No. 21-4132/22-3306

IN THE UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

KARLA HOWELL,

Plaintiff-Appellant,

v.

NAPHCARE INC.; CHRISTINA JORDAN; PIERETTE ARTHUR; JIM NEIL; MATTHEW COLLINI; DANIEL ERWIN; and JUSTIN HUNT,

Defendants-Appellees.

On Appeal from the United States District Court
for the Southern District of Ohio, No. 1:19-cv-00373
Before the Hon. Douglas R. Cole

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STATEMENT IN SUPPORT OF ORAL ARGUMENT

Plaintiff-Appellant Karla Howell requests oral argument because this case involves a substantial factual record, unique procedural history, and the application of a new legal standard recently articulated by this Court. Oral argument will aid the Court by allowing Plaintiff-Appellant to explore the issues presented in her appeal and respond to any inquiries raised.

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STATEMENT OF JURISDICTION

Plaintiff-Appellant Karla Howell, the administrator of Cornelius Howell's estate, filed a complaint in the United States District Court for the Southern District of Ohio asserting federal civil rights claims under 42 U.S.C. § 1983 as well as state law claims. Amended Complaint, R.27. The district court had jurisdiction over these claims under 28 U.S.C. §§ 1331 and 1367.

On November 2, 2021, the district court granted defendants' motions for summary judgment as to the federal claims and declined to exercise jurisdiction over the state claims. Order, R.105. Howell timely filed a notice of appeal on November 28, 2021. Notice of Appeal, R.107. It then came to Howell's attention that the district court had applied an incorrect legal standard to some of his claims; Howell then promptly filed a motion for relief from the judgment pursuant to Federal Rule of Civil Procedure 60(b)(6). Motion For Relief From Judgment, R.112. The district court recognized that it had applied an incorrect standard, but nonetheless denied the motion on March 11, 2022. 60(b)(6) Order, R.119. Howell filed a timely amended notice of appeal from this new order on April 4, 2022. Amended Notice of Appeal, R.121. This Court then docketed a second appeal, which was consolidated with the first. Order, April 28, 2022, ECF #38. This Court has appellate jurisdiction over the consolidated appeal under 28 U.S.C. § 1291.

STATEMENT OF ISSUES

1. Whether the district court erred in awarding summary judgment to a jail nurse where: (a) the nurse knew Howell had sickle cell disease, was in serious pain, and had numb legs; (b) she had training and significant experience related to sickle cell disease; but (c) instead of providing medical care, she placed Howell in a restraint chair and never checked on him; and (d) Howell died.

2. Whether the district court erred in awarding summary judgment to a jail nurse where: (a) the nurse knew Howell had abnormal vital signs when placed in a restraint chair; (b) she knew it was imperative to call a doctor about that placement; but (c) she did not call a doctor or check on Howell; and (d) Howell died.

3. Whether the district court erred in awarding summary judgment to three corrections officers where: (a) all three officers either knew Howell was in medical distress and/or knew about the risks associated with the restraint chair; but (b) all three officers effectively ignored Howell for hours and two of them falsified jail logs to cover up their deficient monitoring; and (c) Howell died.

4. Whether the district court erred in awarding summary judgment to a jail nurse where (a) the nurse placed Howell in a restraint chair without penological purpose and kept him in the chair after such purpose dissipated; and (b) Howell died.

5. Whether the district court erred in awarding summary judgment to the County where (a) it failed to train officers on restraint-chair monitoring; (b) the need

for such training was obvious in light of the officers' duties; and (c) Howell died because the officers failed to properly monitor him and secure medical care.

6. Whether the district court erred in awarding summary judgment to NaphCare where (a) there was a custom of nurses ordering restraint chairs without physician approval; and (b) there is a causal link between that custom and the denial of medical care that led to Howell's death.

STATEMENT OF THE CASE

I. Factual Background[1]

Just one week after Cornelius Howell was booked into jail, he experienced a medical emergency associated with sickle cell disease that caused him severe pain and left parts of his body numb, rendering him unable to walk or stand. Instead of providing treatment, jail nurses and corrections officers placed him in a restraint chair and left him virtually unattended for hours. This took away any opportunity he had to survive. By the time an officer eventually checked on him, nearly four hours later, he had died. The cause of death was a complication of his sickle cell disease.

A. Howell has a medical emergency associated with sickle cell disease and is placed in a restraint chair.

On December 2, 2018, Howell was booked into the Hamilton County Justice Center (HCJC). Order, R.105, PageID #1987. The following day, a nurse conducted

[1] The facts are recited in the light most favorable to Howell, consistent with the standard of review. *Mitchell v. Schlabach*, 864 F.3d 416, 418 (6th Cir. 2017).

his medical screening and noted that he had sickle cell disease on his chart; accordingly, he was placed on NaphCare's chronic care list.[2] Medical Records, R.79-1, PageID #1290-91.

On December 9, 2018, Howell and his cellmate got into a fight. Jordan Depo., R.76, PageID #986. After breaking up the fight, guards brought Howell to the medical unit. *Id*. at PageID #988. Surveillance video shows Howell collapsing and officers carrying him to the elevator before obtaining a wheelchair. Roettker Depo., R.69-13, PageID #715, 2:53-4:05. While waiting for the wheelchair, officers tried to prop Howell against the wall, but he fell almost immediately. *Id*. at 4:05-4:30.

In the medical sallyport, he was assessed by Defendant Nurse Christina Jordan, who saw that he had sickle cell disease on his chart. Jordan Depo., R.76, PageID #989. Howell also told Jordan that he had the disease. *Id*. at PageID #1011. Jordan reported hearing Howell yelling and saying that his legs and back hurt, seeing his eyes "pop[] out a little bit," and observing him "slid[e] out" of the wheelchair. *Id*. at PageID #988-89, 992-93. He "was stating he could not feel his legs." Erwin Depo., R.69-5, PageID #428. And surveillance footage shows Howell sliding out of the wheelchair and lying helpless on the floor. Roetkker Depo., R.69-13, PageID #715, 27:10-37:45. Jordan took Howell's vitals and noted a respiratory rate of 22,

[2] NaphCare provided medical treatment at HCJC. Amended Complaint, R.27, PageID #84. Both nurse defendants in this case were employed by NaphCare. *Id*.

which NaphCare's medical director later called "abnormal." Everson Depo., R.69-6, PageID #447-48. Howell was also in serious pain that he described as 10-out-of-10, and Jordan testified that she "believed" he was in pain. Perdikakis Decl., R.79-1, PageID #1262; Jordan Depo., R.76, PageID #993.

Jordan previously treated sickle cell patients both at the jail and at her previous job. Jordan Depo., R.76, PageID #994-95. She had academic and on-the-job training about sickle cell disease. *Id*. at PageID #1023-24. She knew pain is the primary symptom of the disease and that it often manifests as numbness in the arms and legs. *Id*. at PageID #981-82. But despite her familiarity with sickle cell and her knowledge that Howell had the disease, was in pain, and had numb legs, Jordan did not send him to the hospital. *Id.* at PageID #990. Not even when a sergeant asked her whether Howell "need[ed] to go to the hospital." Terry Depo., R.69-16, PageID #827. In contrast, on two prior occasions when Howell experienced sickle cell complications at the jail, he was sent to the hospital. Guy Aff., R.72, PageID #892, 894. As NaphCare's medical director explained, people with sickle cell are sent to the hospital "for treatments and further evaluation" unavailable at HCJC. Everson Depo., R.69-6, PageID #450.

But Jordan sent Howell to the psychiatric ward. Jordan Depo., R.76, PageID #1001. Officers placed Howell in a restraint chair at 5:40pm—at which time Jordan checked his vitals again and noted abnormally low blood pressure (hypotension) of

90/56—and took him to the psychiatric department where the restraint chair was attached to a wall in a cell. Hunt Depo., R.69-8, PageID #524, 515; Arthur Depo., R. 69-1, PageID #242. While Jordan says an officer made the decision to place him in the restraint chair, Jordan Depo., R.76, PageID #1001, Defendant Sergeant Justin Hunt and other officers said Jordan made that decision, Hunt Depo., R.69-8, PageID #521; Terry Depo., R.69-16, PageID #827-28; Roettker Depo., R.69-13, PageID #690. No matter who ordered Howell into the chair, no one objected to its use. Jordan Depo., R. 76, PageID #1037-38; Hunt Aff., R.82, PageID #1494.

B. Officers Erwin, Collini, and Hunt failed to properly monitor Howell.

1. Officers Erwin and Collini fabricated ten-minute checks.

The HCJC Restraints Policy required officers to check on those in restraint chairs every ten minutes. Erwin Depo., R.69-5, PageID #423. It is now undisputed that Defendant Officers Matthew Collini and Daniel Erwin skipped more than half of these checks and falsified the restraint chair log. Order, R.105, PageID #1989.

Hunt filled out the first two entries on the log. Hunt Depo., R.69-8, PageID #524-25. Then, Collini and Erwin became responsible for the ten-minute checks. Collini logged twelve observations of Howell, but security tape shows (and he admits) that he conducted only four cursory checks. Collini Depo., R.69-4, PageID #348-49, 353-54. Likewise, Erwin logged eleven observations, but security tape shows (and he admits) that he conducted only six cursory checks. Roetkker Depo.,

R.69-13, PageID #714; Erwin Depo., R.69-5, PageID #411. In fact, both officers lied repeatedly. Not only did both lie on the log, but when answering Howell's first set of discovery responses they said they could "neither admit nor deny" that they conducted all the required checks and pointed to the log for support, knowing full well that they fabricated the log. Erwin Discovery Responses, R.88-1, PageID #1767; Collini Depo., R.69-4 at PageID #385.

