UNITED STATES DISTRICT COURT FOR THE
NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

JONATHAN MATTIX, individually and as independent administrator of, and on behalf of the ESTATE OF GEORGIA KAY BALDWIN, and GEORGIA KAY BALDWIN's heir(s)-at-law; JOSHUA MATTIX, individually; and JUSTIN BALDWIN, individually,	§	CIVIL ACTION NO. 4:23-cv-00635-Y
	§	JURY DEMANDED
Plaintiffs,	§	
v.	§	
TARRANT COUNTY, TEXAS,	§	
Defendant.	§	

PLAINTIFFS' RESPONSE TO DEFENDANT TARRANT COUNTY'S
MOTION TO DISMISS AND BRIEF IN SUPPORT

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I. OVERVIEW

Tarrant County makes much ado about a water fountain over a toilet.[1] Presuming that the fountain even worked, which is highly suspect, it has zero relevance to the County's constitutional duty to protect pretrial detainees like Georgia Kay Baldwin, who was mentally ill and could not take care of herself. Try as it might, the County cannot punt its responsibility to take care of pretrial detainees onto an inanimate object.

The County in fact blames Georgia herself for being mentally ill and refusing treatment. But the County was constitutionally required to protect Georgia from harm, even from herself. Georgia undisputedly was experiencing a mental health crisis when she was booked into a Tarrant County jail. She ultimately ended up alone in a cell for months, where she suffered delusions and began talking to people who were not there. She was paranoid, confused, disheveled, afraid, and making nonsensical statements for the duration of her stay. Among other things, she thought someone wanted to kidnap and extradite her to a foreign country as a "worldwide wanted hostage." Georgia, who was severely low functioning because of her mental health, ended up dying, alone and afraid, because she did not drink enough water to keep herself alive—a condition that most

[1] The picture on the left was on Plaintiff's Original Complaint (Doc. 1). The picture on the right is a close-up of the water fountain/sink that the County touts. The Court can consider both because the water fountain is referred to in Plaintiff's First Amended Complaint. *See Sullivan v. Leor Energy, LLC*, 600 F.3d 542, 546 (5th Cir. 2010). There is no indication at this juncture that this water fountain even worked or if it did that any water pouring into the corroded sink was potable.

likely resulted from impaired mental judgment, which caused her to be suspicious and afraid. The County blithely responds that Georgia had that water fountain in her cell, as if that absolves the County of its constitutional duties to protect Georgia and provide the mental healthcare she so desperately needed, as if Georgia held the key to unlock her own mental health crisis.

The County, wringing its hands, insists, "but she refused mental healthcare and water." What really happened is that the County let Georgia languish and die, while providing the bare minimum to be able to *say* she received mental healthcare, which was inadequate.[2] *Georgia was delusional*—that is why she needed to be in a facility or released to her family.[3] Otherwise, the County needed but lacked policies to adequately care for Georgia and scores of other mentally ill pretrial detainees who were waiting for a mental health hospital bed. County employees certainly knew—and it is well documented—that Georgia had serious mental health issues that could not be handled in the jail. This was a repeated pattern of treatment, or lack thereof, consistent with County policies, practices, and customs that for over a decade resulted in dozens of detainee deaths.

II. PLAINTIFFS' ALLEGATIONS RELEVANT TO MOTION TO DISMISS

Georgia left voicemail messages for a law enforcement officer, making nonsensical statements regarding her desire for certain people to die, involving the Mississippi governor and others. (¶ 8)[4] She was taken into custody, charged with terroristic threats, and eventually held at the Lon Evans Corrections Center (Corrections Center). (¶¶ 8-10, 18) A psychiatric examination revealed she was incompetent to stand trial, and she was ordered to be incarcerated for a

[2] "Responding to a serious medical issue with . . . a cursory level of care may still constitute deliberate indifference." *Ford v. Anderson Cnty.*, 90 F.4th 736, 753 n.7 (5th Cir. 2024).

[3] The County insists rather flippantly that it is not liable because County employees purportedly did not know that Georgia was refusing water. The County draws the issue too narrowly. County employees undisputedly knew that Georgia was delusional and could not take care of herself. This is also a summary judgment issue because there are fact questions regarding what County employees knew. For the reasons discussed below, Plaintiffs pleaded plausible claims against the County based on policies, practices, and customs that were a moving force behind Georgia's death.

[4] Paragraph references are to Plaintiffs' First Amended Complaint (Doc. 28).

competency restoration program for no more than 60 days of a 120-day commitment. (¶ 11) During a competency evaluation, a doctor noted that Georgia's health condition and "rational or factual understanding" had not improved. (¶ 12) He stated that Georgia must be "closely monitored as to the effects of her mental state to her functioning." (¶ 12) Georgia was discharged from the competency restoration program approximately 60 days later, but she should have been hospitalized for the remainder of the 120 days of her commitment: her medical records note, "Her symptoms are likely to deteriorate if no intervention is initiated." (¶ 13) Instead, she was moved to a solitary small cell in the Corrections Center, where she could not see through a window or see other people. (¶ 13) Even though Georgia was housed in the mental health wing, the County failed or refused to (1) provide the necessary medical or mental healthcare to keep her alive, (2) release her, or (3) transfer her to an appropriate outside mental health facility.[5] (¶ 14) In fact, Georgia only had five scheduled visits with MHMR personnel during the nearly five months she was incarcerated. (¶ 15) The rest of her visits with a mental health professional were very short and ranged from two minutes only up to 32 minutes. (¶ 15) Even more alarming, after Georgia was supposed to be transferred for inpatient treatment until the day she died, she only spent a total of 18 minutes with a mental health provider over the course of those seven weeks. (¶ 15)

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[5] The County insists that it could not transfer Georgia, who had been declared incompetent to stand trial, to an inpatient facility due to the long waitlist, but the County has not addressed its refusal to release Georgia or institute a policy of adequately caring for mentally ill patients. As the Fifth Circuit and Supreme Court have held,

> The Fourteenth Amendment prohibits a state from confining a criminal defendant "solely on account of his incapacity to proceed to trial" for more than "the reasonable period of time necessary to determine whether there is substantial probability that he will attain that capacity in the foreseeable future." If there is no real probability that defendant will become competent, the state must institute civil commitment proceedings—to gauge the dangerousness of the defendant—or release him.

