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UNITED STATES DISTRICT OF CALIFORNIA

SOUTHERN DISTRICT OF CALIFORNIA

ALBA MARROQUIN DE PORTILLO, individually and as successor in interest to her deceased son, Lester Daniel Marroquin,

Plaintiff,

v.

COUNTY OF SAN DIEGO and CURRENTLY UNKNOWN SAN DIEGO COUNTY SHERIFF'S DEPARTMENT PERSONNEL,

Defendants.

Case No. '22CV0744 BAS RBB

COMPLAINT

DEMAND FOR JURY TRIAL

I. INTRODUCTION

1. In May 2021, Lester Daniel Marroquin ("Mr. Marroquin") was a pretrial detainee in the San Diego County Central Jail.

2. On May 30, 2021, jail staff knew Mr. Marroquin had a history of mental illness and self-harming behavior, and was an ongoing danger to himself, in part because voices in his head were telling him to continually drink water from the toilet.

3. As such, Mr. Marroquin should have been in a safety cell on May 30, 2021. At a minimum, he should have been in Enhanced Observation Housing ("EOH"), with safety checks conducted at least every fifteen minutes.

4. Instead, jail staff recklessly transferred Mr. Marroquin from a safety cell,

where he had been continuously monitored, to a minimally monitored administrative segregation ("ad-seg") cell with the means for Mr. Marroquin to harm himself—including a toilet with running water

5. Mr. Marroquin was then left unchecked, for nearly an hour. During that time, Mr. Marroquin predictably began drinking water from the toilet, motivated by auditory hallucinations. When jail staff finally checked on Mr. Marroquin, it was too late. Mr. Marroquin had consumed so much water, he died from acute water intoxication.

6. Mr. Marroquin should have been admitted to an inpatient facility where he could have received the psychiatric care he required. Instead, he was repeatedly transferred in and out of the jail's safety cells and EOH, never actually receiving the treatment he needed.

7. Mr. Marroquin's death was preventable. Had the Department implemented, for example, one of its own consultant's recommendations—that ad-seg safety checks be conducted every half hour, rather than every hour—it is likely Mr. Marroquin would still be here today.

8. Mr. Marroquin's mother, Plaintiff Alba Marroquin de Portillo, now sues the County of San Diego and Currently Unknown San Diego County Sheriff's Department Personnel for damages, pursuant to 42 U.S.C. § 1983 and California state law.

II. JURISDICTION AND VENUE

9. The Court has subject matter jurisdiction over this action pursuant to 28 U.S.C. §§ 1331, 1343, and 1367, as Plaintiff asserts causes of action arising under 42 U.S.C. § 1983, in addition to a California cause of action that arises from the same controversy giving rise to Plaintiff's federal claims.

10. The Court has personal jurisdiction over all Defendants in this action, as all Defendants are and were, at all times relevant to this complaint, situated, regularly conduct business, and/or are and were domiciled in the State of California.

11. Venue is proper in this district, as the events giving rise to this action occurred in the County of San Diego, California, which is located within the Southern District of

California.

III. PARTIES

12. Plaintiff Alba Marroquin de Portillo ("Plaintiff" or "Ms. Marroquin") is and was, at all times relevant to this complaint, an individual domiciled in California. Ms. Marroquin was decedent Lester Daniel Marroquin's mother. In addition to suing individually for damages arising from Mr. Marroquin's death, Ms. Marroquin sues as Mr. Marroquin's sole successor in interest to prosecute those claims which survived Mr. Marroquin's death. *See* Cal. Civ. Proc. Code § 377.30.

13. Defendant County of San Diego ("County") is and was, at all times relevant to this complaint, a municipal entity duly organized under California law. The San Diego County Sheriff's Department ("Sheriff's Department") is the chief law enforcement agency for the County. The Sheriff's Department manages and operates the San Diego Central Jail ("Central Jail") and was, at all times relevant to this complaint, responsible for the policies, procedures, practices, and customs of the Central Jail, as well as for the hiring, training, supervision, discipline, actions, and inactions of the County's agents and/or employees working in the Central Jail.