The ten-minute checks were critical because of the risks associated with the restraint chair; in fact, other than the chair, only suicide watch required such frequent monitoring. Hunt Depo., R.69-8, PageID #531. Moreover, medical staff relied on officers to complete these checks and report anything unusual. Jordan Depo., R.76, PageID #1000-01; Arthur Depo., R.69-1, PageID #230. Finally, the checks were important because officers could directly "call the ambulance" if they saw someone having "a true medical emergency." Hunt Depo., R. 69-8, PageID #520.

The few ten-minute checks that Collini and Erwin did conduct were inadequate. They only observed Howell through a small window in the cell door and never entered the cell. Collini Depo., R.69-4, PageID #335; Erwin Depo., R.69-5, PageID #407. This made it impossible for them to tell if Howell was sleeping or dead—as Collini acknowledged. Collini Depo., R.69-4, PageID #364.

These troubling practices followed, in part, from training failures; other than generic "on-the-job training," the officers were not trained on how to monitor

someone in a restraint chair. *Id*. at PageID #335-36; Franklin Depo., R.69-7, PageID #471 (confirming that he did *not* train officers on how to conduct restraint-chair observations). And the "on-the-job training" was neither formal nor documented. Callisto Depo., R.80-1, PageID #1411-12.

2. Erwin and Collini conducted no hourly checks and provided no limb exercise, water, or restroom access.

In addition to the ten-minute checks, the Restraints Policy required officers to consider the restrained person for removal from the chair every hour, recommended limb exercise every two hours to prevent blood clots, and required access to the restroom and water. Erwin Depo., R.69-5, PageID #423. None of this happened.

Neither Collini nor Erwin considered removing Howell from the restraint chair, asked whether he needed to use the restroom, exercised his limbs, or offered him water—the lack of water "precluded any chance of survival." Collini Depo., R.69-4, PageID #332, 337, 339-40; Erwin Depo., R.69-5, PageID #408-09; Steinberg Expert Rep., R. 87-3, PageID #1693. In fact, Collini went so far as to falsely write on the log that Howell *did not want* limb rotation, something he later admitted was "not accurate" since he never actually asked Howell. Collini Depo., R.69-4, PageID #349.[3]

[3] Collini also says he asked Hunt at the two-hour mark to assist with limb rotation, but Hunt did not remember such a call. Collini Depo., R.69-4, PageID #339; Hunt Depo., R.69-8, PageID #525. Regardless, Collini did nothing to ensure the limb rotation was performed.

3. The officers knew Howell was unwell and/or understood the risks associated with the chair.

All three officers understood that Howell was at risk of harm. Collini knew that the exercise requirement was to prevent blood clots and to "get blood flow moving." Collini Depo., R.69-4, PageID #338. He also acknowledged that the ten-minute checks were important for the "safety of the inmate" and that he was aware of the risks posed by prolonged time in the chair. *Id*. at PageID #333, 338.

Erwin knew that Howell was experiencing serious medical problems. By his own admission, he knew Howell was so unwell that he "should have gone to the hospital," and he "heard a nurse say inmate Howell was going to the hospital . . . because something was wrong with him." Erwin Depo., R.69-5, PageID #429-30.

Hunt was aware of the risks associated with restraint chairs *and* Howell's medical problems. He knew that Howell's legs were numb, that he was in pain, and that the nurses had debated sending him to the hospital. Erwin Depo., R.69-5, PageID #428; Hunt Depo., R.69-8, PageID #519-20. He also knew that limb rotation was required to "prevent blood clots" and that a "supervisor is supposed to be present" for that rotation—or at least give permission to officers to complete it. Hunt Depo., R.69-8, PageID #516-17.

C. Nurses Jordan and Arthur also failed to monitor Howell.

Jordan and Arthur completely abdicated their duty to monitor Howell. Clinically-ordered restraints required fifteen-minute checks while custodial

restraints required two-hour checks. Arthur Depo., R.69-1, PageID #244-45; Erwin Depo., R.69-5, PageID #424. While there is a dispute over who ordered the restraints, it is undisputed that Jordan and Arthur did not check on Howell every fifteen minutes *or* every two hours. Arthur observed Howell around 6:06pm, which was less than 30 minutes after he was placed in the restraint chair, and neither nurse ever checked on him again. Order, R.105, PageID #1988; Jordan Depo., R.76, PageID #1000.

When Jordan saw Howell that day, she learned that he had sickle cell disease, had just been involved in an altercation, was in excruciating pain, could not walk or stand, was hypotensive, and was incoherent. Jordan Depo., R.76, PageID #988-89, 992-93, 1011; Arthur Depo., R. 69-1, PageID #242. Then, several hours later, Jordan received the restraint log from Arthur showing that no medical professional had seen Howell since 6:06pm. Arthur Depo., R.69-1, PageID #225, 230. And finally, she knew he "need[ed] to be checked on in two hours" and that being in a restraint chair could cause health problems. Jordan Depo., R.76, PageID #1000, 1012, 1027. Yet, she did not monitor him. *Id*. at PageID #998. This was particularly dangerous because, as NaphCare's medical director explained, (1) exertion can "precipitate a sickle cell crisis"; (2) Howell had an "abnormal" respiratory rate; and (3) people with sickle cell "form blood clots" and "that's what causes their death." Everson Depo., R.69-6, PageID #447-48; *see also* Erwin Depo., R.69-5, PageID #423 (HCJC

Restraint Policy explaining that blood clots are a risk associated with the restraint chair).

Not only did Jordan and Arthur fail to monitor Howell, but at no point did either nurse notify a physician that Howell had been placed in a restraint chair, even though Arthur said it was "necessary" to do so. Jordan Depo., R.76, PageID #1005; Arthur Depo., R.69-1, PageID #222.

D. Howell dies as a result of sickle cell complications.

At 9:45pm, Hunt found Howell dead. Guy Decl., R.72, PageID #874. According to a jail report, Collini was the last person to see Howell alive at approximately 7:30pm, when he testified to seeing Howell "staring out the window." Collini Depo., R.69-4, PageID #361.

The coroner identified the cause of death as "[s]ickle cell crisis following physical altercation." Stephens Decl., R.73, PageID #943. Dr. Martin Steinberg—a sickle cell expert—likewise determined that Howell died of a well-known complication of sickle cell disease called rhabdomyolysis, which came on because of "a short period of intense exertion."[4] Steinberg Expert Rep., R. 87-3, PageID #1689, 1692-93. He explained that transfer to a medical facility "would more likely

[4] Rhabdomyolysis damages the heart and kidneys. CDC, https://www.cdc.gov/niosh/topics/rhabdo/. Sickle cell increases the risk of developing Rhabdomyolysis. CDC, https://www.cdc.gov/niosh/topics/rhabdo/who.html.

than not" have prevented his death and the fact that "he was ignored for hours and provided no hydration precluded any chance of survival." *Id*. at PageID #1693.

E. Internal investigations gloss over serious violations.

An internal affairs investigation found no violations of jail policy—though all parties now agree that Collini and Erwin violated the ten-minute check policy and falsified the log—and neither officer was ever disciplined. Order, R.105, PageID #1990; Schoonover Depo., R.69-14, PageID #744. There was also a "criminal investigation" by the internal affairs office, which resulted in no charges. Neil Depo., R.69-11, PageID #616; Order, R.105, PageID #1990.

II. Procedural History

The operative complaint includes four categories of federal claims: (1) claims against Jordan, Arthur, Erwin, Collini, and Hunt alleging the violation of Howell's Fourteenth Amendment rights through deliberate indifference to his serious medical needs; (2) claims against Jordan alleging the violation of Howell's Fourteenth Amendment rights through excessive force; (3) a failure-to-train *Monell* claim against Hamilton County; and (4) a *Monell* claim against NaphCare. Amended Complaint, R.27, PageID #92-94. The operative complaint also included additional federal and state claims not at issue on appeal. *Id*. at PageID #93, 94-97. The district court granted defendants' motions for summary judgment as to the federal claims

and declined to exercise jurisdiction over the state claims. Order, R.105. Howell timely appealed. Notice of Appeal, R.107.

Howell subsequently learned that the district court applied the incorrect standard to the deliberate indifference claims. This Court had changed the applicable standard in *Brawner v. Scott County*, 14 F.4th 585 (6th Cir. 2021), *rehearing en banc denied*, 18 F.4th 551 (Dec. 1, 2021), *petition for cert. filed* (U.S. Mar. 4, 2022) (No. 21-1210), approximately six weeks before the district court issued its decision. Howell promptly filed a motion for relief from the judgment pursuant to Federal Rule of Civil Procedure 60(b)(6) arguing that the district court had applied the incorrect standard and that, under the correct standard, summary judgment should be denied as to the deliberate indifference claims. Motion for Relief from Judgment, R.112.

The district court issued a second opinion on March 11, 2022. 60(b)(6) Order, R.119. Although it "agree[d]" it had "applied the wrong legal standard," it denied the motion because it "would have reached the same result under the new standard." *Id*. at PageID #2213. Howell timely amended the notice of appeal on April 4, 2022. Amended Notice of Appeal, R.121. This Court then docketed a second appeal, which was consolidated with the first. Order, April 28, 2022, ECF #38.

