No. _____

In the Supreme Court of the United States

CORRECTIONAL MEDICAL SERVICES, INC.,
Petitioner,

v.

ALMA GLISSON, Personal Representative
of the Estate of NICHOLAS L. GLISSON,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether in this case's *en banc* majority opinion the Seventh Circuit substantially departed from this Court's precedents established by *Monell v. Department of Soc. Servs.*, 436 U.S. 658 (1978), by authorizing the imposition of corporate liability on a prison medical provider under 42 U.S.C. § 1983 and the Eighth Amendment without requiring any evidence of either culpability for deliberate indifference on the part of the provider, or any causal connection between the provider's alleged failure to implement the policy and the deprivation of federal rights?

2. Whether the Seventh Circuit's *en banc* majority opinion and its reliance on cases from the Ninth Circuit and the Third Circuit, which deviate from the requirements of all other federal appellate courts on the standard of municipal liability under 42 U.S.C. § 1983 and the Eighth Amendment established by *Monell v. Department of Soc. Servs.*, 436 U.S. 658 (1978), justifies review by this Court to reconcile those authorities and clarify that standard?

PARTIES TO THE PROCEEDING

The parties to the proceeding in the Seventh Circuit below (App. 1 - App. 41) are: Respondent Alma Glisson, personal representative of the Estate of Nicholas L. Glisson, Plaintiff-Appellant in the proceeding below, and Petitioner Correctional Medical Services, Inc., Defendant-Appellee in the proceeding below.

Additional defendants before the district court but not parties on appeal were the Indiana Department of Correction, Dr. Malaka G. Hermina, and Nurse Mary Combs.

CORPORATE DISCLOSURE STATEMENT

Pursuant to Rule 29.6, Petitioner states as follows:

Petitioner Correctional Medical Services, Inc., now known as "Corizon," is not a publicly held company, and no publicly held company owns 10% or more of Petitioner's stock.

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Included in the Appendix at Exhibit A (App. 1 - App. 41) is the Opinion and Judgment on Rehearing *En Banc* of the U. S. Court of Appeals for the Seventh Circuit, dated February 21, 2017, reversing the U.S. District Court for the Southern District of Indiana's order and entry of summary judgment in favor of Petitioner, and remanding Respondent's claims against Petitioner for trial. That decision is reported at 849 F.3d 372 (7th Cir. 2017).

Included in the Appendix at Exhibit B (App. 42 - App. 72) is the panel decision of the U. S. Court of Appeals for the Seventh Circuit, dated February 17, 2016, affirming the U.S. District Court for the Southern District of Indiana's order and entry of summary judgment in favor of Petitioner. That decision is reported at 813 F.3d 662 (7th Cir. 2016).

Included in the Appendix at Exhibit C (App. 73 - App. 82) is the opinion of the U. S. District Court for the Southern District of Indiana granting summary judgment in favor of Petitioner.

Included in the Appendix at Exhibit D (App. 83 - App. 141) is the U. S. District Court for the Southern District of Indiana's Order on Respondent's motion for reconsideration of entry of summary judgment in Petitioner's favor.

JURISDICTION

The Order on Rehearing *En Banc* of the U. S. Court of Appeals for the Seventh Circuit was entered on February 21, 2017. The jurisdiction of this Court rests upon 28 U.S.C. § 1254.

CONSTITUTIONAL PROVISION INVOLVED

The Eighth Amendment to the United States Constitution, which states: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishments inflicted."

STATUTORY PROVISION INVOLVED

Title 42 of the United States Code, Section 1983, which states:

> "Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory in the District of Columbia, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress."

STATEMENT OF THE CASE

In a scene that is repeated every day in this country's federal, state, and local courts, Nicholas Glisson, then 50 years of age, was sentenced to a period of imprisonment in the Indiana Department of Correction on August 31, 2010, following a conviction for dealing a controlled substance. He died in prison on October 10, 2010. His health history, although detailed, provides important facts underlying the federal courts' rulings in this case.