14. Defendants Currently Unknown San Diego Sherriff's Department Personnel ("Currently Unknown Department Personnel") are individuals whose identities, titles, and employment/agency relationships are currently unknown to Plaintiff. These unknown individuals include jail staff, detention officers, medical staff, medical providers, supervisors, employees, agents, contractors, and final policymakers who substantially contributed to the acts and omissions giving rise to the damages claimed herein. These defendants each acted under color of state law, within the scope of their agency and/or employment, and with the full knowledge and consent, either express or implied, of their principal and/or employer.

IV. CALIFORNIA GOVERNMENT CLAIMS REQUIREMENTS

15. Plaintiff has complied with the California Government Code requirements to assert the state-law cause of action alleged herein and has, in particular, submitted a tort

claim for damages to the County, which the County denied by letter dated November 29, 2021.

V. FACTS

A. Jail Staff's Deliberate Indifference to Mr. Marroquin's Serious Medical Risks and Needs

16. From December 18, 2020, through May 30, 2021, Mr. Marroquin was a pretrial detainee in County's custody at the Central Jail.

17. For the two years leading up to Mr. Marroquin's incarceration, he struggled with mental health issues. Unable to get the help he needed, Mr. Marroquin's mental health struggles led him directly into the criminal legal system.

18. Fortunately, Mr. Marroquin's mother remained a constant source of healing and comfort to her son, standing by him through all his trials and tribulations. In fact, Ms. Marroquin and her son remained as close as possible through Mr. Marroquin's incarceration by the County. Jail staff, however, severely restricted Mr. Marroquin's contact with his mother at times when his mental health symptoms were most severe. This exacerbated Mr. Marroquin's condition, as his mother was one of the few people that could ease his mind.

19. Shortly after his booking, on or about December 22, 2020, Mr. Marroquin had an interaction with jail deputies where Mr. Marroquin was shot with a taser. After ripping out one of the taser barbs and attempting to cut his own throat, Mr. Marroquin was placed into a safety cell.

20. A "safety cell" is the most restrictive type of cell in which an individual who is a danger to themselves might be placed. The cells are small, windowless rooms with rubberized walls. There is no sink, toilet, furniture, or bedding, leaving the individual to sit or lie on the floor. A grate in the middle of the floor serves as a toilet. Safety cells have a ceiling light that is illuminated 24/7, and a camera for remote observation by custody staff. Individuals are given only a "safety smock" made from heavy tear-free material fastened with straps or Velcro. Individuals are not allowed any personal property

while in a safety cell.

21. On or about January 9, 2021, Mr. Marroquin was placed in a safety cell after injuring his head. He reported that auditory hallucinations were directing him to bang his head on his cell wall.

22. On February 3, 2021, at the request of Mr. Marroquin's public defender, the state criminal court ordered Mr. Marroquin to undergo a psychiatric evaluation, to be conducted on March 4, 2021. The Sheriff's Department did not make Mr. Marroquin available for this evaluation.

23. On or about March 13, 2021, Mr. Marroquin was again placed in a safety cell due to self-harming behavior.

24. On March 18, 2021, Mr. Marroquin's psychiatric evaluation still had not been completed, so the state court continued the criminal proceedings to April 12, 2021.

25. On March 23, 2021, a court-appointed psychiatrist attempted to conduct a remote-video evaluation of Mr. Marroquin. Jail staff failed to produce Mr. Marroquin for the evaluation.

26. On or about March 24, 2021, Mr. Marroquin was again placed in a safety cell due to self-harming behavior. Jail staff had again discovered Mr. Marroquin banging his head on his cell wall.

27. On April 5, 2021, the court-appointed psychiatrist again attempted to conduct a remote-video evaluation of Mr. Marroquin. Jail staff failed to produce Mr. Marroquin for his evaluation.

