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

PLAINTIFF-APPELLANT'S REPLY BRIEF

Konrad Kircher
Ryan J. McGraw
RITTGERS & RITTGERS
12 East Warren Street
Lebanon, OH 45036
(513) 932-2115
konrad@rittgers.com
ryan@rittgers.com

Megha Ram
Elizabeth Bixby*
RODERICK & SOLANGE MACARTHUR JUSTICE CENTER
501 H Street NE, Suite 275
Washington DC 20002
(202) 869-3434
megha.ram@macarthurjustice.org

David M. Shapiro
RODERICK & SOLANGE MACARTHUR JUSTICE CENTER
NORTHWESTERN PRITZKER SCHOOL OF LAW
375 East Chicago Avenue
Chicago, IL 60611
(312) 503-1071
david.shapiro@law.northwestern.edu

Rosalind Eileen Dillon
RODERICK & SOLANGE MACARTHUR JUSTICE CENTER
160 E. Grand Avenue, Floor 6
Chicago, IL 60611
(202) 869-3379
rosalind.dillon@macarthurjustice.org

Counsel for Plaintiff-Appellant Karla Howell
** Admitted only in California; not admitted in D.C. Practicing under the supervision of the Roderick & Solange MacArthur Justice Center.*

TABLE OF CONTENTS

TABLE OF AUTHORITIES ii

INTRODUCTION 1

ARGUMENT 2

I. The District Court Erred In Granting Summary Judgment On The Deliberate Indifference Claims. 2

A. Howell had a serious medical need. 2

B. *Brawner* altered the second prong of the analysis. 4

C. A jury could find the nurse defendants deliberately indifferent. 6

D. A jury could find the officer defendants deliberately indifferent and they are not entitled to qualified immunity. 15

II. The District Court Erred In Granting Summary Judgment To Nurse Jordan On The Excessive Force Claim. 27

III. The District Court Erred In Granting Summary Judgment To The County On The Failure-To Train Claim. 28

A. HCJC provided no training on restraint-chair monitoring. 28

B. The failure-to-train is the result of the County's deliberate indifference. 30

C. The failure-to-train is closely related to Howell's death. 32

IV. The District Court Erred In Granting Summary Judgment To NaphCare On The Policy Claim. 33

CONCLUSION 35

CERTIFICATE OF COMPLIANCE

CERTIFICATE OF SERVICE

TABLE OF AUTHORITIES

Page(s)

Cases

Alspaugh v. McConnell,
643 F.3d 162 (6th Cir. 2011) 6

Barberick v. Hilmer,
727 F. App'x 160 (6th Cir. 2018) 15

Barker v. Goodrich,
649 F.3d 428 (6th Cir. 2011) 17

Baynes v. Cleland,
799 F.3d 600 (6th Cir. 2015) 26

Bd. of Cnty. Comm'rs of Bryan Cnty. v. Brown,
520 U.S. 397 (1997) 34

Bertl v. City of Westland,
2009 WL 247907 (6th Cir. Feb. 2, 2009) 12

Blackmore v. Kalamazoo Cnty.,
390 F.3d 890 (6th Cir. 2004) 2

Boretti v. Wiscomb,
930 F.2d 1150 (6th Cir. 1991) 2

Brawner v. Scott Cnty.,
14 F.4th 585 (6th Cir. 2021) ....*passim*

Brown v. Chapman,
814 F.3d 447 (6th Cir. 2016) 29

Burwell v. City of Lansing,
7 F.4th 456 (6th Cir. 2021) ....*passim*

Farmer v. Brennan,
511 U.S. 825 (1994) ....*passim*

Greene v. Crawford Cnty.,
22 F.4th 593 (6th Cir. 2022) 5, 12, 16, 17

Griffith v. Franklin Cnty.,
975 F.3d 554 (6th Cir. 2020) .... *passim*

Gunther v. Castineta,
561 F. App'x 497 (6th Cir. 2014) 2

Jones v. Muskegon,
625 F.3d 935 (6th Cir. 2010) 3

Jordan v. Howard,
987 F.3d 537 (6th Cir. 2021) 11

LaMarbe v. Wisneski,
266 F.3d 429 (6th Cir. 2001) 9, 12

Leach v. Shelby Cnty. Sheriff,
891 F.2d 1241 (6th Cir. 1989) 34

Ouza v. City of Dearborn Heights,
969 F.3d 265 (6th Cir. 2020) 31

Phillips v. Roane Cnty.,
534 F.3d 531 (6th Cir. 2008) 17, 26, 30

Quigley v. Tuong Vinh Thai,
707 F.3d 675 (6th Cir. 2013) 12

Russo v. City of Cincinnati,
953 F.2d 1036 (6th Cir. 1992) 32

Shadrick v. Hopkins Cnty.,
805 F.3d 724 (6th Cir. 2015) 28, 30, 31

Smith v. Cnty. of Lenawee,
505 F. App'x 526 (6th Cir. 2012) .... *passim*

Sours v. Big Sandy Reg'l Jail Auth.,
593 F. App'x 478 (6th Cir. 2014) .... *passim*

Speers v. Cnty. of Berrien,
196 F. App'x 390 (6th Cir. 2006) 18, 25

Stein v. Gunkel,
-- F.4th --, No. 21-6118, 2022 WL 3210205 (6th Cir. Aug. 9, 2022) 5

Stojcevski v. Macomb Cnty.,
827 F. App'x 515 (6th Cir. 2020) 15

Taylor v. Franklin County,
104 F. App'x 531 (6th Cir. 2004) 9, 10

Villegas v. Metro. Gov't of Nashville,
709 F.3d 563 (6th Cir. 2013) 3, 22

Westmoreland v. Butler Cnty.,
29 F.4th 721 (6th Cir. 2022). 5

Winkler v. Madison Cnty.,
893 F.3d 877 (6th Cir. 2018) 3

INTRODUCTION

When Cornelius Howell experienced a medical emergency that caused him severe pain and left parts of his body numb, rendering him unable to walk or stand, no one helped him.

Nurse Jordan relegated him to a restraint chair and never checked on him again—despite knowing that Howell suffered from sickle cell and exhibited serious symptoms of the disease. Nurse Arthur walked past his cell, but failed to enter, take his vitals, or confirm that he was not in medical distress. Officers Erwin and Collini skipped more than half the checks they were required to conduct, failed to determine whether Howell was even breathing the few times they glanced in his cell, and then falsified records to cover up their conduct. Officer Hunt ignored Howell entirely until he found Howell dead that evening. And the institutions employing these defendants failed Howell in their own right: NaphCare is responsible for the widespread custom of NaphCare nurses ordering detainees into restraint chairs without physician approval and the County is responsible for failing to train its officers to properly monitor detainees in restraint chairs.

