Gonzalez that was the moving force behind Young's asserted injury. Appellants identify several events that occurred around this time, but none of

them are policies, none were adopted with deliberate indifference, and none directly caused Young's suicide. The clinic had more than six times the staffing level required by law (ROA.3325-3328; ROA.3837), and even non-medical detention officers were trained in suicide prevention. ROA.7861-7864.

Third, it is undisputed that former Officer Romero failed to watch Young as ordered and missed state monitoring standards by 44 minutes. However, that was an isolated act of an employee who was promptly fired. Under *Monell*, Appellants cannot survive summary judgment by showing mere negligence of employees. *Garza v. City of Donna*, 922 F.3d 626, 632 (5th Cir. 2019).

ARGUMENT

I.
STANDARD OF REVIEW

A. Standard under Federal Rule of Civil Procedure 56.

A court of appeals reviews summary judgment *de novo* and applies the same standards as the district court. *Mason v. Lafayette City-Parish Consolidated Government*, 806 F.3d 268, 274 (5th Cir. 2015). Federal Rule of Civil Procedure 56 requires a court to grant summary judgment if "the movant shows that 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). "A dispute is genuine 'if the evidence is such that a reasonable jury could return a verdict for the nonmoving party.'" *Westfall v.*

Luna, 903 F.3d 534, 546 (5th Cir. 2018). A fact is material "if its resolution could affect the outcome of the action." *Dyer v. Houston*, 964 F.3d 374, 379-380 (5th Cir. 2020) (internal citations omitted).

A moving party bears the burden of initially pointing out the basis of the motion and identifying the portions of the record demonstrating the absence of a genuine issue for trial. *Duckett v. City of Cedar Park, Texas*, 950 F.2d 272, 276 (5th Cir. 1992). Then "the burden shifts to the nonmoving party to show with 'significant probative evidence' that there exists a genuine issue of material fact." *Hamilton v. Seque Software, Inc.*, 232 F.3d 473, 477 (5th Cir. 2000).

A court reviews facts and reasonable inferences in a light most favorable to the nonmovant but "only when there is an actual controversy—that is, when both parties have submitted evidence of contradictory facts." *Laughlin v. Olszewski*, 102 F.3d 190, 193 (5th Cir. 1996). "Unsupported allegations or affidavit or deposition testimony setting forth ultimate or conclusory facts and conclusions of law are insufficient to defeat a motion for summary judgment." *Clark v. America's Favorite Chicken Co.*, 110 F.3d 295, 297 (5th Cir. 1997).

B. Response to Appellants' request that the Court disregard the testimony of Harris County's witnesses.

Without identifying which witnesses they contend are biased or why, Appellants argue this Court should disregard "Appellees' and Defendants' own statements and experts" as "interested witnesses." Appellants' Brief at 12. To support this wholesale exclusion of evidence, they cite *Abraham v. Raso*, a Third Circuit case where an officer's testimony in a shooting death contradicted physical evidence on central issues and for which there were no other witnesses. *Abraham v. Raso*, 183 F.3d 279 (3d Cir. 1999).

Unlike *Abraham*, the material facts in this case are undisputed, supported by medical records, witnesses, and video, and reviewed by the Sheriff's Office Internal Affairs Department, Texas Rangers, and other agencies. ROA.3395-3472. Further, none of Harris County's witnesses have any personal stake in this litigation.

In contrast, Appellants rely on former Officer Romero's personal opinion that Young's physicians should have foreseen his suicide and changed his housing accommodations. ROA.3553. Romero has no medical credentials and cites no policies or evidence to support his opinions. He is a former employee who was fired, dishonorably discharged, and referred for criminal prosecution for his role in this case, and his "account will invariably be favorable to himself." Appellants' Brief at

12. However, Romero's statements are also not material to the issues before the Court and will have no bearing on the outcome.

Similarly, Appellants cannot use the opinions of their expert, Dr. David Axelrad, to create a material fact:

> What an expert opines is irrelevant and quite beside the point if the facts and applicable law do not create liability. The court, not the expert, determines whether the applicable law and facts raise a genuine issue of material fact. Moreover, expert testimony or opinion is ordinarily insufficient to establish deliberate indifference.

Posey v. Southwestern Bell Telephone L.P., 430 F. Supp.2d 616, 624 (N.D. Tex.2006). Appellants asked this Court to disregard Harris County's witnesses; however, two of their own witnesses have offered testimony that exceeds the scope of summary judgment review.

C. Standard to establish liability against Harris County under 42 U.S.C. § 1983 for an episodic act or omission.

1. Standard in a *Monell* case.

Appellants sued Harris County under 42 U.S.C. § 1983. A county cannot be liable under § 1983 for negligence. *Kingsley v. Henderickson*, 576 U.S. 389, 396 (2015). A county cannot be vicariously liable for the acts of employees. *Estate of Davis v. City of North Richland Hills*, 406 F.3d 375, 381 (5th Cir. 2005). A public entity can only be liable under § 1983 when a plaintiff shows that an official policymaker adopted an unconstitutional policy "with deliberate indifference to the known or obvious

consequences that constitutional violations would result." *Piotrowski v. City of Houston*, 237 F.3d 567, 579-580 (5th Cir. 2001); *Monell v. Department of Social Services of City of New York*, 436 U.S. 658 (1978).

An unconstitutional practice can be so persistent and widespread that it fairly represents an official policy. To establish the existence of an official policy this way, a plaintiff must show official misconduct "is so common and well settled as to constitute a custom that fairly represents the municipality's policy." *Cox v. City of Dallas, Texas*, 430 F.3d 734, 748-749 (5th Cir. 2005). A court cannot infer a policy "merely because harm resulted from some interaction with a governmental entity." *Colle v. Brazos County, Texas*, 981 F.2d 237, 244-245 (5th Cir. 1993).