28. On April 12, 2021, Mr. Marroquin's psychiatric evaluation still had not been completed, so the state criminal court ordered the Sheriff's Department to produce Mr. Marroquin for a psychiatric evaluation at the courthouse on April 30, 2021. The Sheriff's Department did not produce Mr. Marroquin for this evaluation.

29. On or about April 25, 2021, Mr. Marroquin was again placed in a safety cell due to self-harming behavior. Specifically, jail staff had discovered Mr. Marroquin attempting to strangle himself with a noose he had made from a shirt.

30. On or about April 29, 2021, Mr. Marroquin was again placed in a safety cell due to self-harming behavior. He was trying to strangle himself with a towel.

31. Throughout this period, Mr. Marroquin was also experiencing delusions and auditory hallucinations that resulted in him attempting to drown himself in the toilet, including uncontrollably drinking water from the toilet.

32. Jail staff repeatedly found Mr. Marroquin with his head in the toilet, attempting to drown himself, and Mr. Marroquin was repeatedly transferred to safety cells because of this self-harming behavior.

33. By May 21, 2021, Mr. Marroquin's psychiatric evaluation still had not been completed, causing the state court to again continue his criminal proceedings until June 2021. Incidentally, jail staff failed to produce Mr. Marroquin for this court hearing, apparently misrepresenting that Mr. Marroquin had refused to attend court.

34. On or about May 28, 2021, Mr. Marroquin was again placed in a safety cell due to self-harming behavior.

35. On May 30, 2021, after being under near constant observation for approximately two days, Currently Unknown Department Personnel made the decision to transfer Mr. Marroquin from a safety cell to an ordinary ad-seg cell.

36. The decision to transfer Mr. Marroquin was remarkable for several reasons, including the fact that it occurred on a Sunday when the mental health treatment team that usually treated Mr. Marroquin were off work, as well as the fact that a clinical supervisor with little to know actual knowledge of Mr. Marroquin's condition approved the transfer of Mr. Marroquin.

37. The ad-seg cell required only one-hour safety checks. More alarmingly, the ad-seg cell was equipped with running water and a toilet.

38. Mr. Marroquin was, in short, transferred from the most protective cell on the floor (a safety cell) to the least protective cell on the floor (an ordinary ad-seg cell). Several alternatives between these two extremes were available to safeguard Mr. Marroquin's life, including putting him in EOH, where safety checks would have been

conducted at least every fifteen minutes.

39. During an hour of unchecked time in his ordinary ad-seg cell, Mr. Marroquin predictably stuck his head into the toilet and began drinking, uncontrollably.

40. When deputies finally checked on Mr. Marroquin, it was too late. He had died from acute water intoxication.

41. In total, Mr. Marroquin had been placed in a safety cell at least eleven times, and had been placed on EOH at least seventeen times, during his incarceration by the County.

42. At no time during his incarceration by the County was Mr. Marroquin ever taken to a hospital for inpatient psychiatric treatment. To the contrary, jail staff repeatedly failed to produce Mr. Marroquin for court-ordered psychiatric evaluations and court dates.

43. The County took Mr. Marroquin into its custody then failed to ensure his safety.

B. County's Deliberate Indifference to Suicides in County Jails

i. Disability Rights California's Findings and Recommendations

44. Disability Rights California ("DRC") is a nonprofit agency and the largest disability rights group in the nation. DRC is established under federal law to protect and advocate for the rights of people with disabilities.

45. In 2015, DRC opened an investigation into conditions at County jails.

46. In April of 2018, DRC published its finding: "Suicides in San Diego County Jail: A System Failing People with Mental Illness" ("DRC Report").

47. DRC found "an extremely high number of jail inmates with significant mental health treatment needs."

48. DRC found "significant deficiencies in County's suicide prevention practices."

49. DRC found the "County's jail system subjects inmates with mental health needs to a grave risk of psychological and other harms by failing to provide adequate mental health treatment."