Because of the defendants' actions, Howell suffered greatly and died alone in a cell while strapped to a restraint chair. His estate's claims should go to a jury.

ARGUMENT

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

A. Howell had a serious medical need.

Both sets of defendants are flatly wrong to argue that no jury could find Howell had a serious medical need—extensive evidence shows that he had sickle cell disease, suffered extraordinary pain, could not feel his legs, *and ultimately died*. Opening Br. 12-13, 19, 25-26. This Court repeatedly has held that "pain qualifies as an objectively serious medical need." *Gunther v. Castineta*, 561 F. App'x 497, 501 (6th Cir. 2014); *see also Blackmore v. Kalamazoo Cnty.*, 390 F.3d 890, 899-900 (6th Cir. 2004); *Boretti v. Wiscomb*, 930 F.2d 1150, 1154-55 (6th Cir. 1991). Further, a prisoner's inability to "put[] pressure on his legs" satisfies the medical need prong because such a condition is "easily recognized as needing a doctor's attention." *Gunther*, 561 F. App'x at 501. But more to the point, Howell, a 33-year-old man, went into sickle cell crisis and died—so there can be no question he had a serious medical need in the hours before his death when he lay moaning in pain, unable to feel his legs or stay seated in his wheelchair. This Court has "routinely held that a condition resulting in death is 'sufficiently serious.'" *Burwell v. City of Lansing*, 7 F.4th 456, 463 (6th Cir. 2021). That should end the matter.

Contrary to the argument by Defendants Arthur, Jordan, and NaphCare ("NaphCare Defendants"), these arguments were fully preserved below. *See*

NaphCare Response 43. The estate asserted that Howell "died, evidencing that he had a serious medical issue," "had sickle cell," had "pain in his legs" and "pain in his back," that "he could not feel his legs," and that each of those "conditions on their own" would be "sufficient to establish" a serious medical need. MSJ Response, R.96, PageID#1890-91. The NaphCare Defendants' preservation arguments thus have no merit.

Unlike the NaphCare Defendants, Defendants Neil, Hunt, Erwin, and Collini ("Corrections Defendants") agree that Howell had a serious medical issue; they nonetheless argue the first prong is not satisfied because they were unaware of the serious medical need. Corrections Response 25. Their argument misunderstands the prong one inquiry, where the question is only whether Howell had a "serious medical need" or was placed in conditions that "increase[d] [his] risk of medical complications." *Villegas v. Metro. Gov't of Nashville*, 709 F.3d 563, 570-71 (6th Cir. 2013). For instance, the first prong was satisfied where a detainee had been diagnosed with colorectal cancer and later died, even though none of the defendants were aware of that diagnosis. *Jones v. Muskegon*, 625 F.3d 935, 942 (6th Cir. 2010); *see also Winkler v. Madison Cnty.*, 893 F.3d 877, 890 (6th Cir. 2018) (finding first prong satisfied where detainee died without inquiring into defendants' knowledge of detainee's condition). But even if the Corrections Defendants were correct about the standard, it would be satisfied here because copious evidence shows that they

were aware of Howell's serious medical needs, that the restraint chair increased his risk of medical complications, or both. *See infra* Part I.C-D.

B. *Brawner* altered the second prong of the analysis.

The second prong of the deliberate indifference analysis was altered by this Court's decision in *Brawner v. Scott County*, 14 F.4th 585 (6th Cir. 2021). Opening Br. 24-25. The Corrections Defendants agree that *Brawner* sets out the operative standard. Corrections Response 23-24. While they quibble with the language used to describe that standard, they go to on to encapsulate it exactly: the issue, in their own words, is whether "the officers act[ed] recklessly in the face of an unjustifiably high risk that is either known or so obvious that it should be known." *Id*. at 29.

Meanwhile, the NaphCare Defendants dispute the applicability of the *Brawner* standard, arguing that it is not "binding precedent" for two reasons. NaphCare Response 35. First, they note that a panel decision may alter a legal standard only in limited circumstances, including where there is an inconsistent decision by the Supreme Court. *Id*. at 33. But that cuts against their argument, because *Brawner* specifically recognized that there was "an inconsistent Supreme Court decision" requiring modification of this Court's caselaw. *Brawner*, 14 F.4th at 596. And as they concede, this determination was undisturbed by the *en banc* Sixth Circuit, which denied rehearing. NaphCare Response 39. Second, the NaphCare Defendants suggest the *Brawner* standard is "mere dicta" because, in their

view, this Court did not need to reach the issue. *Id*. at 35-37. But *Brawner* refuted that too: it explained that deciding the issue was "necessary" to properly instruct the jury on remand. *Brawner*, 14 F.4th at 592 n.2. And again, the *en banc* Sixth Circuit left that determination untouched.

Most importantly, this Court has repeatedly affirmed that the *Brawner* standard controls. It expressly rejected an invitation to "interpret *Brawner*'s extension of *Kingsley* as non-binding dictum," instead reiterating that it is "bound" by *Brawner*. *Greene v. Crawford Cnty.*, 22 F.4th 593, 607 (6th Cir. 2022). In a subsequent case, it explained that *Brawner* "directly confronted" and decided the issue. *Westmoreland v. Butler Cnty.*, 29 F.4th 721, 727 (6th Cir. 2022), *reh'g en banc denied*, 35 F.4th 1051 (6th Cir. 2022). In yet another case, it reaffirmed that *Brawner* "altered the test for a pretrial detainee alleging that jail officials were deliberately indifferent to medical needs." *Stein v. Gunkel*, -- F.4th --, No. 21-6118, 2022 WL 3210205, at *5 (6th Cir. Aug. 9, 2022). There is no question that the *Brawner* standard applies. It has been repeatedly affirmed and is accepted by half the defendants in this matter. Put simply, "*Brawner* changed things." *Greene*, 22 F.4th at 606.[1]

[1] Even if the pre-*Brawner* standard applied, claims against four of the individual defendants would *still* go to a jury. Opening Br. 33-35, 43, 46, 48.

C. A jury could find the nurse defendants deliberately indifferent.

1. Nurse Jordan

Jordan knew Howell's legs were numb, knew he was in excruciating pain, and knew he had sickle cell disease. She nonetheless consigned him to a restraint chair and never checked on him again. On these facts—undisputed by Jordan—a rational juror could infer that Jordan knew or should have known that her actions exposed Howell to a serious risk of ongoing pain and grave medical harm.

