UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
NEW ALBANY DIVISION

LAVITA MCCLAIN as Administratrix and Personal Representative of the Estate of Ta'Neasha Chappell,	)	
Plaintiff,	)	
v.	)	No. 4:21-cv-00165-SEB-KMB
SCOTT FERGUSON, et al.,	)	
Defendants.	)	

ORDER GRANTING IN PART AND DENYING IN PART DEFENDANTS' MOTION FOR SUMMARY JUDGMENT AND GRANTING IN PART AND DENYING IN PART PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT

Ta'Neasha Chappell was a pretrial detainee at the Jackson County, Indiana, Jail when, on the evening of July 15, 2021, she fell ill. From 8:00 PM until 3:30 PM the following day, Ms. Chappell interacted with various jail staff members until being transported to an area hospital, where she died within two hours.

Lavita McClain, as administratrix and personal representative of Ms. Chappell's Estate ("The Estate"), filed this lawsuit against fourteen defendants alleging claims under the Due Process Clause of the Fourteenth Amendment, policy-or-practice claims under *Monell v. Dept. of Social Services*, 436 U.S. 658 (1978), and state tort claims.

Both the Estate and Defendants filed cross motions for partial summary judgment. Dkts. [90], [95]. Defendants Sheriff Meyer, Commander Everhart, Officers Michael Davisson, Matt Stillwell, Mark Reynolds, David Ridlen, Wendy Boshears, and Tami Baxter move for summary judgment on all claims against them. These defendants argue, among other things, that they are entitled to qualified immunity. The Estate moves for summary judgment on Fourteenth Amendment

claims against Defendants Seth Boyd, Scott Ferguson, Kevin Rodriguez, Clayton Banister, Ryah Smith, Milton Rutan, Mark Reynolds, and Tami Baxter. For the reasons below, both motions are **granted in part and denied in part**.

I.
Standard of Review

Parties in a civil dispute may move for summary judgment, which is a way of resolving a case short of a trial. *See* Fed. R. Civ. P. 56(a). Summary judgment is appropriate when there is no genuine dispute as to any of the material facts, and the moving party is entitled to judgment as a matter of law. *Id.*; *Pack v. Middlebury Comm. Sch.*, 990 F.3d 1013, 1017 (7th Cir. 2021). A "genuine dispute" exists when a reasonable factfinder could return a verdict for the nonmoving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). "Material facts" are those that might affect the outcome of the suit. *Id.*

When reviewing a motion for summary judgment, the Court views the record and draws all reasonable inferences from it in the light most favorable to the nonmoving party. *Khungar v. Access Cmty. Health Network*, 985 F.3d 565, 572-73 (7th Cir. 2021). It cannot weigh evidence or make credibility determinations on summary judgment because those tasks are left to the factfinder. *Miller v. Gonzalez*, 761 F.3d 822, 827 (7th Cir. 2014). The Court is required to consider only the materials cited by the parties, *see* Fed. R. Civ. P. 56(c)(3); it is not required to "scour every inch of the record" for evidence that is potentially relevant. *Grant v. Tr. of Ind. Univ.*, 870 F.3d 562, 573-74 (7th Cir. 2017).

"[A] party seeking summary judgment always bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of 'the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any,' which it believes demonstrate the absence of a genuine issue of material fact." *Celotex Corp. v.*

Catrett, 477 U.S. 317, 323 (1986). "[T]he burden on the moving party may be discharged by 'showing'—that is, pointing out to the district court—that there is an absence of evidence to support the nonmoving party's case." *Id*. at 325.

When reviewing cross-motions for summary judgment, all reasonable inferences are drawn in favor of the party against whom the motion at issue was made. *Valenti v. Lawson*, 889 F.3d 427, 429 (7th Cir. 2018) (citing *Tripp v. Scholz*, 872 F.3d 857, 862 (7th Cir. 2017)). The fact of cross-motions for summary judgment having been filed does not imply that there are no genuine issues of material fact. *R.J. Corman Derailment Servs., LLC v. Int'l Union of Operating Engineers, Local Union 150, AFL-CIO*, 335 F.3d 643, 647 (7th Cir. 2003).

II.
Factual Background

Because the parties, respectively, have moved for partial summary judgment under Rule 56(a), the Court views and recites the evidence "in the light most favorable to the non-moving party and draw[s] all reasonable inferences in that party's favor." *Zerante v. DeLuca*, 555 F.3d 582, 584 (7th Cir. 2009) (citation omitted).

The cross-motions for summary judgment target the claims against Mark Reynolds and Tami Baxter, so the Court reviews these motions "one at a time[,]" analyzing the evidence and drawing all reasonable inferences "in favor of the non-moving party." *American Family Mut. Ins. v. Williams*, 832 F.3d 645, 648 (7th Cir. 2016).

A. Jackson County Jail Policies and Procedures

1. Chain of Command at the Jail

Rick Meyer is the Jackson County Sheriff, and Chris Everhart is the Jail Commander. Dkt. 96-7 at 3 (5:3−4); dkt. 91-16 at 2 (7:6−9).[1] Each is responsible for overseeing the operations of the jail. Dkt. 96-7 at 3 (5:8−19); dkt. 91-16 at 2 (7:8−9). Lt. David Ridlen works directly beneath Commander Everhart and is responsible for day-to-day oversight, and below Lt. Ridlen are four sergeants. Dkt. 91-16 at 2−4 (7:22−25, 8:1−6, 8:14−25, 9:1−4). The sergeants work as "shift supervisors"—i.e., they oversee and supervise the officers on each shift. *Id.* at 4 (9:5−10). If a sergeant is not on duty, an officer is appointed to lead the shift. *Id.* at 4 (9:11−15). When one shift ends, the shift supervisor is expected to brief the incoming supervisor regarding any urgency that occurred during the previous shift, including any medical concerns. Dkt. 96-9 at 6 (19:22−20:16). This communication is typically conducted via email. *Id.* at 10 (34:25−35:4).

The jail contracts with Advanced Correctional Healthcare, Inc. ("ACH") to provide medical services and to guide inmates' medical care decisions. Dkt. 96-7 at 4 (9:16−18); dkt. 91-6. Both correctional and medical staff are instructed that inmates have a constitutional right to medical care, that they cannot be denied medical care, and that it is impermissible to allow an inmate's condition to deteriorate without providing necessary medical care. *See, e.g.*, dkt. 96-6 at 9 (31:23−25, 32:1−17); dkt. 96-2 at 10 (30:14−22).

Jail regulations required Sheriff Meyer or Commander Everhart to perform weekly walk-throughs of the jail. Dkt. 106-13 at 7 (26:10−17). Commander Everhart reported that there was no set schedule for these visits and that he could not recall if he conducted his walk-throughs weekly, monthly, or at all in 2021. *Id.* at 7 (26:18−27:23). Sheriff Meyer estimated that he performed "[a]

[1] When the Court cites to deposition testimony or interview transcripts, it will first cite to the page of the PDF and then to the page of the deposition or interview in parentheses.

total walk-through" of the jail about once a month, although he was frequently present in the jail. Dkt. 106-11 at 13 (51:1−18).

2. Medical Policies

During the period relevant to this suit, the Jackson County Jail had in place specific Policies and Procedures concerning inmate medical care. Dkt. 91-2. These policies were designed to ensure that inmates at the Jackson County Jail received adequate medical treatment. *Id.*; dkt. 132-1 at ¶ 9. However, Sheriff Meyer and Commander Everhart—neither of whom was a medical professional—relied upon ACH and Dr. Ronald Everson to serve as the Jail's "Responsible Health Authority." *See* dkt. 132-1 at ¶¶ 4, 9; dkt. 91-6. As the Responsible Health Authority, ACH was responsible for arranging all levels of health care, providing quality and accessibility of health services to inmates, and ensuring proper delivery of their services. Dkt. 91-2 at 13−15.

In July 2021, the Jackson County Jail employed one nurse, Ed Rutan. Dkt. 96-6 at 3 (5:6−8; 7:25−8:3). Nurse Rutan had been an employee at the Jackson County Jail for ten years. *Id.* at 3 (5:10). He is a Licensed Practical Nurse ("LPN") and as an LPN, he worked directly under a doctor's supervision. *Id.* at 3 (8:12−20). The scope and specific functions were limited; for most decisions regarding medical care, he was required to contact a provider. *Id.* at 4, 9−10 (9:2−7, 31:11−19, 36:8−23). For example, if a patient repeatedly vomited, he was to contact the medical provider. *Id.* at 11 (38:15−18, 39:7−12). If a patient expressed a need to go to the hospital, Nurse Rutan would consult with the provider. *Id.* at 12 (43:5−10).

In the context of his practice at the Jackson County Jail, Nurse Rutan worked under the supervision of the medical professionals provided by ACH, generally, Dr. Everson. *Id.* at 3 (8:18−23). In the event he was unable to reach Dr. Everson, a second physician was on-call, and an ACH regional supervisor was available to contact anytime. *Id.* at 4 (11:12−22). Dr. Everson

conducted weekly on-site visits at the jail. *Id*. at 5 (13:25, 14:1−13).

The jail had formulated policies and procedures with respect to the medical screenings of new inmates. *Id*. at 6 (17:23−25, 18:1−4). Two screenings were conducted: one by a jail officer at book-in and another by the medical department during the first 14 days of an inmate's admission. *Id*. at 6 (18:15−18). The screenings were intended to alert the jail and medical staff to any immediate medical needs and any preexisting conditions. *Id*. at 6 (20:9−15). When a new inmate was booked into the jail, the booking officer was expected to complete a medical assessment to identify any medical issues the inmate might present. Dkt. 91-16 at 8 (15:7−17); dkt. 91-2 at 89. The document became part of the inmate's file and served to alert staff and medical personnel to the inmate's medical issues. Dkt. 91-16 at 9 (16:1−12). The 14-day assessment provided a more comprehensive evaluation of the inmate's medical needs. Dkt. 91-2 at 93.

When an inmate made a medical complaint, Nurse Rutan typically escorted the inmate to the medical room to check vitals and assess the nature and extent of the inmate's condition. Dkt. 96-6 at 5 (14:22−25, 15:1−2). If an emergency situation presented, in addition to gathering information from the officers, Nurse Rutan was to "put[ ] eyes on" the inmate to determine his or her condition. *Id*. at 5 (15:6−16). He consulted documents referred to as assessment sheets and a protocol book that outlined the specific information he should obtain from the inmate. *Id*. at 5 (15:22−25, 16:1−12). Nurse Rutan had been trained by ACH on the correct ways to fill out the protocol sheets and the necessity of completing them as part of his assessment of inmates. *Id*. at 5 (16:13−21).