In October 2003, Mr. Glisson underwent surgery to treat throat cancer involving partial removal of his

jawbone and teeth, removal of his larynx, and a partial pharyngectomy. He was left with a stoma (an opening in the throat), a tracheostomy tube, and a voice prosthesis. He was later treated for non-cancerous lesions on his neck and in his throat. Due to removal of tissue, he developed painful neck contractures which made it difficult for him to hold his head up and use his voice prosthesis. He occasionally wore a neck brace for this problem.

Mr. Glisson also had swallowing problems leading to severe weight loss and malnutrition. He had a gastrojejunostomy tube, or "g-tube," placed in his abdomen for tube feeding. In 2009, he underwent another extensive neck surgery and had recurrent cancerous lesions removed from his palate and tongue. He also had neuropsychological testing which confirmed neurocognitive decline and depression. Mr. Glisson was an alcoholic who continued to drink regularly after his cancer treatment.

Mr. Glisson entered prison on September 3, 2010. During his imprisonment, medical and mental health care was provided by employees of Petitioner Correctional Medical Services, Inc., now known as Corizon, and/or by physicians who independently contracted with Corizon.[1]

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[1] Petitioner was identified as "Correctional Medical Services, Inc.," in the original complaint, and was referred to alternatively as "Correctional Medical Services," "CMS," and "Corizon" in various trial court pleadings and briefs submitted to the Seventh Circuit. In the opinion of the Seventh Circuit on which writ of certiorari is sought, the Court referred to Petitioner as "Corizon." Accordingly, Petitioner refers to itself herein as Corizon.

At the time of Mr. Glisson's imprisonment, the Indiana Department of Correction imposed a Health Care Services Directive on Corizon that provided:

> 1. Offenders with serious chronic health conditions need to receive planned care in a continuous fashion, whether they are transferred within the Department or remain in a single facility. This care should be delivered in a cost-effective manner, with minimal duplication and avoidance of off-site travel when possible.
>
> Care provided to this group of patients should be organized and planned and should be consistent across facility lines. The care itself should be consistent with community standards of practice in Indiana and in correctional settings around the United States.
>
> 2. In general, the organization of chronic disease care should be as follows:
>
> a. A chronic health condition is identified or a diagnosis is made. The diagnosis should be as clear as possible and adequate support for it must be fully documented in the health record. Chronic health conditions should be included on the master problem list.
>
> b. Following identification of a chronic condition, a treatment plan must be established.... While it may not be possible immediately to develop a long-term treatment plan, an initial treatment plan should be made at the time of

> diagnosis and, over time, refined to become a complete individualized treatment plan incorporating activities of all involved disciplines. The treatment plan, including the objectives for care, should be maintained current and act as a table of contents to the treatment provided. As care needs change, the treatment plan should be updated. The treatment plan should be able to serve as a table of contents to the care subsequently provided.
>
> c. Establishment of both the problem list and the treatment plan is the responsibility of the practitioner.
>
> d. Care provided and outcomes should be compared with objectives and goals as defined in the treatment plan. This permits the care providers to determine whether the care provided is successful and to guide care changes as required. The ongoing review of the care provided guides changes in the treatment plan itself.

Mr. Glisson was first housed in the Reception Diagnostic Center in Plainfield, Indiana, where he was assessed by a registered nurse on the day he arrived. His medications, tracheostomy needs, and g-tube were noted. His weight on arrival in prison was 122 pounds. He remained in the Diagnostic Center for 14 days, during which he had frequent interactions with nurses and physicians.

Mr. Glisson was evaluated by a psychiatrist on September 9, 2010, who prescribed an antidepressant. On September 10, 2010, a physician assessed him, identified his diagnoses of hypertension, hypothyroidism, neoplasm of the digestive system, a skin disorder, and documented a treatment plan for chronic pain and malnutrition.