2. Standard for an episodic act or omission case.

A detainee's due process claim is classified as either a "condition of confinement" or "episodic act or omission." *Cadena v. El Paso County*, 946 F.3d 717, 727-728 (5th Cir. 2020); *Hare v. City of Corinth, Mississippi*, 74 F.3d 633, 645 (5th Cir. 1996). Appellants argue that they stated claims under both theories (Appellants' Brief at 32-33), but their claim is squarely related to an episodic act or omission.

To plead an unconstitutional condition of confinement, Appellants would have needed to show (1) a rule or restriction or identifiable intended condition or practice, (2) not reasonably related to a legitimate governmental objective, and (3)

which caused the violation of plaintiff's constitutional rights. *Cadena*, 946 F.3d at 727. "[T]he proper inquiry is whether those conditions [complained about] amount to punishment of the detainee" for no reason. *Cadena*, 946 F.3d at 727.

A condition of confinement claim requires a detainee to "demonstrate a pervasive pattern of serious deficiencies in providing for basic human needs." *Cadena*, 946 F.3d at 728, quoting *Sheperd v. Dallas County*, 591 F.3d 445, 454 (5th Cir. 2009). An example is when a disabled prisoner acquires an infection from being forced to bathe in toilet water because the prison's policy is to refuse to accommodate his disability. *Bradley v. Puckett*, 157 F.3d 1022, 1025 (5th Cir. 1998).

However, in *Cadena*, even seemingly punitive policies such as unjustified delays in medical care and requiring that inmates on crutches carry their food trays back to their cells were not "sufficiently extended or pervasive" to rise to the level of a condition of confinement claim. *Cadena*, 946 F.3d at 728.

In *Scott*, this Court held that a detainee could not state a condition of confinement claim when she was sexually assaulted by a jailer in a jail so inadequately staffed that her attacker was the only person on duty as he attacked her for eight hours. *Scott v. Moore*, 114 F.3d 51, 52 (5th Cir. 1997). This Court held that a condition of confinement claim relates to things such as "the number of bunks in a cell or . . .

television or mail privileges" rather than "an episodic event perpetrated by an actor interposed between" the government and the plaintiff. *Scott*, 114 F.3d at 54.

In *Anderson*, an inmate in the Dallas County Jail told staff he was suicidal but they failed to communicate the proper protocols to protect him. As a result, he was provided a jumper and plastic spoons that he used to kill himself. This Court held that was not a condition of confinement claim because "plaintiffs ultimately take issue with the DSOs' and physician assistants' failure to follow those policies and procedures. This is a classic episodic-act-or-omission case." *Anderson v. Dallas County, Texas*, 286 Fed. Appx. 850, 859 (5th Cir. 2008). Similarly, *Garza* was held to be an episodic act or omission case because "[t]he theory of the distracted jailers, for instance, turns on the jailers' alleged omission of required cell checks." *Garza v. City of Donna*, 922 F.3d 626, 633 (5th Cir. 2019).

To support their condition of confinement claim, Appellants cite an unreported district court case where the plaintiff asserted that a jail had policies designed to deny mental health care and made the conscious choice not to adequately train staff to assess inmates' risk of suicide. *Gann v. Montgomery County Texas*, No. 4:14-CV-01575, 2016 WL 10807190 (S.D. Tex. Sept. 27, 2016).

In that case, the "Inmate Handbook" stated that the jail would not provide mental health services unless a detainee already had a provider and prescription from

"outside of this facility" and a way to have medication delivered to him within the facility. *Gann*, 2016 WL 10807190, at *12 (S.D. Tex. Sept. 27, 2016). The facility's decision to maintain this punitive policy and train its employees to follow it—even for detainees known to be suicidal—led the district court to deny summary judgment on plaintiffs' condition of confinement claim. *Id.*

This case is nothing like *Gann*. Appellants have not identified any policy designed to punish detainees arbitrarily or deny basic human needs. Instead, Appellants contend Young was injured by the independent acts of third parties such as Dr. Lau, who used his medical judgment to prescribe a Librium taper and failed to recognize that Young was at risk for suicide, and former Officer Romero, who violated policy by not monitoring Young every 25 minutes. Accordingly, this is analyzed as an episodic act or omission case.

II.
APPELLANTS FAIL TO STATE A CONSTITUTIONAL VIOLATION FOR INADEQUATE MEDICAL CARE AND SUPERVISION

A pretrial detainee has a Fourteenth Amendment Due Process right to medical care and "protection from known suicidal tendencies." *Estate of Bonilla by & through Bonilla v. Orange County, Texas*, 982 F.3d 298, 304 (5th Cir. 2020) (emphasis added), quoting *Baldwin v. Dorsey*, 964 F.3d 320, 326 (5th Cir. 2020);

Sibley v. Lemaire, 184 F.3d 481 (5th Cir. 1999).[38] Officials must take reasonable measures to prevent suicide once they know of a suicide risk, although the contours "as to what those measures must be" are still developing. *Jacobs v. West Feliciana Sheriff's Department*, 228 F.3d 388, 394-395 (5th Cir. 2000).

To establish a violation of the right to medical care, a plaintiff must show deliberate indifference to a serious medical need that caused "unnecessary and wanton infliction of pain." *Estelle v. Gamble*, 429 U.S. 97, 104-105 (1976). A serious medical need is "one for which treatment has been recommended or for which the need is so apparent that even laymen would recognize that care is required." *Gobert v. Caldwell*, 463 F.3d 339, fn.12 (5th Cir. 2006).