Harris v. Clay Cnty., 47 F.4th 271, 277 (5th Cir. 2022) (quoting and citing *Jackson v. Indiana*, 406 U.S. 715, 738 (1972)). A prolonged detention without a chance of competency being restored, which was the case here in part because Georgia refused to participate in the competency program, or a pending civil proceeding that could result in commitment based on dangerousness meant that Georgia was entitled to go free. *See id*. Yet, the County chose to keep her in custody. Also, it is not a defense to say that the fault lies with the courts or prosecutor. *See id*. Holding Georgia for nearly five months without bringing her before a judge violated her due process rights. *See id*.

Plaintiffs alleged a timeline outlining almost daily incidents showing the County knew Georgia was experiencing an extreme mental health crisis while she was incarcerated.[6] County employees thus let Georgia languish in this state for over four months, while she mostly was alone in her cell. (¶ 16) Georgia died on September 14, 2021, her entirely avoidable death caused by "severe hypernatremic dehydration": a high concentration of sodium in the blood generally caused when someone does not drink enough water. (¶¶ 17, 18, 26) She was found, unresponsive and pants-less, in her cell, which was in a state of disarray "with papers shredded and distributed all over the room." (¶¶ 22-25) Texas Ranger Dendy noted as part of his investigation that hypernatremia "usually occurs because of impaired mental judgment."[7] (¶ 26)

The County's argument that Plaintiffs have not sufficiently pleaded *Monell* liability is simply without merit. The complaint plainly describes County policies, practices, and customs and articulates how they were a moving force behind Georgia's death. These include failing to provide emergency or necessary medical and mental healthcare, lack of or inadequate monitoring, and understaffing. These failures resulted in many detainee deaths.[8] (¶¶ 43-100)

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[6] Located at pages 12 through 15 of Plaintiff's First Amended Complaint (¶ 16). Plaintiffs also included a summary of these allegations in their response to the County's first motion to dismiss but have not included it here because of page limitations. (*See* Doc. 9 at 2-3) Page number references to previously filed documents in this case are to the page numbers at the bottom of the page.

[7] "Examples include someone with dementia." (¶ 26) The County is arguing that it does not have any responsibility, other than to provide a water fountain, to take care of someone who is so mentally impaired that she does not know to drink enough water to stay alive. That is equivalent to putting water and food into an Alzheimer's patient's room but not making sure the patient eats or drinks. That amounts to woefully inadequate, cursory medical care under any standard of care. *See Ford*, 90 F.4th at 753 n.7.

[8] It is convenient for the County to argue that the Court cannot consider other deaths in Tarrant County jails, particularly when the County has had so many detainee deaths and the County jail houses so many people with mental health needs. Interestingly, the County fails to acknowledge what courts in the Northern, Southern, Eastern, and Western districts have all acknowledged, "In the context of municipal liability, as opposed to individual officer liability, it is exceedingly rare that a plaintiff will have access to (or personal knowledge of) specific details regarding the existence or absence of internal policies or training procedures prior to discovery" and thus plaintiffs can rely on minimal factual allegations at the pleading stage. *Gallaher v. City of Maypearl*, No. 3:17-CV-1400-M, 2018 WL 700252, at *3 (N.D. Tex. Feb. 2, 2018) (Exhibit A); *Rosales v. Tex. City of Tyler*, No. 6:23-CV-00245-JDK, 2023 WL 6474419, at *5 (E.D. Tex. Sept. 12, 2023) (Exhibit B), *report and recommendation adopted sub nom.*, No. 6:23-CV-245-JDK, 2023 WL 6465864 (E.D. Tex. Oct. 4, 2023); *Sanchez v. Gomez*, 283 F. Supp. 3d 524, 532 (W.D. Tex. 2017);

III. LEGAL STANDARDS

A. Standard of Review – Rule 12(b)(6) Motion to Dismiss

A complaint "will survive dismissal . . . if it contains sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Legate v. Livingston*, 822 F.3d 207, 210 (5th Cir. 2016). "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). A complaint "does not need detailed factual allegations," but the facts alleged "must be enough to raise a right to relief above the speculative level." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007). "[T]he central issue is whether, in the light most favorable to the plaintiff, the complaint states a valid claim for relief." *Hughes v. The Tobacco Inst., Inc.*, 278 F.3d 417, 420 (5th Cir. 2001). Thus, the inquiry focuses on the allegations in the pleadings and not on whether the plaintiff actually has sufficient evidence to succeed on the merits. *Ackerson v. Bean Dredging LLC*, 589 F.3d 196, 209 (5th Cir. 2009).

The federal rules do not permit a heightened pleading standard in section 1983 cases. *Johnson v. City of Shelby*, 574 U.S. 10, 11 (2014) (citing *Leatherman v. Tarrant Cnty. Narcotics Intelligence and Coordination Unit*, 507 U.S. 163, 164 (1993)). The Supreme Court emphasized the purpose of pleadings is to allege facts rather than legal theories. *Id*. Thus, even in the absence

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Thomas v. City of Galveston, 800 F. Supp. 2d 826, 842 (S.D. Tex. 2011). *See infra* 6-7. The County's ipse dixit otherwise does not make it so. As a great example of this in action, after the Court granted Plaintiffs' motion to amend and Plaintiffs filed the first amended complaint on January 29, 2024, the County produced documents on February 20, 2024, that named one person who, similar to Georgia, died from dehydration and one person whose cause of death was pending. Then on March 13, 2024, the custodial death report for this person was amended to reflect for the first time that that person also died from dehydration. Both people, like Georgia, exhibited mental health problems before their deaths. If the Court were to conclude that Plaintiffs have insufficiently pleaded details regarding other deaths in the County jail, Plaintiffs request another opportunity to amend their complaint to reflect this information and other relevant information learned through discovery. *See Jacquez v. Procunier*, 801 F.2d 789, 792-93 (5th Cir. 1986). But these details are best saved for summary judgment, after the parties have had adequate time for discovery. *See infra* 6-7.

Exhibits are attached to and made part of Plaintiffs' appendix in support of this brief.

of any stated legal theory, a complaint will withstand a motion to dismiss if the facts are sufficient to support a proper legal theory. *See id*. at 12; *see also Crane v. City of Arlington*, 50 F.4th 453, 461 (5th Cir. 2022). In considering motions to dismiss, courts are required to "accept all facts as pleaded and construe them in the light most favorable to the plaintiff." *Crane*, 50 F.4th at 461.