50. DRC found "the existing systems of jail oversight have failed" to properly monitor jail conditions, implement suicide-prevention practices, and provide adequate mental-health treatment practices.

51. DRC experts identified twenty-four "Key Deficiencies" and provided forty-six recommendations to address deficiencies in the County's suicide-prevention and related mental-health treatment delivery efforts.

52. DRC provided nine components necessary for a correctional suicide prevention program to be effective, including, but not limited to: "Supervision of At-Risk Inmates" and "Suicide Prevention Training."

53. The County and its policymakers knew of and failed to implement the foregoing recommendations, thus substantially contributing to Mr. Marroquin's death.

ii. National Center on Institutions and Alternatives' Findings and Recommendations

54. Following the DRC Report, Lindsay Hayes, a project director with the National Center on Institutions and Alternatives, assessed the suicide-prevention practices within County jails. His report, "Report on Suicide Prevention Practices within the San Diego County Jail System" ("Hayes' Report"), was released in June 2018.

55. Hayes' Report focused on eight critical components of a suicide prevention policy which include staff training, identification/screening, communication, housing, levels of supervision/management, intervention, reporting, and follow-up/mortality-morbidity review. Based on his on-site assessment, as well as a review of various Department policies and procedures related to suicide prevention, Hayes found several policies inadequate to prevent suicide.

56. Hayes found "[t]he suicide prevention training requirements . . . are vague." Hayes found that, in 2017, only 31% of deputies and only 73% of medical personnel had received annual suicide prevention training.

57. Hayes found "the conditions for suicidal inmates placed in safety cells and Enhanced Observation Housing ("EOH") cells were harsher than for those on segregation

status," and that the safety cells are "generally overly restrictive, and seemingly punitive." Hayes further stated that confining a suicidal inmate to his/her cell twenty-four hours a day only enhances isolation and is anti-therapeutic.

58. Hayes found "various suicide prevention policies provide limited guidance regarding the observation of suicidal inmates, simply stating that custody personnel are required to provide direct visual observation of suicidal inmates 'at least twice in every thirty (30) minute period.'" Hayes found there was "*no* option in any [Department] policy for constant and continuous observation of inmates at the highest risk for suicide."

59. Hayes' Report set forth thirty-two actionable recommendations.

60. Hayes "strongly recommended that the [suicide prevention] policy be revised to include a more robust description of the requirements for both pre-service and annual suicide prevention training, to include the duration of each workshop and an overview of the required topics."

61. Hayes "strongly recommended that possessions and privileges provided to inmates on suicide precautions should be individualized and commensurate with their level of risk."

62. Hayes "strongly recommended that all . . . suicide prevention policies be revised to include two levels of observation that specify descriptions of behavior warranting each level of observation." Additionally, "consistent with the standard of care, an inmate identified as potentially suicidal (or placed on suicide precautions after hours by non-mental health personnel) should be immediately referred to a mental health clinician for completion of a suicide risk assessment."

63. Hayes strongly recommended "officials conduct a comprehensive physical plant review of all jail cells utilized for the housing of suicidal inmates to ensure that they are reasonably suicide-resistant."

64. The County and its policymakers knew of and failed to implement the foregoing recommendations, thus substantially contributing to Mr. Marroquin's death.

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iii. California State Auditor's Findings and Recommendations

65. Very recently, on February 3, 2022, the California State Auditor published a report entitled, "San Diego County Sheriff's Department: It Has Failed to Adequately Prevent and Respond to Deaths of Individuals in Its Custody."

66. The audit concluded that, "Alarmingly, a total of 52 individuals in the San Diego Sheriff's Department's jails died by suicide over the past 15 years, which is more than twice the number in each of the comparable counties."

67. The audit noted that, "in one case, an incarcerated individual who had previously threatened suicide was released from a safety cell placement and enhanced observation housing. . . . the Sheriff Department's policy at that time did not specify time frames for ongoing follow-up after such placement . . . [and] mental health staff followed up only once with the individual after release from enhanced observation housing . . . . Two weeks after the individual's discharge from enhanced observation housing and about 12 days after the individual's lone follow-up encounter with a mental health clinician, the individual died by suicide."