Jordan herself admitted that she "believed" Howell was in pain, saw him slide out of the wheelchair due to an inability to put pressure on his legs, and noted his abnormally low blood pressure. Jordan Depo., R.76, PageID#989, 993; Arthur Depo., R.69-1, PageID#242. She also admitted she knew Howell had sickle cell disease. Jordan Depo., R.76, PageID#989, 1011. She even admitted that she knew pain and numbness were classic symptoms of sickle cell disease. Jordan Depo., R.76, PageID#981-82. And yet she did nothing but order Howell into a restraint chair. Hunt Depo., R.69-8, PageID#521; Jordan Depo., R.76, PageID#998. A jury presented with these facts could easily find that Jordan's conduct was "so woefully inadequate as to amount to no treatment at all" for someone in a sickle cell crisis, or even just someone experiencing severe pain and numbness. *Alspaugh v. McConnell*, 643 F.3d 162, 169 (6th Cir. 2011). Relatedly, a jury could find that she failed to act to mitigate a risk of harm that she knew about, *Griffith v. Franklin Cnty.*, 975 F.3d

554, 568 (6th Cir. 2020), or that she should have known about, *Brawner*, 14 F.4th at 597. At the very least, a jury could find that by placing Howell in a restraint chair and sending him away despite his troubling symptoms, Jordan "declined to confirm inferences of risk that [s]he strongly suspected to exist," conduct for which she cannot "escape liability" (even under the pre-*Brawner* standard). *Farmer v. Brennan*, 511 U.S. 825, 843 n.8 (1994).

Indeed, this Court's decision in *Sours v. Big Sandy Reg'l Jail Auth.*, 593 F. App'x 478 (6th Cir. 2014) is functionally identical to this case and underscores why summary judgment is inappropriate:

- The *Sours* nurse knew the prisoner had diabetes, 593 F. App'x at 485; Jordan knew Howell had sickle cell disease, Jordan Depo., R.76, PageID#989, 1011.

- The *Sours* nurse observed serious symptoms of diabetes complications, 593 F. App'x at 485; Jordan observed telltale symptoms of sickle cell complications, Jordan Depo., R.76, PageID#988-89, 992-93.

- The *Sours* nurse knew the observed symptoms were tied to diabetes, 593 F. App'x at 485; Jordan knew that pain and numbness were sickle cell symptoms, Jordan Depo., R.76, PageID#981-82.

- A nursing expert said the *Sours* nurse should have "arrange[d] medical care," 593 F. App'x at 485; two medical experts said Jordan should have obtained emergency care, Steinberg Rep., R.87-3, PageID#1690-93; Roscoe Rep., R.87-6, PageID#1708.

- The *Sours* nurse did not arrange medical care, 593 F. App'x at 486; Jordan did not check on Howell or obtain medical care for him, Jordan Depo., R.76, PageID#998-1000.

- The *Sours* nurse said she believed the prisoner was detoxing, 593 F. App'x at 481; Jordan says she believed Howell had a psychological issue, Jordan Depo., R.76, PageID#1006.

Jordan asserts that *Sours* is "inapposite" because that nurse suffered from the same condition as the prisoner. NaphCare Response 58. But that was only one of *nine* facts this Court relied upon to conclude that a jury could find the nurse inferred a risk of harm. *Sours*, 593 F. App'x at 585. Jordan does not suggest that this Court distinguishes between sources of knowledge, and here there is evidence that Jordan knew about sickle cell through academic training and hands on experience. Jordan Depo., R.76, PageID#994-95, 1023-24. So, just like the *Sours* nurse, Jordan is not entitled to summary judgment. 593 F. App'x at 485-86.

Contrary to Jordan's argument, the point is not just that Jordan got the diagnosis wrong—it's that she refused to do anything to treat clear symptoms that demonstrated an obvious risk of serious harm. *See* NaphCare Response 48-49, 56-59. A jury could find Jordan deliberately indifferent to Howell's excruciating pain. Alternatively, a jury could find her deliberately indifferent to physical symptoms, like numbness and hypotension, that indicated further impending harm. Either way, a jury could find her deliberately indifferent to a serious medical need. Indeed, this Court has reversed district courts that relied on the same fallacious misdiagnosis argument Jordan makes here, explaining that while medical providers don't have to get every diagnosis right, they cannot ignore pain and other physical symptoms just

because they got a particular diagnosis wrong. For instance, in *Taylor v. Franklin County*, the district court held a nurse could not be liable simply because she "failed to diagnose" the prisoner's tumor. 104 F. App'x 531, 541 (6th Cir. 2004). This Court reversed, explaining that the nurse could be liable—not because she failed to diagnose the prisoner, but because a jury could find she "should have been on notice as to the seriousness of [his] condition" when he "appeared in front of her office lying immobile" and in "pain." *Id*. Similarly, in *LaMarbe v. Wisneski*, a doctor was "[u]nable to discover the reasons" for fluid in a prisoner's abdomen. 266 F.3d 429, 433 (6th Cir. 2001). Despite the doctor's failure to pinpoint the exact condition causing the symptoms, this Court explained that a jury could still find that he was "aware of the facts from which a substantial risk of serious harm could be inferred." *Id*. at 438. Jordan's assertion that this Court "does not equate a misdiagnosis to deliberate indifference," NaphCare Response 57, is therefore as true as it is irrelevant: a jury could still find her liable based on her response to Howell's excruciating pain, debilitating numbness, and hypotension.

Jordan's misdiagnosis defense is problematic for another reason: it relies entirely on believing Jordan's claim that she was ignorant of Howell's sickle cell crisis. As this Court explained in *Sours*, a defendant nurse's "own statement of her lack of knowledge regarding [the prisoner's condition] is not dispositive where the record includes significant documentary and/or circumstantial evidence to the

contrary." 593 F. App'x at 485; *see also Taylor*, 104 F. App'x at 541 (denying summary judgment because of factual disputes regarding nurse's "professed ignorance" of prisoner's medical needs). Accordingly, this Court's analysis should not focus on Jordan's "statement of her knowledge," but on the evidence showing that Jordan knew of Howell's sickle cell disease or at least "the obviousness of the risk" stemming from his symptoms. *Sours*, 593 F. App'x at 485.

Ultimately, then, the evidence in this case presents three routes to liability. First, a jury could find that Jordan either knew or should have known that Howell was suffering from a sickle cell crisis. Second, a jury could find that even if Jordan was unaware that Howell was experiencing a sickle cell crisis, she was aware of his excruciating pain, debilitating numbness, and hypotension, and therefore either knew or should have known of a serious risk of harm. Third, a jury could find that she declined to confirm inferences of risk that she strongly suspected to exist. Howell has presented evidence to support all three findings: Jordan (1) knew Howell was in pain; (2) knew his legs were numb; (3) knew he had abnormal vital signs; (4) knew he had sickle cell disease; (5) had both training and experience related to sickle cell disease; and (6) knew that pain and numbness were classic symptoms of the disease. Jordan Depo., R.76, PageID#981-82, 989, 993-95, 1011, 1023-24; Arthur Depo., R.69-1, PageID#242. To be sure, throughout her response, Jordan lists evidence to suggest that she believed Howell was suffering from psychiatric issues. NaphCare

Response 48-49, 54-55. But this recitation merely underscores the importance of the disputed facts in this case. The district court's "premature entry of summary judgment" in the face of such material factual disputes improperly "supplant[ed] the role of the factfinder in adjudicating liability." *Jordan v. Howard*, 987 F.3d 537, 542 (6th Cir. 2021).