B. Liability for Violation of Constitutional Rights of Pretrial Detainees to Protection from Harm and Medical Care

"The constitutional rights of a pretrial detainee . . . flow from both the procedural and substantive due process guarantees of the Fourteenth Amendment." *Hare v. City of Corinth*, 74 F.3d 633, 639 (5th Cir. 1996) (en banc) (citing *Bell v. Wolfish*, 441 U.S. 520 (1979)). These rights include the right to "basic human needs, including medical [and mental health] care and protection from harm." *Id*. at 650; *Sanchez v. Young Cnty.* (*Sanchez I*), 866 F.3d 274, 279 (5th Cir. 2017); *Converse v. City of Kemah*, 961 F.3d 771, 775 (5th Cir. 2020). Although local governments have no respondeat superior liability, they are liable for a policy, practice, or custom that causes a constitutional injury. *Leatherman*, 507 U.S. at 166-69; *see also Monell v. New York City Dept. of Soc. Servs.*, 436 U.S. 658, 691 (1978). Regarding municipal liability, "it is exceedingly rare that a plaintiff will have access to (or personal knowledge of) specific details regarding the existence or absence of internal policies or training procedures prior to discovery." *Sanchez v. Gomez*, 283 F. Supp. 3d 524, 532 (W.D. Tex. 2017) (quoting *Thomas v. City of Galveston*, 800 F. Supp. 2d 826, 842-43 (S.D. Tex. 2011)); *see also Gallaher v. City of Maypearl*, No. 3:17-CV-1400-M, 2018 WL 700252, at *3 (N.D. Tex. Feb. 2, 2018) (Exhibit A). Accordingly, "while stating a claim against a municipality requires more than a barebones recitation of the elements of municipal liability, plaintiffs need not 'specifically state what the [municipal] policy is' and can rely on 'minimal factual allegations' at this stage in the litigation." *Sanchez*, 283 F. Supp. 3d at 532; *see also Schaefer v. Whitted*, 121 F. Supp. 3d 701, 718 (W.D. Tex. 2015). "[F]ederal courts and litigants

must rely on summary judgment and control of discovery to weed out unmeritorious claims sooner rather than later." *Thomas*, 800 F. Supp. 2d at 845 (quoting *Leatherman*, 507 U.S. at 168-69).

The elements of *Monell* liability are (1) "an official policy (or custom)," (2) "a policy maker [that] can be charged with actual or constructive knowledge," and (3) "a constitutional violation whose 'moving force' is that policy (or custom)." *Newbury v. City of Windcrest*, 991 F.3d 672, 680 (5th Cir. 2021). The first element requires showing that an official policy or custom existed that led to a constitutional violation. *Id*. A custom may give rise to liability under *Monell* if the practice is "so persistent and widespread as to practically have the force of law." *Connick v. Thompson*, 563 U.S. 51, 61 (2011). But plaintiffs are not required to provide specific examples to meet this element. *Moore v. LaSalle Mgmt. Co.,* 41 F.4th 493, 509 (5th Cir. 2022). It is well established in the Fifth Circuit that a municipality's post-incident conduct, including the failure to discipline or make changes, can support a finding of official policy. That is because post-incident "inaction arguably shows acquiescence to the misconduct such that a jury could conclude that it represents official policy." *Sanchez v. Young Cnty.* (*Sanchez II*), 956 F.3d 785, 793 (5th Cir. 2020); *see also Moore*, 41 F.4th at 509 ("[P]olicymakers failing to take corrective action after subordinates violate the constitution is some evidence that they knew about an unconstitutional custom."); *Grandstaff v. City of Borger*, 767 F.2d 161, 171 (5th Cir. 1985) (same).

The second element requires plaintiffs to demonstrate a policymaker constructively or actually knew of the policy, custom, or practice. *See Newbury*, 991 F.3d at 680. "Constructive knowledge can be attributed to . . . policymaker[s] 'on the ground that [they] would have known of the violations if [they] had properly exercised [their] responsibilities, as, for example, where the violations were so persistent and widespread that they were the subject of prolonged public discussion." *Moore*, 41 F.4th at 511. Likewise, "policymakers failing to take corrective action after

subordinates violate the constitution is some evidence" of their actual knowledge. *Id*. at 510 & n.56 (citing *Grandstaff*, 767 F.2d at 171). "If a municipality condones an unlawful custom, it cannot avoid liability by claiming that it did not authorize its agents in writing to break the law in the course of their duties." *Id*. According to the Fifth Circuit:

> It is virtually always the case that, when an unwritten custom is challenged under *Monell*, that custom conflicts with some governing written policy or law. If a municipality condones an unlawful custom, it cannot avoid liability by claiming that it did not authorize its agents in writing to break the law in the course of their duties.

Id. at 511.

Plaintiffs are not required to identify the County's policymaker in their pleadings. *See Groden v. City of Dallas*, 826 F.3d 280, 283-84 (5th Cir. 2016) ("[C]ourts should not grant motions to dismiss for failing to plead the specific identity of the policy maker."). The identity of the policymaker is a question of law, which a plaintiff does not need to address in a complaint. *Id*. at 284-85 (citing *City of St. Louis v. Praprotnik*, 485 U.S. 112, 124 (1988)).

The third element requires the policy to be a moving force behind the constitutional violation, meaning that "there must be a direct causal link" between the policy and violation. *Moore*, 41 F.4th at 511-12; *Piotrowski v. City of Houston*, 237 F.3d 567, 580 (5th Cir. 2001).

C. Conditions of Confinement Versus Episodic Acts or Omissions

Plaintiff's *Monell* claims are based on conditions of confinement. As the Fifth Circuit recently recognized in *Garcia v. City of Lubbock*, No. 21-11134, 2023 WL 4636896, at *8 n.8 (5th Cir. July 20, 2023) (Exhibit C), a court should not second guess counsel's decision to assert conditions of confinement theories. A plaintiff has the right to assert both conditions and episodic acts theories in the alternative. *Id*. Failure to consider a plaintiff's conditions-of-confinement theories is error. *Sanchez I*, 866 F.3d at 279 (remand for consideration of conditions-of-confinement theory).

Plaintiff's allegations track the language of a pivotal case addressing conditions of confinement. *See Sanchez II*, 956 F.3d at 791-95. Those claims challenge the "general conditions, practices, rules, or restrictions of pretrial confinement [that] amount to punishment." *Id*. at 791 (quoting *Hare*, 74 F.3d at 639, and *Bell*, 441 U.S. at 535). A plaintiff must show "a condition—a rule, a restriction, an identifiable intended condition or practice, or sufficiently extended or pervasive acts or omissions of jail officials—that is not reasonably related to a legitimate government objective and that caused the constitutional violation." *Id*. A plaintiff can do so in several ways, including but not limited to presenting evidence of (1) "practices that are sufficiently extended or pervasive, or otherwise typical of extended or pervasive misconduct"; (2) TCJS records; (3) failures to reprimand; (4) "consistent testimony of jail employees"; and (5) a "mutually enforcing effect" of multiple interacting policies. *Id*. at 792-94, 796.