The jail had previously employed two nurses, but by the end of 2020 the second nurse was no longer on staff, leaving only Nurse Rutan. Dkt. 91-16 at 16−18 (24:21-25, 25:1-25, 26:1). Sheriff Meyer authorized the issuance of an advertisement in an effort to locate and hire a replacement,

but his efforts proved unavailing due to a lack of applicants. *Id*.; dkt. 91-17 at 4 (21:14-21). Sheriff Meyer also had contacted ACH to inquire about the availability of a second nurse to assist at the jail, but was offered only a contract nurse. Around the same time, Sheriff Myer, in consultation with the county's juvenile group home, proposed that the two facilities share a nurse, which discussions preempted the offer of a contract nurse by ACH. Dkt. 91-17 at 4 (22:5-13).

In the absence of a second staff nurse, Sheriff Meyer and Commander Everhart assigned jail personnel to dispense medications to assist Nurse Rutan. Dkt. 91-16 at 17 (25:11-17). Nurse Rutan had expressed his concerns to Commander Everhart in being overworked and to inquire about the status of efforts to hire a second nurse. *Id*. at 17 (25:18-25). According to Nurse Rutan, by July 6, 2021, a three-to-four-month backlog of 14-day medical screenings of inmates had arisen, awaiting completion by the medical staff. Dkt. 96-6 at 7 (24:5-8). Neither Sheriff Meyer nor Commander Everhart was aware of this backlog at the time. *Id.* at 15−16 (23:17−25, 24:1−4); dkt. 91-17 at 3−4 (20:24-25, 21:1-2). Though Sheriff Meyer had known Nurse Rutan was very busy, Nurse Rutan had not complained to him of being overwhelmed or unable to handle his responsibilities as jail nurse. Dkt. 91-17 at 4 (23:2-12). On April 26, 2021, a Regional Nurse Manager with ACH, who performed a routine site-visit of the Jackson County Jail medical department, reported that the department was "organized and running efficiently." Dkt. 91-8.

3. Non-Medical Staffing and Medical Training for Officers

All correctional officers were required to be certified in CPR/AED and First Aid. Dkt. 91-16 at 7 (13:4−5). In addition, newly hired correctional officers underwent on-the-job training, consisting of shadowing veteran officers, various in-service training, and a review of the Jail's Standard Operating Procedures and Medical Policies and Procedures. *Id*. at 7 (13:13−25); dkt. 96-1 at 4 (8:10−25). Correctional officers were also required to complete the Indiana Jail Academy

40-hour training during their first year of their employment. Dkt. 91-16 at 7 (13:11−22).

As part of their training, jail officers were required to attend training courses provided by ACH, which included ACH protocols for responding to inmate medical issues when nursing staff was unavailable. Dkt. 132-1 at ¶ 11; dkt. 91-3 at 25−41; dkt. 91-4. One such training module included a slide entitled, "How to prevent being successfully sued," which provided this instruction: "Don't take medical responsibility. Call the doctor." Dkt. 96-8 at 2.

Required first-aid training included instructions on how to recognize and respond to signs and symptoms of serious medical crises, part of which directed the officers to immediately call 911 or other local emergency responders. Dkt. 96-3. The first aid training manual specified that 911 should be called when an individual is vomiting blood, is suspected of having a head injury, or shows signs of an altered mental status. *Id.* at 3−5. An ACH Protocol sheet directed that jail staff must place an urgent call to a nurse practitioner, physician, or physician assistant when an inmate is vomiting blood or displays a sudden change in mental alertness. Dkt. 96-4 at 2−3.[2]

When a jail officer received a medical complaint from an inmate, he was required to notify his shift supervisor or medical personnel and to document his interaction with the inmate in an electronic log as an "Inmate Medical Event," utilizing a computer program format known as Spillman. Dkt. 96-9 at 6 (17:7−9, 18:11−12).

Although the jail officers testified that they were trained to call 911 or contact the ACH doctor in the case of an emergency, few recalled ever actually having done so. *See, e.g.* dkt. 96-1 at 5 (13:10−13); dkt. 96-23 at 4 (11:2−25, 12:1−22); dkt. 96-29 at 7 (22:14−24). Usually, they simply informed their supervisors or the jail nurse about the situation. Dkt. 96-1 at 5 (13:14−18);

[2] Thus, while there is some conflict between these two training modules, both require that officers reach out to a medical provider or an emergency responder when they encounter an inmate with certain symptoms.

dkt. 96-23 at 4−4 (12:23−25, 13:1−2).

If an inmate reported an illness when medical staff was not present, jail officers were required to complete ACH Medical Protocol Sheets, which elicited specific information as to various medical conditions and presentations. Dkt. 96-7 at 5−6 (16:15−17:9); dkt. 96-4 at 5−8. Certain information was to be obtained directly from the inmate, such as his vital signs and medical history, which was communicated to the on-call physician, who established a plan of care and issued appropriate orders, all of which officers were to document on the protocol sheet. *Id.* In medical emergencies, if no medical staff was available in the building, jail staff was to summon an ambulance and have the inmate transported to the hospital. Dkt. 96-6 at 9−10 (32:18−25, 33:1−13). When Nurse Rutan was not physically present at the jail, he remained always on call. *Id*. at 10 (35:2−4). When he was entirely unavailable, the officers were to contact ACH directly, using the contact information posted throughout the jail. *Id*. at 10 (35:15−25, 36:1).

Officer Stillwell testified that he thought Nurse Rutan had become "jaded," frequently expressing the belief that inmates were lying about being sick. Dkt. 96-27 at 5 (16:11−16). With respect to his responsibilities, if Officer Stillwell disagreed with Nurse Rutan's medical assessments, he would contact a supervisor and have the inmate placed on medical watch. *Id.* at 5−6 (16:18−19, 18:8−23). Officer Stillwell testified that Nurse Rutan's view that inmates were faking illness was well-known amongst jail officers. *Id.* at 6 (20:4−9).

B. Timeline of Relevant Events

May 26, 2021

When Ms. Chappell was booked into the Jackson County Jail as a pretrial detainee, no medical screening procedures were performed. Dkt. 96-6 at 29 (109:21−25). In addition, Nurse Rutan had not been able to conduct the 14-day assessment before Ms. Chappell fell ill. *Id.* at 29

(111:1−9).

July 15-16, 2021

Night Shift

8:00 to 8:30 PM

Ms. Chappell placed a call by intercom from her cell to Officer Boyd in the central control room to report that she had vomited blood for the second time that day. Dkt. 96-10 at 0:00−0:35. Officer Boyd sent jail officer Isaac Hardin to Ms. Chappell's cell to respond to her report, whereupon Ms. Chappell showed him what she identified as blood in the toilet. Dkt. 96-11 at 13 (12:23−25, 13:1). Officer Hardin did not believe that the substance in the toilet was blood. *Id.* at 14 (13:3−8). Ms. Chappell requested to be taken to the hospital. *Id.* at 16 (15:3−7). Officer Hardin observed that Ms. Chappell appeared sick, like she had just thrown up. *Id.* at 14 (13:10−17). She reported that she was also lightheaded. *Id.* at 17 (16:1−8). Officer Hardin suspected Ms. Chappell might be dehydrated. *Id.* at 17 (16:10−12). Officer Hardin informed his supervisor, Sergeant Ferguson, that to him the substance in the toilet appeared more like mucus than bloody vomit. *Id.* at 15 (14:6−11).

Sergeant Ferguson contacted Nurse Rutan to determine what action to take with Ms. Chappell. Dkt. 96-9 at 7 (22:15−18). Nurse Rutan responded that, given the lack of blood observed in Ms. Chappell's vomit, she would have to wait to be assessed until he returned to work the following morning. *Id.* at 7 (23:20−23). Ms. Chappell's request to go to the hospital was denied. Dkt. 96-11 at 15−16 (14:13−15:6). Officer Hardin advised her to rest, lie down and drink water, and if she started feeling worse, she should contact an officer. *Id.* at 15, 17 (14:21−25, 16:1−12).

10:00 PM – 12:00 AM

Officer Boyd rotated to Control Area 3, where he was in charge of the female side of the

jail. Dkt. 96-12 at 3 (4:13−17).

Shortly after 11:00 PM, as Officer Boyd conducted the headcount in Ms. Chappell's pod, multiple inmates reported that Ms. Chappell had been sick throughout the day. *Id.* at 14 (47:25−48:10). Officer Boyd checked on Ms. Chappell in her cell and observed that she was on the floor and vomiting by the toilet. *Id.* at 14 (49:13). At 11:28 PM, Officer Boyd granted the request from Ms. Chappell's cellmate, Kim Rosales, to be let out of the cell after she became concerned that she might become ill, herself, due to Ms. Chappell's continuous vomiting and the strong smell. Ex. 10 at 0:35−0:48; dkt. 96-1 at 15 (50:20−51:12). Officer Boyd permitted Inmate Rosales to move to another cell due to Ms. Chappell's illness. *Id.* at 15 (51:13−16).

July 16, 2020 - 12:34 AM to 12:47 AM

At 12:34 AM, Ms. Chappell, again using the intercom, requested officer assistance. Ex. 10 at 0:48−1:35. When Officer Boyd responded, Ms. Chappell again requested medical attention. Officer Boyd observed that Ms. Chappell's condition had worsened. Dkt. 96-1 at 17 (61:3−5). Ms. Chappell requested a bucket be provided for her to vomit into so that she would not have to keep going back and forth to the toilet. *Id.* at 16 (56:20−57:3). When Officer Boyd brought in the bucket, Ms. Chappell was in bed and clearly not well. *Id.* at 17 (58:14−25). Officer Boyd told Sgt. Ferguson that Ms. Chappell was continuing to vomit. *Id.* at 17 (58:1−4). Sgt. Ferguson testified that his reason for ordering Officer Boyd to provide a bucket was both for Ms. Chappell's comfort and to allow jail officers to determine whether there was blood in her vomit because "she kept saying she was vomiting blood. And the nurse said we needed evidence of the blood." Dkt. 96-9 at 8 (25:21−25, 26:1−6).

1:33 AM

At 1:33 AM, Ms. Chappell again contacted Officer Boyd via the intercom stressing that she needed assistance because of her stomach problems. Ex. 10 at 1:35−2:20. Her voice sounded weak as she repeatedly said, "I need help." *Id.* Officer Boyd responded to her request, saying, "Well, I don't know what you want me to do unless you're coughing up something crazy." *Id.* In a barely audible voice, Ms. Chappell stated, "I need a nurse…I need to go to the hospital." *Id.* Officer Boyd then went to Ms. Chappell's cell and observed her vomiting blood in the bucket. Dkt. 96-1 at 17 (61:10−12). Officer Boyd told Sgt. Ferguson that the vomit had blood in it, *id.* at 17 (61:13−15), though Sgt. Ferguson denies having known about the blood, dkt. 96-9 at 7 (22:11−14). Sgt. Ferguson recalled that jail officers reported that "she just consistently kept vomiting." Dkt. 96-9 at 7 (23:19−24). Still, he did not direct them to take any action beyond "keep[ing] an eye on her." *Id.* at 8 (25:3−6).