Next, Jordan posits that she cannot be liable because she "actually provided care." NaphCare Response 57. Not so. As an initial matter, the only "care" she points to is providing glucose and hydration, taking vitals, asking why he was yelling, and telling Arthur about Howell. *Id*. at 57-59. Elsewhere in her brief, she also argues that the restraint chair was an appropriate response to Howell's medical need. *Id.* at 49-50. On the other hand, Howell has presented evidence that—in Jordan's own words—"all [she] did was do a housing assignment to say that he should be in psych." Jordan Depo., R.76, PageID#1003. She did not order a psychiatric evaluation. *Id*. She did not call a psychiatrist. *Id*. at PageID#1005; Hunt Depo., R.69-8, PageID#521. She did not refer Howell to additional medical care, nor did she ever check on him—instead she admitted that she "[p]retty much" disclaimed responsibility over him after placing him in the restraint chair, even though she was the nurse in charge and knew that no other nurse looked in on him after Arthur. Jordan Depo., R.76, PageID#974-75, 998-99, 1005-07. This "avoidance of

knowledge does not permit [Jordan] to escape liability." *Bertl v. City of Westland*, 2009 WL 247907, at *7 (6th Cir. Feb. 2, 2009).

At bottom, Jordan contends this case should not go to a jury because she did *something*. NaphCare Response 57-59. Wrong. "[T]he provision of some treatment by a medical professional does not immunize that official from liability." *Sours*, 593 F. App'x at 486; *see also Greene*, 22 F.4th at 613 (denying summary judgment to jail official who referred detainee to mental health care but "did not seek [additional] medical assistance"); *LeMarbe*, 266 F.3d at 439 (explaining "a prisoner is not required to show that he was literally ignored by the staff," so medical professionals are "not automatically immunize[d]" just because they do *something*).

Jordan then makes a set of arguments concerning expert evidence—evidence that is not necessary to defeat summary judgment, but does make Howell's case even stronger. Howell detailed the importance of this expert evidence under this Court's precedent. *See* Opening Br. 27-29 (citing *LeMarbe*, 266 F.3d at 439, and *Quigley v. Tuong Vinh Thai*, 707 F.3d 675 (6th Cir. 2013)). Jordan has little to say in response. *See* NaphCare Response 60. She says the experts in *LeMarbe* and *Quigley* testified at length that the risk was obvious and went ignored. *Id.* But the same can be said of the experts in this case. That is, while Jordan argues that Nurse Roscoe did not explain "how a reasonable nurse armed with the [sic] Nurse Jordan's actual knowledge would have determined Mr. Howell would have required emergent care,"

id. at 61-62, Nurse Roscoe did just that. She first identified Jordan's "actual knowledge"—a patient before her with sickle cell disease who was complaining of pain, was hypotensive, and laying on the floor—and then explained that a nurse with that knowledge "should have immediately" obtained emergency care. Roscoe Rep., R.87-6, PageID#1706-08. Jordan's objection to Dr. Steinberg's expert testimony is similarly weak: she cherry-picks pieces of his testimony and omits his conclusion that Jordan should have foreseen the need for emergency 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#1638-39. To the extent she believes a jury could draw different conclusions from the expert testimony, that is, of course, a reason to deny summary judgment.[2]

[2] Jordan also makes the remarkable argument that Howell failed to establish the requisite causation. NaphCare Response 65-67. Wrong. For starters, Jordan brazenly asserts that the failure to check on Howell was not causally related to his death by misstating the content of the coroner's declaration—the coroner "suggest[ed]" that Howell died "closer to the time he was last noted to be moving and yelling than the time he was discovered to be without pulse or respirations [at 9:45pm]." Stephens Decl., R.73, PageID#949. That is perfectly consistent with a finding that Jordan's failure to send Howell to medical care when she saw him in the medical sallyport or at any other time thereafter was causally related to his death. On top of that, Dr. Steinberg explained that "there was sufficient time to transfer Howell to a skilled medical facility to save his life," Steinberg Aff., R.87-1, PageID#1638, and that such transfer "more likely than not" would have prevented Howell's death, Steinberg Rep., R.87-3, PageID#1693. A jury could therefore find the requisite causation.

In sum, a jury could find that Jordan "failed to act with reasonable care" even though she "should have known" of an excessive risk of harm, as required under *Brawner*, 14 F.4th at 597. A jury could also find that she failed to act despite actually knowing of a substantial risk of harm, as required pre-*Brawner*. *Griffith*, 975 F.3d at 568.[3] At the very least, a jury could find that by placing Howell in a restraint chair and sending him away despite his troubling symptoms, Jordan "declined to confirm inferences of risk that [s]he strongly suspected to exist"—something for which she cannot "escape liability." *Farmer*, 511 U.S. at 843 n.8.

2. Nurse Arthur

Arthur argues that Howell "mischaracterizes the facts" in noting that she left her shift without checking on him or calling a doctor. NaphCare Response 50. But that's what a jury could find from the evidence: instead of checking on Howell, the one time she "stop[ed] by," she did not actually enter his cell, take his vitals, or confirm he was not in medical distress. Arthur Depo., R.69-1, PageID#224. As she put it, she "just kind of walk[ed] away." *Id.* She also admitted to never calling a doctor. *Id*. at PageID#225. She effectively ignored Howell, and did so despite knowing (1) he was in a restraint chair; (2) "it's a necessary thing" to call the doctor

[3] While *Brawner* governs, nearly all the cases cited in this brief were decided under the more stringent pre-*Brawner* standard, making clear that summary judgment is not warranted under either standard.

when someone is in a restraint chair; and (3) he had abnormally low blood pressure when placed in the chair. *Id*. at PageID#224, 222, 242. In light of this troubling evidence, a jury could find that she "failed to act reasonably to mitigate" a risk of harm that she "should have known" about. *Brawner*, 14 F.4th at 597 (cleaned up).[4]

D. A jury could find the officer defendants deliberately indifferent and they are not entitled to qualified immunity.

Officers may rely on a medical 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), and "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). Accordingly, officers are deliberately indifferent if they fail to monitor a detainee at risk of harm even if medical personnel already assessed the detainee. *Smith v. Cnty. of Lenawee*, 505 F. App'x 526, 537 (6th Cir. 2012). The Corrections Defendants are therefore wrong to suggest they are immune from liability because they "reasonably relied on [medical] assessment[s]." Corrections Response 27, 29.