SUMMARY OF ARGUMENT

I. The district court erred in granting summary judgment on Howell's deliberate indifference claims. **A.** Howell's sickle cell disease, excruciating pain, numb legs, and death all independently show that he had a serious medical need and faced a risk of harm. **B.** All the defendants failed to act reasonably to mitigate that risk of harm even though reasonable officials in their position would have known about the risk. **1.** Nurse Jordan knew that Howell had sickle cell disease, believed his complaints of pain, knew his legs were numb, and had experience with sickle cell disease. She nevertheless placed him in a restraint chair and never checked on him again. **2.** Nurse Arthur knew that Howell had abnormally low blood pressure when he was placed in the restraint chair and that it is imperative to call a doctor when someone is restrained. But she did not contact a doctor, take his vitals, or confirm that he was not in medical distress at any point. **3-4.** Officers Collini and Erwin either knew Howell was in medical distress or knew about the risks associated with the restraint chair, but nevertheless ignored him for hours and falsified jail logs to cover up their deficient monitoring. **5.** Sergeant Hunt knew both that Howell was in medical distress and that there were serious risks associated with the restraint chair, yet he too ignored Howell for hours. **C.** All five defendants should be denied qualified immunity: Nurses Jordan and Arthur may not claim immunity because they are employed by a private medical provider, and Officers Collini, Erwin, and Hunt

are not entitled to qualified immunity because they violated clearly established law requiring them to adequately monitor Howell.

II. The district court erred in granting summary judgment on Howell's excessive force claim against Jordan. She placed him in a restraint chair without any penological purpose and kept him there even after any threat of self-harm dissipated.

III. The district court erred in granting summary judgment on Howell's failure-to-train claim against the County. **A.** The County failed to train officers on restraint-chair monitoring; testimony from officers and an expert report confirm as much. **B.** The failure-to-train constitutes deliberate indifference because the need for the training was obvious in light of the officers' duties and the risks associated with the restraint chair. **C.** Howell ultimately died because the officers failed to properly monitor and secure medical care for him as a result of their deficient training.

IV. The district court erred in granting summary judgement on Howell's claim against NaphCare. NaphCare nurses routinely ordered restraint chairs without physician approval and, as a result of that practice, Howell did not receive required medical care.

STANDARD OF REVIEW

This Court reviews "a district court's denial of summary judgment de novo." *Siggers-El v. Barlow*, 412 F.3d 693, 699 (6th Cir. 2005). In this review, "[a]ll justifiable inferences must be drawn in the light most favorable to the non-moving

party." *Id*. "Qualified immunity is a question of law" that this Court "also review[s] de novo." *Id*.

ARGUMENT

I. The District Court Erred In Granting Summary Judgment On The Deliberate Indifference Claims.

Until last year, this Court employed the same "two-part framework" for deliberate indifference claims whether they were brought by pretrial detainees under the Fourteenth Amendment or by post-conviction prisoners under the Eighth Amendment. *Burwell v. City of Lansing*, 7 F.4th 456, 463 (6th Cir. 2021). This framework contained both "an objective component," requiring "proof that the detainee had a sufficiently serious medical need," and "a subjective component," requiring "proof that the official had a sufficiently culpable state of mind." *Id*. (internal citation and quotation marks omitted). This changed after *Brawner v. Scott Cnty.*, 14 F.4th 585 (6th Cir. 2021).

In *Brawner*, this Court recognized that *Kingsley v. Hendrickson*, 576 U.S. 389 (2015), "requires modification of [this Court's] caselaw." 14 F.4th at 596. It explained that "*Kingsley*'s clear delineation between claims brought by convicted prisoners under the Eighth Amendment and claims brought by pretrial detainees under the Fourteenth Amendment" made "applying the same analysis to these constitutionally distinct groups [] no longer tenable." *Id.* Accordingly, this Court

"amend[ed] [the] standard" for claims by pretrial detainees "to be consistent with *Kingsley*." *Id*.

Under the new standard, the first component—requiring proof of a sufficiently serious medical need—remains unchanged. However, the second component—which previously required "proof that the official had a sufficiently culpable state of mind," *Burwell*, 7 F.4th at 463 (internal citation and quotation marks omitted)—may now be satisfied by proof that the official "failed to act with reasonable care" even though the official "knew, or should have known, that the condition posed an excessive risk to health or safety," *Brawner*, 14 F.4th at 597 (internal citation and quotation marks omitted). Here, Howell satisfies this two-part test with respect to all five individual defendants.

A. Howell had a serious medical need.

Howell easily satisfies the first prong of the analysis. He *died* as a result of complications stemming from sickle cell disease. Stephens Decl., R.73, PageID #943. There "is no question" that a plaintiff has a sufficiently serious medical need where it "ultimately caused his death." *Winkler v. Madison Cnty.*, 893 F.3d 877, 890 (6th Cir. 2018); *see also Jones v. Muskegon Cnty.*, 625 F.3d 935, 942 (6th Cir. 2010) (noting the parties "agree[d]" that plaintiff showed "a sufficiently serious medical need because [he] . . . died").

If that were not enough, Howell's serious medical need is clear in three other ways. First, his sickle cell disease was "diagnosed by a physician as mandating treatment." *Blackmore v. Kalamazoo Cnty.*, 390 F.3d 890, 897 (6th Cir. 2004). Second, he reported 10-out-of-10 pain, Perdikakis Decl., R.79-1, PageID #1262, and "pain qualifies as an objectively serious medical need," *Gunther v. Castineta*, 561 F. App'x 497, 501 (6th Cir. 2014). Third, he was vocal that "he could not feel his legs," Erwin Depo., R.69-5, PageID #428, and "even a lay person would easily recognize the necessity for a doctor's attention" based on such a concerning symptom, *Harrison v. Ash*, 539 F.3d 510, 518 (6th Cir. 2008).

B. The defendants failed to act with reasonable care even though they knew—or should have known—of the excessive risk of harm.

The evidence also shows that all five defendants "failed to act reasonably to mitigate" a risk of harm that reasonable officials in their positions "should have known" about. *Brawner*, 14 F.4th at 597. In fact, as to four of the defendants, the evidence satisfies even the more stringent pre-*Brawner* test requiring proof of a "sufficiently culpable state of mind." *Burwell*, 7 F.4th at 463.

1. Nurse Jordan

Jordan knew that Howell had sickle cell disease, heard him yelling in pain he described as 10-out-of-10 severity, saw him fall out of his wheelchair because his legs went numb, and had both training and significant experience related to sickle

cell disease. She nonetheless sent him away in a restraint chair and failed to check on him for hours. A jury could easily find a constitutional violation on these facts.

To start, the evidence supports a finding that "a reasonable official in [Nurse Jordan's] position would have known" about the risk of harm. *Brawner*, 14 F.4th at 597. Jordan *knew* that Howell had sickle cell disease; she saw it on his chart and Howell told her. Jordan Depo., R.76, PageID #989, 1011. She heard Howell yelling that his legs and back hurt, and she "believed" he was in pain. *Id*. at PageID #988-89, 992-93. She witnessed him sliding out of the wheelchair because his legs were numb. *Id*. at PageID #989. And she knew he was hypotensive. Arthur Depo., R. 69-1, PageID #242. Because Howell told Jordan about his condition, she confirmed it on his chart, and she observed related symptoms, a jury could certainly find that she knew—or at least should have known—about the risk of harm. *Est. of Carter v. City of Detroit*, 408 F.3d 305, 313 (6th Cir. 2005) (holding jury could infer risk of harm where officer was "directly informed" by detainee that she was in distress); *Johnson v. Karnes*, 398 F.3d 868, 872, 875-76 (6th Cir. 2005) (holding jury could find doctor was aware of risk of harm where prisoner informed him about condition via medical request forms).

Moreover, two medical experts explained that any minimally competent nurse faced with these facts should have known about the need for medical care. Dr. Steinberg explained that "[p]ain in sickle cell disease can be a precursor of a

clinically severe and even fatal event." Steinberg Expert Rep., R.87-3, PageID #1693. He further noted that Jordan should have foreseen the need for emergency medical care when "Howell presented to medical writhing in pain, unable to use his legs, with a history of sickle cell, and a low blood pressure." Steinberg Aff., R.87-1, PageID #1638-1639. Nurse Roscoe similarly explained that a nurse who saw a patient in Howell's condition "should have immediately" sent him to the emergency department and that "even a layperson" would know to do that. Roscoe Report, R.87-6, PageID #1708. In fact, a layperson *did* ask Jordan whether Howell needed hospital care. Terry Depo., R.69-16, PageID #827.