Appellants first argue that Harris County knew Young had a serious medical need because he made an off-hand comment to a cellmate 36 hours before committing suicide. However, Young was later interviewed by a mental health team and examined by jail physicians and Ben Taub Hospital physicians. Young had never attempted suicide before and repeatedly denied suicidal ideation. See, e.g., ROA.3650; ROA.3665. None of Young's physicians believed he had a serious

[38] Appellants assert that "[p]retrial detainees are entitled to a greater degree of medical care than convicted inmates." (Appellants' Brief at 16). However, "there is no significant distinction between pretrial detainees and convicted inmates concerning basic human needs such as medical care." *Gibbs v. Grimmette*, 254 F.3d 545, 548 (5th Cir. 2001).

medical need to be protected from suicide and no "treatment ha[d] been recommended." *Gobert*, 463 F.3d 339, fn.12. The last time anyone saw Young, he was clinically stable, denied suicidal ideation, housed in a medical infirmary, and able to request medical care through a button in his cell. ROA.7855-7856. Nothing about that indicated an obvious serious medical need.

This Court has observed that "[s]uicide is inherently difficult for anyone to predict, particularly in the depressing prison setting." *Domino v. Texas Department of Criminal Justice*, 239 F.3d 752, 756 (5th Cir. 2001). For that reason, generalized evidence of an inmate's mental illness does not indicate a substantial risk of self-harm." *Bonilla*, 982 F.3d at 306.

At most, Appellants argue that Young's doctors made a mistake by not anticipating his suicide and former Officer Romero made a mistake by missing his observation rounds. However, a constitutional violation requires more than mere negligence in failing to supply medical treatment or providing the wrong treatment. *Gibbs v. Grimmette*, 254 F.3d 545, 549 (5th Cir. 2001). As the Supreme Court explained, "[m]edical malpractice does not become a constitutional violation merely because the victim is a prisoner." *Estelle*, 429 U.S. at 106.

Assuming, *arguendo*, that individuals violated Young's constitutional rights with deliberate indifference, Harris County would still not be liable because *Monell*

also requires Appellants to show that the constitutional injury was directly caused by an official policy or custom attributed to a policymaker and promulgated with deliberate indifference. *Pineda v. City of Houston*, 291 F.3d 325, 328 (5th Cir. 2002). Appellants cannot do that for the reasons explained below.

III.
THE DISTRICT COURT PROPERLY GRANTED SUMMARY JUDGMENT REGARDING MR. YOUNG'S MEDICAL TREATMENT

(Response to Appellants' Brief at pages 25-35.)

A. There is not an official "No Xanax" policy.

1. Response to Appellants' Seventh Circuit cases.

Even if Appellants stated a constitutional injury, they must still show the existence of an official policy as to each of their claims. *Piotrowski*, 237 F.3d 579-80; *Monell*, 436 U.S. at 693-694. Appellants cite several Seventh Circuit cases to suggest that the lack of a policy can be construed as a policy. Appellants' Brief at 26-32.

In *Glisson*, a medical provider's neglect caused a prisoner to die because there was nothing "resembling a complete [medical] chart" and each doctor was unaware of what others were prescribing. *Glisson v. Indiana Department of Corrections*, 849 F.3d 372, 375 (7th Cir. 2017). The Seventh Circuit found this lack of coordination so severe that it could be considered a "policy" under *Monell*. *Glisson* is not binding in this circuit and irrelevant because Harris County provided coordinated care and had access to Young's jail medical records dating to 2007, as well as Harris Health records

for the County's psychiatric hospital and Ben Taub Hospital records. ROA.3650; ROA.6734.

Appellants also cite *J.K.J.*, where two jailers were permitted to sexually assault inmates for years because of a lack of training, policies that made it impossible for inmates to anonymously report assault, and the lack of any meaningful consequences for those caught. *J.K.J. v. Polk County*, 960 F.3d 367, 372 (7th Cir. 2020). This is also inapplicable because it is undisputed that Harris County enforced its observation policies and took swift action by terminating former Officer Romero 11 days after he violated them. ROA.3341-3347.

2. Dr. Laxman Sunder testified there was not a "No Xanax" policy.

Appellants contend Young had a constitutional right to Xanax for his benzodiazepine addiction and that Harris County violated that right by having a "No Xanax policy" that encouraged Dr. Lau to prescribe a less effective Librium taper. The first problem with Appellants' argument is that there was never a "No Xanax policy" promulgated by an official policymaker. In February 2017, Dr. Laxman Sunder was a staff physician with the Harris County Jail. ROA.7735. There is no evidence that he was a policymaker or created any official jail policy at that time.[39]

[39] Sheriff Ed Gonzalez is Sheriff's Office policymaker. *Baughman v. Garcia*, 254 F.Supp.2d 848, 887 (S.D. Tex. 2017). Appellants do not claim the Sheriff knew of a "No Xanax" policy or custom that would have the effect of a policy. (See Section IV for the legal standard to show a custom.)

As a staff physician, Dr. Sunder helped develop an easy-to-understand detoxication flowchart that he recommended to other physicians, nurse practitioners, and physicians' assistants when a detainee arrived in jail with an addiction.[40] The recommendations were made available to medical staff during orientation and posted in a common room where other physicians and nurses wrote prescriptions and completed their paperwork. ROA.7736-7737.