68. The audit report further noted, "the Sheriff's Department's records indicate that a deputy did not perform a required safety check in a housing area, in part because of poor communication between this deputy and the station deputy. One hour after the deputy should have performed this check, sworn staff found an individual in this housing area unresponsive after attempting suicide. A physician pronounced this individual deceased at the scene after staff and paramedics were unsuccessful at saving the individual's life."

69. The audit report further outlined several policy changes that consultants and reviewing agencies have recommended to address the number of suicides in County jails, including increasing the frequency of safety checks in ad-seg units, using wristbands to identify inmates with a history of self-harm, and giving individuals in EOH access to visits and phone calls. As of the date of the state auditor's report, however, none of these recommendations had been implemented.

C. Mr. Marroquin's Wrongful Death

70. Currently Unknown Department Personnel were deliberately indifferent to, and recklessly disregarded, Mr. Marroquin's health, safety, and welfare.

71. Currently Unknown Department Personnel failed to appropriately house and monitor Mr. Marroquin, an individual under their care and custody who they knew was suffering from psychosis and was actively engaged in self-harming and suicidal behaviors by, among other things, providing him with access to adequate psychiatric care, diligently monitoring him, and ensuring he did not have access to the means to attempt suicide.

72. Currently Unknown Department Personnel had no reasonable justification, and in fact acted recklessly, when they transferred Mr. Marroquin from a safety cell to an ordinary cell with running water and only one-hour safety checks.

73. As an actual and proximate result of Defendants' tortious conduct, as alleged herein, Mr. Marroquin suffered damages prior to his death, including those arising from his pre-death pain and suffering, in an amount to be proven at trial. Ms. Marroquin, moreover, suffered damages arising from Mr. Marroquin's wrongful death and the conscience-shocking deprivation of her parent-child relationship with Mr. Marroquin.

VI. CAUSES OF ACTION

FIRST CAUSE OF ACTION

42 U.S.C. § 1983 – Deliberate Indifference to Serious Medical Needs

(By Mr. Marroquin's Successor in Interest Against Currently Unknown Department Personnel)

74. All prior paragraphs are incorporated herein by this reference.

75. Ms. Marroquin asserts this cause of action as Mr. Marroquin's successor in interest.

76. On May 30, 2021, Mr. Marroquin was a pretrial detainee in Defendants' custody.

77. At all times relevant to this cause of action, Defendants were acting under color of state law.

78. On May 30, 2021, Defendants subjectively knew (or, objectively, should have known) that Mr. Marroquin faced serious medical risks and had serious medical needs, including being actively suicidal.

79. Despite this knowledge, Defendants were deliberately indifferent to Mr. Marroquin's serious medical risks and needs by, among other things, failing to provide Mr. Marroquin with sufficient psychiatric care, providing Mr. Marroquin with the means to complete suicide (e.g., running water), and leaving Mr. Marroquin unmonitored for nearly an hour.

80. By being deliberately indifferent to Mr. Marroquin's serious medical risks and needs, Defendants violated Mr. Marroquin's Fourteenth Amendment right to be free from such deliberate indifference as a pretrial detainee.

81. As an actual and proximate cause of Defendants' deliberate indifference to Mr. Marroquin's serious medical risks and needs, Mr. Marroquin suffered damages prior to his death, including those arising from his pre-death pain and suffering, in an amount to be proven at trial.

82. Defendants, moreover, acted (or failed to act) in deliberate and/or reckless disregard of Mr. Marroquin's constitutionally protected rights. Plaintiff thus seeks an award of exemplary damages against these defendants in an amount sufficient to punish this conduct and to deter such conduct in the future.