The district court's decision to discount this highly relevant expert testimony from Dr. Steinberg and Nurse Roscoe is error under this Court's caselaw. *See* Order, R.105, PageID #2025-26; 60(b)(6) Order, R.119, PageID #2229-30. In *LaMarbe v. Wisneski*, for instance, this Court explained that summary judgment was properly denied where a general surgeon failed to adequately address a prisoner's bile leak because an expert opined that "any general surgeon would have known" about the condition and that the risk of harm from the condition would have been "obvious to anyone with a medical education." 266 F.3d 429, 434, 437 (6th Cir. 2001). Likewise, in *Quigley v. Tuong Vinh Thai*, this Court explained that a jury could infer that a prison doctor "was aware of [the] risk" where he knew a detainee was taking two drugs and experts "state[d] that it is well known in the psychiatric profession" that

the two drugs should not be administered together. 707 F.3d 675, 682 (6th Cir. 2013). Just as in *LaMarbe* and *Quigley*, a jury could infer that Jordan knew—or at least should have known—about the risk of harm based on the circumstances she confronted and the corresponding expert testimony. Indeed, that is particularly true in light of Jordan's experience: She previously treated sickle cell patients, had both academic and on-the-job training about sickle cell, and *knew* that pain and numbness are symptoms of the disease. Jordan Depo., R.76, PageID #994-95, 1023-24, 981-82. Certainly, a jury could find that "a reasonable official in [her] position would have known" about the risk of harm. *Brawner*, 14 F.4th at 597.[5]

Next, the evidence permits a jury to find that Jordan "failed to act reasonably to mitigate" that risk of harm in two ways. *Id*. First, when Howell came to her screaming in pain, with numb legs, and explaining that he had sickle cell disease, she chose not to pursue any medical treatment whatsoever—despite the consensus in the medical community that excruciating pain combined with sickle cell disease is a medical emergency, Steinberg Expert Rep., R.87-3, PageID #1690-93. To reiterate, she provided no care despite *believing* he was in excruciating pain. Jordan Depo., R.76, PageID #993. Instead, she ordered Howell strapped to a restraint chair

[5] Indeed, much of this evidence shows that Jordan specifically, rather than a medical professional in her position generally, would have understood the risk of harm. That suffices even under the more stringent pre-*Brawner* standard.

and sent him to the psychiatric unit, but never bothered to call the psychiatrist on call. *Id*. at PageID #990, 1005; Hunt Depo., R.69-8, PageID #521.[6] A jury could find on these facts that Jordan did not "act reasonably" to mitigate harm. *Est. of Carter*, 408 F.3d at 313 (denying summary judgment to official who failed to confirm hospital transport for detainee in distress); *Greene v. Crawford Cnty.*, 22 F.4th 593, 613 (6th Cir. 2022) (denying summary judgment to jail official who referred detainee to mental health care but "did not seek [additional] medical assistance").

Jordan failed to act reasonably in a second way when, over the next four hours, as the Charge Nurse, she failed to check on Howell or ensure that others were checking on him. Jordan Depo., R.76, PageID #974-76, 998-1000. A jury could find this failure violated both policy and the Constitution.[7] All Jordan did was take vitals (some of which indicated medical distress) and send Howell on his way in a restraint chair, without ever checking on him again. And she did next to nothing despite *knowing* about his poor condition and the risks associated with the restraint chair. *Id*. at PageID #1026-27. Her conduct was "so cursory as to amount to no treatment

[6] Jordan says an officer decided to use the restraint chair, Jordan Depo., R.76, PageID #990, 1001, but officers say she made that decision, *see, e.g.*, Hunt Depo., R.69-8, PageID #521. Because inferences must be drawn in Howell's favor, the proper inference here is that Jordan ordered the restraint chair.

[7] As to policy, fifteen-minute medical checks for signs of medical distress were required. Arthur Depo., R.69-1, PageID #244-45. Although another policy required less frequent checks, Erwin Depo., R.69-5, PageID #424, the summary judgment standard requires assuming that fifteen-minute checks were required.

at all," and a jury could find deliberate indifference on those facts. *Terrance v. Northville Reg'l Psychiatric Hosp.*, 286 F.3d 834, 843-44 (6th Cir. 2002) (internal citation omitted).

The district court found otherwise because, in its view, "nurses are not deliberately indifferent when they provide treatment pursuant to a diagnosis consistent with the detainee's symptoms, even if that diagnosis is ultimately mistaken." 60(b)(6) Order, R.119, PageID #2229. That reasoning does not apply here for three reasons.

First, the district court relied heavily on *Britt v. Hamilton Cnty.*, No. 21-3424, 2022 WL 405847, at *3 (6th Cir. Feb. 10, 2022), for the proposition that misdiagnosis cannot be a constitutional violation. 60(b)(6) Order, R.119, PageID #2229-30. But *Britt* is inapposite. There, misdiagnosis did not constitute deliberate indifference because the nurse had no basis to connect the plaintiff's symptoms to anything but a heroin overdose, which turned out to be the wrong diagnosis. *Britt*, 2022 WL 405847 at *3. Here, there was every reason to connect Howell's symptoms to sickle cell disease—or at least to a serious medical rather than psychological emergency. *See supra* at pp.19-21. So, while it is certainly not true that a nurse must always correctly diagnose to avoid liability, a nurse is deliberately indifferent when she fails to recognize an obvious and substantial risk posed by a clearly evident condition. *LaMarbe*, 266 F.3d at 434, 437 (affirming denial of summary judgment

where general surgeon erroneously concluded prisoner was not suffering from bile leak because expert explained that "any general surgeon would have known" that the correct diagnosis was a leak); *Sours v. Big Sandy Reg'l Jail Auth.*, 593 F. App'x 478, 485 (6th Cir. 2014) (denying summary judgment to nurse who disclaimed knowledge that detainee had diabetes where it was obvious: detainee said he was diabetic and had high blood sugar levels).

Second, in *Britt*, the nurse took steps to "confirm that the detainee's symptoms were not indicative" of something more serious. *Britt*, 2022 WL 405847 at *3. After the plaintiff in that case was placed in a restraint chair, the nurse "checked on him every 15 minutes, finding him relaxed and alert, and called [the doctor] to get his input on what to do next." *Id.* at *4. Again, this case could not be more different: Jordan admits that she *failed* to check on Howell after his placement in the restraint chair, Jordan Depo., R.76, PageID #1000, and admits that she *failed* to call a doctor for input, *id.* at PageID #1005. This precludes summary judgment. *See Greene*, 22 F.4th at 613 (denying summary judgment where official with EMT training "did not seek medical assistance" despite awareness of concerning symptoms).

Third, assuming arguendo that a nurse could never be deliberately indifferent based on misdiagnosis, a jury could *still* find Jordan deliberately indifferent because she failed to provide any treatment whatsoever for Howell's pain and numb limbs. This Court has made clear that "pain qualifies as an objectively serious medical

need," *Gunther*, 561 F. App'x at 501, and Jordan "believed" Howell was in pain, Jordan Depo., R.76, PageID #993. Moreover, a condition is serious when "even a lay person" recognizes the need for medical attention, *Harrison*, 539 F.3d at 518, and here a layperson actually *did* recognize the need for hospital care, Terry Depo., R.69-16, PageID #827. So even if Jordan was unaware that Howell was experiencing a sickle cell crisis, she was obligated to address his concerning physical symptoms—at the very least, by calling the doctor or sending Howell to the hospital. Her referral to the psychiatric ward was woefully inadequate: "the provision of some treatment by a medical professional does not immunize that official from liability." *Sours*, 593 F. App'x at 486 (explaining that nurse was not entitled to summary judgment just because "she took *some* actions . . . including placing [the plaintiff] in a medical observation cell and instructing the guards to monitor [him]"); *Greene*, 22 F.4th at 613 (explaining that officer who "sought help from [a mental health provider]" could still be liable because "he did not seek medical assistance" despite clear need); *LeMarbe*, 266 F.3d at 439 (explaining that "prisoner is not required to show that he was literally ignored by the staff" and that a medical professional is "not automatically immunize[d]" just because he does *something*).

Although this Court should stop its analysis here, it is worth noting that the evidence would defeat summary judgment against Jordan even under the obsolete

pre-*Brawner* standard.[8] Under that standard, the question is whether a jury could find that the defendant "perceived facts from which to infer substantial risk to the prisoner" and that the defendant "did in fact draw the inference." *Burwell*, 7 F.4th at 466. Under the subjective standard, "[i]f a risk is obvious or if it is well-documented and circumstances suggest that the official has been exposed to information such that she must have known of the risk, the evidence is sufficient for a jury to find that the official had knowledge." *Sours*, 593 F. App'x at 484. Indeed, this Court denied summary judgment to a nurse under the pre-*Brawner* standard where a detainee told the nurse that he was diabetic and she saw his high blood sugar levels because "a jury could find" from that evidence that the nurse "had subjective knowledge of a substantial risk of serious harm." *Id*. at 485. And that was true even though that nurse had made a "statement of her lack of knowledge regarding [his] diabetes." *Id*.

The same outcome is compelled here in light of evidence that (1) Jordan knew Howell had sickle cell, believed that he was in pain, and knew he his legs were numb; and that (2) Jordan previously treated sickle cell patients, had both academic and on-the-job training about sickle cell, knew that pain was the primary symptom of the disease, and knew that sickle cell often manifests in numbness. Jordan Depo., R.76,

[8] Indeed, almost all the cases discussed above were either Eighth Amendment cases or Fourteenth Amendment cases decided under the pre-*Brawner* standard. Because those standards are more stringent than the *Brawner* standard, it follows that standard is met here.