Dr. Sunder testified that he created this flowchart because some medical providers confuse benzodiazepine taper procedures with opiate procedures, and he wanted to remind them of the differences. ROA.7738. For example, a person on benzodiazepine, like Young, was more likely to respond well to the Librium taper, which should be administered in the clinic. In contrast, detainees with opiate addictions could receive Clonidine while housed in general population. ROA.7738.

Dr. Sunder made clear during his deposition that Harris County did not have a "No Xanax" policy and that the jail's medical staff would prescribe Xanax if there was a medical need:

> Q. But you don't understand Harris County to have a no-Xanax policy in its jail? . . .
>
> A. There is no such policy, no.

[40] ROA.7638. Charts such as these are not unusual in a correctional setting. For example, the Correctional Managed Care Pharmacy & Therapeutics Committee produced a similar chart in 2008 titled "Opioid Discontinuation." See ROA.3684-3693.

> Q. How do you know there's no such policy?
>
> A. Because if a psychiatrist wants to prescribe Xanax for whatever reason, I have an excellent team of psychiatrists who will be able to prescribe if they want to prescribe Xanax, they will be able to just go ahead and do it.

ROA.7740.

For Appellants to claim—seven times in their Brief—that Harris County had a "written 'No Xanax' policy" is inaccurate and unsupported by the record. Dr. Sunder advises new providers to "look at the patient, use your clinical judgment, and based on your judgment, do your best." ROA.7744. Harris County respected the medical decisions of physicians, which included respecting Dr. Sunder's clinical experience that the Librium taper was the most successful approach to detoxifying patients from benzodiazepine addiction. While Dr. Sunder made recommendations to his colleagues, nothing barred other physicians from prescribing Xanax.[41]

[41] Appellants fail to provide evidence of any widespread custom of the jail barring physicians from prescribing Xanax. The fact that Dr. Sunder only prescribed it once in his career does not reflect the experiences of other physicians or infer a custom that would rise to the level of an unofficial policy. *Cox*, 430 F.3d at 748-749 (5th Cir. 2005).

B. It is not deliberately indifferent to follow a physician's advice to use a Librium taper protocol or Ativan.

1. Standard for deliberate indifference.

This Court has long held that jail staff cannot be deliberately indifferent to a suicide risk unless the staff knew about the risk of suicide occurring under similar circumstances. In *Cope v. Cogdill*, jail staff knew that an inmate had attempted suicide by hanging the day before, yet placed him in a cell with a phone cord that he used to hang himself. This Court found jail staff were not deliberately indifferent because "the record does not suggest that any inmate had previously attempted suicide by strangulation with a phone cord" and there was no evidence that officers were aware of this specific danger. *Cope v. Cogdill*, 3 F.4th 198, 210–211 (5th Cir. 2021).

Two months ago, this Court reiterated the "extremely high standard" for deliberate indifference:

> A detainee can establish a jail official's deliberate indifference by showing that the official "refused to treat him, ignored his complaints, intentionally treated him incorrectly, or engaged in any similar conduct that would clearly evince a wanton disregard for any serious medical needs." *See Johnson v. Treen*, 759 F.2d 1236, 1238 (5th Cir. 1985). Deliberate indifference can also be shown where a jail official knows that a detainee faces "a substantial risk of serious harm and disregards that risk by failing to take reasonable measures to abate it." *See Farmer v. Brennan*, 511 U.S. 825, 847, 114 S.Ct. 1970, 128 L.Ed.2d 811 (1994). On the other hand, "[u]nsuccessful medical treatment, acts of negligence, or medical malpractice do not constitute deliberate indifference." *Gobert v. Caldwell*, 463 F.3d 339, 346 (5th Cir. 2006).

Ford v. Anderson County, Texas, 90 F.4th 736, 752 (5th Cir. 2024). Thus, Appellants must show that Harris County officials knew of a substantial risk of serious harm to Young and responded to that risk with deliberate indifference.

2. Librium is a recommended withdrawal medication, and Mr. Young successfully completed the Librium taper at least three times before February 2017.

This is not a case where jail staff refused to treat Young for his withdrawal symptoms or ignored clear evidence that Young was suicidal. Even before seeing clinical evidence of symptoms, Harris County medical staff took the initiative to prescribe Young medication to ease his anticipated withdrawal from Xanax. ROA.6715. Rather than give him more Xanax, they prescribed Librium, which is the brand name for chlordiazepoxide (a long-acting benzodiazepine). This Librium taper is "commonly used to treat and prevent alcohol and/or benzodiazepine withdrawal and associated complications." ROA.3651.

Young successfully completed the Librium taper program at least three other times in the Harris County Jail—in 2007 (ROA.3651-3652), 2010 (ROA.3652), and again in 2012. ROA.3654. Each time, his withdrawal symptoms improved, and he never showed signs of being suicidal. In 2010, Young only required a Librium taper for one day, and then it was discontinued when his withdrawal symptoms abruptly ended. ROA.3652.

This protocol is well documented and supported in the correctional medical community by physicians such as Harris County medical expert Dr. Joseph Penn. Dr. Penn is a triple board-certified psychiatrist who devoted his career to working in correctional settings and has been a Certified Correctional Health Professional-Mental Health since 2004. He has academic, leadership, and clinical expertise dealing with treatment protocols for people with serious mental illness and withdrawal from substances such as benzodiazepine in correctional settings, and he is Director of Mental Health Services for the University of Texas Medical Branch Correctional Managed Care. ROA.3633-3643; ROA.3744-3775. In this role, he oversees the provision of psychiatric, psychological, and mental health services to approximately 110,000 adult offenders in Texas prisons, which represents 80 percent of the entire Texas prison population. ROA.3634.