On September 17, 2010, he was transferred to the infirmary at the Plainfield Correctional Facility. After five days, he was transferred to general population. The next day, September 23, 2010, his mental health status changed, and he was returned to the infirmary.

On September 27, 2010, Dr. Malak Hermina examined Mr. Glisson, noted his medical history, and ordered additional lab work and treatment including nutritional supplements. Dr. Hermina assessed him again on September 29, 2010, and noted that his cachexia, or malnutrition, could be the result of recurrence of cancer. In the early afternoon of September 29, 2010, Dr. Hermina reviewed his recent lab results indicating acute renal failure. Dr. Hermina immediately directed that he be transferred by ambulance to Wishard Hospital, where he was treated for the next eight days.

Mr. Glisson returned to the prison infirmary on October 7, 2010. His hospital discharge form identified the following conditions and treatment:

- Acute renal failure with chronic kidney disease, probably caused by Prozac and volume depletion, for which Mr. Glisson had received intravenous fluids and bicarbonate.

- Acute respiratory insufficiency/pneumonia treated with antibiotics.
- Placement of a new voice prosthesis during hospitalization.
- Hypothyroidism, for which Mr. Glisson was re-started on thyroxine.
- Malnutrition, for which the supplements Dr. Hermina had ordered were continued. Mr. Glisson weighed 119 pounds in the hospital.
- Squamous cell carcinoma of the left lateral tongue, which was to be followed up on with an ear, nose and throat specialist as an outpatient.
- Hypertension, for which Mr. Glisson was continued on Lisinopril.
- Chronic pain, for which Mr. Glisson was to continue receiving narcotic pain medication as prescribed in prison.
- Dementia/psych disorder/depression.
- A pressure wound on the sacrum which developed during hospitalization.

Dr. Hermina examined Mr. Glisson in the infirmary on the morning he returned from the hospital and documented compliance with the hospital orders. Dr. Hermina examined him again on the morning of Friday, October 8, 2010, and noted that he was hard to understand and had difficulty with oral intake. Dr. Hermina ordered that he be fed through a g-tube until he could have a speech therapy evaluation the following Monday.

Early on the morning of October 10, 2010, the nursing staff noted that Mr. Glisson had been wandering through the infirmary during the night. Nurse Mary Combs found him in another patient's bed grabbing his lower extremities. She transferred him to a medical isolation room where he could be observed by cameras. At 7:48 a.m., Nurse Combs noted that he was restless. At 8:20 a.m., Nurse Combs noted that she had been alerted by prison staff that he was not moving, and that there was possibly blood on his bed. Nurse Combs observed him sitting on the bed in an upright position with a large ring of brown fluid under his left shoulder on the bed. He was unresponsive and cold, had no reflexes, and had fixed dilated pupils. He was pronounced dead at 8:35 a.m.

The coroner investigated and concluded that Mr. Glisson's death resulted from complications of laryngeal cancer, with contributory chronic renal disease. The coroner also provided medical records to a forensic pathologist who agreed that his death was directly related to throat cancer and laryngectomy.

Respondent Alma Glisson, Mr. Glisson's mother, filed a lawsuit against Corizon, the Department of Correction, Dr. Hermina, and Nurse Combs. Mrs. Glisson alleged that the defendants were deliberately indifferent to Mr. Glisson's serious medical needs, and were accordingly liable for his death under the Eighth Amendment and 42 U.S.C. § 1983. Mrs. Glisson further alleged that the defendants were liable for Mr. Glisson's death under principles of state law medical negligence.