PageID #981-82, 988-89, 992-95, 1011, 1023-24; Hunt Depo., R.69-8, PageID #519; Erwin Depo., R.69-5, PageID #428. Just as in *Sours*, a jury could infer from this evidence that Jordan "had subjective knowledge of a substantial risk of serious harm" even if she says otherwise. *Sours*, 593 F. App'x at 485; *see also LeMarbe*, 266 F.3d at 434, 436-39 (holding that jury could infer that prison surgeon had knowledge of serious risk posed by bile leak where there was evidence that he knew of bile leak and that "any general surgeon would have known" that it was serious); *Phillips v. Roane Cnty.*, 534 F.3d 531, 540-41 (6th Cir. 2008) (holding there was sufficient evidence for jury to infer that guards knew of substantial risk of harm where diabetic exhibited related symptoms).

2. Nurse Arthur

Arthur knew that Howell was in a restraint chair and that he required a doctor's attention, but nevertheless left her shift without checking on him or calling a doctor. A jury could find a constitutional violation on these facts.

First, "a reasonable official in [Arthur's] position would have known" about the risk of harm facing Howell. *Brawner*, 14 F.4th at 597. She knew that (1) Howell was in a restraint chair; (2) "it's a necessary thing" to call the doctor when someone is in a restraint chair; and (3) Howell had abnormally low blood pressure when placed in the chair. Arthur Depo., R.69-1, PageID #224, 222, 242. A jury could find that a nurse in that position—that is, a nurse who knows a patient with abnormal

vitals is restrained in a way that warrants a doctor's attention—should have understood the risk of harm.

Second, the evidence permits a jury to find that Arthur "failed to act reasonably to mitigate" that risk of harm. *Brawner*, 14 F.4th at 597. She did not ensure a doctor had been consulted or regularly observe Howell; she never even checked on him. The one time she "stop[ed] by," she did not enter his cell, take his vitals, or confirm he was not in medical distress. Arthur Depo., R.69-1, PageID #224. As a nursing expert noted, it was particularly important to obtain a new set of vitals because of the abnormalities noted at the time Howell was restrained—abnormalities noted on the restraint chair log that Arthur saw. Roscoe Report, R.87-6, PageID #1709; Arthur Depo., R.69-1, PageID #242. Her conduct was "so cursory as to amount to no treatment at all," and a jury could therefore find her deliberately indifferent. *Terrance*, 286 F.3d at 843-44 (internal citation omitted).

3. Officer Erwin

When Erwin began his assigned watch over Howell on the last day of Howell's life, he knew that Howell was in medical distress, had seen Howell "slumped over" in the medical sallyport, and—in his own words—believed "Howell should have gone to the hospital." Erwin Depo., R.69-5, PageID #401-02, 430. Yet he left Howell virtually unattended for hours by skipping approximately half the required ten-minute checks; failing to verify Howell was alive during the checks he

did conduct; falsifying the check log; and ignoring the water, restroom, and limb exercise requirements. A jury could easily find that he was deliberately indifferent to Howell's medical needs.

When investigators interviewed Erwin just hours after Howell's death, he told them that he was "upset about the situation" because he believed "Howell should have gone to the hospital." Erwin Depo., R.69-5, PageID #430. That belief makes sense: he saw that Howell was "slumped over in the chair" and that he ultimately "ended up on the floor" in the medical sallyport, and he specifically testified that he did not believe these actions were a form of protest or resistance. *Id*. at PageID #401-02. And though Erwin claimed that Howell was only "making noises" and "grunting a little bit" while in the sallyport, *id.* at PageID #429, other officers reported that he was "moaning," "complaining about back pain," and yelling that "his legs wouldn't work" and that he "could not feel his legs," *Id*. at PageID #428; Pierani Depo., R.69-12, PageID #652. Moreover, one of the officers who transported Howell in the restraint chair with Erwin testified that Howell continued to "moan[]" in pain on the walk from the sallyport to the cell. Pierani Depo., R.69-12, PageID #653; Erwin Depo., R.69-5, PageID #403. All this evidence supports a finding that a reasonable official in Erwin's position "should have known" that Howell faced a risk of harm. *Brawner*, 14 F.4th at 597 (internal quotation marks and citation omitted). After all, all Howell must show is that Erwin was "aware of facts from which the inference of

substantial risk of harm *could be* drawn." *Garretson v. City of Madison Heights*, 407 F.3d 789, 798 (6th Cir. 2005) (emphasis added).

Despite all this, Erwin *still* skipped nearly half the ten-minute checks he was required to conduct; falsified the log; and ignored the water, restroom, and limb exercise requirements. Roetkker Depo., R.69-13, PageID #714; Erwin Depo., R.69-5, PageID #408-09, 411. On these facts, a jury could find that he "failed to act with reasonable care." *Brawner*, 14 F.4th at 597. Turning first to the skipped checks, Erwin now admits that he conducted only approximately half the checks even though he logged all of them. Roetkker Depo., R.69-13, PageID #714; Erwin Depo., R.69-5, PageID #411. And the few times Erwin did check on Howell—who, again, Erwin believed to be so ill he needed to go to the hospital—Erwin did not actually ensure that Howell was breathing. Instead, he merely glanced at Howell through a small window in the cell door, Erwin Depo., R.69-5, PageID #407, which made it impossible to know whether he was sleeping or dead, Collini Depo., R.69-4, PageID #364; Pierani Depo., R.69-12, PageID #648. This despite the fact that he could have "open[ed] the door to check" if he wanted to. Hunt Depo., R.69-8, PageID #516.

This Court has denied summary judgment in markedly similar circumstances. In *Speers v. Cnty. of Berrien*, an officer heard that a prisoner had a number of troubling symptoms, including that he "collapsed." 196 F. App'x 390, 398 (6th Cir. 2006). The officer nevertheless conducted his checks by "look[ing] through the

plexiglass" and took no further steps when he saw the prisoner apparently "sleeping." *Id*. at 397. This Court found that was sufficient to deny summary judgment because the officer "should have contacted medical personnel" or "at least should have tried to engage [the prisoner] verbally or entered his cell." *Id*. at 398. A similar result is compelled here. As in *Speers*, Erwin knew of Howell's concerning symptoms (and unlike *Speers*, he actually witnessed these symptoms himself), but he still skipped nearly half the required checks and did not bother to ensure Howell was breathing or alive during the few checks he did conduct from outside the cell. As in *Speers*, then, he is not entitled to summary judgment.

Indeed, the facts here are even more compelling than in *Speers*. Here, Erwin not only failed to properly conduct his checks, but he also never offered Howell water despite being required to do so. The provision of water could well have saved Howell's life. *See* Steinberg Depo., R.69-15, PageID #777 (explaining that the fact that Howell was "ignored for hours and provided no hydration precluded any chance of survival"). Nor did Erwin offer him restroom access or perform the required limb rotation—which, if performed, may have alerted him to Howell's condition in time for life-saving treatment. *See id*. A jury presented with all these facts could easily find that Erwin "failed to act with reasonable care." *Brawner*, 14 F.4th at 597.

The district court gave two reasons for finding otherwise, neither of which hold up. First, it reasoned that Erwin was immunized from liability because he

"relied on the conclusion from trained NaphCare nurses that Howell did not need immediate medical care." 60(b)(6) Order, R.119, PageID # 2226. But an officer may rely on such a determination only "for a reasonable period of time after it is issued." *Barberick v. Hilmer*, 727 F. App'x 160, 163-64 (6th Cir. 2018). That is, a nurse's determination at one point in time that a detainee does not require a doctor's care does not forever immunize the officer from liability: officers still "have a duty to reengage medical staff if an inmate's condition has significantly worsened since the inmate received medical care." *Stojcevski v. Macomb Cnty.*, 827 F. App'x 515, 522 (6th Cir. 2020) (cleaned up). Moreover, regardless of any medical conclusion, Erwin was still required to check on Howell every 10 minutes, which he did not do. *See Barberick*, 727 F. App'x at 164 (explaining that officer may rely on medical opinion for a reasonable period "absent . . . a violation of policy"). These cases lead to the inescapable conclusion that Erwin should have monitored Howell in the hours *after* his placement in the restraint chair so that he could call for medical help if Howell's condition deteriorated; a jury could find that his failure to do so was unreasonable.

This Court reached a similar conclusion in *Smith v. Cnty. of Lenawawee*, 505 F. App'x 526 (6th Cir. 2012). In *Smith*, a doctor put a detainee suffering from alcohol withdrawal on medication and kept her at the jail instead of sending her to the hospital; an officer responsible for monitoring her was denied summary judgment because he "did nothing to make sure that [she] had not taken a turn for the worse."

Id. at 530, 533-35. Although he went in her cell, he "left the cell [] after only a minute" instead of "ascertain[ing] her condition" *Id*. at 535. Another officer who violated a policy requiring 15-minute checks by failing to check on the detainee for 40 minutes was also denied summary judgment; this Court specifically noted that this officer had "exposure" to the detainee's condition and nonetheless conducted "inadequate monitoring." *Id*. at 537.

As *Smith* makes clear, a medical professional's *initial* determination that a person experiencing some sort of medical issue does not require emergency medical care does not let officers off the hook for *subsequently* failing to monitor that person, especially if the officer knows that the detainee is in medical distress. Just as in *Smith*, Erwin had "exposure" to Howell's condition, and just as in *Smith*, he nonetheless conducted "inadequate monitoring" and "did nothing to make sure that [he] had not taken a turn for the worse." *Id*. at 535, 537. Just as in *Smith*, then, he should be denied summary judgment. *See also Greene*, 22 F.4th at 608-09 (even if officers' deference to mental health professional's assessment was "reasonable at the time of her evaluation," a jury could find that detainee became "in obvious need of *some* medical attention in the hours following [that] evaluation") (internal quotation marks, citation, and alterations omitted).