Several days after Ms. Chappell's death, Officer Boyd created an "Inmate Medical Event" log to document his observations of Ms. Chappell on July 15 and 16. Dkt. 96-13. In the log, he recorded that Ms. Chappell was constantly throwing up, that there was blood in the vomit, that Ms. Chappell was "too weak to make it to the toilet," and that she had advised Officer Boyd that she had a history of stomach ulcers and other medical problems. *Id.* Officer Boyd also noted that each time he interacted with Ms. Chappell he reported his observations, including the bloody vomit, to his supervisor, Sgt. Ferguson. *Id.* According to the report, each time Sgt. Ferguson responded saying that "he had discussed the matter with the nurse and that she was fine." *Id.*

2:25 AM

Ms. Chappell contacted Officer Rodriguez again via the intercom, telling him three times that she was throwing up blood and that she needed to go to the hospital. At the end of the call, she

audibly moaned for a period lasting approximately ten seconds. Ex. 10 at 2:11−3:11. Officer Rodriguez ended the call without taking any action. *Id.* He neither logged the call nor reported Ms. Chappell's complaint to Sgt. Ferguson. Dkt. 96-14 at 17 (63:19−25−64:1).

3:03 AM

Officer Rodriguez performed his routine walk-through of the female pods, entering Ms. Chappell's cell where she was lying in her bed. Id. at 7−8 (24:9−14, 26:1−20). After checking on her, he left Ms. Chappell's cell and returned to his station, taking no further action.

3:10 AM to 3:12 AM

Ms. Chappell again contacted Officer Rodriguez via the intercom to report that she had been throwing up blood, that her bucket was full of vomit, and that she was dehydrated. Ex. 10 at 3:32−4:22. *Id.* She requested to see a doctor and be taken to the hospital. *Id.* Officer Rodriguez's response was to disconnect the call. Ms. Chappell called back, asking if he had heard her when she said she was throwing up blood. *Id.* Officer Rodriguez replied that he was going to talk to his supervisor (Sgt. Ferguson). *Id.* Within a minute, Officer Rodriguez contacted Ms. Chappell via the intercom to tell her that he had talked to his supervisor and that she had to wait until the morning to see the nurse. *Id.*

Day Shift - J-Pod

At 6:00 AM, the work shifts changed at the jail, part of which process entailed the preparation of a report by Sgt. Ferguson advising incoming officers of all significant events occurring during his shift, including any medical issues. Dkt. 96-9 at 10 (34:25−35:4). His email report regarding this shift change did not make any reference to Ms. Chappell. *Id.* at 10 (35:8−11).

8:12 AM

When Officer Tony England began his work shift, inmate Sierra Lawson advised him and

Officer Reynolds that throughout the night Ms. Chappell had been throwing up very loudly and asking to go to the hospital. Dkt. 96-16 at 8 (7:10−14). Inmate Lawson asked if anyone was going to take any action in response to Ms. Chappell's situation. *Id.* at 8 (7:2−3).

8:31 AM

Inmate Rosales called Officer Stillwell, the assigned shift commander, to report that Ms. Chappell was physically unable to get up and that she needed medical assistance. Ex. 10 at 4:30−4:47. Officer Stillwell and Officer England communicated with one another via radio, prompting Officer England to locate Nurse Rutan, who was with Officer Stillwell in the central control area engaged in discussions with other staff. Dkt. 96-16 at 8−9 (7:23−8:5−15).

8:45 to 8:47 AM

Officer England and Nurse Rutan visited Ms. Chappell's cell. *Id.* at 10 (9:7−17). She was lying down but able to report that she had sickle cell disease and bleeding stomach ulcers. *Id.*; ex. 10 at 4:49. Nurse Rutan observed the bucket of vomit on the floor beside her. Dkt. 96-6 at 14 (49:14−15). Later, when shown a picture of the bucket of vomit taken after it had been removed from Ms. Chappell's cell revealing a substantial amount of dark liquid, Nurse Rutan confirmed that the photo depicted what he had observed during his 8:45 AM interaction with Ms. Chappell. *Id.* at 47 (184:6−16); *see* dkt. 96-17 (photograph).[3]

The intercom recording of the call between Ms. Chappell and Nurse Rutan abruptly ended at the point where she was reporting her medical history. When the call resumed, Nurse Rutan is heard informing Ms. Chappell that she may need Omeprazole. Ex. 10 at 5:20. Nurse Rutan forwent the formal assessment process for Ms. Chappell because at the time she was wrapped in a blanket

[3] Defendants object to the Estate's characterization of the pictures in exhibit 17 as a "bucket of blood" or their characterization that the pictures clearly show blood. Dkt. 112 at 2. The Court accepts as true that the contents of the bucket were not unambiguously blood, without making a specific finding at this stage of the litigation as to the contents of the bucket.

and unclothed underneath the blanket, and he believed it would have been inappropriate to do a physical assessment of her while she was naked. Dkt. 96-6 at 14 (51:1−52:9). However, he did check her pulse and blood pressure, which registered normal. Dkt. 91-7 at 3. Nurse Rutan informed Ms. Chappell that he would return in the afternoon, after which he departed her cell.

9:00 AM

Nurse Rutan asked Officer Davisson to take Ms. Chappell's temperature, which Officer Davisson did, reporting a reading of 99.7 degrees. Dkt. 91-7 at 4. Officer Davisson observed that Ms. Chappell was not wearing a jail uniform and was sweating when he communicated the temperature reading to Nurse Rutan. *Id.* This information was documented in the Spillman log, and was apparently the only notation specifically recorded before Ms. Chappell's death. *See id.* at 1−10.

9:20 AM

Ms. Chappell again called for assistance via the intercom, informing Officer Smith that she was again throwing up while trying to sleep. Ex. 10 at 5:37. After obtaining Ms. Chappell's name, Officer Smith said "alrighty" and ended the conversation. Officer Smith neither logged the call nor reported it to anyone, as best she recalled. Dkt. 96-19 at 4 (9:7−10). Officer Smith's employment at the jail had begun only in February 2021, and she had received no formal training, so she "wasn't sure what exactly to do about [this situation with Ms. Chappell] since [she] hadn't received any training yet." *Id.* at 3−4 (6:17−21, 9:13−14). Nurse Rutan testified that Officer Smith should have reported the call from Ms. Chappell to him. Dkt. 96-6 at 48 (186:3−24). When questioned about her lack of response during the call, Officer Smith admitted that she knew she was not to ignore an inmate's medical concern, but was uncertain as to the reason she ignored Ms. Chappell's reported problems. Dkt. 96-19 at 4 (10:13−11:3).

9:55 AM

Ms. Chappell again called for help via the jail intercom, reaching Officer Smith in Control 3. Ex. 10 at 6:04−7:09. Ms. Chappell cried out "I need help," a total of nine times over the span of a single minute. During his deposition, after listening to a recording of the call, Nurse Rutan admitted that it was obvious at that point that Ms. Chappell was in distress and that the call should not have been ignored. He also testified that, had he known of the message on that call, he would have sent her for medical observation. Dkt. 96-6 at 48 (187:10−188:1). In her deposition, Officer Smith conceded that she should have summoned help for Ms. Chappell following receipt of this call because clearly "something [was] wrong" with her. Dkt. 96-19 at 4 (12:15−25).

10:02 AM

Nurse Rutan entered Ms. Chappell's cell and left a Tylenol packet for her by the sink. Ex. 10 at 7:10−17. He told Ms. Chappell he would return later that afternoon, but he did not inquire as to how she was feeling or conduct any medical assessment. His visit to her in her cell lasted less than 10 seconds.

10:48 AM

Unless specifically noted otherwise, the following narrative describes Ms. Chappell's movements as they were made visible on the video surveillance device trained of the J-Pod unit.[4] Ex. 20.

Ms. Chappell entered the J-Pod dayroom wearing only her underwear covered in green feces.[5] *Id.* Ms. Chappell was visibly disoriented as she staggered to the front of the pod. She

[4] No audio is available for the video in the J-Pod unit. However, audio is available for the other videos submitted into evidence and discussed later in this Order.

[5] Officer Smith and Officer Banister both deny that they were aware that Ms. Chappell had soiled herself when they went to the common area to assist her. Dkt. 96-19 at 7 (23:3−11); dkt. 96-22 at 5 (12:13−17).

stumbled into a wall and attempted to push with her hand a metal plate located there. She moved the trash can to a spot in front of the metal plate, stumbled backwards, and then moved back again toward the plate. Ms. Chappell braced herself against the wall, stumbled backwards, and attempted to stabilize herself by holding onto the trash can. Ms. Chappell attempted again to push the metal plate, as if it were the call button on the intercom, after which she collapsed onto the floor.

When no officers responded to her distress and her collapse onto the floor, another inmate contacted Officer Smith via the intercom to ask if Officer Smith had observed on the video surveillance that a "naked lady [was on] on the floor in here." Ex. 10 at 7:28. Officer Smith passed along the information to fellow officer Clayton Banister, but was unsure why she had not tried to contact or enlist the nurse or a supervisor. Dkt. 96-19 at 6 (17:2−16).

Five minutes thereafter, Officer Banister entered J-Pod followed by Officer Smith. Ex. 20. Officer Smith had informed Officer Banister that Ms. Chappell had been checked out by the nurse and that "her vitals were good." Dkt. 96-21 at 17 (16:19−25). Officer Banister took no action, merely standing over Ms. Chappell for another five minutes. Ex. 20. When Officer Banister asked Ms. Chappell if she was okay, Ms. Chappell "mumbl[ed] words" and appeared "responsive" to him, and he told her she seemed fine to him. Dkt. 96-21 at 21 (20:10−19). However, Officer Banister's description of Ms. Chappell as "responsive" was belied by the video in which she appeared bewildered, with her gaze shifting from side to side. Ex. 20.

Ms. Chappell remained on the floor for more than 10 minutes before Officer Smith and Officer Banister physically hoisted her up to her feet, whereupon Ms. Chappell began to stagger towards the front of the pod and Officer Smith and Officer Banister had to redirect her to her cell. Ex. 20.

In her deposition, after reviewing the video, Officer Smith admitted that Ms. Chappell's

condition was very concerning, with clear indications of a serious medical emergency. Dkt. 96-19 at 6 (19:2−9). She recalled that Ms. Chappell had been unable to verbally communicate with them, only shaking her head "yes" and "no," and that at one point she shook her head "no" when they asked her if she knew what was going on. *Id.* at 6−7 (20:10−17, 21:1−19).