Dr. Penn thoroughly reviewed all relevant medical records and documents (ROA.3643-3645) and agreed with Dr. Lau and Dr. Sunder that the Librium taper was the best choice for Young and that Xanax would have been a poor choice to wean him off of a Xanax addition. ROA.7741; ROA.3648-3649.

3. Appellants provided no evidence that officials knew that the Librium taper resulted in suicides in the Harris County Jail.

Appellants have not identified anyone aware of any instance where a Librium taper resulted in suicide at the Harris County Jail. See *Cope*, 3 F.4th at 210–211.

Instead, Appellants simply state: "[b]etween 2001 and 2009, Harris County had only three suicides in its jail facilities. Since 2009, Harris County has had far beyond three suicides." Appellants' Brief at 8.

This scant "evidence" is a chart that Harris County objected to in the district court because it was purportedly made by a lawyer, is unauthenticated hearsay without supporting data, and fails to identify reasons, circumstances, or locations in the jail for each suicide.[42] Even if considered, this chart does not attempt to show how any policymaker would have known that a Librium taper was likely to result in Young's suicide. See *Pineda v. City of Houston*, 291 F.3d 325, 329 (11 incidents of unconstitutional searches out of 500 narcotics incidents does not constitute a widespread practice sufficient to put a policymaker on notice).

4. Jail staff had no duty to find "Dr. Lee" or any other physician willing to prescribe Xanax to Mr. Young.

Appellants contend that jail staff had a duty to "immediately" bring Young to a psychiatrist so he could be prescribed Xanax. Appellants' Brief at 38-39. However, as noted, none of the physicians who saw Young believed that Xanax was medically appropriate or that Young needed a psychiatrist so urgently that he could not wait

[42] Appellants' chart is at ROA.7703 and Harris County's objections are at ROA.7867.

until he finished his drug taper. ROA.6757-6758 (Medical staff planned to evaluate Young after detoxification).

Rather than provide evidence that Young had a specific medical need for Xanax, Appellants relied on "Dr. Lee," an "outside physician" who supposedly prescribed Xanax to Young since he was 17 years old. Appellants' Brief at 38; ROA.5795. However, Appellants never found "Dr. Lee" or his records. Mr. Young's family never heard of "Dr. Lee" and did not know Young to use any physician or pharmacy to get Xanax. ROA.3621-3622; ROA.3627-3628; ROA.3441-3449; ROA.3614; ROA.3648-3649; ROA.5801-5802.

During litigation, the parties acquired Young's medical records from the Harris County Jail dating to 2007, Harris County Health Services Bureau dating to 2009, Memorial Hermann Hospital Emergency Department dating to 2015, Social Security SSI and SSDI records, MHMRA (now known as The Harris Center) mental health records, and pharmacy records. None of these records identified a "Dr. Lee" or a history of taking legally prescribed Xanex or being at risk for suicide. ROA.3646-3647; ROA.3650; ROA.3487-3511.

During his encounters with medical staff, Young never explained why he needed Xanax and never provided a way to contact the illusive "Dr. Lee," who he supposedly saw for years. When Appellants could not find a pharmacy that legally

administered Xanax to Mr. Young,[43] Harris County tried to help them by sending subpoenas to the largest pharmacies in Texas—CVS, Walgreens, The Kroger Company, H-E-B Grocery Company, and Wal-Mart. The only prescriptions Mr. Young filled were for Prednisone and Acyclovir. ROA.3487- 3511.

Dr. Penn opined that "Dr. Lee" probably did not exist because it was highly unlikely for any physician to have prescribed Xanax to Mr. Young while he was a 17-year-old minor or continued to write Xanax prescriptions for more than a decade because there is no medical reason to do so:

> In my experience, background and fellowship training and qualifications and clinical and forensic psychiatric experience as a board-certified child and adolescent and forensic psychiatrist, I am prepared to opine that benzodiazepines and in particular, Xanax, are rarely prescribed for children and adolescents, and certainly not as a first line agent for anxiety symptoms or an anxiety disorder.

ROA.3649.

Importantly, Young never mentioned his alleged prescription to the parole officer who brought him to jail based in part on his positive drug test. However, he previously admitted to the jail clinic that he purchased Xanax as a "street drug." ROA.3653.

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[43] Appellants could have easily accomplished this by sending a subpoena to the Texas Prescription Program, which requires all Texas pharmacies dispensing controlled substances to file a report with the State and permits patients to review their controlled substances prescription records. See Tex. Adm. Code § 315.16.

Rather than simply acknowledge this, Appellants are trying to reverse the burden of proof by claiming "[n]o one—including Dr. Lau, or any other LPHA or Harris County medical professional—bothered to locate and contact Dr. Lee—whom Young stated was the physician who prescribed the twice-a-day Xanax." Appellants' Brief at 38. It is disingenuous for Appellants to criticize busy physicians for not stopping their work to go on a snipe hunt for an imaginary doctor that Appellants have been unable to find after six years of litigation. And even if "Dr. Lee" existed and prescribed Xanax to Mr. Young, that does not mean another physician was negligent—much less deliberately indifferent—for choosing a different treatment.

5. The Harris County Jail treated Mr. Young for anxiety.

The Librium taper was not the only treatment Young received. When he showed signs of anxiety on February 13, 2017, Dr. Lau calmed him with Ativan, which is the brand name for lorazepam (a short-acting benzodiazepine). ROA.3651. Dr. Sunder's clinical experience—like Dr. Lau's clinical experience—was that Ativan is better than Xanax for anxiety.[44]

There are also practical reasons to use Ativan over Xanax. As the third largest jail in the United States, the Harris County Jail is experienced with helping detainees

[44] ROA.7741. Dr. Penn agreed that Xanax is a poor choice to treat anxiety. ROA.3648-3649.

suffering from withdrawal and often provides intravenous medication to quickly ease anxiety and withdrawal symptoms. That is impossible with Xanax because there is no intravenous or intramuscular formulation like there is for Ativan. ROA.7744.