Indeed, in another case where an officer violated policy by "fail[ing] to check on [a detainee] for a forty-minute period," this Court denied summary judgment *even though* a doctor had recently signed off on the detainee's condition and the officer

[4] Prison nurses employed by a private medical provider, like Jordan and Arthur, may not assert qualified immunity. Opening Br. 49.

said she didn't want "to second guess" the doctor's judgment. *Smith*, 505 F. App'x at 530, 537. *Smith* also denied summary judgment to another officer who did nothing to "ascertain [the detainee's] condition" while monitoring her the morning after the doctor had signed off. *Id*. at 535. While the Corrections Defendants try to distinguish *Smith* by arguing that the officers in that case "were aware of the inmate's medical situation," Corrections Response 29, the same can be said of this case: all three officers knew Howell was unwell, knew the risks associated with the chair, or both. Opening Br. 36-48. The parallels to this case are obvious and make clear that Erwin, Collini, and Hunt cannot simply rely on Howell's trip to medical to evade liability. In fact, such reliance is particularly problematic in light of Jordan's testimony that she was relying on the officers to properly monitor Howell and report back to her. Jordan Depo., R.76 at PageID#1000-01. Simply put, even if reliance on a medical professional was "reasonable at the time of [the medical] evaluation," a jury could find the need for medical attention existed "in the hours following" the evaluation and therefore hold officers liable for engaging in "bare minimum observation" during that time. *Greene*, 22 F.4th at 609.[5]

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[5] The Corrections Defendants try to distinguish the facts of *Greene* by noting that the detainee in that case had symptoms for many hours after the medical evaluation. *See* Corrections Response 28-29. They do not explain why that is a meaningful difference or how it undermines *Greene*'s central conclusions that a detainee could evince the need for medical attention even after a medical evaluation, and that "bare minimum observation ceases to be constitutionally adequate" at that point. *Greene*,

Here, the blatant policy violations serve as persuasive evidence that the officers engaged in just this kind of constitutionally inadequate "bare minimum observation." *Id*. When faced with the stark reality of these violations, the Corrections Defendants fall back on the argument that policy violations do not, on their own, constitute constitutional violations. Corrections Response 35. But Howell doesn't suggest otherwise; rather, the opening brief shows policy violations are *persuasive* evidence of deliberate indifference. Opening Br. 42-43. And the Corrections Defendants have little to say about that: they merely distinguish the facts of *Barker v. Goodrich*, 649 F.3d 428, 436 (6th Cir. 2011), and *Phillips v. Roane Cnty*., 534 F.3d 531 (6th Cir. 2008), without undermining their relevant conclusions about policy violations. Corrections Response 36-37. More importantly, they fail to contend with several cases where the policy violations *do* bear a striking factual similarity to the facts of this case. For instance, in *Burwell*, just as in this case, an officer "violated the cell check policy" by failing to "look or stop at [the detainee's] cell." 7 F.4th at 461. In denying the officer summary judgment, this Court explained that "whether an officer complied with policy can be relevant to establishing the officer's knowledge of the risk to an inmate and whether the officer disregarded that risk." *Id*. at 476 & n.7; *see also Smith*, 505 F. App'x at 537 (affirming denial of

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22 F.4th at 609. Moreover, this Court has found deliberate indifference where monitoring failures occurred over a three-hour period, a shorter timeframe than the one at issue here. *Burwell*, 7 F.4th at 474.

summary judgment to officer for "inadequate monitoring" where officer failed to check on detainee for 40 minutes despite policy requiring 15-minute checks).

In any case, Howell does not rely solely on policy violations: putting policy considerations to the side, the evidence shows that the officers (1) witnessed obvious signs of medical distress, admitted awareness of the risks associated with the restraint chair, or both; (2) infrequently checked on Howell; (3) failed to confirm he was alive or breathing the few times they did glance in the cell; and (4) falsified the log to cover their failures. *See* Opening Br. 36-48. So, no matter what policy required, a jury could find based on the remaining evidence that the officers were deliberately indifferent. *See, e.g.*, *Speers v. Cnty. of Berrien*, 196 F. App'x 390, 398-99 (6th Cir. 2006) (denying summary judgment to officers who, despite their awareness of possible harm, didn't "engage [the prisoner] verbally or enter[] his cell" even though there were no policy violations). The evidence detailed here would allow a jury to reach this conclusion under the *Brawner* standard—the standard that the Corrections Defendants agree governs this case, Corrections Response 23-24—and under the pre-*Brawner* standard requiring actual knowledge of a substantial risk of harm, *Griffith*, 975 F.3d at 568.

1. *Officer Erwin*

The evidence shows that Erwin knew Howell was in medical distress, had seen Howell "slumped over" in the medical sallyport, and 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 many of the required ten-minute checks; failing to verify Howell's condition during the checks he did conduct; falsifying the check log; and ignoring the water, restroom, and limb exercise requirements.

Despite this evidence, Erwin blithely asserts that he "could not have known and had no reason to know" that Howell was suffering from a medical emergency. Corrections Response 33. To support this assertion, he says the statement he made to investigators just hours after Howell's death—that he was "upset about the situation" because he believed "Howell should have gone to the hospital," Erwin Depo., R.69-5, PageID#430—was "obviously made in retrospect," Corrections Response 33. It is decidedly not obvious from the statement itself, and it was only much later, during his deposition, that Erwin backtracked on his earlier statement. *Id*. (citing Erwin Depo., R.69-5, PageID#410). A jury could easily believe the statement he made to an investigator hours after the incident over his post-hoc rationalization of the statement in his deposition after being sued.

Erwin's assertion that he thought Howell was "sleeping and safe" is also contradicted by record evidence. *Id.* The evidence shows that he saw Howell "slumped over in the chair," saw him "on the floor" in the medical sallyport, and heard him moaning in pain and yelling that his legs did not work both in the sallyport

and the restraint chair. Opening Br. 37. A jury could thus conclude that Erwin knew there was a risk of harm, *Griffith*, 975 F.3d at 568, or at least "should have known" that Howell faced a risk of harm, *Brawner*, 14 F.4th at 597—even if he now says he thought Howell was sleeping.

A jury could further find that despite his awareness of potential harm, Erwin completed an inadequate number of checks and did not bother to confirm Howell was actually alive during the few checks he did conduct. Opening Br. 38. Howell presented evidence that other officers actually ensured people were alive by "look[ing] for chest rising" when they did these checks, Franklin Depo., R.69-7, PageID#475, and that officers could and should "open the door" to check on people in restraint chairs when needed, Hunt Depo., R.69-8, PageID#516. Thus, a jury could find that Erwin's few checks were constitutionally inadequate and that he "failed to act with reasonable care" when he did not go in the room or actually confirm Howell was okay. *Brawner*, 14 F.4th at 597; *see also Burwell*, 7 F.4th at 476 (denying summary judgment to officer who engaged in monitoring failures); *Smith*, 505 F. App'x at 537 (affirming denial of summary judgment to officer for inadequate monitoring). At the very least, a jury could find that by skipping checks or failing to properly complete them, he "declined to confirm inferences of risk that he strongly suspected to exist," *Farmer*, 511 U.S. at 843 n.8. An officer who does that cannot "escape liability." *Id*. Erwin is not entitled to summary judgment.