This is all the more true in light of caselaw establishing that an officer cannot "escape liability" where the evidence shows that "he merely refused to verify

underlying facts that he strongly suspected to be true, or declined to confirm inferences of risk that he strongly suspected to exist." *Farmer v. Brennan*, 511 U.S. 825, 843 n.8 (1994). Here, Erwin himself testified that he saw Howell in medical crisis and thought Howell needed to go to the hospital. Erwin Depo., R.69-5, PageID #401-02, 430. And yet he stuck his head in the sand and refused to verify Howell's condition by properly monitoring him.

Second, the district court reasoned that Erwin was "entitled to summary judgment even though [he] failed to check on Howell as frequently as jail policy required" because "failure to follow internal policies, without more, does not equal deliberate indifference." 60(b)(6) Order, R.119, PageID #2226 (citations and internal quotation marks omitted). But, in fact, the "disregard of prison protocols" is "persuasive" evidence of deliberate indifference. *Phillips*, 534 F.3d at 541; *see also Barker v. Goodrich*, 649 F.3d 428, 436 (6th Cir. 2011) ("A defendant's deviation from normal practice and prison policies can also provide notice that his actions are improper."); *Burwell*, 7 F.4th at 476 & n.7 (explaining that "whether an officer complied with policy can be relevant" and denying summary judgment to officer in part because he "violated the jail's cell check policy"); *Smith*, 505 F. App'x at 537 (affirming denial of summary judgment to officer for "inadequate monitoring of a detainee" based in part on officer failing to check on detainee for 40 minutes despite policy requiring 15-minute checks); *Bertl v. City of Westland*, No. 07-2547, 2009

WL 247907, at *6 (6th Cir. Feb. 2, 2009) (affirming denial of summary judgment to nurse in part because she "did not comply with stated jail policy"). Just as in all these cases, the fact that Erwin blatantly ignored jail policy is persuasive evidence of his deliberate indifference: a jury could find from the very fact that people in restraint chairs required 10-minute checks that there was a risk of harm associated with the chair that officers should have been aware of—especially if, as here, that officer was *already* profoundly concerned about the detainee's medical condition.

Moreover, Howell's argument does not rely on policy violations alone. Rather, Erwin failed to "act with reasonable care," *Brawner*, 14 F.4th at 597, because he effectively ignored someone for hours despite believing that person had a medical issue so serious that it warranted hospitalization—and a jury could reach that conclusion irrespective of how frequently policy required him to conduct checks. Put simply, leaving a person experiencing obvious medical distress virtually unattended for hours is deliberately indifferent regardless of policy requirements.

As a final matter, it is worth noting that almost all of the cases cited in this section were decided pre-*Brawner* and therefore applied the more stringent standard. Because each of those cases supports a denial of summary judgment here, it follows that the facts of this case are certainly sufficient to defeat summary judgment under the *Brawner* standard.

4. Officer Collini

Collini knew the risks associated with the restraint chair, but nevertheless skipped most of the required checks, failed to verify Howell was alive during the checks he *did* conduct; falsified the check log; and ignored the water, restroom, and limb exercise requirements. A jury could easily find him liable.

For starters, Collini knew frequent checks were required when someone was in the restraint chair for "the safety of the inmate." Collini Depo., R.69-4, PageID #333. He also knew the two-hour limb rotation was important so that the detainee did not "lose blood flow" or "develop blood clots," and that restraining someone for long periods of time poses risks to their health. *Id.* at PageID #355. Despite his understanding of these risks, Collini performed only a third of the required checks and then lied on the log. *Id*. at PageID #348-49, 353-54. And during Collini's infrequent checks, he did not actually confirm that Howell was breathing or alive; he observed Howell from outside the cell, which made it impossible to tell whether he was "alive or asleep." *Id*. at PageID #352, 364. From these facts alone, a jury could find that Collini was deliberately indifferent. *Garretson*, 407 F.3d at 798 (finding deliberate indifference where jail official was "aware of facts from which the inference of substantial risk of harm *could be* drawn") (emphasis added).

Even more evidence supports such a finding, though. Collini observed that Howell's head was "down" at 7:40pm, and that by 9:20pm, it was hanging "[m]ore

straight down." Collini Depo., R.69-4, PageID #352, 364. Despite this change—coming around Howell's fourth hour in the chair, and after Collini knew the two-hour limb rotation had not been performed—Collini did nothing to determine whether Howell was alive. *Id.* at PageID #352, 364, 350. In remarkably similar circumstances, this Court has denied summary judgment. *Speers*, 196 F. App'x at 398 (denying summary judgment to officer who saw prisoner apparently "sleeping" and knew there was a risk of harm but only "look[ed] through the plexiglass" and did not "contact[] medical personnel" or "engage [the prisoner] verbally or enter[] his cell"). On top of that, despite knowing that the two-hour limb rotation was important so the detainee did not "lose blood flow" or "develop blood clots," and that restraints pose health risks, *see id.* at PageID #355, he either didn't call his supervisor to perform the limb check, *see* Hunt Depo., R.69-8, PageID #525, or else *did* call but did nothing when Hunt failed to show up, Collini Depo, R.69-4, PageID #339. He also covered up his failures by logging that Howell did not want a limb rotation when, in fact, Collini never offered him one. *Id*. at PageID #349.

In sum, a jury could easily find that "a reasonable official" in Collini's position should have known that Howell faced a risk of harm and that he nonetheless "failed to act with reasonable care." *Brawner*, 14 F.4th at 597. In reaching the opposite conclusion, the district court relied on the same two reasons discussed above, and was wrong to do so. *See supra* pp.31-35. Ultimately, Collini admitted to

understanding the risks associated with the restraint chair, but still skipped two-thirds of the required checks and, when he did conduct checks, refused to verify whether Howell was even breathing. No matter which standard is applied—the correct *Brawner* standard or the pre-*Brawner* standard—a jury could find Collini deliberately indifferent.

5. Sergeant Hunt

Hunt saw Howell in medical distress, heard discussion of hospitalization and sickle cell disease, and understood the risks associated with the restraint chair, but still failed to comply with an important safety protocol. That suffices to defeat summary judgment.

When Hunt first encountered Howell in the medical area, Howell was in a wheelchair, telling staff he "could not feel his legs," and "yelling and stating he was in pain." Erwin Depo., R.69-5, PageID #428. As Hunt recounted to investigators just hours after Howell's death, Howell "continued yelling that his legs wouldn't work" and repeatedly slid out of his chair. *Id.* He also "complained about back pain." *Id*. Even a year-and-a-half after Howell's death, Hunt recalled hearing Howell "moaning and groaning," and that he "was not [] able to remain" in the wheelchair on his own. Hunt Depo., R.69-8, PageID #519. Others who were present in the medical area at the same time as Hunt reported that Howell described his pain as 10-out-of-10 severity. Perdikakis Decl., R.79-1, PageID #1262. Hunt also heard

discussion of sending Howell to the hospital and of his sickle cell disease. Hunt Depo., R.69-8, PageID #520, 523. Finally, he knew there are "risks" associated with the restraint chair and that limb rotation was important to "prevent[] possible blood clots." *Id.* at PageID #512, 517. All this evidence supports a finding that "a reasonable official" in Hunt's position would have known that Howell faced a risk of harm—both because he was in medical distress and because there are risks inherent to the restraint chair. *Brawner*, 14 F.4th at 597; *Garretson*, 407 F.3d at 798 (finding deliberate indifference where jail official was "aware of facts from which the inference of substantial risk of harm *could be* drawn") (emphasis added).

Still, Hunt never came down to perform the two-hour limb rotation when called; he dismissively told his supervisee "I'll be down when I can." Collini Depo., R.69-4, PageID #339. Hunt did not arrive for another *two hours*; by then, Howell was dead. Erwin Depo., R.69-5, PageID #429. He failed to comply with this important safety protocol even though he did not dispute another officer's report that "nothing out of the ordinary" happened that day. Hunt Depo., R.69-8, PageID #526. That is, there was no good reason for Hunt to have ignored his obligation to perform the two-hour limb rotation. *See id.* at PageID #525-26.

At minimum, then, Hunt's intentional decision to ignore the limb-rotation requirement was a "reckless fail[ure] to act with reasonable care." *Brawner*, 14 F.4th at 597. And denying him summary judgment would not—as the district court

suggested—be premised solely on his failure to follow policy. *See supra* pp.34-35. Rather, as in *Smith*, Hunt was "on notice that [Howell] was very ill." 505 F. App'x at 535. He had personally witnessed Howell experiencing extreme pain and complaining of non-functioning limbs, and saw that he was unable to stay seated in a wheelchair on his own. Yet Hunt "did nothing to make sure that [Howell] had not taken a turn for the worse." *Id.* Instead, he chose to skip the limb rotation for no good reason, and in so doing he declined to confirm serious inferences of risk. *See supra* pp.33-34.

