Detention and Corrections CASELAW QUARTERLY

Second Interim Supplement for the
25th Edition Detention and Corrections Caselaw Catalog

Issue No. 66

This issue of *Detention and Corrections Caselaw Quarterly* (DCCQ) provides summaries of 63 federal court decisions that were published after the *25th Edition Detention and Corrections Caselaw Catalog (2015)* was released. It serves as the second interim supplement for the 25th Edition, or may be used as a stand-alone review of cases by readers who do not have the *Catalog*.

PART 1 provides complete case summaries in alphabetical order.

PART 2 presents the case summaries according to 50 major topics, using the same organization and format as the *Detention and Corrections Caselaw Catalog*. Cases are presented alphabetically by topic. The left margin identifies the level of court and subtopics for each case summary.

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U.S. Appeals Court
WRONGFUL DEATH
MEDICAL CARE
INTIMIDATION

Estate of Henson v. *Wichita County, Tex.*, 795 F.3d 456 (5th Cir. 2015). The estate of a pretrial detainee who died from chronic obstructive pulmonary disease (COPD) while being held in a county jail brought a § 1983 action against the county, jail physician, and others, alleging violation of the detainee's Fourth and Fourteenth Amendment rights, and asserted claims under state law for negligence and breach of contract. The district court granted in part, and denied in part, the defendants' motions for summary judgment based on qualified immunity. The court of appeals reversed and remanded in part. The physician and county moved for reconsideration. The appeals court granted the motion and the estate appealed. The court held that there was no unstated policy of intimidation at the jail to prevent sending detainees to a hospital, and thus, the doctor could not be liable for alleged enforcement of such a policy. According to the court, the county's multi-tiered health services plan, which provided that the county jail would employ six licensed vocational nurses, rather than registered nurses, and one jail physician, to provide medical care for pretrial detainees, and which did not require the nurses and physician to be present at jail facility at all times, but required them to be available via telephone and regularly present for sick call clinics, and provided that detainees facing emergency situations would be transported to a hospital, did not violate the due process rights of the pretrial detainee who died of chronic obstructive pulmonary disease (COPD) while held at the jail. According to the court, the county's plan was reasonably related to its legitimate interest in providing medical attention to detainees with varying levels of need, and there was no showing that serious injury and death were the inevitable results of the plan. (Wichita County Jail, Texas)

U.S. District Court
PRETRIAL DETAINEE
INADEQUATE CARE
DELIBERATE
INDIFFERENCE

Frary v. *County of Marin*, 81 F.Supp.3d 811 (N.D.Cal. 2015). A deceased detainee's wife, mother, daughter, and estate brought an action against a county and certain county jail employees, alleging that the employees were deliberately indifferent to the detainee's serious medical needs while he was in custody. The defendants moved for summary judgment. The district court granted the motion in part and denied in part. The district court held that summary judgment was precluded by genuine issues of material fact as to: (1) whether a deputy was aware of a substantial risk to the detainee's serious medical needs and disregarded that risk by failing to monitor the detainee more closely; (2) whether another deputy knew of and disregarded an excessive risk to the detainee's health when she failed to ascertain the circumstances of the detainee's prolonged unconsciousness, and when she falsely radioed another deputy falsely suggesting that the detainee had consciously refused breakfast; (3) whether a nurse recognized a serious risk to the detainee's health from ingesting street morphine pills and then failed to take reasonable precautionary steps to protect the detainee from that risk; (4) whether the sheriff's duties with respect to the county jail were causally connected to the alleged violations of the detainee's due process rights; (5) whether the county's policy and practice of indirect monitoring at the county jail was a moving force behind the alleged violation of the detainee's due process rights; and (6) whether the county's failure to implement policies at the county jail about how to monitor detainees with medical needs was the moving force behind the alleged violation of the due process rights of the detainee. The plaintiffs alleged that the Jail's regular practice and operating procedure was only to observe inmates indirectly, using "tower checks" where deputies looked out the tower window to observe the inmates from dozens of feet away, or listening to inmates through intercoms in their cells. (Marin County Jail, California)

U.S. District Court
ALCOHOL/DRUGS
DELIBERATE
INDIFFERENCE
FAILURE TO PROVIDE
CARE
INADEQUATE CARE

M.H. v. *County of Alameda*, 90 F.Supp.3d 889 (E.D. Cal. 2013). Children of a deceased inmate brought a § 1983 action against a doctor, a nurse, prison health services, a county, a sheriff, ten deputies, and a county social worker. The inmate died from anoxic encephalopathy due to cardiac arrest following excessive physical exertion, multiple blunt injuries, and tasering, which occurred while he was incarcerated, and while he was experiencing severe alcohol withdrawal. The defendants moved to dismiss. The district court granted the motions in part and denied in part. The court held that the children sufficiently stated a claim under California law that the nurse was deliberately indifferent to the inmate's medical needs, by alleging that the nurse knew that the inmate was at risk of severe alcohol withdrawal, violated prison and county procedure in failing to attend to his medical needs, and failed to satisfy the medical standard of care, which resulted in substantial harm to the inmate. According to the court, the children also stated valid *Monell* claims by alleging that the doctor's and the prison health services corporation's customs, practices, or lack thereof, constituted deliberate indifference to the prisoners' medical needs, and also stated a claim for supervisory liability. The inmate had broken a food tray in his cell, blocked his toilet, and made a mess of his cell. A deputy allegedly entered his cell alone with a taser in one hand and handcuffs in the other. The deputy tased the inmate for two cycles, or ten seconds, causing the inmate to run for the door, slip on the wet floor, and fall. The children alleged that the deputy and at least nine other deputies then severely beat, punched, kicked, stomped, tased, and brutalized the inmate. The inmate was taken to a hospital where he was found to suffer anoxic brain damage, severe acidosis, several cardiac arrests, and respiratory failure. The inmate died two days later. An autopsy determined that the inmate died from anoxic encephalopathy due to cardiac arrest following excessive physical exertion, multiple blunt injuries, and tasering. (Corizon Health Inc, and Santa Rita Jail, Alameda County Sheriffs' Department, California)