2. *Officer Collini*

The evidence would permit a jury to find that Collini knew the risks associated with the restraint chair, but nevertheless skipped most of the required checks; failed to check Howell's condition during the checks he *did* conduct; falsified the check log; and ignored the water, restroom, and limb exercise requirements.

Collini does not actually dispute any of this evidence, instead arguing that he "reasonably—and constitutionally—relied on the judgment of the medical professionals." Corrections Response 34. This argument fails for the reasons detailed above. His related assertion that he did not know about Howell's sickle cell condition, Corrections Response 34, is equally unavailing; the "case law does not require" Collini to "correctly diagnose" Howell, *Burwell*, 7 F.4th at 475. Finally, it is for a jury to decide whether the infrequent "visual checks" that Collini touts were constitutionally adequate, *see* Corrections Response 34—and Howell has submitted evidence that would permit a jury to conclude they were not. The evidence shows that (1) Collini knew the restraint chair could cause people to "lose blood flow" and "develop blood clots," that it posed risks to their health, and that frequent checks were required for "the safety of the inmate," Collini Depo., R.69-4, PageID#355, 333; (2) Collini admitted to performing only a third of the required checks and to falsifying the log, *id*. at PageID#348-49, 353-54; and (3) Collini only observed

Howell from outside the cell, which made it impossible to tell whether he was "alive or asleep," *id*. at PageID#352, 364.

A jury could easily find that Collini knew the restraint chair "increase[d] the risk of medical complications," *Villegas*, 709 F.3d at 570-71, and in skipping checks or conducting them in a cursory manner, he either "declined to confirm [that] inference[] of risk," *Farmer*, 511 U.S. at 843 n.8, "recklessly failed to act" to mitigate a risk he should have known about, *Brawner*, 14 F.4th at 597, or failed to act despite knowledge of a serious risk, *Griffith*, 975 F.3d at 568; *see also Burwell*, 7 F.4th at 476 (denying summary judgment to officer who engaged in monitoring failures); *Smith*, 505 F. App'x at 537 (affirming denial of summary judgment to officer for inadequate monitoring). He is not entitled to summary judgment.

3. Sergeant Hunt

The evidence shows that Hunt saw Howell in medical distress, heard discussion of hospitalization, and understood the risks associated with the restraint chair, but still failed to comply with an important safety protocol.

Hunt testified that he heard Howell "moaning and groaning," and recalled that Howell "was not [] able to remain" in the wheelchair on his own. Hunt Depo., R.69-8, PageID#519. And several others present in the same space as Hunt said Howell "complained about back pain" and "yell[ed] that his legs wouldn't work." Erwin Depo., R.69-5, PageID#428. He even heard the nurses discuss hospitalization. Hunt

Depo., R.69-8, PageID#520.[6] Even though Hunt says that he "observed behavior and activity inconsistent" with pain and numbness, Corrections Response 31, a jury could rely on this evidence to find that he knew or should have known of a serious risk of harm.

A jury could further find that even though he was armed with this knowledge, Hunt ignored Howell. Hunt contests this by arguing that "there is no evidence he intentionally ignored any limb rotation requirements," Corrections Response 32, but that is belied by the evidence. Collini specifically testified that he asked Hunt to perform a limb rotation and that Hunt did not come down for hours. Collini, R.69-4, PageID#339. That is direct evidence from a fellow officer that Hunt ignored an important duty despite having seen Howell in a state of medical distress. A jury could find that this decision, and the decision not to check on Howell at all until 9:45, was a "reckless fail[ure] to act with reasonable care," *Brawner*, 14 F.4th at 597, a failure to act despite knowledge of a serious risk, *Griffith*, 975 F.3d at 568, or a decision not "to confirm [an] inference[] of risk," *Farmer*, 511 U.S. at 843 n.8. Accordingly, Hunt is not entitled to summary judgment.

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[6] Hunt argues that hearing the nurses discuss hospitalization "confirms" this was a decision for medical. Corrections Response 31-32. But a jury presented with evidence that Hunt saw Howell in medical distress and heard the nurses discuss hospitalization could conclude that Hunt was on notice of a potential medical issue and the need for close monitoring.

4. The officers are not entitled to qualified immunity.

When the facts are properly construed in Howell's favor, the officers violated clearly established law in two ways. First, they violated clearly established law requiring them to adequately monitor detainees at risk of harm. Opening Br. 49-51. Second, they violated clearly established law when they declined to confirm inferences of risk they strongly suspected to exist. *Id*. at 51-52. On top of this, they committed such an "obvious" constitutional violation that they would not be entitled to qualified immunity even in the absence of clearly established law. *Id*. at 52-53. The Corrections Defendants say nothing about the second strand of clearly established law or the obvious violation route to liability—these concessions are sufficient to deny qualified immunity on their own.[7]

And the Corrections Defendants' limited argument as to the first strand of clearly established law—namely, that *Speers* is insufficiently similar to the facts of this case—fails for two reasons. Corrections Response 40-41. First, it fails because *Speers* is, in fact, sufficiently similar and their attempts to distinguish it fall short. The Corrections Defendants note that the detainee in *Speers* was unwell for three days as opposed to four hours, but that makes little difference; the officers who were denied summary judgment in *Speers* had contact with the detainee for only one

[7] The Corrections Defendants state that there was no clearly "established duty to *override*" medical decisions. Corrections Response 40. This strawman argument fails for a simple reason: it is not the clearly established violation Howell alleges.

shift—just as in this case. Corrections Response 40; *Speers*, 196 F. App'x at 397. They next argue that Howell "appeared to be sleeping," Corrections Response 41, but one of the officers in *Speers* also claimed to believe the detainee was "sleeping in his underwear" and not "in any danger," *Speers*, 196 F. App'x at 397. Then, they note that another detainee may have told the *Speers* officers about concerning symptoms, but here there is evidence that the officers themselves witnessed Howell's concerning symptoms. *Id.* at 397-98; *see* Opening Br. 36-48; *supra* Part I.D.1-3. Finally, they note that the policy in this case "does not require the officers to go into the cell to wake up Howell and verbally engage him," Corrections Response 41, but no such policy existed in *Speers*, either. So, in both cases, the officers "knew that [the detainee's] condition was serious enough that he needed to be checked regularly." *Speers*, 196 F. App'x at 399. Accordingly, the officers were on notice that when they saw Howell listless in the chair, they "should have contacted medical personnel" or "at least should have tried to engage [him] verbally or entered his cell." *Id.* at 398. Put simply, *Speers* clearly established that officers cannot simply "check [a detainee's] cell, and upon seeing him lying on the floor"—or, in this case, immobile in a chair—"do nothing more." *Id.*