SECOND CAUSE OF ACTION

42 U.S.C. § 1983 – Substantive Due Process Violation

(By Ms. Marroquin Against Currently Unknown Department Personnel)

83. All prior paragraphs are incorporated herein by this reference.

84. On May 30, 2021, Defendants knew Mr. Marroquin had a history of suicide attempts while in County jails, that Mr. Marroquin had engaged in suicidal behavior for several days prior, and that Mr. Marroquin was actively suicidal, including hearing command hallucinations to hurt and kill himself.

85. Defendants were not faced with rapidly evolving circumstances on Sunday,

May 30, 2021, in the sense that they needed to make split-second decisions. Rather, they had time to deliberate and decide on how they were going to address Mr. Marroquin's serious medical risks and needs.

86. Despites their knowledge of Mr. Marroquin's serious medical risks and needs, and the fact that they had time to adequately address these risks and needs, Defendants allowed Mr. Marroquin to be transferred from near constant observation in a safety cell to a cell equipped with running water and only one hour safety checks. This shocks the conscience.

87. Mr. Marroquin died as an actual and proximate result of Defendants' conscience-shocking conduct.

88. As an actual and proximate result of Mr. Marroquin's death, Ms. Marroquin was deprived of her Fourteenth Amendment right as a parent to enjoy the familial companionship and society of her son.

89. As a direct and foreseeable result of this denial of substantive due process, Plaintiff suffered non-economic damages, in an amount to be determined at trial, including loss of love, companionship, comfort, care, assistance, protection, affection, society, and moral support.

90. Defendants, moreover, acted (or failed to act) in deliberate and/or reckless disregard of Plaintiff's constitutionally protected rights. Plaintiff thus seeks an award of exemplary damages against these defendants in an amount sufficient to punish this conduct and to deter such conduct in the future.

THIRD CAUSE OF ACTION

Wrongful Death

(By Ms. Marroquin Against Currently Unknown Department Personnel)

91. All prior paragraphs are incorporated herein by this reference.

92. At the time of his death, Mr. Marroquin had no spouse or issue. Thus, Plaintiff, as Mr. Marroquin's parent, has standing to assert a cause of action for the wrongful death of Mr. Marroquin. *See* Cal. Civ. Proc. Code § 377.60.

93. As alleged herein, Mr. Marroquin died as a result of Defendants' tortious conduct, to wit, Defendants' deliberate indifference to Mr. Marroquin's serious medical risks and needs. Mr. Marroquin's death was, therefore, "wrongful" for purposes of a claim for damages under California Code of Civil Procedure section 377.60. *See Estate of Prasad v. County of Sutter*, 958 F. Supp. 2d 1101, 1118 (E.D. Cal. 2013).

94. As a direct and foreseeable result of Mr. Marroquin's wrongful death, Ms. Marroquin suffered non-economic damages, in an amount to be determined at trial, including loss of love, companionship, comfort, care, assistance, affection, society, and moral support.

VII. PRAYER FOR RELIEF

95. Pursuant to the foregoing causes of action, Plaintiff prays for the following relief:

a. on all causes of action, that judgment be rendered in favor of Plaintiff and against Defendants;

b. on all causes of action, that compensatory damages (including noneconomic damages) be awarded as permitted by federal and state law, in amounts to be determined at trial;

c. on the First and Second Causes of Action, that punitive damages be awarded against the individual defendants to these causes of action, as permitted by federal law, and in an amount sufficient to deter and make examples out of these individuals, to be determined at trial;

d. reasonable attorney fees, expenses, and costs of suit pursuant to 42 U.S.C. § 1988, California Code of Civil Procedure section 1021.5, and any other relevant statutory or case law; and

e. any and all other relief in law or equity to which Plaintiff may be entitled and which this Court deems just and proper.

VIII. DEMAND FOR JURY TRIAL

96. Pursuant to Rule 38 of the Federal Rules of Civil Procedure and the Seventh

Amendment to the Constitution, Plaintiff hereby demands a trial by jury of this action.

Dated: May 23, 2022

s/Trenton G. Lamere

Attorney for Plaintiff