And as with Erwin and Collini, Hunt's liability is not absolved—as the district court found—by the mere fact that nursing staff evaluated Howell. Even if Hunt could not be expected to overrule a nurse's decision not to hospitalize Howell, he *was* required to act with "reasonable care"—here, ensuring that his detainee, whom he knew to be "very ill," "had not taken a turn for the worse" in the hours following the nursing staff's evaluation. *Smith*, 505 F. App'x at 535; *see generally supra* at pp.31-34. Hunt's intentional, unjustified failure to perform the limb rotation despite seeing Howell in significant distress robbed Howell of an important opportunity to be checked on from inside his cell, thereby "preclud[ing] any chance of survival." Steinberg Expert Rep., R.87-3, PageID #1693. No matter which standard is applied—the correct *Brawner* standard or the pre-*Brawner* standard—a jury could find Hunt deliberately indifferent.

C. The defendants are not entitled to qualified immunity.

1. The nurses are not entitled to qualified immunity.

This Court has squarely decided that prison nurses employed by a private medical provider may not assert qualified immunity. *Harrison*, 539 F.3d at 521-25. Because Jordan and Arthur are employed by NaphCare—a private medical provider—they are not entitled to qualified immunity.

2. The officers are not entitled to qualified immunity.

Officials are not entitled to qualified immunity if (1) "the facts viewed in the light most favorable to the plaintiff[] show that a constitutional violation has occurred"; and (2) "the violation involved a clearly established constitutional right." *Brown v. Lewis*, 779 F.3d 401, 411 (6th Cir. 2015) (quotation marks and citations omitted). As discussed above, the constitutional violation prong has been satisfied. *See supra* Sections I.A-I.B. As to the clearly established prong, "an action's unlawfulness can be 'clearly established' from direct holdings, from specific examples describing certain conduct as prohibited, or from the general reasoning that a court employs." *Baynes v. Cleland*, 799 F.3d 600, 612 (6th Cir. 2015). Importantly, "the precise factual scenario need not have been found unconstitutional . . . for the right to be 'clearly established.'" *Id*. at 611; *see also Hope v. Pelzer*, 536 U.S. 730, 741 (2002) (holding factually similar cases "are not necessary"); *Moderwell v. Cuyahoga Cnty.*, 997 F.3d 653, 660 (6th Cir. 2021) (explaining "there

does not need to be a case directly on point"). Here, the unlawfulness of the officers' actions was clearly established, at least twice over.

"As early as 1972," this Court explained that "where the circumstances are clearly sufficient to indicate the need of medical attention for injury or illness, the denial of such aid constitutes the deprivation of constitutional due process." *Greene*, 22 F.4th at 615. And it has applied that clearly-established principle to cases where officers failed to adequately monitor detainees and prisoners at risk of harm. For instance, in *Phillips*, this Court denied qualified immunity to officers who were tasked with "monitor[ing] closely the [prisoner's] health status" but failed to do so. 534 F.3d at 540. It explained that the officers were "exposed to [the prisoner's] serious condition at some point," but nonetheless failed to "transport [the prisoner] to a hospital emergency room." *Id.* at 541. In *Speers*, this Court denied summary judgment to officers who had observed a prisoner exhibit concerning symptoms, but nevertheless monitored the prisoner only by "look[ing] through the plexiglass" instead of "engag[ing] [the prisoner] verbally or entering his cell" when he appeared to be sleeping. 196 F. App'x at 397-98.[9] And in *Smith*, this Court denied qualified

[9] This Court should deny the officers qualified immunity on the basis of both the published and unpublished cases discussed in this section. As this Court recently explained, "binding authority is not required to overcome qualified immunity." *Young v. Kent Cnty. Sheriff's Dep't*, No. 21-1222, 2022 WL 94990, at *5 (6th Cir. Jan. 10, 2022) (Boggs, J.) (relying on unpublished case to affirm denial of qualified immunity).

immunity to two officers tasked with monitoring a detainee: one of them "did nothing to make sure that [the detainee] had not taken a turn for the worse" because he only entered her cell for "a minute" and did not "ascertain her condition," 505 F. App'x at 535, while the other one engaged in "inadequate monitoring" of the detainee by failing to check on her for 40 minutes when jail policy required 15-minute checks, *id*. at 537.

Thus, case after case shows that the officers are not entitled to qualified immunity: all of them either knew that Howell was experiencing highly concerning medical symptoms, were aware of the serious risks associated with the restraint chair, or both; all were tasked with monitoring Howell; and all did nothing or next to nothing to make sure he did not take a turn for the worse. Under this Court's caselaw, they are not entitled to qualified immunity.

Another strand of Supreme Court and Sixth Circuit caselaw clearly establishes a second important proposition that independently requires denial of qualified immunity: an officer may not "decline[] to confirm inferences of risk that he strongly suspected to exist." *Farmer*, 511 U.S. at 843 n.8. Consistent with this principle, this Court has "denied summary judgment on qualified immunity grounds to prison officials based on their avoidance of knowledge." *Bertl*, 2009 WL 247907, at *7; *Phillips*, 534 F.3d at 541 (denying qualified immunity and reasoning that officers avoided knowledge of serious medical issues); *Linden v. Washtenaw Cnty*., 167 F.

App'x 410, 424 (6th Cir. 2006) (denying qualified immunity to officer who made "repeated pledges of ignorance" and noting that he could not escape liability "just because he declined to confirm the inferences of risk" that existed) (internal quotation marks and citation omitted).

Here, all the officers either knew that Howell was experiencing highly concerning medical symptoms, were aware of the serious risks associated with the restraint chair, or both. Yet all three took steps to avoid learning whether these risks were bearing out. Erwin and Collini knowingly skipped checks and did not even determine whether Howell was alive or dead during the few checks they did conduct, and Hunt skipped the two-hour limb rotation despite being alerted to it by another officer. The officers cannot now claim qualified immunity on the basis of ignorance when they each took steps to avoid learning about Howell's condition.

Both of these clearly established principles on their own bar qualified immunity. Taken together, they make that result unavoidable. And even if prior caselaw did not put defendants on notice, they are still not entitled to qualified immunity because they committed such "obvious" constitutional violations. *Hope*, 536 U.S. at 741; *see also id.* (explaining the "salient question" is whether officials have "fair warning"); *Barker*, 649 F.3d at 436-37 (holding that "a wide variety of sources . . . can provide defendants with fair warning" that their conduct is unconstitutional and "deviation from normal practice and prison policies" can show

"that Defendants knew their conduct was unconstitutional"). After all, what could be more obviously unconstitutional than leaving a person in medical distress virtually unattended for hours in a device that is itself known to cause harm and then covering up that conduct?

II. The District Court Erred In Granting Summary Judgment To Nurse Jordan On The Excessive Force Claim.

In *Blackmon v. Sutton*, then-Judge Gorsuch denied summary judgment to jail officials where the evidence suggested that they had "shackled [the plaintiff to a restraint chair] without *any* legitimate penological purpose" and then "kept [him] there for extensive periods after any threat of self-harm had dissipated." 734 F.3d 1237, 1242 (10th Cir. 2013); *see also Kingsley*, 576 U.S. at 397 (holding that pretrial detainee need only show that force "used against him was objectively unreasonable"). Here, the evidence shows that Jordan did the very same thing.

As an initial matter, a jury could find from officer testimony that Jordan made the decision to put Howell in a restraint chair. *See, e.g.*, Hunt Depo., R.69-8, PageID #521. In granting summary judgment, the district court said Howell was "uncooperative" and that he had been in a fight, determining that it was therefore reasonable "to place Howell into a restraint chair with a view to preventing him from harming himself or other cellmates." Order, R.105, PageID #2014, 2032. While a jury could credit this view of the facts, there is contrary evidence: the NaphCare Health Services Administrator testified that the circumstances did *not* warrant the

restraint chair. Perdikakis Depo., R.86-1, PageID #1620. And a jury could find from this testimony that Jordan had no legitimate penological purpose.

Next, the district court found that leaving Howell in the chair for four hours could not constitute a constitutional violation because he appeared to be "sleeping peacefully." Order, R.105, PageID #2015-16, 2032. But a jury could draw the exact opposite conclusion—that sleeping means the "threat of self-harm had dissipated," *Blackmon*, 734 F.3d at 1242—especially as Jordan herself testified that she never checked on Howell and so could not have removed him when the threat dissipated. Jordan Depo., R.76, PageID #1000.

Summary judgment is not appropriate where "the factual record . . . points in more than one direction." *Blackmon*, 734 F.3d at 1242. And while a jury may ultimately take the district court's view, there is sufficient evidence pointing the other direction to defeat summary judgment.[10]

III. The District Court Erred In Granting Summary Judgment To The County On The Failure-To Train Claim.

A jury could find that the County failed to train its officers on monitoring detainees placed in restraint chairs and that the failure was causally related to

[10] Jordan is not entitled to qualified immunity as an employee of a private medical provider. *Harrison*, 539 F.3d at 521-25.

Howell's tragic death. The district court therefore erred in granting summary judgment to the County.[11]

A municipality is liable under § 1983 when it evinces deliberate indifference to the constitutional rights of its inhabitants by failing to train its employees. *City of Canton v. Harris*, 489 U.S. 378, 388-89 (1989). That liability is triggered when evidence shows that "[1] the training program at issue is inadequate to the tasks that officers must perform; [2] that the inadequacy is the result of the [municipality's] deliberate indifference; and [3] that the inadequacy is 'closely related to' or 'actually caused' the plaintiff's injury." *Russo v. City of Cincinnati*, 953 F.2d 1036, 1046 (6th Cir. 1992). Here, there is evidence satisfying all three requirements.[12]

A. HCJC provided no training on restraint-chair monitoring.

The first prong is easily satisfied where a municipality does not "adequately train its officers" about "a task they are required to perform." *Brown v. Chapman*,

[11] A suit against Sheriff Neil in his official capacity is "a suit against the County itself." *Leach v. Shelby Cnty.*, 891 F.2d 1241, 1245-46 (6th Cir. 1989).