For both conditions of confinement and episodic acts or omissions, a plaintiff must show "(1) that a constitutional violation occurred and (2) that a municipal policy was the moving force behind the violation." *See id*. at 791. For conditions claims, a plaintiff is not required to show deliberate indifference because "intent to punish . . . may be inferred from the decision to expose a detainee to an unconstitutional condition." *Shepherd v. Dallas Cnty.*, 591 F.3d 445, 452, 454-55 (5th Cir. 2009). Plaintiffs have alleged unconstitutional conditions of confinement, which the Court should analyze individually and collectively, including failures to provide emergency or necessary medical and mental healthcare, failures to monitor or to adequately monitor, and understaffing. *See, e.g., Sanchez II*, 956 F.3d 785 at 793-94, 796; *Shepherd*, 591 F.3d at 452-54.

Even if the Court concludes that some or all these claims are based on episodic acts or omissions, Plaintiffs have also plausibly alleged claims under that theory. To establish liability for episodic claims, a plaintiff must show that one or more municipality employees "acting with

subjective deliberate indifference, violated [the plaintiff's] constitutional rights [and] the [municipality employee's or] employees' acts resulted from a municipal policy or custom adopted with objective indifference to the detainee's constitutional rights."[9] *Sanchez I*, 866 F.3d at 280; *see also Olabisiomotosho v. City of Houston*, 185 F.3d 521, 526 (5th Cir. 1999). "What a prison official subjectively knew 'is a question of fact subject to demonstration in the usual ways [including inference from circumstantial evidence].'" *Sanchez v. Oliver*, 995 F.3d 461, 473 (5th Cir. 2021) (quoting *Farmer v. Brennan*, 511 U.S. 825, 842 (1994)).

IV. ARGUMENT

Plaintiffs pleaded ample plausible facts that, when construed in the light most favorable to Plaintiffs, would support findings that County policies, practices, and customs were a moving force behind the violations of Georgia's constitutional rights to protection from harm and to medical and mental healthcare. The County attempts to sidestep its constitutional responsibility to protect Georgia by glibly pointing out a water fountain. There is no indication that the water fountain pictured above *actually worked* or was even turned on. Setting that aside, Plaintiffs clearly and specifically pleaded facts demonstrating that Georgia was delusional and in a mental health crisis while in the County jail and could not possibly care for herself. Sticking Georgia into a cell with a water fountain, even presuming that it worked, was woefully and constitutionally inadequate to protect her or and did nothing to address the medical and mental healthcare that she desperately and obviously needed.

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[9] Although other circuits disagree, the Fifth Circuit currently applies a subjective deliberate indifference standard to pretrial detainee episodic acts or omissions claims outside the context of excessive force. *Sims v. Griffin*, 35 F.4th 945, 950 n.10 (5th Cir. 2022). Plaintiffs assert that the Supreme Court in *Kingsley v. Hendrickson*, 135 S. Ct. 2466 (2015) changed the standard and now requires courts to apply an objective standard to all pretrial detainee claims under section 1983. Plaintiffs seek to preserve error on this issue.

The care that the County provided was cursory at best. As discussed, Georgia was incompetent to stand trial, yet the County kept her incarcerated. After she was supposed to be transferred for inpatient treatment until the day she died, she only spent a total of 18 minutes with a mental health provider over the course of those seven weeks. (¶ 15) That cursory level of care does not pass constitutional muster.[10] As set forth below, Plaintiffs plausibly alleged that de facto County policies, practices, and customs were a moving force behind the violation of Georgia's constitutional rights that culminated in her unnecessary suffering and death. Taking Plaintiffs' allegations as true and construing them and all inferences in Plaintiffs' favor shows that the County also had unconstitutional conditions of confinement based on "different, compounding ways that [the County's] alleged policies might interact, [from which] a jury could reasonably conclude that they had a 'mutually enforcing effect' that deprived" Georgia of her constitutional rights. *See Sanchez II*, 956 F.3d at 796.

A. Inapplicable Authorities Relied on by County

Insisting that Plaintiffs have not alleged unconstitutional conditions of confinement, the County relies on several cases that simply do not apply. As noted, "it is exceedingly rare" for a plaintiff to have access to specific details regarding a municipality's policies, practices, or customs prior to discovery. *Gomez*, 283 F. Supp. at 532. Plaintiffs "can rely on 'minimal factual allegations' at this stage." *Id.*; *see also Schaefer*, 121 F. Supp. 3d at 718. In this district, dismissal is erroneous

[10] *See, e.g., Ford*, 90 F.4th at 753 n.7 ("Responding to a serious medical issue with such a cursory level of care may still constitute deliberate indifference.") (citing *Austin v. Johnson*, 328 F.3d 204, 206, 210 (5th Cir. 2003) (finding that a nearly two-hour delay in calling an ambulance could constitute deliberate indifference, even though a defendant had administered first aid), *Ledesma v. Swartz*, 134 F.3d 369 (5th Cir. 1997) (finding that treating complaints of a broken jaw with only over-the-counter pain medication and a liquid diet could constitute deliberate indifference), and *Mandel v. Doe*, 888 F.2d 783, 789 (11th Cir. 1989) ("When the need for treatment is obvious, medical care which is so cursory as to amount to no treatment at all may amount to deliberate indifference.")). It is also no answer that Georgia refused care. She was delusional and incompetent to stand trial and thus could not make a knowing, voluntary, intelligent waiver. The case the County relies on involved detainees who knowingly refused care. (Doc. 29 at 17)

when a plaintiff alleges "(1) past incidents of misconduct by the defendant to others; (2) multiple harms that occurred to the plaintiff [herself]; (3) the involvement of multiple officials in the misconduct; or (4) the specific topic of the challenged policy or training inadequacy." *Flanagan v. City of Dallas*, 48 F. Supp. 3d 941, 947 (N.D. Tex. 2014); *Hill v. Turknett*, No. 3:19-CV-2871-K, 2020 WL 3872743, at *2 (N.D. Tex. July 9, 2020) (Exhibit D). Plaintiffs have alleged all four. The County conveniently ignores this caselaw. *See also supra* n.8.