Appellants are simply wrong when they claim, "Young received no treatment for anxiety, depression, and delusion while in custody in 2017." Appellants' Brief at 8. Harris County treated Young for all known medical problems, and it was certainly not indifferent to his medical needs.

C. The Librium taper was not the moving force behind Mr. Young's suicide.

Finally, Appellants cannot show causation between the Librium taper and Young's suicide. Causation is strictly construed, and there must be a "direct causal link between the municipal policy and the constitutional deprivation." *Piotrowski v. City of Houston*, 237 F.3d 567, 580 (5th Cir. 2001).

The Librium taper successfully weaned Young from his Xanax addiction at the Harris County Jail three times without any negative outcome. ROA.3651-3654. While Appellants point out that Xanax withdrawal has been linked to suicide (Appellants' Brief at 19), they do not establish that the Librium taper was the "moving force" behind Mr. Young's suicide.

IV.
THE DISTRICT COURT PROPERLY GRANTED SUMMARY JUDGMENT AS TO APPELLANTS' CLAIMS THAT MR. YOUNG HAD TO WAIT TO SPEAK WITH A MENTAL HEALTH OFFICER ON FEBRUARY 12, 2017

(Response to Appellants' Brief at 36-37.)

Appellants next argue that it took too long for mental health officers to speak with Mr. Young after Officer Dogan referred him for a psychiatric evaluation. Appellants' Brief at 36-37. As noted, shortly after midnight on February 12, 2017, a detainee told Officer Dogan that he heard Young make a comment he interpreted to be related to suicide. Although Young denied he was suicidal and did not ask for medical assistance, he was involuntarily referred for evaluation and safely housed until morning. ROA.3430; ROA.3518; ROA.6781-6783.

When mental health staff arrived at 7:15 a.m., Young was talking to his cellmate but refused to talk to them. ROA.7851. He was brought to the clinic, where physicians realized for the first time that his high blood pressure and physical symptoms should be checked at the hospital. ROA.6732-6733; ROA.3660. Hospital staff ran a battery of tests and discharged Young without any indication that he was at risk of suicide. ROA.3650-3660.

Appellants failed to explain how waiting until morning to see a physician violated Mr. Young's constitutional rights, or how any Harris County policy was created with deliberate indifference to those rights. No one refused to treat Young,

ignored his complaints, intentionally treated him incorrectly, or engaged in conduct that would clearly evince a wanton disregard for any serious medical needs. *Perniciaro v. Lea*, 901 F.3d 241, 258 (5th Cir. 2018).

This Court has held that much longer delays for more serious reasons are not deliberate indifference. See, *Manemann v. Garrett*, 484 F. App'x 857, 859 (5th Cir. 2012) (several hour delay resulted in leg being amputated); *Gracia Ledezma v. United States*, 382 F. App'x 381, 383 (5th Cir. 2010) (diabetic inmate did not see a physician until the following Monday); *Young v. Bexar County Sheriff's Office*, No. SA-09-CV-965-XR, 2010 WL 723282, at *3 (W.D. Tex. Mar. 2, 2010) (thirty-two hour wait to go to the hospital for vomiting) ("[i]t is common knowledge that people in the free world outside of jail sometimes have to wait over one day for an appointment to be seen by a doctor when they are experiencing Plaintiff's symptoms.")

Young received treatment on February 12 because Officer Dogan insisted, and there is no indication he would have brought himself to a medical facility or been seen between 12:10 a.m. and 7:15 a.m. in the free world. Finally, Young failed to show any causation or injury from waiting a few hours to be seen by mental health staff. Young did not commit suicide until 36 hours later—after he was cleared by physicians at Ben Taub Hospital and the Harris County Jail. This February 12 delay could not have been the moving force behind Young's alleged constitutional injury.

V.
THE DISTRICT COURT PROPERLY GRANTED SUMMARY JUDGMENT AS TO APPELLANTS' CLAIMS OF INADEQUATE TRAINING, STAFFING, AND HOUSING

(Response to Appellants' Brief at 37-39.)

A. Harris County's policies comply with all applicable laws.

Appellants argue that Harris County should be liable for inadequate housing and supervision of Young. As noted in Section II, Harris County did not violate Young's constitutional rights, and as explained below, it also did not adopt any official policy with deliberate indifference to Young's rights. *Monell*, 436 U.S. 658, 691 (1978); *Pineda*, 291 F.3d 325, 328 (5th Cir. 2002).

Harris County Sheriff Ed Gonzalez, who is the policymaker for the Sheriff's Office, provided his understanding that:

> The policies and procedures of the Harris County Sheriff's Office in 2017 met all applicable state standards and laws, and covered a variety of matters including use of force, medical care for inmates and proper training and supervision of personnel. The policies of the HCSO have been and were in 2017 approved by the Texas Commission of Accreditation of Law Enforcement Agencies.

ROA.3318.

Margo Frasier is a 40-year law enforcement veteran who served as sheriff of Travis County, Texas and oversaw 1,350 deputies and a budget of more than $90 million. ROA.3522. She now testifies on behalf of the United States Department of

Justice and serves as Lead Monitor overseeing implementation of the Orleans Parish Consent Judgment. ROA.3522.