Second, even if *Speers* did not clearly establish the law, other cases clearly established the law. In *Smith*, this Court affirmed the denial of qualified immunity to an officer who "did nothing to make sure that [the detainee] had not taken a turn

for the worse" during a cell check and to another officer who "fail[ed] to check on [a detainee] for a forty-minute period." 505 F. App'x at 530, 535, 537. In *Phillips*, this Court did the same for officers who "had been exposed to [the prisoner's] serious condition at some point" and nonetheless "fail[ed] to transport her to a hospital." 534 F.3d at 541, 545. In *Burwell*, this Court denied qualified immunity to an officer who recorded a cell check that he did not complete and who "did nothing" after a subsequent cell check when he "could not determine whether [the detainee] was breathing." 7 F.4th at 461, 477-78. Indeed, there is no shortage of decisions clearly establishing the right to "have medical assistance summoned immediately" when the circumstances indicate the need for medical attention. *Id.* at 477 (quoting *Rich v. City of Mayfield Heights*, 955 F.2d 1092, 1097 (6th Cir. 1992)). The "direct holdings" and "general reasoning" of these prior cases clearly establish the law—and the Corrections Defendants don't mention any of them in their qualified immunity analysis. *Baynes v. Cleland*, 799 F.3d 600, 612 (6th Cir. 2015).[8]

The Corrections Defendants then take a different tack, arguing that "there is no clearly established constitutional right for the specific policy provisions and

[8] The Corrections Defendants argue that the officers were not on notice that if "they do not check Howell every ten minutes per policy after just having been seen by medical, he is going to die of some unknown and unforeseeable sudden cardiac death." Corrections Response 40. Such highly-specific factual similarity is not required. *See Baynes*, 799 F.3d at 612. In any case, the cases discussed here and in the opening brief are factually analogous.

alleged violations thereof." Corrections Response 41. But this reflects a misunderstanding of the qualified immunity inquiry, which asks whether "an *action's* unlawfulness [is] clearly established." *Id.* (emphasis added). There is no need to identify a case saying, for example, that 10-minute checks are constitutionally mandated. Rather, it is sufficient to show, as Howell has, that clearly established law requires officers to adequately monitor detainees at risk of harm and confirm inferences of risk they strongly suspected to exist.

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

Jordan makes two arguments on the excessive force claim. She begins by disputing that she placed Howell in a restraint chair. NaphCare Response 67-68. But several officers testified that she was the one who ordered the chair. *See, e.g.*, Hunt Depo., R.69-8, PageID#521. Next, she argues that even if she did order the chair, it was "based upon a legitimate penological purpose." NaphCare Response 68. But the NaphCare Health Services Administrator said that the circumstances of this case did not warrant use of the chair. Perdikakis Depo., R.86-1, PageID#1620-21. These two disputes of fact preclude summary judgment; a jury must weigh the testimony of the officers and of the Health Services Administrator to decide whether Jordan ordered the chair without any legitimate penological purpose.

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

The Corrections Defendants canvass the substantial record and use select pieces of evidence to tell a story exempting the County from municipal liability. They are entitled to tell that story to a jury, but it does not entitle them to summary judgment—other evidence in the record creates material disputes of fact on all the critical issues.

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

Officers failed to identify any training on observing detainees in restraint chairs, supervisors conceded that they did not offer such training, and a correctional expert found training failures on that very issue. Opening Br. 56-57.

In response, the Corrections Defendants insist the officers were trained on "observation of inmates in the chair," citing testimony by Sergeant Franklin that a field training officer offered such training after the academy. Corrections Response 44. But Howell presented contrary testimony from Hunt: Hunt said "No" when asked whether there were any "training courses on the use of restraints" after the academy. Hunt Depo., R.69-8, PageID#509. Likewise, Collini testified that he only learned about policies during the academy, and that he did not have any training thereafter other than "on-the-job training." Collini Depo., R.69-4, PageID#329. Because "limited on-the-job training" is insufficient in the absence of "a training program," *Shadrick v. Hopkins Cnty.*, 805 F.3d 724, 740 (6th Cir. 2015), this contradictory

evidence raises a genuine factual dispute about whether HCJC "adequately train[ed] its officers" about "a task they are required to perform." *Brown v. Chapman*, 814 F.3d 447, 463 (6th Cir. 2016).

Perhaps because there is such little evidence of relevant training, the Corrections Defendants repeatedly note that the officers "were aware of the restraint policy and knew of their obligations to follow the policy." Corrections Response 44-45; *see also id*. at 45. This argument misses the mark because the failure-to-train here is not merely the failure to train the officers about requirements contained in the policy, but the failure to train them to recognize when detainees are in medical distress, when it is necessary to enter the cell of a restrained detainee for a closer check, and how to make sure a restrained detainee is conscious and breathing. Because this training did not exist, the few times Collini and Erwin actually completed their checks, they looked at Howell through a window in a manner so inadequate that they could not tell if he was alive or dead; meanwhile, other officers monitoring restrained detainees would actually open the door or look for signs of breathing—things every officer should have been trained to do. Opening Br. 58-59.

Ultimately, the Corrections Defendants themselves highlight the lack of training; they argue that decisions about interacting with detainees or checking on them from inside the cell "depends entirely on the circumstances." Corrections

Response 45. But they say nothing about training officers to understand when the circumstances warrant such conduct—and that is precisely the problem.

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

Municipal deliberate indifference may be demonstrated by evidence that "a particular situation will recur" and that "an employee who lacks proper tools to respond to the situation will violate a citizen's federal rights." *Shadrick*, 805 F.3d at 739.[9] Tracking those considerations, Howell submitted evidence showing that (1) officers had to frequently monitor detainees in restraint chairs; and (2) restraint chairs were medically perilous. Opening Br. 57-58. The Corrections Defendants don't dispute the first point; on the second point, they submit evidence suggesting restraint chairs are not dangerous. *See* Corrections Response 46-47. But Howell's evidence on this point creates a genuine dispute of fact: the jail's own policy showed that restraint chairs were medically perilous enough to require consultation with the medical team or supervisors before use, completion of ten-minute checks, hourly consideration for removal, and more. Erwin Depo., R.69-5, PageID#423-24. Indeed, the risks of restraints are widely acknowledged: jails routinely require more frequent cell checks for restrained detainees. *See, e.g.*, *Burwell*, 7 F.4th at 461. The jail's

[9] The Corrections Defendants argue that Sheriff Neil "was not aware of any danger to inmates," Corrections Response 46, but that's irrelevant—this isn't a supervisory claim. *See Phillips*, 534 F.3d at 544 (distinguishing between supervisory and *Monell* claims).

conduct after Howell's death further bolsters a finding of deliberate indifference: the jail's internal investigation found *no* violations of jail policy, no one was disciplined, and no one investigated whether the death was related to monitoring failures. Order, R.105, PageID#1990; Schoonover Depo., R.69-14, PageID#744; *Shadrick*, 805 F.3d at 743 (explaining post-death conduct can support finding of municipal deliberate indifference).