The County relies on two summary judgment cases and two cases on appeal after jury trial to support its argument that Plaintiffs have not alleged unconstitutional conditions of confinement. *See Connick*, 563 U.S. 51 (jury trial); *Duvall v. Dallas Cnty.*, 631 F.3d 203 (5th Cir. 2011) (jury trial); *Peterson v. City of Fort Worth*, 588 F.3d 838 (5th Cir. 2009) (summary judgment); *Estate of Davis ex rel. McCully v. City of N. Richland Hills* (*McCully*), 406 F.3d 375 (5th Cir. 2005) (summary judgment). These cases do not support dismissal on that basis alone. *See, e.g., Converse*, 961 F.3d at 776 ("We have criticized defendants for arguing that cases dismissed on summary judgment supported dismissal of their cases at the pleadings stage.") (collecting cases); *Lewis v. Dallas Cnty.*, No. 3:15-CV-4014-L, at *5 (N.D. Tex. 2017) (Lindsay, J., Order Denying Motion to Dismiss) (Exhibit E) ("Cases that deal with a summary judgment or trials do not assist the court in any manner as to whether a party has sufficiently pleaded allegations to state a claim upon which relief can be granted."). And they do not otherwise demonstrate that Plaintiffs' claims should be dismissed.[11] *Peterson* and *McCully*, both excessive force cases, simply state that to show a pattern requires similarity and specificity. *Peterson*, 588 F.3d at 851; *McCully*, 406 F.3d at 383. The Fifth Circuit in *Duvall* similarly noted that showing a pattern requires evidence that "violations were

[11] The County also cites *Vardeman v. City of Houston*, No. CV H-20-3242, 2021 WL 1701009, at *1 (S.D. Tex. Apr. 29, 2021) (Exhibit F), which is inapposite. It involved an excessive-force allegation against a "Houston Airport System" employee. *Id*. at *3. The plaintiff relied on "unrelated incidents of Houston police and correctional officer violence." *Id*. Here, all of Plaintiffs' allegations involve only incidents at Tarrant County jails.

serious, extensive and extended, and . . . more than *de minimis*." 631 F.3d at 208. In that case, the court concluded there was "a surfeit of evidence that the County knew of the conditions complained of, yet continued to house inmates in those conditions." *Id*. at 207-08. Just so here.

Plaintiffs, moreover, were not required to plead that other detainees died from hypernatremia. It is enough to plead that the County's evaluation, monitoring, and treatment of detainees was "grossly inadequate due to poor or non-existent procedures and understaffing of guards and medical personnel," which Plaintiffs have done. *See Shepherd*, 591 F.3d at 453; *see also Nichols v. Brazos Cnty.*, No. CV H-19-2820, 2020 WL 956239, at *6 (S.D. Tex. Feb. 26, 2020) (Exhibit G) (holding allegations regarding "inadequate policy and practice of supervising medical care of inmates and [allowing] medical personnel to ignore . . . serious medical needs" and "policies and practices [that did] not require any follow up or monitoring even after receiving an inmate's medical records reflecting several chronic illnesses" asserted *Monell* claim). The County cites *Garcia* and *Johnson* for the proposition that other instances of conduct must be similar to the conduct in this case. *See Garcia*, 2023 WL 4636896, at *9; *Johnson v. Harris Cnty.*, 83 F.4th 941, 946 (5th Cir. 2023). Even though Plaintiffs are not required to provide specific examples, *see Moore*, 41 F.4th at 509, they have done so. Plaintiffs alleged numerous instances involving detainees who, like Georgia, suffered from mental health issues and died in the County's care, not to mention the two other detainees who died from dehydration, like Georgia, *see supra* n.8. (¶¶ 46, 48, 54-55, 60-61, 63, 70, 72, 75, 79, 82-83, 91-92)

The County also cites *Connick* for the proposition that "subsequent conduct cannot establish a pattern of violations." 563 U.S. at 63 n.7. That footnote, however, does not make the County's post-incident conduct irrelevant. The Fifth Circuit has repeatedly held that post-incident conduct by a municipality, including the failure to discipline or make changes, can support a

finding of official policy because it "arguably shows acquiescence to the misconduct such that a jury could conclude that it represents official policy." *Sanchez II*, 956 F.3d at 793; *see also Moore*, 41 F.4th at 509; *Grandstaff*, 767 F.2d at 171.[12] The County's conduct was the same both before and after Georgia's death and resulted in many likely unnecessary deaths in County jails.

B. Failing to Provide Emergency or Necessary Medical and Mental Healthcare Combined with Understaffing and Inadequate Communication Policies

The County failed to provide—or delayed providing—necessary medical and mental healthcare treatment, understaffed County jails and had lax communication among jailers, so that detainees like Georgia could languish in her cell experiencing an ongoing mental health crisis to the point of death. *See Shepherd*, 591 F.3d at 453. A municipality can have a de facto policy of grossly inadequate "evaluation, monitoring, and treatment" of detainees based on "poor or non-existent procedures and understaffing of guards." *Id*. Plaintiffs alleged Georgia was experiencing an ongoing mental health crisis, including delusions, from before the time she was incarcerated until her unnecessary death over four months later. But the County chose not to send Georgia for inpatient mental healthcare or release her. She is one of many who died in the County's care because it failed to provide necessary medical and mental healthcare. These policies, practices, and customs, working together with understaffing and lax communication, resulted in Georgia's suffering and death.

Plaintiffs pleaded County policies, practices, and customs of (1) failing to treat untreated mental illness as a medical emergency; (2) failing to transport mentally ill detainees to a mental

[12] The County argues that the facts of this case are not "extreme" enough for *Grandstaff* to apply and then cites a 1998 Fifth Circuit case, ignoring more recent Fifth Circuit caselaw applying *Grandstaff*. It is hard to envision a more extreme circumstance than watching someone in a mental health crisis languish over months until death and not providing her adequate medical or mental healthcare. But this case also shares similarities with *Sanchez II*, in which the Fifth Circuit held *Grandstaff* applied. 956 F.3d at 793. In that case, officers let a pretrial detainee languish and die in a cell. *Id*. at 788. Moreover, Plaintiffs in this case have alleged a pattern of violations in addition to the County's failure to make changes in response to Georgia's unnecessary death.

health facility despite being ordered to do so; (3) not providing or instituting a plan to provide medication to mentally ill detainees who were not competent to refuse medications; (4) failing to provide necessary treatment to mentally ill detainees when the County would not or could not transport those detainees for inpatient care, despite the fact that the County jail houses more individuals with mental health needs than any other County facility; and (5) rotating jailers in and out of special medical and mental healthcare observation pods, resulting in jailers not getting to know specific detainees or their needs, combined with not informing jailers of detainees' medical or mental healthcare needs. (¶ 29)