[12] This Court has yet to decide whether "a municipality's liability under § 1983 is always contingent on a finding that an individual defendant is liable for having committed a constitutional violation." *Winkler*, 893 F.3d at 901. It need not reach that question here if it finds that one of the individual defendants violated Howell's rights. However, if it finds otherwise, it should hold that the County may still be liable—as other circuits have held. *See, e.g., Barnett v. MacArthur*, 956 F.3d 1291, 1301-02 (11th Cir. 2020); *Fagan v. City of Vineland*, 22 F.3d 1283, 1294 (3d Cir. 1994).

814 F.3d 447, 463 (6th Cir. 2016). Here, the County provided *no* training on how to monitor people in restraint chairs despite requiring officers to complete that task.

Jail personnel testified there was no relevant training. Sergeant Franklin said there was no relevant training between the time he became a sergeant in 2016 and Howell's death in 2018, and that "medical has never trained [them] as far as the restraint chair." Franklin Depo., R.69-7, PageID #470, 473. And Collini could only point to "on-the-job training" during which a supervisor might say, "Hey, this is a new trick." Collini Depo., R.69-4, PageID #329. But "limited on-the-job training" is insufficient when "there is no proof of a training program" to teach officials about important components of their jobs. *Shadrick v. Hopkins Cnty.*, 805 F.3d 724, 740 (6th Cir. 2015).

The inadequacy of training is further shown where, as here, supervisors "concede[] that [they] did not offer any type of training." *Id*. at 741. Lieutenant Buchanan testified that he did not train Collini or Erwin on restraint-chair monitoring. Buchanan Depo., R.69-3, PageID #305. Hunt likewise testified that there was no training on monitoring detainees in the restraint chair—he just distributed the policy and encouraged officers to review it. Hunt Depo., R.69-8, PageID #509.

In addition, correctional expert Anthony Callisto explained that HCJC "failed to properly train and supervise" officers on "proper supervision and careful

observation of inmates" in restraint chairs. Callisto Report, R.87-9, PageID #1733. At summary judgment, "[e]specially in the context of a failure to train claim," this Court may rely on expert testimony that "call[s] into question the adequacy of a municipality's training procedures." *Russo*, 953 F.2d at 1047; *see also Gregory v. City of Louisville*, 444 F.3d 725, 754 (6th Cir. 2006) (relying on "expert reports that the City failed to properly train its officers" to deny summary judgment).

B. The failure-to-train is the result of the County's deliberate indifference.

Next, there must be evidence that "the risk of the constitutional violation is so obvious or foreseeable that it amounts to deliberate indifference" for the municipality not to prepare officials for it. *Ouza v. City of Dearborn Heights*, 969 F.3d 265, 287 (6th Cir. 2020). The risk of violation is foreseeable where officials lack training to handle "recurring situations," *id*. at 289, or situations they "will inevitably confront in the jail setting," *Shadrick*, 805 F.3d at 740; *see also City of Canton*, 489 U.S. at 390 n.10 (holding the "need to train" officers on use of deadly force was "obvious" because they were provided with firearms and were required to arrest fleeing felons); *Cherrington v. Skeeter*, 344 F.3d 631, 647 (6th Cir. 2003) (holding that training on probable cause determinations was required because it "surely is foreseeable" that officers would "occasionally make warrantless arrests").

Here, a jury could find that the need to monitor detainees in restraint chairs was "recurring" and "inevitabl[e]" in light of evidence that (1) restraint chairs were

used frequently at HCJC, Arthur Depo., R.69-1, PageID #221; and (2) officers were required to conduct ten-minute checks on detainees in restraint chairs, Erwin Depo., R.69-5, PageID #423. Not only that, but evidence also shows that restraint chairs were medically perilous enough to (1) require consultation with the medical team or supervisors; (2) require officers to consider the restrained detainee for removal every hour; and (3) allow restrained detainees to rotate their limbs every two hours to prevent blood clots. *Id*. These safeguards only serve to underscore the dangers associated with restraint chairs and make the need for training more obvious.

C. The failure-to-train is closely related to Howell's death.

As to the third and final requirement, a jury could find that HCJC's deliberate indifference was "closely related" to Howell's death. *Russo*, 953 F.2d at 1046.

Because the officers were not trained to properly monitor someone in a restraint chair, the few times they actually *did* conduct checks, they did not make sure Howell was conscious or even breathing. As Erwin explained, in the absence of training, he believed that monitoring involved "look[ing] in the window, the small little window that we have in the door, and observ[ing] the inmate." Erwin Depo., R.69-5, PageID #407. Collini agreed that "the inmates were only observed through a small window" and that he was "never trained to have any physical interaction with inmates while they were in the restraint chair." Collini Depo., R.69-4, PageID #335. In fact, Collini admitted that from his vantage point, Howell "could have been

alive or he could have been dead." *Id*. at PageID #364. This feckless monitoring was not the only option. Indeed, Hunt explained that officers *could* "open the door to check" on people in restraint chairs. Hunt Depo., R.69-8, PageID #516. And Sergeant Franklin explained that he would make sure people were alive by "look[ing] for chest rising." Franklin Depo., R.69-7, PageID #475.

But since there was no relevant training, Collini and Erwin were not trained to enter the room and observe Howell, to ask whether he felt okay, or to even confirm that he was breathing. As a result, the few checks they conducted were meaningless and effectively meant Howell went unmonitored for hours. And as Dr. Steinberg explained, the fact that he was "ignored for hours and provided no hydration precluded any chance of survival." Steinberg Expert Rep., R.87-3, PageID #1693. But if medical intervention *had* been provided, it's "more likely than not" that Howell would have survived. *Id*. A jury could find on these facts that if the officers had been properly trained they would have observed Howell's deterioration and obtained medical help, and that the lack of training was therefore closely related to his death.

* * *

This Court should reverse the district court and deny summary judgment to the County. The County failed to train its officers to properly monitor detainees in restraint chairs. That failure raised the obvious risk of a constitutional violation

because detainees were left virtually unattended in restraint chairs for hours. That risk became reality when Howell died because no one was properly monitoring him and so no one could provide him the medical treatment he so desperately needed.

IV. The District Court Erred In Granting Summary Judgment To NaphCare On The Policy Claim.

A private contractor "is liable for a policy or custom of that private contractor," *Johnson*, 398 F.3d at 877, if there is a "direct causal link" between the policy and the denial of adequate medical care, *Jones*, 625 F.3d at 946. Here, there is evidence showing that nurses routinely ordered restraint chairs and that such a custom caused the denial of adequate medical care here.

First, "a 'custom' that has not been formally approved by an appropriate decisionmaker" may occasion liability "on the theory that the relevant practice is so widespread as to have the force of law." *Bd. of Cnty. Comm'rs of Bryan Cnty., Okl. v. Brown*, 520 U.S. 397, 404 (1997). Here, officer testimony shows that nurses routinely authorized restraint chairs despite official policy prohibiting that. Terry Depo., R.69-16 at PageID #821 (answering "Yes" when asked whether it was "typical for nurses to be the ones who are authorizing the restraint chair"); Arthur Depo., R.69-1 at PageID #244 ("[R]estraints must be ordered by an advanced clinical provider.").

Second, there is evidence of the requisite "causal link." *Jones*, 625 F.3d at 946. A jury could find from expert testimony that if Jordan had contacted a doctor,

that doctor would likely have ordered Howell to the emergency room instead of placing him in the restraint chair. *See* Steinberg Aff., R.87-1 at PageID #1639 (explaining the need for higher-level care was "foreseeable" based on Howell's condition); Roscoe Report, R.87-6, PageID #1708 (similar).

The district court erred in failing to meaningfully consider this claim at all. Order, R.105 at PageID #2033-34.

CONCLUSION

For the foregoing reasons, this Court should reverse the district court and remand for further proceedings.

Dated: June 8, 2022

Respectfully submitted,

/s/ Megha Ram

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CERTIFICATE OF COMPLIANCE WITH FED. R. APP. P. 32(a)(7)

1. This Brief complies with type-volume limitation of Rule 32(a)(7)(B) of the Federal Rules of Appellate Procedure and Circuit Rule 32(b) because, according to the word count function of Microsoft Word 2019, the Brief contains 12,978 words excluding the parts of the brief exempted by Rule 32(f) of the Federal Rules of Appellate Procedure.

2. This Brief complies with the typeface and type style requirements of Rule 32(a)(5) and (6) of the Federal Rules of Appellate Procedure and Circuit Rule 32(b) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2019 in 14-point Times New Roman font for the main text and 14-point Times New Roman font for footnotes.

Dated: June 8, 2022 */s/ Megha Ram*

CERTIFICATE OF SERVICE

I, Megha Ram, hereby certify that on June 8, 2022, I electronically filed the foregoing document through the court's electronic filing system, and that it has been served on all counsel of record through the court's electronic filing system.

/s/ Megha Ram

DESIGNATION OF RELEVANT DISTRICT COURT DOCUMENTS

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