Former Sheriff Frasier reviewed the evidence and opined that Harris County adopted adequate policies for the provision of medical and mental health care to inmates, adequately trained and scheduled staff, and that detention staff properly alerted medical staff about "any possible mental health issues" Young had. She found no fault in either the policies or actions of jail staff. ROA.3519.

Appellants identify four events that they contend support a *Monell* claim: (1) Young was housed in the infirmary but not in a "rubber room" with every possible suicide precaution in place, (2) inadequate training and supervision of former Officer Romero, (3) inadequate "pass-on" information for former Officer Romero, and (3) inadequate staffing levels. Each allegation is discussed below.

B. Mr. Young was provided appropriate housing and there was no policy or custom promulgated with deliberate indifference to his needs.

Mr. Young was housed in the infirmary where he was monitored by both medical and detention staff. Detention staff were required to log observations every 25 minutes—a standard more stringent than the 60 minutes required by state law for non-suicidal detainees or the 30 minutes required for detainees known to be suicidal. Tex. Adm. Code § 275.1. Appellants contend Young should also have been placed in

a restrictive "rubber room," denied a blanket, and subjected to additional precautions. Appellants' Brief at 7-8 & 18-19.

Harris County Sheriff's Office Major Patrick Dougherty testified that the jail's policy was to provide Young with any reasonable accommodation that medical staff believed he needed:

> If they're handicap and need a handicap tank we'll put them in a handicap tank. If there's somebody who needs to be housed in the infirmary, they [medical staff] are the ones who will tell us that this person needs to be housed in the infirmary. . . . But again, that is a medical decision made by a medical professional to security staff.

ROA.3323.

Dr. Penn opined that the medical staff had requested a "clinically appropriate placement" for Young given that he had just been "medically cleared" by Ben Taub Hospital:

> Mr. Young was housed in the clinically appropriate placement, in the designated Harris County Jail's medical infirmary with ready access to custody, nursing and medical staff. Designated health care and custody staff routinely monitored Mr. Young upon his return to the medical infirmary after being medically cleared at the Ben Taub Hospiral Emergency Department where neither benzodiazepine withdrawal, delirium, nor any psychotic disorder was diagnosed, nor was any suicide ideation, intent or plan or risk identified.

ROA.3650. Dr. Penn further explained:

> There was no clinical indication to place any restrictions, such as suicide watch observation or restrictions, remove Mr. Young's clothing, sheets, personal items, other potential ligature items, or to

> order a paper gown, suicide smock, or to transfer him to a psychiatric unit onsite or off-site for further evaluation or management.

ROA.3666. Former Sheriff Fraiser also found no fault with the jail's policy of deferring to medical staff when making housing arrangements. ROA.3519-3520.

Appellants have not shown how Sheriff Gonzalez acted with deliberate indifference by creating this policy, or how that was the moving force behind Young's death. *Cope v. Cogdill*, 3 F.4th 198, 210 (5th Cir. 2021).

It is also important to note that, while Appellants advocate placing Young into a "suicide smock" (Appellants' Brief at 7-8) and a "rubber room" (Appellants' Brief at 18), those are extreme measures to impose on someone without a documented medical suicide risk. Under the suicidal-until-proven-not standard that Appellants advocate, Young would have been denied basic comforts indefinitely.[45] It was not deliberately indifferent to heed medical recommendations and provide Young a bed, blanket, and clothing while he was in the infirmary.

Appellants also contend Young's housing was inadequate because Nurse Thompson indicated "the cell Young was placed in had a distress call button ring to an unmanned booth and was useless." Appellants' Brief at 9. However, Thompson submitted an affidavit correcting that statement to say:

[45] Young had forfeited bail and was awaiting trial for 12 open warrants and a new charge for possession of crack cocaine. ROA.3426-3427; ROA.3438; ROA.3450.

> When an inmate pushed the call button, it went to where several deputies or detention officers sit in a pod – the MDCC. There always was at least one officer there. It is never unmanned.
>
> On the audio call, which acts like a two-way speaker – the inmate tells the officer what his issue, needs or concerns are. In my experience, it can be a request for anything, not just a medical issue. For example, the inmate may request a chaplain or use of the telephone.
>
> In my experience, if the request is medical, the deputy or detention officer immediately contacts the nurses' station and we respond immediately.

ROA.7855-7856. When Thompson made her original statement, she did not understand why the call button rang to a room manned by officers, rather than nurses. Thompson later learned this is because such a large percentage of calls were for non-medical reasons and "it was best to keep the officers as the initial point of contact" to avoid tying up medical resources. ROA.7855-7856. There was nothing deliberately indifferent about this decision.

Appellants supplied no evidence that Young ever pressed this button or sought help, so the call button could not have been the moving force behind his suicide. Detainees Jesse Jones and Frederico Sanz-Lopez were housed next to him and could see or hear in his cell, yet they never heard him ask for help and never realized that he had committed suicide. ROA.3420.

C. Harris County's training and supervision did not violate Mr. Young's constitutional rights, was not promulgated with deliberate indifference, and was not the "moving force" behind his suicide.