Instead of meaningfully disputing this prong, the Corrections Defendants make several irrelevant arguments. First, they contend the policies were appropriate, but that has little to do with this failure-to-*train* claim. Corrections Response 47. Next, they note the officers "regret[]" violating policy, but that has nothing to do with the *municipality's* deliberate indifference. *Id*. at 47-48. And finally, they contend that the officers' decisions about "performing visual checks" and "go[ing] into the cell to check on Howell" are "decisions made during the scope and course of their employment." *Id*. at 48-49. But that's just the point: they were required to make such decisions, those decisions had serious consequences, and they were still not trained about how to make them. That shows deliberate indifference. *Ouza v. City of Dearborn Heights*, 969 F.3d 265, 287 (6th Cir. 2020) ("[A] municipality was deliberately indifferent by fail[ing] to equip law enforcement officers with specific tools to handle recurring situations.") (cleaned up).

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

Howell presented substantial evidence that would permit a jury to find the requisite causal link between the lack of training and Howell's death. First, the evidence shows that some officers opened cell doors, checked for signs of breathing, and knew they could call an ambulance in emergencies. Opening Br. 15, 58-59. Second, it shows that Erwin and Collini were not trained to take any of those important steps; instead, they conducted checks so cursory that they could not even tell whether Howell was alive or dead. *Id*. And third, it shows that Howell had no chance of survival because he was "ignored for hours," that it was "more likely than not" Howell would have survived with timely intervention, and that "there was sufficient time to transfer Howell to a skilled medical facility to save his life," Steinberg Rep., R.87-3, PageID#1693; Steinberg Aff., R.87-1, PageID#1638. Thus, the Corrections Defendants are simply wrong to say there is "no evidence that any training or lack thereof with respect to restraint chairs caused Howell's death." Corrections Response 49. A jury could find on these facts that properly-trained officers would have noticed Howell's deterioration and obtained medical help, and that the lack of training was therefore "closely related" to his death. *Russo v. City of Cincinnati*, 953 F.2d 1036, 1046 (6th Cir. 1992).

The argument that training failures were not closely related to Howell's death because he died "within minutes (as opposed to hours) after the altercation" is

equally contested. Corrections Response 49-50. The evidence would allow a jury to find that his death took longer than mere minutes and that there was indeed time for intervention: Dr. Steinberg said so, Steinberg Rep., R.87-3, PageID#1693; Steinberg Aff., R.87-1, PageID#1638, and Howell was heard yelling by several people around 30 minutes after being placed in the restraint chair, and seen "staring out the window" about two hours later. Hunt Depo., R.69-8, PageID#524; Arthur Depo., R.69-1, PageID#225, 230; Collini Depo., R.69-4, PageID#361.

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

The evidence shows that nurses routinely ordered restraint chairs and that such a custom caused the denial of adequate medical care to Howell. Opening Br. 60-61. As an initial matter, a jury could conclude that there was a "widespread" custom of nurses ordering the restraint chair; testimony showed it was both typical practice and described as permissible during training. Terry Depo., R.69-16, PageID#821.[10] Contrary to NaphCare's contention, Howell does not rely on "one instance" of

[10] NaphCare argues that Howell didn't provide this evidence at the district court. NaphCare 64. That is false. *See* Response to Summary Judgment, R.96, PageID #1873-74, 1903-04.

misconduct because the testimony from Officer Terry speaks to "typical practice" at the jail. *Id.*[11]

Next, 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 strapped to a restraint chair. *See* Opening Br. 60-61. This expert evidence is not mere "speculation," NaphCare Response 65, but rather well-reasoned expert opinion that "medical staff should have recognized" the need for emergency medical care and that his death was "foreseeable." Steinberg Rep., R.87-3, PageID#1692; Steinberg Aff., R.87-1, PageID#1638-39. This evidence could allow a jury to determine that a doctor (rather than a nurse) would have ensured Howell received medical care, and not consigned him to a restraint chair.

In light of the genuine disputes of fact as to the existence of the custom and its causal relationship to Howell's death, summary judgment should be denied.

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[11] NaphCare also argues that this claim requires "a pattern of inadequately investigating similar claims." NaphCare Response 64. But the case they cite merely says that such a pattern provides "[f]urther evidence" of liability, not that it is necessary. *Leach v. Shelby Cnty. Sheriff*, 891 F.2d 1241, 1248 (6th Cir. 1989). And Supreme Court precedent requires only evidence that the relevant practice is "widespread." *Bd. of Cnty. Comm'rs of Bryan Cnty. v. Brown*, 520 U.S. 397, 404 (1997).

CONCLUSION

This Court should reverse and remand for further proceedings.

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Respectfully submitted,

/s/ Megha Ram
Megha Ram
Elizabeth Bixby*
RODERICK & SOLANGE
MACARTHUR JUSTICE CENTER
501 H Street NE, Suite 275
Washington DC 20002
(202) 869-3434
megha.ram@macarthurjustice.org

** Admitted only in California; not admitted in D.C. Practicing under the supervision of the Roderick & Solange MacArthur Justice Center.*

Rosalind Eileen Dillon
RODERICK & SOLANGE
MACARTHUR JUSTICE CENTER
160 E. Grand Avenue, Floor 6
Chicago, IL 60611
(202) 869-3379
rosalind.dillon@macarthurjustice.org

David M. Shapiro
RODERICK & SOLANGE
MACARTHUR JUSTICE CENTER
NORTHWESTERN PRITZKER
SCHOOL OF LAW
375 East Chicago Avenue
Chicago, IL 60611
(312) 503-1071
david.shapiro@law.northwestern.edu

Konrad Kircher
Ryan J. McGraw
RITTGERS & RITTGERS
12 East Warren Street
Lebanon, OH 45036
(513) 932-2115
konrad@rittgers.com
ryan@rittgers.com

Counsel for Plaintiff-Appellant
Karla Howell

CERTIFICATE OF COMPLIANCE

1. This Brief complies with type-volume limitation set forth by this Court in its Order Granting Motion to File an Oversized Brief, not to exceed 8,500 words, ECF 51-2, filed July 21, 2022 because, according to the word count function of Microsoft Word 2019, the Brief contains 8,487 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: August 10, 2022 *_/s/ Megha Ram_*

CERTIFICATE OF SERVICE

I, Megha Ram, hereby certify that on August 10, 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