Officer Banister testified that he did not know at the time what was wrong with Ms. Chappell or why she was on the floor. Dkt. 96-22 at 4 (8:16−21). He admitted that he knew it was not normal for an inmate to have collapsed and be unable to get up off the floor in the common area. *Id.* at 5 (12:5−9). At the time, Ms. Chappell was unable to provide a verbal response beyond a mumble to any of Officer Banister's communications. *Id.* at 4 (9:14−23). He assumed that she understood him because, when he spoke to her, she looked at him. *Id.* at 5 (10:1−17). Officer Banister has acknowledged that he knew from his training that he was expected to compile a chronology of the details of the medical situation based on as much information as possible in order to inform the medical staff. *Id.* at 7 (18:21−19:4).

Upon their return to the control room, Officer Banister and Officer Smith contacted their supervisor, Lt. Ridlen, to discuss Ms. Chappell's situation. *Id.* at 9 (26:5−11). Lt. Ridlen directed that a medical watch on Ms. Chappell be initiated, which required the officers to personally observe Ms. Chappell every fifteen minutes and document their observations on a medical watch log. *Id.* at 9 (26:17− 29:14). Neither Officer Smith nor Officer Banister complied with this directive. Dkt. 96-19 at 8 (28:22−25); dkt. 96-22 at 9 (29:1−14).

11:16 AM

An inmate sharing living quarters with Ms. Chappell reported via intercom to Officer Smith in Control 3 that Ms. Chappell was still in need of help. Ex. 10 at 7:50. Officer Smith responded (also via the intercom) that Ms. Chappell would have to get up and hit the call button herself, if

she needed help. *Id.* Officer Smith also told the inmate that she would be sending a mop bucket to clean up J-Pod because "inmates had advised [her] that [Ms. Chappell] had gotten stuff onto the floor." Dkt. 96-19 at 9 (29:10−24).

In her deposition, Officer Smith conceded that she could have, and should have, reached out to Ms. Chappell at that point via the intercom. Dkt. 96-19 at 9 (30:4−15).

11:41 AM

Ms. Chappell again called Officer Smith via the intercom in Control 3 to get the help she needed. Ex. 10 at 8:02. The audio recording confirms that Ms. Chappell had lost any ability to speak coherently. The call concluded with only her continued moaning. *Id.* at 8:42. Officer Smith nonetheless ignored the call. She concedes, however, that Ms. Chappell's incomprehensible speech was another sign of a serious medical emergency and that Ms. Chappell should have received assistance. Dkt. 96-19 at 9 (31:4−32:2).

12:15 PM to 12:27 PM

An inmate in J-Pod called Central Control to advise Officer Stillwell that Ms. Chappell was screaming, that other inmates were mocking her, and that someone needed to respond to provide assistance to Ms. Chappell. Ex. 10 at 8:45. Officer Reynolds arrived at Ms. Chappell's cell at 12:17 PM and stood in the doorway but did not enter the cell. The initial interaction between them was recorded. *Id.* at 9:44. Ms. Chappell repeatedly requested help, and her speech was barely intelligible. Officer Reynolds repeatedly ordered her to put on her jumpsuit. The recording ends after Ms. Chappell asked Officer Reynolds to take hold of her hand.

Officer Reynolds has testified that he observed a slimy, yellowish diarrhea-type substance on the floor of Ms. Chappell's cell during his visit. Dkt. 9-23 at 11 (39:13−23). He observed that Ms. Chappell was having difficulty comprehending her situation and appeared to be suffering from

a serious medical condition. *Id.* at 12 (41:25−42:10). Officer Reynolds summoned Officer Smith to assist Ms. Chappell in putting on her jumpsuit before she was escorted from her cell to the holding cell. *Id.* at 12 (41:14−21). Officer Smith admits that it was clear at this point that something was very wrong with Ms. Chappell's health. Dkt. 96-19 at 10 (36:7−15). Officer Smith also observed the greenish liquid on the floor of Ms. Chappell's cell and that Ms. Chappell was suffering from a serious medical emergency and needed medical aid as soon as possible at a hospital. *Id.* at 11, 13 (37:15−21, 38:6−10, 40:4−7, 45:3−8).

In his deposition, Officer Reynolds testified that he recalls that Officer Stillwell was the person who determined that Ms. Chappell should be escorted to a holding cell and placed under medical observation, that is, the regular, 15-minute visual checks. Dkt. 96-23 at 12 (42:12−24); dkt. 91-11 at 14 (50:20−25).

Day Shift - Holding 1

12:27 PM to 12:30 PM

Officer Reynolds escorted Ms. Chappell from J-Pod to a group holding cell (Holding 1). He recalls that Ms. Chappell was stumbling, staggering, disoriented, unable to walk a straight line, and appeared to pose a risk of a serious fall. Dkt. 96-23 at 16 (59:3−60:10). He observed Ms. Chappell when she collapsed to the floor in Holding 1 after he had let go of her. *Id.* at 17 (61:1−5).

12:30 PM to 12:59 PM

Video footage of Ms. Chappell inside the group holding cell captured images revealing the severity of her medical condition. Ex. 24. The following description summarizes that record:

From 12:32 to 12:45 PM, Ms. Chappell was sprawled out on the floor of the cell in clearly visible distress. Although one inmate ridiculed her, another said, "I don't think she's okay." When

another inmate asked her if she is okay, Ms. Chappell did not respond. During this time, another inmate covered her with a blanket. At 12:35 PM, Ms. Chappell attempted to stand up but for six minutes remained in a crouch. At 12:41 PM, Ms. Chappell attempted to walk, first by leaning on the wall, then staggering and falling to the floor, which landed her on top of other inmates. She intermittently stroked the other inmates' arms or faces, perhaps seeking comfort. Meanwhile, Officer Stillwell and Officer Reynolds were both watching these events unfold via the surveillance camera monitor. Dkt. 96-23 at 15 (53:1−17). Officer Reynolds later reported as follows:

> After she (Ms. Chappell) was in Holding Cell 1 for a very brief period of time she stood up from where she was laying [*sic*] just inside the cell door and walked directly to her right towards other inmates that were laying [*sic*] on their beds and she then fell onto an Inmate laying [*sic*] on the floor. It was at that time Jail Officer Matt Stillwell contacted me via the phone system inside the Jail and asked me if I had saw [*sic*] Inmate Chappell.

Dkt. 96-25.

At 12:47 PM, other inmates who were being housed in the holding cell with Ms. Chappell called via the intercom to report something was wrong with her. Officer Stillwell responded that Ms. Chappell was going to be moved. Four minutes later, inmates repeated their warnings, to which Officer Stillwell replied, "We're aware. We are coming to get her." However, Ms. Chappell was not removed from the cell until 12:59 PM, twelve minutes after the first alert was given by the inmates.

Day Shift - Holding 3

12:59 PM to 1:22 PM

Officer Reynolds, Davisson, and Stillwell transported Ms. Chappell into Holding Cell 3. Ex. 26. Within five minutes of being placed in the holding cell, Ms. Chappell had removed all her clothes. *Id.* Officer Reynolds has conceded that, by this point, it was obvious that Ms. Chappell's condition was continuing to worsen. Dkt. 96-23 at 14 (52:12−19). Officer Reynolds has also

acknowledged that, during this time period, he was advised that Ms. Chappell suffered from sickle cell disease. *Id.* at 9 (31:8). After reviewing her inmate file, he was unable to confirm that an initial medical screening had been conducted. *Id.* at 9 (31:8−10). Officer Reynolds informed Nurse Rutan that Ms. Chappell suffered from sickle cell disease, to which Nurse Rutan responded that she was sick, that there was nothing to be done for her, and that she did not appear to be showing signs of a sickle cell crisis. *Id.* at 9, 25 (31:15−25, 96:5−7); *see also*, Spillman Log, dkt. 91-7 at 6 ("My conversation with Jail Nurse Rutan was brief and he stated that she was sick but did not believe any other issues were present other than her being sick.").

1:25 PM

Video footage revealed Ms. Chappell to stagger back to her bunk and collapse, during which fall she struck her head on the steel bed frame, causing her to fall to the floor, moaning in apparent pain. Ex. 26 at 5:00−03. When Officer Reynolds and Officer Davisson approached her cell, only Officer Davisson made entry. *Id.* at 5:21; Ex. 28 at 2:35. Officer Davisson examined Ms. Chappell's eyes using a flashlight, asked her a few questions, but departed without taking further action. Ex. 26 at 5:21−5:48. Following Ms. Chappell's death, Officer Reynolds recorded in his incident report that while he and Officer Davisson were reviewing the video transmission, both failed to observe that Ms. Chappell had struck her head. Dkt. 96-25 at 2. Officer Davisson's deposition testimony contains his acknowledgement that he was aware from his training that vomiting blood and a serious head injury are both situations that require an officer to call 911. Dkt. 96-27 at 5 (13:7−25).

1:39 PM to 2:30 PM

When Officer Reynolds and Officer Davisson returned to Ms. Chappell's cell, they did not enter, choosing only to leave behind at the cell threshold a blanket and a mat, without specifically

checking on Ms. Chappell's condition. Ex. 26 at 6:06. From the video footage of the ensuing 50 minutes, Ms. Chappell can be seen falling to the floor several times and continuing to stumble around her cell. *Id.* at 6:10−10:03.

2:31 to 2:33 PM

Ms. Chappell remained unattended until 2:31 PM, when Nurse Rutan approached her cell. *Id.* at 10:03. He kicked a piece of trash from the hallway into the cell but did not personally enter the cell. He called in instructions to Ms. Chappell telling her to get dressed and step out of the cell so he could "see about getting [her] some medication." *Id.* Ms. Chappell was clearly disoriented and struggling at that time, moaning audibly and unable to dress herself. Nurse Rutan closed the cell door and departed the area, returning two minutes later, where, again from the area of the cell door threshold, he directed her as follows: "Last chance, either you get up and get dressed and come out and talk to me, or I'm just gonna go back to doing my thing." *Id.* at 10:46.

Over the ensuing several minutes, as visible on the video, Ms. Chappell clearly struggled to comply with Nurse Rutan's instructions. Her several attempts to put on her shoes were thwarted by the fact that there were no shoes in the area. She continued to stagger and struggle to maintain her balance before returning to her steel bunk. *Id.* at 10:50−12:31. Eventually, she crawled onto the floor and lay down on the mat, in a clearly altered mental state.

Around this same time, Nurse Rutan informed Officer Stillwell that jail staff should transport Ms. Chappell to Schneck Medical Center, which is a nearby hospital. Officer Stillwell directed Officer Boshears and Officer Reynolds to prepare Ms. Chappell to be transported. Dkt. 91-7 at 10.