Plaintiffs also alleged the County had a policy, practice, and custom of understaffing. (¶¶ 29, 42) A private contractor, CGL Companies (CGL), determined well before Georgia's death that County jails were "significantly understaffed." (¶ 29) Compared to other jails across the country, Tarrant County jails had fewer detention officers per detainee. (¶ 29) The County had funded 975 employees when 1,330 employees were needed. (¶ 29) The most critical vacancies were tied to facilities that housed the most difficult to manage detainees. (¶ 29) Corrections Center, where Georgia was housed, had significant staffing issues. (¶ 29) CGL determined that facility was 43 employees short of its recommended staffing level and thus recommended that the County prioritize staffing efforts on filling vacancies there. (¶ 29) The facility's design also caused specific areas of concern, with poor sight lines and the inability to provide "meaningful out-of-cell" time because the facility lacks adjacent recreational or dayroom space. (¶ 29) According to CGL, the facility "has more intense staffing needs due to the fact it houses a higher custody population and inmates with special needs." (¶ 29) At Corrections Center, staff were pulled from observation duties to escort detainees, take detainees out of their cells, take approved breaks, or perform other

collateral duties. (¶ 29) Understaffing, like the above policies, practices, and customs, resulted in many detainee deaths. (¶¶ 43-100)

TCJS reports also reflect these County policies, practices, and customs. As far back as 2014, a TCJS inspector found that jailers were not including medical paperwork in detainee files, which prevented jailers and others from acquiring information necessary to determine whether detainees such as Georgia needed special services. (¶ 31) Another inspection revealed a magistrate was not notified that a detainee may have been suffering from mental illness or mental impairment. (¶ 33) Subsequently, an inspector found that medical paperwork was not being kept in the medical section of detainees' files. (¶ 34) Again in 2021, on four occasions a magistrate was not notified within 12 hours as required that detainees likely had mental health issues. (¶ 40) This inspection shows customs and practices prior to Georgia's death and landed the County on the TCJS list of noncompliant jails. (¶¶ 40-41) In 2022, TCJS determined that the County jail had a staff shortage of 133 correctional officers. (¶ 42) As a result, the County instituted a standard work week of 52 hours. (¶ 42) This incident, which reflects that the County had not corrected its staffing shortage after Georgia's death, is relevant to show "acquiescence to the misconduct such that a jury could conclude that it represents official policy." *See Sanchez II*, 956 F.3d at 793.

Plaintiffs also included a list of over 50 detainees who died (and one who was injured) starting in 2010, apparently resulting from County jailers' failing to provide adequate, necessary medical or mental healthcare, combined with understaffing.[13] (*E.g.*, ¶¶ 43-100) KERA News in fact reported in 2020 that ten inmates died in the County jail, which the County sheriff attributed to "fate" and "the relative ill health of the people who enter his jail." (¶ 88) The article reflects the overall attitude of the policymaker and his knowledge of County policies, practices, and customs

[13] Not to mention the two other detainees who died from dehydration, similar to Georgia, *see supra* n.8.

not to provide adequate medical or mental healthcare. In fact, the County jail lost its state certification as a result of one detainee death, which reflects the County's failure to comply with known jail standards (¶ 88). *See Lombardo v. City of St. Louis*, 210 L. Ed. 2d 609, 141 S. Ct. 2239, 2241-42 (2021) (recognizing that the failure to follow "well-known police guidance" can support finding of constitutional violation). Another detainee gave birth in jail unbeknownst to any jailer, and the baby died. (¶ 88) These incidents show County policies, practices, and customs of failing to provide adequate, necessary medical and mental healthcare, combined with understaffing and poor communication policies, which led to dozens of detainee deaths. *See, e.g., Sanchez II*, 956 F.3d at 792-93; *Shepherd*, 591 F.3d at 453-54.

The above-referenced examples of multiple TCJS reports and other incidents all show that the County knew, constructively or actually, that it had policies, practices, and customs of unconstitutional conditions of confinement that resulted in the violation of Georgia's constitutional rights. The consistent behavior of County employees in all these instances also supports an inference of such unconstitutional conditions of confinement. *E.g., Sanchez II*, 956 F.3d at 794; *Montano v. Orange Cnty.*, 842 F.3d 865, 875 (5th Cir. 2016). This consistent behavior includes Plaintiffs' specific and detailed allegations that *all the jailers* ignored Georgia's medical and mental health needs while she languished in her cell, which is not a naked assertion, as the County would like the Court to believe. Plaintiffs specifically articulated Georgia's condition, which undisputedly was well known at the County jail. If, as Plaintiffs have alleged, the County failed to reprimand any jailers as a result of the incidents leading to Georgia's suffering and death, or otherwise to make changes, that also shows the County knew of and acquiesced to jailer misconduct, which resulted in Georgia's mental health deteriorating to the point of her untimely death. *E.g., Moore*, 41 F.4th at 510; *Sanchez II*, 956 F.3d at 793; *Grandstaff*, 767 F.2d at 171. The

combined force of these allegations, taken as true, would support a reasonable inference that the County had numerous policies that deprived Georgia of her constitutional rights. *See Sanchez II*, 956 F.3d at 796. As discussed above, these policies cannot be viewed in a vacuum. They must be considered along with the de facto policies involving failures to monitor, discussed in detail below. *See id*. ("Given the different, compounding ways that these alleged policies might interact, a jury could reasonably conclude that they had a 'mutually enforcing effect' that deprived [the decedent] of [her constitutional right to] needed medical care.").

C. Failures to Monitor and Related Policies

The County was required to provide an effective watch for its detainees, particularly for detainees suffering from a mental health crisis, like Georgia. But the County's de facto policies allowed Georgia's mental health to deteriorate until she died. A municipality such as the County can have a de facto policy of failing to monitor or inadequately monitoring detainees, which is an unconstitutional condition of confinement. *See id*. Plaintiffs alleged the County chose not to take many steps required by minimum jail standards to prevent exactly what happened to Georgia. The County had policies, practices and customs of (1) failing to adequately monitor detainees as required by TCJS, which led to detainees such as Georgia not receiving proper nutrients and care; (2) not checking electronic records against video recordings of cell checks to make sure they were being done; (3) creating false observation records to make the jail look good; and (4) allowing lax pass-down procedures. (¶ 29)