"In limited circumstances, a local government's decision not to train certain employees about their legal duty to avoid violating citizens' rights may rise to the level of an official government policy for purposes of § 1983." *Connick v. Thompson*, 563 U.S. 51, 61 (2011). However, "[a] municipality's culpability for a deprivation of rights is at its most tenuous where a claim turns on a failure to train." *Id.*

This Court has held that municipalities must only provide "minimal training to detect 'obvious medical needs of detainees with known, demonstrable, and serious medical disorders,' but a 'failure to train custodial officials in screening procedures to detect latent suicidal tendencies does not rise to the level of a constitutional violation.'" *Whitt v. Stephens County*, 529 F.3d 278, 284 (5th Cir. 2008). "In the absence of 'manifest signs' of suicidal tendencies, a city may not be held liable for a detainee's suicide in a § 1983 suit based on a failure to train." *Id.*

Former Officer Romero was a licensed Texas Peace Officer with four and a half years as a jailer. ROA.7859. His records show he had 2,050 hours of training (ROA.7864), including three courses in suicide prevention. ROA.7861-7862. There is no question that Harris County had a constitutional suicide training policy and that

Young gave no "manifest signs" of suicidal tendencies on February 13. Harris County was not deliberately indifferent in its suicide prevention training.

D. Former Officer Romero's failure to complete his observation rounds had nothing to do with the "pass on" information he received.

Appellants contend that former Officer Romero missed his observation rounds because Harris County had a policy of poor communication between detention officers and medical staff. Appellants' Brief at 37-38. They base this solely on Romero's personal opinion that "[i]n hindsight, I believe Inmate Young was not properly evaluated" by jail physicians and "[i]f Inmate Young was properly evaluated, he would have been housed in accordance with an inmate who suffers from suicidal tendencies."[46] Appellants and Romero infer that if medical staff had informed Romero that Young was suicidal, Romero would have timely completed his rounds.

While former Officer Romero received training on suicide prevention, he is not a board-certified physician qualified to render an opinion as to whether a doctor conducted a proper medical evaluation. Because Mr. Young was not Romero's patient, it would also have been inappropriate for healthcare providers to pass on unnecessary details about Young's medical condition to Romero.

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[46] ROA.3553. See also, Section I (B), pages 26-27 (discussing why Romero is not a disinterested witness).

Major Patrick Dougherty testified that the jail defers to physicians to determine what information needs to be passed on to security staff—"things that we need to know, such as where the person needs to be housed because of their medical condition, what kind of supervision and things like that based on their medical condition." ROA.3323-3324.

A physician determined that Mr. Young should be allowed to keep his bedding but was to be monitored every 25 minutes. Former Officer Romero knew he was required to check on Young every 25 minutes, accurately document the time on the Daily Observation Logs at the end of each hallway, and add any additional comments that would be helpful to other staff. ROA.3341; ROA.3353.

The fact that Romero did not know that Young had made a suicide outcry 36 hours earlier does not excuse him from missing his rounds. Policy 220 did not give Romero the choice to decide that some patients could be monitored less often at his discretion. ROA.3345-3346.

This was an isolated incident, and there is no evidence that a policymaker was aware of or adopted a widespread custom of staff missing their rounds. Former Officer Romero had no disciplinary infractions or criminal history, except for two traffic violations. ROA.3410.

Medical Assistant Bora Yskollari worked with Romero on February 13, 2017 and told the Internal Affairs Department that he escorted and assisted her that day. She had no concerns about his work ethic and believed "Deputy Romero comes into work and can be counted on to perform his duties when I am around him." ROA.3417. Officer Yskollari did not realize Romero had skipped his round on February 13. She recalled him stepping away and assumed he left her to make his rounds. ROA.3417.

As further evidence that Romero's actions did not reflect Harris County's policies, he knew there would be consequences for his omission and tried to cover up his mistake. Detention Officer Steven Longoria reported that Romero tried to "pencil" in his missing time, but his peers refused to let him do so and reported him to supervisors. ROA.3412-3413.

Despite former Offer Romero's lack of a disciplinary record, Harris County fired and dishonorably discharged him based on this incident. It is well-settled "'that negligent inaction by a jail officer does not violate the due process rights of a person lawfully held in custody of the State.'" and "an officer's acts must constitute at least more than a mere 'oversight.'"*Jacobs*, 228 F.3d at 395. Further, "a plaintiff cannot bootstrap government entity liability from the individual failures of employees

because there is no respondeat superior liability under Section 1983." *Sanchez v. Young County, Texas*, 866 F.3d 274, 281 (5th Cir. 2017).

Harris County is not legally responsible for former Officer Romero's negligence, and Appellants' claim about the lack of "pass-on" information is a red herring.

E. Harris County's staffing levels on February 13, 2017 were six times higher than the state required.

Finally, Appellants incorrectly suggest Mr. Young's death was caused by a deliberately indifferent policy of understaffing. Major Dougherty testified that the Texas Commission on Jail Standards requires a ratio of one officer to 48 inmates on each floor. ROA.3325-3328. During the second shift on February 13, 2017, 31 employees were available to work in the clinic if scheduled, and 19 officers and Sergeant Danny Meece were scheduled and worked. ROA.3837.

Not considering medical staff, this provided a ratio of one officer to 7.73 detainees in the medical unit and one officer to 19.53 detainees in the mental health unit. ROA.3837; ROA.3777-3842. This is far above the required ratio, and former Officer Romero was working in an environment with six times the number of detention officers as required by state law. Appellants have no basis to argue Mr. Young's constitutional rights were violated due to understaffing.

CONCLUSION AND PRAYER

Vincent Young tragically took his life in a Harris County infirmary jail cell. While the circumstances are regrettable, as a matter of law, Harris County is not liable under *Monell* and respectfully asks this Court to Affirm the district court's judgment in its entirety, award costs, and for any other relief to which it is entitled.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on March 19, 2024, I filed a true and correct copy of the foregoing brief via the Court's CM/ECF system, which will automatically serve a copy on all parties' counsel. I further certify that I emailed an electronic copy of this brief to the counsel of record below:

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CERTIFICATE OF COMPLIANCE

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