3:08 PM

In preparation for transporting Ms. Chappell to the hospital, Officer Baxter and Officer

Boshears went to her cell and told her to get dressed so they could get her some help.[6] *Id.* at 13:13−54. Ms. Chappell, at the time lying unclothed on the floor, was holding her head, moaning and grimacing. She rose to her knees but was unable to stand. *Id.* Neither of the officers ever entered her cell, assisted her, or asked her any questions. As they began to close the cell door, Ms. Chappell pleaded, "Can you help me please?", but neither officer acknowledged the request. *Id.* at 13:50. Officer Baxter closed the door and the officers departed, leaving Ms. Chappell alone in the cell.

3:09 PM to 3:12 PM

Officer Baxter and Officer Boshears remained in the jail's book-in area over the course of the next several minutes, never attempting to gather additional information regarding the history of Ms. Chappell's condition during this time. Ex. 28 at 3:09−3:12; dkt. 96-2 at 7 (19:12−22); dkt. 96-29 at 13 (47:3−13). Officer Baxter has testified that she was aware that Nurse Rutan was also not making any efforts during this time to check on Ms. Chappell's condition or to provide medical assistance. Dkt. 96-2 at 12−13 (41:19−42:9).

3:12 PM to 3:14 PM

Officer Baxter and Officer Boshears returned to Ms. Chappell's cell where she had remained in a crouched position on the cell floor. Ex. 25 at 14:00.

Officer Boshears entered the cell and informed Ms. Chappell that she could not get any help until she got dressed, as Officer Boshears grabbed Ms. Chappell's jumpsuit off the bunk. *Id.* Officer Baxter added, "This is just making us think that you're faking it. So, if you're not gonna get up and get dressed, we're gonna leave you alone. And you can just sit there and suffer." *Id.* at 14:06−14:15. Ms. Chappell replied that she was not faking and that she felt like she was "on fire."

[6] Although Officer Boshears and Officer Reynolds were the transporting officers, Officer Baxter was presumably tasked with getting Ms. Chappell ready to leave because, like Officer Boshears, she is female.

Id. at 14:15−15:00.

Officer Boshears instructed Ms. Chappell to put on her jumpsuit, though Ms. Chappell was able to remain on her feet for no more than a few seconds before staggering around, losing her balance, and collapsing back to the floor, causing her to land very hard and moan out in pain, hold her head, and mumble, "Oh God. Please." *Id.* at 15:24. Officer Baxter ordered Officer Boshears to leave the cell and shut the cell door. Officer Baxter's parting remark to Ms. Chappell was, "You're not in kindergarten." *Id.*

3:14 PM to 3:36 PM

Nurse Rutan directed Officer Baxter to call EMS to request that an ambulance be dispatched. Dkt. 96-2 at 8 (24:17−24). Officer Baxter informed the 911 dispatcher that they needed an ambulance because "there was a female that needed to go to the hospital." *Id.* at 8 (25:1−6). Officer Baxter knew she was required to provide EMS with as much detail as possible regarding the inmate's medical situation, but between the time of the EMS dispatch and the ambulance's arrival, Officer Baxter made no attempt to gather additional information in order to brief the first responders. *Id.* at 9 (28:4−29:7). Despite Nurse Rutan's role as the jail's medical nurse, he made no efforts to consult with the responding EMS personnel. Dkt. 96-6 at 20 (73:5−21). In fact, from the time EMS was dispatched until they arrived, no member of the jail staff made contact with Ms. Chappell, observed her, or otherwise attempted to communicate with her. Ex. 28 at 3:14−3:29.

At 3:29 PM, Officer Boshears returned to the cell, accompanied by EMS personnel. Ex. 26 at 15:43. When she again advised Ms. Chappell that she must get herself dressed, Ms. Chappell could barely stand, having to lean herself against the wall as she attempted to dress herself. Indeed, she was apparently so confused that she attempted to put on her blanket as if it were a jumpsuit. With Officer Boshears standing nearby and still offering no assistance to her, Ms. Chappell

stumbled and collapsed onto the stretcher. *Id.* at 17:10. Emergency responders reported that Ms. Chappell was visibly jaundiced, with prominent yellowing to her eyes, mouth, face, and chest. Dkt. 96-30 at 6.

4:00 PM to 5:42 PM

Thirty minutes thereafter, when Ms. Chappell was delivered to the emergency room, the hospital nurse was unable to obtain a comprehensive medical history, and Officer Reynolds and Officer Boshears were unable to provide supplemental information from observations made at the jail. Dkt. 96-32 at 8−9 (5:22−6:1). Because the attending nurse at the hospital recognized that Ms. Chappell was seriously ill, she immediately began an IV and postponed filling out the required paperwork. *Id.* at 9 (6:8−12).

Shortly after the hospital nursing staff departed the emergency room, Officer Reynolds noticed Ms. Chappell had begun agonal breathing. Dkt. 96-25 at 3. Officer Boshears stated, "It looks like she's grinding her teeth and foaming at the mouth." *Id.* Officer Boshers went to retrieve a nurse. *Id.*

Two nurses promptly returned and determined that Ms. Chappell required intubation. Id. at 4. One nurse uttered, "Oh no!" As they attempted to locate Ms. Chappell's pulse, the officers were ordered to vacate the hospital room. *Id.*

Medical staff began CPR at 4:13 PM and continued that effort through 5:42 PM, when the attending physician declared Ms. Chappell deceased. Dkt. 96-3 at 4−5.

C. Cause of Death

Following Ms. Chappell's death, conflicting opinions were cited regarding the cause. The attending physician initially determined that it was likely due to toxicity from the ingestion of an unknown substance, a conclusion which was supported by the medical examiner. Dkt. 96-35 at 29.

The attending physician later revised his opinion, concluding that Ms. Chappell suffered a sickle cell crisis that had become fatal. *Id.*

The respective medical experts retained by both the Estate and the Defendants, however, appear to agree that Ms. Chappell died from sepsis due to an infection. Dkt. 96-36 at 5; dkt. 96-34 at 6. One of the Estate's experts, Dr. Louis Profeta, has opined that timely medical intervention would have kept Ms. Chappell alive and also mitigated her suffering. Dkt. 96-34 at 6. Defendants' expert, Dr. Kerry Cleveland, has opined that, given the uncertainty about the cause of Ms. Chappell's death, no reasonable medical professional could state with a reasonable degree of medical probability that transporting Ms. Chappell to the hospital at an earlier point in her illness would have prevented her death. Dkt. 113-5 at 3.

III.
Discussion

The Estate has moved for summary judgment on its Fourteenth Amendment claims against defendants Ferguson, Banister, Reynolds, Baxter, Rutan, Boyd, Rodriguez, and Smith. Defendants have moved for summary judgment on all claims against Reynolds, Baxter, Boshears, Everhart, Meyer, Stillwell, Davisson, and Ridlen. We address below the Estate's claims against defendants in their individual capacities before addressing the *Monell* claims against Sheriff Meyer and Commander Everhart.

A. Fourteenth Amendment Claims

A pretrial detainee's unconstitutional medical care claim, brought under the Due Process Clause of the Fourteenth Amendment, is to be analyzed according to the objective unreasonableness inquiry laid out in *Kingsley v. Hendrickson*, 576 U.S. 389 (2015). *Miranda v. County of Lake*, 900 F.3d 335, 352 (7th Cir. 2018).[7]

[7] The deliberate indifference standard applies to convicted prisoners. *Id.*

A defendant violates a pretrial detainee's due process right to constitutionally acceptable medical care if:

> (1) there was an objectively serious medical need; (2) the defendant committed a volitional act concerning the [plaintiff's] medical need; (3) that act was objectively unreasonable under the circumstances in terms of responding to the [plaintiff's] medical need; and (4) the defendant act[ed] "purposefully, knowingly, or perhaps even recklessly" with respect to the risk of harm.

Gonzalez v. McHenry County, Ill., 40 F.4th 824, 828 (7th Cir. 2022) (quoting *Miranda*, 900 F.3d at 353−54). "This standard requires courts to focus on the totality of facts and circumstances faced by the individual alleged to have provided inadequate medical care and to gauge objectively—without regard to any subjective belief held by the individual—whether the response was reasonable." *Williams v. Ortiz*, 937 F.3d 936, 942 (7th Cir. 2019) (cleaned up).

Courts have "'long recognized' that correctional institutions typically 'engage in the division of labor' between medical professionals and other security and administrative staff." *McGee v. Parsano*, 55 F.4th 563, 569 (7th Cir. 2022) (quoting *Miranda*, 900 F.3d at 343). Thus, if a detainee is receiving care provided by medical professionals, non-medical jail staff may defer to their medical judgment unless the "jail official 'had reason to know that the[ ] medical staff w[as] failing to treat or inadequately treating an inmate." *Id.* (quoting *Miranda*, 900 F.3d at 343).

Defendants here argue that material disputes of fact exist as to whether any of them knew Ms. Chappell suffered from a serious medical need or condition. Dkt. 112 at 16. As the Seventh Circuit has ruled,

> An objectively serious medical condition is one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would perceive the need for a doctor's attention. A medical condition need not be life-threatening to be serious; rather, it could be a condition that would result in further significant injury or unnecessary and wanton infliction of pain if not treated.

Gayton v. McCoy, 593 F.3d 610, 620 (7th Cir. 2010) (cleaned up). Vomiting is a serious medical event if the ill person is "vomiting continuously for a long period of time, [has] blood in one's vomit," or presents some other medical condition of which defendants had or should have had notice. *Id.* at 621.

The undisputed evidence before us establishes that Ms. Chappell's continuous vomiting as well as her additional symptoms, including an inability to walk or dress without assistance and increased difficulties with communication, constituted a serious medical need. Our analysis below examines each defendant's actions and potential liability in detail based on the undisputed evidence with respect to that person's contemporaneous awareness or knowledge of Ms. Chappell's condition.

1. David Ridlen

The undisputed evidence reveals that Lt. Ridlen's involvement consisted of his directing Officer Banister and Officer Smith to initiate a medical watch on Ms. Chappell after they had called him to report her deteriorating condition. Dkt. 96-22 at 9 (26:5−29:14). "Individual liability under § 1983 … requires personal involvement in the alleged constitutional deprivation." *Colbert v. City of Chicago*, 851 F.3d 649, 657 (7th Cir. 2017) (internal quotation omitted). No jury could find this action taken by Lt. Ridlen to have been unreasonable. Thus, he is entitled to summary judgment in his favor, and all claims against him shall be **dismissed with prejudice**.[8]

2. Seth Boyd

Officer Boyd had multiple encounters with Ms. Chappell between 8:00 PM and 1:30 AM on the dates at issue. There is no factual dispute over his awareness of Ms. Chappell's serious

[8] In a footnote in its brief, the Estate has informed the Court that "an agreed order dismissing Ridlen, with prejudice, is being filed, thereby rendering his Motion moot." Dkt. 106 at 1, n.1. Since the parties have not filed such a stipulated order, given that his lack of personal involvement warrants a ruling in his favor, summary judgment will be granted.

medical condition: he was aware that she had been vomiting throughout the day, and he personally observed the residual signs of her having done so, he brought her a bucket to allow her to deal with the vomiting without having to leave her bed, and he observed that blood appeared in her vomit. Dkt. 96-1 at 14−17 (47−61).