The Fifth Circuit has recognized that TCJS inspection reports showing failures to monitor can support findings of unconstitutional conditions of confinement. *E.g., Sanchez II*, 856 F.3d at 792; *cf. Shepherd*, 591 F.3d at 451, 453 (involving a commissioned report and DOJ report). The Supreme Court has also recognized that the failure to comply with known jail standards supports a finding of a constitutional violation. *See Lombardo*, 141 S. Ct. at 2241-42. TCJS inspects Texas

county jails for issues regarding noncompliance with jail standards. (¶ 30) TCJS inspection reports referenced in the complaint show ongoing failures by the County to monitor (or effectively monitor) its detainees over a period of at least five years leading up to and including Georgia's death. As far back as 2015, a TCJS inspector found that jailers were not documenting required face-to-face observations of certain detainees every 60 minutes, which is a minimum jail standard. (¶ 32) Those failures to monitor apparently led to the death of a detainee. (¶ 32) Again, in 2020, 30-minute observations that were required for a detainee were being made late.[14] (¶ 38) That detainee also died. (¶ 38)

Plaintiffs have also included a list of dozens of detainees who died (and one who was injured) starting in 2010, apparently resulting from County jailers' failing to monitor or adequately monitor detainees who needed medical attention. (*E.g.*, ¶¶ 43-46, 48, 54-58, 60, 63, 66, 69-73, 75-79, 81-84, 86, 92, 95-96) These are additional examples (not to mention the two other detainees who died from dehydration similar to Georgia, *see supra* n.8) that would support a finding of unconstitutional conditions of confinement based on failures to adequately monitor and protect detainees. *See, e.g., Sanchez II*, 956 F.3d at 792-93; *Shepherd*, 591 F.3d at 453-54. The above-referenced examples of multiple TCJS reports and other incidents all show that the County knew, constructively or actually, that it had policies, practices, and customs of unconstitutional conditions of confinement that resulted in the violation of Georgia's constitutional rights. The consistent behavior of County employees in all these instances also supports an inference of such unconstitutional conditions of confinement. *E.g., Sanchez II*, 956 F.3d at 794; *Montano*, 842 F.3d at 875.

[14] While complying with TCJS standards is not a safe harbor from constitutional violations, failures to comply with such standards have been recognized as evidence of unconstitutional conditions of confinement. *E.g., Sanchez II*, 856 F.3d at 792.

Plaintiffs also alleged and it is a reasonable inference that that the County failed to reprimand any jailers or otherwise to make changes as a result of the incidents leading to Georgia's suffering and death. Taking these allegations as true and construing them in Plaintiffs' favor leads to the conclusion that the County knew of and acquiesced to jailer misconduct in failing to adequately monitor Georgia, which resulted in her mental health deteriorating to the point that she became dehydrated and died. *E.g., Moore*, 41 F.4th at 510; *Sanchez II*, 956 F.3d at 793; *Grandstaff*, 767 F.2d at 171. The combined force of these allegations, taken as true, would support a reasonable inference that the County had numerous policies that deprived Georgia of her constitutional rights. *See Sanchez II*, 956 F.3d at 796.

D. Deliberate Indifference Plausibly Alleged as to Episodic Acts or Omissions

Plaintiffs alleged episodic acts or omissions in the alternative to conditions of confinement. Plaintiffs alleged the County adopted policies, practices, and customs with objective indifference to Georgia's constitutional rights, which resulted in one or more County employee, acting with subjective deliberate indifference, violating those rights. *See Sanchez I*, 866 F.3d at 280. To show subjective deliberate indifference, "a prison official 'must both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists, and . . . also draw the inference.'" *Oliver*, 995 F.3d at 473 (quoting *Farmer*, 511 U.S. at 837). "What a prison official subjectively knew 'is a question of fact subject to demonstration in the usual ways [including inference from circumstantial evidence].'"[15] *Id*. Even "taking some reasonable precautions" is not enough; an official must behave reasonably "on the whole." *See Converse*, 961 F.3d at 779.

[15] The County relies on *Edmiston v. Borrego*, 75 F.4th 551 (5th Cir. 2023), a suicide case, to support its argument that Plaintiffs were required to show County employees knew Georgia was not drinking enough water. But the constitutional standards for providing medical and mental healthcare and protecting suicidal detainees are articulated differently as "the right to medical care" and "the right to be protected from *known* suicidal tendencies." *Sanchez II*, 956 F.3d at 791 (emphasis added). It would be absurd to allow the County to pass the buck by turning a blind eye to Georgia's inability to care for herself. Her mental illness was well documented and undisputedly known

Plaintiffs were not required to name the individual officers involved to plausibly allege deliberate indifference, which the County seems to imply. (Doc. 29 at 20) This is particularly true prior to discovery. *See Thomas*, 800 F. Supp. 2d at 842-43. The County cites three summary judgment cases in support of this argument, which, as noted above, do not apply at the pleading stage. Moreover, those cases do not hold that Plaintiffs are required to identify all the individual actors by name to establish a *Monell* claim. They merely stand for the unremarkable proposition that a plaintiff seeking to establish *Monell* liability must show that a constitutional violation occurred. *E.g., Hinton v. Harris Cnty.*, No. 21-20550, 2022 WL 2752805, at *3 (5th Cir. July 14, 2022) (Exhibit H) ("[P]laintiffs' failure to show that Morehouse, Cooper, or *anyone else* violated Hinton's rights dooms their claim against Harris County.") (emphasis added); *Brown v. Wilkinson Cnty. Sheriff Dep't*, 742 Fed. App'x 883, 884 (5th Cir. 2018) (holding plaintiff failed to show officers, as opposed to inmates, violated his constitutional rights); *Harris v. Serpas*, 745 F.3d 767, 773-74 (5th Cir. 2014) (holding there was no Fourth Amendment violation based on warrantless search when third-party consented to officers' entry). For all the reasons articulated in this brief, Plaintiffs alleged the County violated Georgia's constitutional rights to protection from harm and to receive necessary medical and mental healthcare.

The County incredibly argues that *none* of the other deaths or incidents in Plaintiffs' complaint concern deliberate indifference because Plaintiffs have not alleged that other inmates died by hypernatremia. (Doc. 29 at 13) That is not the test—the test is whether "the official had subjective knowledge of a substantial risk of serious harm to a pretrial detainee but responded with deliberate indifference to that risk." *Olabisiomotosho*, 185 F.3d at 526. Plaintiffs have plausibly

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by County employees. It does not pass constitutional muster for the County to dismissively assert that it did not know Georgia was suffering from hypernatremia, when it was well known to everyone involved that she was too mentally impaired to care for herself and had been found incompetent.

alleged one or more County employees knew or should have known that *Georgia was in a mental health crisis for over four months while in the County jail*. She was delusional and acted erratically for the entire duration. As Plaintiffs alleged, "hypernatremia . . . usually occurs because of impaired mental judgment," which is what Ranger Dendy wrote in his investigation report. (¶ 26) The substantial risk of serious harm to Georgia was clear because she was in an ongoing mental health crisis for the entire duration she was incarcerated and did not receive even the minimum medical or mental healthcare necessary to keep her alive. *See Ford v. Anderson Cnty.*, 90 F.4th 736, 753 n.7 (5th Cir. 2024).