Officer Boyd conveyed frequent updates to his immediate supervisor, Sgt. Ferguson, regarding Ms. Chappell's condition, including that Ms. Chappell had vomited blood, though Sgt. Ferguson disputes having known about the blood in her vomit. Dkt. 96-9 at 7 (22:11−14). Sgt. Ferguson informed Officer Boyd that he had conferred with Nurse Rutan and instructed jail officers to keep an eye on her until Nurse Rutan could assess her condition in the morning. Dkt. 96-9 at 7−8 (23:19−24, 25:3−6); dkt. 96-13.

There is no dispute that Officer Boyd failed to comply with his formal training requirements by not personally calling the medical provider or 911 when he observed blood in Ms. Chappell's vomit. Nor did he create a log entry to report her illness or her deteriorating medical condition. He also failed to fill out a protocol sheet. However, he did follow the jail's customary practice by reporting Ms. Chappell's illness to his supervisor. Thus, a reasonable jury might conclude that his response was reasonable in light of his supervisor's assurances that he had conferred with Nurse Rutan and nothing more than observation was required at that time. Because the evidence permits contrary conclusions, a jury must resolve the issue, making summary judgment unavailable to the Estate on its claims against Officer Boyd.

3. Kevin Rodriguez

Officer Rodriguez spoke with Ms. Chappell around 2:30 AM, when she reported that she was throwing up blood and needed to go to the hospital. Ex. 10 at 2:11−3:11. Though Officer Rodriguez failed to report this information to Sgt. Ferguson, who was the shift supervisor, he did

check on Ms. Chappell's condition about a half hour later while walking through the female pods. Officer Rodriguez also fielded a call via the intercom again at 3:10 AM, when Ms. Chappell repeated her symptoms and requested to go to the hospital. Ex. 10 at 3:32−4:22. At that point, Officer Rodriguez did report what he knew to Sgt. Ferguson, only to be told by Sgt. Ferguson that Ms. Chappell needed to wait for the nurse's arrival in the morning to receive care. *Id.*

As with Officer Boyd, Officer Rodriguez failed to comply with his training in failing to log interactions with Ms. Chappell, in not contacting a medical provider or 911 directly upon becoming aware that she was vomiting blood, and in not completing any jail protocol forms. A jury might conclude, however, that by reporting her condition to his supervisor he acted reasonably. Thus, given the conflicting views arising from the evidence before us, the Estate's motion for summary judgment must be **denied** as to its claims against Officer Rodriguez.

4. Scott Ferguson

Sgt. Ferguson, who was the jail supervisor on duty from the time when Ms. Chappell first reported her illness, to wit sometime after 8:00 PM on July 15, until 6:00 AM the next morning. The undisputed evidence discloses that, between 8:30 PM and 3:15 AM the next day, Officer Hardin, Officer Boyd, and Officer Rodriguez all informed Sgt. Ferguson that Ms. Chappell was ailing and vomiting in her cell. Sgt. Ferguson contacted Nurse Rutan once during the 8:00 PM hour to convey the information that Ms. Chappell had vomited, but that jail officers were unable to confirm that there was blood present in the vomit. Dkt. 96-9 at 7 (22−23). Following that initial call to Nurse Rutan, no other information regarding Ms. Chappell's continuous vomiting episodes and requests to go to the hospital was conveyed to Nurse Rutan by Sgt. Ferguson. As he explained in his deposition, other officers were --

> reporting she was still vomiting. She kept saying she didn't feel well. I was advised that, you know, since there was no blood in the vomit that the nurse would see her

> in the morning to check her out. Condition didn't worsen through the night. But she just consistently kept vomiting.

Id. at 7 (23:19−24). Following the 6:00 AM shift change, Sgt. Ferguson also failed to pass along information about Ms. Chappell's illness to his successor jail supervisor. *Id.* at 10 (35:8−11).

Whether a jury could conclude that Sgt. Ferguson acted unreasonably by failing to call Nurse Rutan or ACH's on-call medical provider to report that Ms. Chappell was continuously vomiting over the course of *seven* hours, blood or no blood, and/or by failing to convey to the successor shift supervisor that Ms. Chappell had been vomiting for hours and had reported blood in her vomit is not necessarily compelled based on the evidence before us. *Gayton*, 593 F.3d at 621 (noting that continuous vomiting is a sign of a serious medical condition). A jury could determine that Sgt. Ferguson acted reasonably when he relied on Nurse Rutan's advice that no action beyond continued observation was needed until Nurse Rutan could examine her in the morning. *McGee*, 55 F.4th at 569 (noting that in most circumstances, correctional officers may rely on medical providers). Accordingly, summary judgment again must be denied as to the Estate's claims against Sgt. Ferguson.

5. Ryah Smith

Officer Smith's first interaction with Ms. Chappell was in response to a call from Ms. Chappell placed at 9:20 AM reporting that she had vomited in her sleep. Ex. 10 at 5:37. Officer Smith—at the time, new on the job and lacking any formal training—responded saying "alrighty," after which she hung up but failed to report the information to anyone or otherwise log the information. Dkt. 96-19 at 3−4 (6:17−21, 9:7−14). Ms. Chappell called again at 9:55 AM, repeating nine times her plea, "I need help." Again, Officer Smith, who had fielded the call, took no action. Nurse Rutan testified that at a minimum, in response to such calls, he would have

initiated a process of medical observation of Ms. Chappell, had he been aware of them. Dkt. 96-6 at 48 (187:10−188:1).

Shortly thereafter, Officer Smith and Officer Banister assisted Ms. Chappell's return to her cell after other inmates had reported that she was lying naked on the floor in the common area. Ex. 20. Officer Smith did not observe that Ms. Chappell had soiled herself, but she did notice that Ms. Chappell was unable to speak in complete sentences and, at one point, shook her head "no," when she was asked if she knew what was going on. Dkt. 96-19 at 6−7 (20:10−17, 21:1−19).

After Officer Smith and Officer Banister returned to the control room, Officer Banister contacted Lt. Ridlen, who directed them to begin a medical log, but Officer Smith failed to do so. Officer Smith also failed to act when an inmate reported at 11:16 AM that Ms. Chappell needed help, simply replying that Ms. Chappell had to personally request help. Ms. Chappell did call Officer Smith twenty-five minutes later, moaning and speaking incoherently. Ex. 10 at 8:02−8:42. Again, however, Officer Smith took no action in response to that call.

No reasonable juror could conclude from the evidence of these encounters that Officer Smith acted reasonably in response to Ms. Chappell's serious medical need. Officer Smith's relative inexperience and lack of formal training do not excuse her failures to contact her supervisor or the jail nurse to report Ms. Chappell's deteriorating condition.[9] Even when Officer Banister called Lieutenant Ridlen and was instructed that Officer Smith and Officer Banister should begin a medical log, she failed to do. Thus, summary judgment as to the Estate's Fourteenth Amendment claims against Officer Smith is warranted and will be granted.

[9] Defendants assert that there is a dispute of material fact with respect to whether Officer Smith knew Ms. Chappell was sick because she did not personally observe her vomiting. Dkt. 112 at 17. This factual equivocation does not overcome or otherwise justify her reactions to Ms. Chappell 's repeated calls to her or Ms. Chappell's confused state in the J-Pod when Officer Smith and Officer Bannister personally tended to her. Indeed, Officer Smith acknowledged in her deposition testimony that, by approximately 9:55 AM at the latest, she recognized "something [was] wrong" with Ms. Chappell. Dkt. 96-19 at 4 (12:15−25).

6. Clayton Banister

Officer Banister's involvement was limited to a single instance of providing care to Ms. Chappell when she was lying naked on the floor in J-Pod. Officer Banister maintains that he did not recognize at the time that Ms. Chappell was seriously ill due to her responsiveness to him, which consisted of her looking in his direction when he spoke to her and mumbling "yes" or "no" in response to his questions. Dkt. 96-22 at 4−5 (8−10). We have our doubts as to the believability of Officer Banister's explanation, given Ms. Chappell's readily observable disorientation and difficulty moving herself without assistance as recorded in the video. Ex. 20. However, Officer Banister did report his findings to Lieutenant Ridlen prior to resuming his duties in another area of the jail. Thus, again whether his response was sufficient and reasonable to escape liability must be resolved by a factfinder, making summary judgment unavailable on the claims against Officer Banister.

7. Nurse Rutan

Nurse Rutan was the only medical professional employed at the jail during the entirety of Ms. Chappell's incarceration. Regarding his inaction and unresponsiveness on July 16, a jury could easily find his conduct was objectively unreasonable. He refused on multiple occasions to conduct a full medical assessment, ostensibly because Ms. Chappell was throughout this time undressed, but which even he acknowledged was not an acceptable reason to deny treatment. Dkt. 96-6 at 31 (120:11−25). He never contacted Dr. Everson or ACH to consult as to her serious and deteriorating physical condition, despite requirements that he do so, in light of his limited expertise as an LPN in terms of making medical diagnoses or treating patients. When Officer Reynolds contacted him around mid-day on July 16 to advise him that no 14-day assessment had been performed for Ms.

Chappell despite reports that she suffered from sickle cell disease, Nurse Rutan took no action. Dkt. 96-25 at 9, 25 (31:15−25, 96:5−7).

Disputes of material fact permeate the issues regarding what Nurse Rutan knew and when he knew it and what response he took. When Nurse Rutan observed Ms. Chappell during the morning hours, her vitals were stable and she was still speaking coherently. Dkt. 91-7 at 3. During his deposition, after reviewing the audio and video footage of Ms. Chappell's interactions with officers at various points during the day, Nurse Rutan testified that no one had alerted him at the time to her deteriorating state and further claimed that, had he known, he would have placed her on medical observation earlier or sent her to the hospital. Dkt. 96-6 at 47−48 (181:16−25, 182:1−14, 188:5−18)). Disputes of material fact related to Nurse Rutan's knowledge of Ms. Chappell's condition saturate the record before us, along with many others. Thus, the Estate's motion for summary judgment against Nurse Rutan must be denied.

8. Mark Reynolds

Officer Reynolds's first interactions with Ms. Chappell occurred when Officer Stillman enlisted him to help relocate Ms. Chappell from the J-Pod to Holding Cell 1. Dkt. 9-23 at 11 (39:9−12). There is no dispute that during this encounter he recognized that she was suffering from a serious medical condition, as evidenced by diarrhea residue which was in clear view on the floor of her cell, her difficulty with comprehension, and her inability to walk without assistance. *Id.* at 12 (41−42). After Officer Smith assisted Ms. Chappell in donning her jumpsuit, together they escorted Ms. Chappell to the holding cell and, under Officer Stillwell's direction, placed her under medical observation. *Id.* at 12 (42).

Officer Reynolds had become aware of Ms. Chappell's sickle cell disease sometime during the early afternoon, prompting him to contact Nurse Rutan. Nurse Rutan dismissed Officer

Reynolds's concerns, telling him that he did not think Ms. Chappell was experiencing a sickle cell crisis and that "she was sick but he did not believe any other issues were present other than her being sick." Dkt. 91-7 at 6.

After reviewing video surveillance within the cell showing Ms. Chappell falling, Officer Reynolds wrote in a report that he and Officer Davisson didn't believe she had hit her head. Dkt. 96-25 at 2. Thus, he did not contact Nurse Rutan about the fall.

Based on this evidence, a jury could conclude that Officer Reynolds reasonably relied on Nurse Rutan's assessment that Ms. Chappell was not suffering from sickle cell disease and that he genuinely believed that she had not hit her head on the bunk, which findings would defeat the Estate's motion for summary judgment regarding the claims against Officer Reynolds.

However, a jury could also conclude, based on this evidence, that Officer Reynolds had "reason to know that [Rutan] [was] failing to treat or inadequately treating" Ms. Chappell, making his deference to Rutan unreasonable and indefensible. *Miranda*, 900 F.3d at 343. In addition, whether or not Ms. Chappell struck her head, there is no indication that Officer Reynolds took any steps to communicate to appropriate jail staff Ms. Chappell's increasingly disoriented state during the early afternoon hours when she was under medical observation. These disputes of material fact as to whether Officer Reynolds violated Ms. Chappell's rights must be resolved by a factfinder. Whether he is entitled to qualified immunity is a matter the Court will be required to resolve in due course. Summary judgment is, in any event, not appropriate.

9. Matt Stillwell and Michael Davisson

Officer Stillwell first learned of Ms. Chappell's illness during the early morning hours when he began his shift as supervisor, which prompted him to contact Nurse Rutan to request a check

on her. Dkt. 91-11 at 13 (36:9−22). At Nurse Rutan's direction, Officer Davisson took Ms. Chappell's temperature and conveyed the read-out to Nurse Rutan. Dkt. 91-7 at 4.

Later that same day, beginning around 1:15 PM, Officer Stillwell contacted Officer Reynolds to enlist him in helping Officer Smith escort Ms. Chappell to a holding cell. Dkt. 91-7 at 6, 9. When Officer Stillwell observed Ms. Chappell fall on top of other inmates in the holding cell, he alerted Officers Reynolds and Davisson to provide their assistance in moving Ms. Chappell to Holding Cell 3 for medical observation. Dkt. 96-23 at 12 (42:12−24); dkt. 91-7 at 10.

When Ms. Chappell fell and hit her head on the bunk, Officer Davisson entered her cell to examine her eyes with a flashlight, but left after a brief check, without taking further action. Ex. 26 at 5:21−5:48.

After Nurse Rutan (finally) decided that Ms. Chappell should be taken to the hospital, Officer Stillwell issued directions to others to prepare her for transport. Dkt. 91-7 at 10.

Defendants contend, based on this evidence, that Officers Stillwell and Davisson are entitled to summary judgment because they reasonably relied on Nurse Rutan's medical expertise. Dkt. 92 at 30−31. Perhaps, however, a jury might conclude that their actions were unreasonable, since there is no evidence that either of them contacted Nurse Rutan during the early afternoon hours to advise him of Ms. Chappell's quickly deteriorating condition. Having non-medical staff simply observe a seriously ill inmate, rather than obtaining medical help or otherwise delaying her access to medical care, might be viewed as objectively unreasonable. A jury could otherwise find that the officers' reliance on Nurse Rutan was unreasonable because as an LPN with limited authority to diagnose or treat patients, his ability to address or ameliorate the serious medical needs presented by Ms. Chappell was obviously lacking. We address this issue more fully in our *Monell* analysis, *infra*. The Court will also be required to resolve the issues of qualified immunity. Thus,

summary judgment in favor of either party is unavailable relating to the claims against Defendants Stillwell and Davisson.

10. Wendy Boshears and Tami Baxter

Officer Boshears and Officer Baxter both seek summary judgment on the claims against them, respectively. The Estate seeks summary judgment as to the claims only against Officer Baxter.

Officer Boshears's and Officer Baxter's respective involvement began at 3:08 PM, when they went to Ms. Chappell's cell to assist her with getting dressed so she could be medically assessed by Nurse Rutan. Ex. 26 at 13:13−54. When they arrived, Ms. Chappell was physically unable to get up from the floor and repeatedly requested their help. They walked away, however, without providing assistance, only to return several minutes later to attempt to get her to put on her jumpsuit. *Id.* at 14:00−15:00. Officer Baxter accused Ms. Chappell of faking her symptoms, chiding her by saying that she could just "sit there and suffer." *Id.* at 14:06−14:15. Ms. Chappell responded that she was not faking it and felt like she was "on fire." *Id.* When she attempted to get up, she again fell to the floor, whereupon Officer Baxter ordered Officer Boshears to leave the cell. As Officer Baxter closed the cell door, she told Ms. Chappell, "You're not in kindergarten."

At approximately 3:15 PM, Nurse Rutan directed Officer Baxter to contact EMS, though no one attempted to gather any information about Ms. Chappell's condition as they waited for the ambulance to arrive.

Beyond Officer Baxter's callous statements to Ms. Chappell, the undisputed evidence reveals that neither officer had any direct involvement in delaying or denying Ms. Chappell access to medical care. Their sole function was to attempt to help her get dressed so she could be

medically evaluated by Nurse Rutan. Once it was clear that she was too sick to participate in getting dressed, Nurse Rutan directed Officer Baxter to call for an ambulance.

Even if a jury viewed these officers' responses as unreasonable under the circumstances, it could not reasonably conclude that their actions had any impact on the timing of Ms. Chappell's access to or quality of her medical treatment. *Cf. Estate of Perry v. Wenzel*, 872 F.3d 439, 455 (7th Cir. 2017) (reversing grant of summary judgment where officers refused to obtain medical help for inmate based on their belief he was faking his symptoms). Although the Estate relies on the failure of the officers to gather information regarding her condition to inform EMS personnel during the minutes they waited for the ambulance's arrival, they cite no caselaw or other authority finding such conduct alone suffices as a constitutional violation. Accordingly, both Officer Baxter and Officer Boshears are entitled to summary judgment on the Estate's claims against them.

11. Qualified Immunity

Having determined that disputes of material fact permeate the claims against Officers Reynolds, Stillwell, and Davisson, we move to consider the issue of whether any of these officers is entitled to qualified immunity.

"Qualified immunity is a doctrine that protects government officials from liability for civil damages insofar as their conduct does not violate clearly established statutory or constitutional rights of which a reasonable person would have known." *Leiser v. Kloth*, 933 F.3d 696, 701 (7th Cir. 2019) (cleaned up). Once a defendant invokes qualified immunity as a defense, the burden shifts to the plaintiff to attempt to defeat it by showing "two elements: first, that the facts show a violation of a constitutional right, and second, that the constitutional right was clearly established at the time of the alleged violation." *Id.* (cleaned up). "'If either inquiry is answered in the negative,

the defendant official' is protected by qualified immunity." *Koh v. Ustich*, 933 F.3d 836, 844 (7th Cir. 2019) (quoting *Reed v. Palmer*, 906 F.3d 540, 546 (7th Cir. 2018)) (emphasis omitted).

We focus our analysis here on the second element because questions of fact foreclose decision-making as to the first. "A clearly established right is one that is sufficiently clear that every reasonable official would have understood that what he is doing violates that right. . . . Put simply, qualified immunity protects all but the plainly incompetent or those who knowingly violate the law." *Mullenix v. Luna*, 577 U.S. 7, 11−12 (2015) (cleaned up). Courts cannot define "clearly established law at a high level of generality," but rather must assess "whether the violative nature of *particular* conduct is clearly established." *Id.* (cleaned up). The doctrine of qualified immunity "gives government officials breathing room to make reasonable but mistaken judgments[.]" *Carroll v. Carman*, 574 U.S. 13, 17 (2014).

As Defendants have noted, the Estate did not specifically respond to their qualified immunity arguments. Dkt. 114 at 18. Thus, Defendants argue, the Estate has waived any claim that the officers are not entitled to qualified immunity. *Id.* We conclude in this instance that waiver is not appropriate, however, given the Estate's reliance on caselaw predating 2021 as support for their argument that qualified immunity is not available to these officers. Dkt. 106 at 31−32.

By 2021, caselaw had clearly established the constitutional principle that "[i]f a prisoner is writhing in agony, the guard cannot ignore him on the ground of not being a doctor; he has to make an effort to find a doctor, or . . . *some* medical professional." *Dobbey v. Mitchell-Lawshea*, 806 F.3d 938, 941 (7th Cir. 2015). Further, it was clearly established law that a correctional officer cannot defer to a medical professional, if he knows or has reason to believe that the medical professional is failing to provide care for an inmate. *See Miranda*, 900 F.3d at 343 (citing *King v. Kramer*, 680 F.3d 1013, 1018 (7th Cir. 2012)).

Here, the officers are not entitled to qualified immunity. *See Ferguson v. McDonough*, 13 F.4th 574, 584 (7th Cir. 2021) (explaining that though factual issues made qualified immunity at the summary judgment stage improper, "a jury may resolve disputed facts in [the defendants'] favor, and the district court could then determine he is entitled to qualified immunity as a matter of law."). Factual disputes remain as to whether the officers acted unreasonably by failing to either provide information to Nurse Rutan (especially after Ms. Chappell fell on the bunk) or contact a doctor or 911 directly, but the controlling legal principles were clearly established which foreclose any entitlement to qualified immunity.

B. *Monell* Claims

Defendants have sought summary judgment as to all the municipal liability claims, pursuant to *Monell v. Dept. of Social Services*, 436 U.S. 658 (1978). While the Complaint targets Sheriff Meyer and Commander Everhart for *Monell* liability, we refer here only to the Sheriff, for sake of clarity.