Plaintiffs identify targeted County policies, practices, and customs along with factual support demonstrating past incidents of County misconduct, involvement of multiple jailers in the misconduct, or the specific topic of the challenged policy or misconduct that occurred in the open. (¶¶ 29-100) The deliberate indifference exhibited by County jailers was facilitated by the County's deliberate indifference in running a jail in a manner that does not protect detainees' constitutional rights. The County had a policy, practice, or custom of creating false observation records and allowing a jailer to make entries for other jailers at the proper intervals even for observations that were not actually made. The County thus stressed the administrative requirement of documentation over the actual practice of observing detainees for safety. The County's practices or customs meant Georgia's jailers were intent on documenting, not observing, as their primary obligation.

Even if an observation occurred, the County's policy did not require jailers to watch for the rise and fall of a detainee's chest (¶ 29); in other words, the County's policy, practice, or custom did not require a jailer to establish Georgia was actually still living during the observation. Furthermore, the County had a practice or custom of allowing lax pass-down procedures. These practices or customs, individually and acting together, meant that the County demanded of jailers

no effort to conduct routine observations so that they could be reported to future shifts, so terrible events masked as routine (such as Georgia's passing) went unnoticed.

The County assigned too few jailers to conduct meaningful cell checks. The County also rotated jailers in and out of special medical and mental health observation areas. Jailers were therefore not provided an opportunity to get to know and retain essential information for Georgia's particular medical or mental health needs. Jailers never had enough time or knowledge to be effective "keepers" of Georgia, because County practices and customs did not allow it. Because of the way the jail was staffed, none of the employees had time to or were able to make face-to-face observations with high risk detainees or provide detainees necessary medical or mental healthcare. Additionally, the County failed to oversee cell checks by taking samples of the log to compare with the video records to determine accuracy. All these facts, considered together, would support a finding of deliberate indifference.

E. Moving Force Adequately Alleged

In maintaining these practices or customs, the County's de facto policies had the effect of failing to protect Georgia from harm and failing to provide much needed medical and mental healthcare, which led to her suffering and death. *See, e.g., Shepherd*, 591 F.3d at 454 ("Here, Shepherd demonstrated that serious injury and death were the inevitable results of the jail's gross inattention to the needs of inmates with chronic illness."); *Nichols,* 2020 WL 956239, at *9 (declining to dismiss condition of confinement claim based on allegations that policy or lack thereof was to blame for failure of nurses to give detainee medication, even after receiving his medical records, or to refer him to a physician to get medication); *Feliz v. El Paso Cnty.*, 441 F. Supp. 3d 488, 504 (W.D. Tex. 2020) (denying county's motion to dismiss because plaintiff alleged policy or widespread practice of "failing to provide care to inmates with disabilities" and "failing to properly train employees . . . to recognize and respond to the needs of detainees with mental

illness and medical conditions" and de facto policy of failing to provide adequate medical treatment to detainees with mental-health-related disabilities, which was the moving force behind decedent's death). Plaintiffs pleaded the existence of County policies, practices and customs, which individually or, in the alternative, working together, were moving forces behind Georgia's suffering and death. *See Sanchez II* at 796.

F. *Monell* Policymaker Sufficiently Pleaded

Plaintiffs alleged the County sheriff, or in the alternative, the jail administrator or the commissioners' court, was the relevant chief policymaker.[16] (¶ 107) According to the County, Plaintiffs were required to tie policymaking authority and knowledge to the provision of water. (Doc. 29 at 21) To the contrary, Plaintiffs were required to allege—and did—that the policymaker constructively or actually knew of a policy, custom, or practice that was the moving force behind a constitutional violation. *See Newbury*, 991 F.3d at 680. The constitutional violations at issue involve the rights to reasonable medical and mental healthcare, to be protected, and not to be punished. (¶ 105)

Plaintiffs included detailed factual allegations regarding the timeline of events leading up to Georgia's death, including very detailed entries describing her mental health condition and her delusional activities. (¶ 16) Not only that, but the County notified a magistrate at the time it booked Georgia that she was "suspected of having mental illness and mental retardation." (¶ 14) And yet Georgia was left to her own devices in isolation in a cell, until her physical health deteriorated along with her mental health. At a minimum, the policymaker would have had constructive knowledge of the information in Georgia's file. In addition, the sheriff knew about multiple deaths

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[16] *See, e.g., Garza v. City of Donna*, 922 F.3d 626, 637(5th Cir. 2019) ("We have previously found that Texas police chiefs are final policymakers for their municipalities, and it has often not been a disputed issue in the cases.").

in the County jail and attributed those deaths to "fate" and "ill health" of detainees. (¶ 88) This is enough to support an inference that the policymaker knew about policies in the County jail that were a moving force behind detainee injuries and death. *Compare Pena v. City of Rio Grande City*, 879 F.3d 613, 623 (5th Cir. 2018) (requiring more than speculation that policymaker had actual or constructive knowledge about alleged custom), *with Groden*, 826 F.3d at 286 (allegation that city spokesperson announced a policy allowed inference of policymaker knowledge). Several of Plaintiffs' allegations, moreover, involve staffing or management practices. It is a reasonable inference that the sheriff and jail administrator who, after all, ran the jail, and county commissioners, who oversaw its budget, knew the established practices or customs in staffing. Plaintiffs also included the litany of TCJS inspections through which jail administration would have been made aware of the assortment of problems discovered with the County jail over the years. It is a reasonable inference that the sheriff, jail administrator, and commissioners would have been privy to those inspections, which are also part of the public record. Plaintiff has sufficiently pleaded a *Monell* policymaker with constructive or actual knowledge of County policies, practices, and customs that violated Georgia's constitutional rights.

V. Conclusion

For the foregoing reasons, the County's motion to dismiss should be denied. Plaintiffs further pray for such other relief they may be justly entitled.

Respectfully submitted:

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CERTIFICATE OF SERVICE

I hereby certify that on March 26, 2024, I electronically filed the foregoing document with the clerk of the court for the U.S. District Court, Southern District of Texas, using the electronic case filing system of the court, which provided notice to the following attorneys who have appeared in this matter:

Melvin Keith Ogle
Phil Sorrells
Tarrant County Criminal District Attorney's Office
Civil Division

Attorney for Defendant Tarrant County, Texas

/s/ Jennifer Kingaard
Jennifer Kingaard