Two *Monell* claims are advanced in the Second Amended Complaint: (1) that the Sheriff failed to implement or enforce policies to ensure constitutionally adequate access to medical care ("the customs claim"); and (2) that the Sheriff failed to adequately train the correctional officers regarding constitutionally medical care for the inmates ("the training claim"). Dkt. 61 at 51−55.

1. Relevant Legal Principles

To succeed on its *Monell* claims, the Estate must show first that Ms. Chappell was deprived of a federal right, and then that the deprivation was caused by the jail's custom or policy or failure to implement a needed policy. *Dean v. Wexford Health Sources, Inc.*, 18 F.4th 214, 235 (7th Cir. 2021). As the Seventh Circuit has explained:

> There are at least three types of municipal action that may give rise to municipal liability under § 1983: (1) an express policy that causes a constitutional deprivation

> when enforced; (2) a widespread practice that is so permanent and well-settled that it constitutes a custom or practice; or (3) an allegation that the constitutional injury was caused by a person with final policymaking authority. Inaction, too, can give rise to liability in some instances if it reflects a conscious decision not to take action.

Id. The Sheriff cannot be held liable under the common-law theory of respondeat superior for his employees' actions. *Howell v. Wexford Health Sources, Inc.*, 987 F.3d 647, 653 (7th Cir. 2021). "The critical question under *Monell* . . . is [whether] the action about which the plaintiff is complaining [is] one of the institution itself, or is it merely one undertaken by a subordinate actor?" *Glisson v. Indiana Dep't of Corrections*, 849 F.3d 372, 381 (7th Cir. 2017).

Further, although the individual liability claims are analyzed under the Due Process Clause of the Fourteenth Amendment, *Monell* liability attaches only if the municipality acted with deliberate indifference. *J.K.J. v. Polk County*, 960 F.3d 367, 377 (7th Cir. 2020); *Board of County Comm'rs of Bryan County, Okl. v. Brown*, 520 U.S. 397, 407 (1997); *see also Miranda*, 900 F.3d at 345, 352 (applying deliberate indifference standard to pretrial detainee's *Monell* claim despite disavowing that standard for pretrial detainee's claims against individual defendants).

The Estate does not challenge the constitutional adequacy of the written policies in place at the time leading up to Ms. Chappell's death. Dkt. 106 at 35. Instead, the Estate alleges that the widespread practices of the jail caused Ms. Chappell's injury. In most circumstances, to succeed on a *Monell* claim, a plaintiff must show a pattern of widespread constitutional violations that harmed other inmates. *See Hildreth v. Butler*, 960 F.3d 420, 426 (7th Cir. 2020). That said, "a single incident can be enough for [*Monell*] liability where a constitutional violation was highly foreseeable." *Miranda*, 900 F.3d at 341. For instance, in *Glisson*, the Seventh Circuit determined that there was a triable issue as to whether the need for protocols regarding comprehensive medical

care was "so obvious" that the absence of such protocols caused one inmate's death. *Glisson*, 849 F.3d at 382.

2. Discussion

In the Second Amended Complaint, the Estate contends that the Sheriff's failure to train jail staff in identifying and responding to inmates' medical needs demonstrated a deliberate indifference. Dkt. 61 at 54−55. However, in its response to Defendants' motion for summary judgment, the Estate omits any claim that the Sheriff failed to adequately train jail staff. Rather, it focuses on the failure to enforce the policies that had been promulgated and that staff had been trained on. *See* dkt. 106. Accordingly, given the Estate's abandonment of a failure to train theory, we hold here that Sheriff Meyer and Commander Everhart are entitled to summary judgment on that claim. We address the failure to enforce theory below.

The Estate does allege as well that various practices and customs at the Jackson County Jail violated Ms. Chappell's right to adequate medical care, including: (1) the failure by staff to perform adequate health checks or monitor detainees' health needs and respond to their requests for medical attention; (2) the disregard by jail staff of the written medical policies and protocols, including those related to medical recordkeeping and communicating inmates' illnesses to medical personnel; (3) the failure by the Sheriff to maintain adequate staffing levels at the jail of persons with medical expertise; and (4) the failure by the Sheriff to properly supervise jail officers.

No reasonable juror could find that the lack of adequate medical staffing levels caused Ms. Chappell's injury. The undisputed evidence established that additional medical staff was available by telephone, but no one ever attempted to call Dr. Everson or ACH for guidance on what to do with Ms. Chappell. In addition, the evidence established that Sheriff Meyer was trying to hire an additional nurse during the relevant timeframe, and thus he could not be said to be acting with

deliberate indifference. *Rasho v. Jeffreys*, 22 F.4th 703, 710−11 (7th Cir. 2022) (concluding that prison administrators' efforts to hire additional mental health staff defeated deliberate indifference claim despite their lack of success in alleviating staffing shortage). The undisputed evidence further reveals that Nurse Rutan's failure to treat Ms. Chappell was not because he was too busy with other patients, but because he was uncomfortable tending to an undressed female patient. Thus, the defendants are entitled to summary judgment on this theory in the Estate's *Monell* claim.

Disputes of material fact infect the remaining *Monell* customs claims with regard to the failure to enforce various policies. A jury could hold that the lack of enforcement of the jail's written medical policies caused Ms. Chappell's suffering and ultimately her death.[10] Correctional and medical staff were trained to screen inmates for medical conditions upon their incarceration, to log medical encounters with inmates in the Spillman program, to contact the medical provider (either Dr. Everson or the ACH on-call nurse) or 911 if an inmate had certain symptoms, and to share information about ill inmates when shifts changed. However, the testimony of various staff members established that the actual practice at the jail was simply to report a sick inmate to an immediate supervisor or to Nurse Rutan for appropriate care to be provided. A reasonable jury could conclude that it was foreseeable that a failure to monitor sick inmates, a breakdown of communication among the on-site staff, and/or an inordinate reliance on a single licensed practice nurse (who was not qualified to diagnose or treat patients) to make all medical decisions would cause inmates additional pain and suffering−or, as here, death. A reasonable jury could also conclude that it was foreseeable that the lack of supervision by Sheriff Meyer and Commander

[10] Although the Defendants argue that Ms. Chappell must produce evidence that these customs were the proximate cause of her death, "the causation inquiry is quite broad: the constitutional violation in question here is the failure to provide adequate medical care in response to a serious medical condition, not causing her death." *Estate of Perry*, 872 F.3d at 459 (cleaned up).

Everhart contributed to this lax environment. Thus, summary judgment is unavailable and must be denied as to the remaining aspects of the *Monell* customs claim.

C. State Law Claims Against Defendants Davisson, Reynolds, Ridlen, Stillwell, Boshears and Baxter

Defendants Davisson, Reynolds, Ridlen, Stillwell, Boshears, and Baxter seek immunity as to the state law negligence claims against them. In the Second Amended Complaint, the Estate advances a state law negligence claim against the individual officers based on their (1) failure to obtain or provide medical treatment for Ms. Chappell; (2) failure to consult with a qualified medical professional; (3) failure to transport Ms. Chappell to a hospital; and (4) failure to appropriately monitor her. Dkt. 61 at ¶ 425.

The Indiana Tort Claims Act ("ITCA") "governs lawsuits against political subdivisions and their employees[,]" and it "provides substantial immunity for conduct within the scope of a public employee's employment[.]" *Chang v. Purdue University*, 985 N.E.2d 35, 51 (Ind. Ct. App. 2013). "A lawsuit alleging that an employee acted within the scope of the employee's employment bars an action by the claimant against the employee personally." Ind. Code § 34-13-3-5(b). This means that a plaintiff cannot sue a government employee "personally if the complaint, on its face, alleges that the employee's acts leading to the claim occurred within the scope of employment." *Bushong v. Williamson*, 790 N.E.2d 467, 471 (Ind. 2003); *Ball v. Indianapolis*, 760 F.3d 636, 645 (7th Cir. 2014) ("Under the [ITCA], there is no remedy against the individual employee so long as he was acting within the scope of his employment.") (citing Ind. Code § 34-13-3-5(b)).

Conduct within the "scope of employment" is conduct "of the same general nature as that authorized, or incidental to the conduct authorized." *Celebration Fireworks, Inc. v. Smith*, 727 N.E.2d 450, 453 (Ind. 2000). The Second Amended Complaint alleges that the defendant officers "were on duty during periods of July 15, 2021 and/or July 16, 2021 during the time of

Ms. Chappell's requests for medical attention, during her serious needs for medical attention, and/or during her state of deteriorating medical condition." Dkt. 61 at ¶ 7. The undisputed facts thus establish that the officers were acting within the scope of their employment. An employee is not entitled to immunity, however, if his or her conduct is willful and wanton. *See Ellis v. City of Martinsville*, 940 N.E.2d 1197, 1204−05 (Ind. Ct. App. 2011).

The Estate did not respond to the defendant officers' argument that they are entitled to immunity because they were acting within the scope of their employment. Accordingly, the Estate has waived any argument that these officers are not entitled to immunity based on their conduct being willful and wanton. *Marcavage v. City of Chicago*, 659 F.3d 626, 638 (7th Cir. 2011). Summary judgment is **granted** to these individual officers on the state law negligence claims.

IV.
Conclusion

For the foregoing reasons, the motions for summary judgment are **granted in part and denied in part.**

With respect to Defendants' motion, dkt. [90], summary judgment is **granted** with respect to the Fourteenth Amendment claims against defendants Ridlen, Boshears, and Baxter; the failure-to-train *Monell* claim against Sheriff Meyer and Sheriff Everhart; the subpart of the *Monell* customs claims alleging that Sheriff Meyer and Commander Everhart failed to adequately staff the jail with medical professionals; and the Indiana tort claims against defendants Davisson, Stillwell, Reynolds, Ridlen, Boshears, and Baxter. Summary judgment is **denied** with respect to the Fourteenth Amendment claims against defendants Davisson, Stillwell, and Reynolds. **The clerk is directed** to dismiss David Ridlen, Wendy Boshears, and Tami Baxter and redact their names as defendants on the docket going forward. No partial final judgment shall issue.

The Estate's motion, dkt. [95], is **granted** with respect to the Fourteenth Amendment claims against defendant Smith and **denied** as to the other defendants.

Jury trial is scheduled to commence on October 2, 2023, on the claims against Defendants Ferguson, Banister, Reynolds, Rutan, Everhart, Meyer, Boyd, Stillwell, Davisson, Rodriguez, and Smith.[11] The magistrate judge is requested to convene a settlement conference as soon as practicable in view of the fast-approaching trial date.

IT IS SO ORDERED.

Date: 7/25/2023

SARAH EVANS BARKER, JUDGE
United States District Court
Southern District of Indiana

Distribution:

All Electronically Registered Counsel

Magistrate Judge Kellie Barr

[11] While the Estate's motion for summary judgment is granted as to Officer Smith, the jury will be required to determine the appropriate amount of damages.