During the course of discovery, Corizon responded to a Request for Production from Mrs. Glisson as follows:

> REQUEST NO. 2: Please produce a copy of all policies, procedures, and/or protocols relied on in developing the course of treatment for Nicholas Glisson.
>
> ANSWER: Objection. This Request is too broadly stated to permit Defendant to provide a meaningful response. A wide range of applicable health care services directives may have been in some way pertinent to some portion of the treatment Mr. Glisson received during his incarceration at IDOC, but would not be relevant to any of the matters at issue in this action. If Plaintiff will provide a more specific description of the types of directives she wishes to review, Defendant will produce copies of any such directives reasonably related to the matters at issue in this action.
>
> Subject to and without waiving any objection, Defendant responds as follows: Mr. Glisson's medical care and treatment at IDOC were based on standards of medical and nursing care, and generally were not dictated by written policies, procedures or protocols. IDOC does implement Health Care Services Directives, but generally none of those directives were relied upon in rendering medical care and treatment to Mr. Glisson. An index of the IDOC Health Care Services Directives is produced herewith. Defendant will consider producing a copy of specific directives identified by Plaintiff which

appear relevant to the care Mr. Glisson received at IDOC.

All defendants moved for summary judgment. In responding to Corizon's motion, Mrs. Glisson argued that the discovery response set forth above constituted an admission that Corizon's care and treatment of Mr. Glisson did not comply with the Health Care Services Directive for offenders with serious chronic health conditions.

The district court entered summary judgment for all defendants on the federal claims, and remanded the state law negligence claims against Corizon, Dr. Hermina, and Nurse Combs to state court for further proceedings. Mrs. Glisson appealed only the federal claims asserted against Corizon. A divided three-judge panel of the Seventh Circuit affirmed the district court.

The Court of Appeals granted Mrs. Glisson's petition for re-hearing *en banc.* A six-judge majority of the Seventh Circuit reversed the entry of summary judgment in Corizon's favor, and concluded that Mrs. Glisson's presentation of some evidence suggesting that Corizon did not comply with the Health Care Services Directive in Mr. Glisson's case was sufficient to support corporate liability under *Monell v. Department of Soc. Servs.*, 436 U.S. 658 (1978) and its progeny. Four judges dissented on the grounds that Mrs. Glisson had presented no evidence of corporate culpability, and no evidence of a causal link between Corizon's alleged failure to comply with the Health Care Services Directive and injury to Mr. Glisson.

REASONS FOR GRANTING THE PETITION

I. THE *EN BANC* MAJORITY OPINION SUBSTANTIALLY DEPARTED FROM THIS COURT'S PRECEDENTS BY AUTHORIZING THE IMPOSITION OF CORPORATE LIABILITY ON A PRISON MEDICAL PROVIDER UNDER 42 U.S.C. § 1983 AND THE EIGHTH AMENDMENT WITHOUT EVIDENCE OF CULPABILITY ON THE PART OF THE PROVIDER, OR EVIDENCE OF A CAUSAL LINK BETWEEN THE PROVIDER'S ACTION AND THE ALLEGED DEPRIVATION OF FEDERAL RIGHTS.

This Court's precedents provide that for a *Monell* claim to advance there must be evidence of institutional fault or culpability, and importantly, a causal connection between an alleged lack of a health care policy and the injury. Such evidence is absent in this case, and the Seventh Circuit *en banc* majority employed an evidentiary threshold which improperly expanded the scope of liability under *Monell*.

A. This Court Has Consistently Required That For A Governmental Entity To Be Found Liable Under § 1983 And *Monell*, A Plaintiff Must Present Evidence Of Both Institutional Culpability And A Causal Link Between The Governmental Policy Or Custom At Issue And A Constitutional Injury To The Plaintiff.

Mrs. Glisson seeks to hold Corizon liable pursuant to § 1983 for the alleged violation of Mr. Glisson's Eighth Amendment right to be free from cruel and

unusual punishment.[2] Under this Court's jurisprudence, a governmental entity may not be held vicariously liable under § 1983 for an injury inflicted solely by its employees or agents. Instead, it is when execution of a government's policy or custom inflicts the injury that the governmental entity is responsible under § 1983. *Monell*, 436 U.S. at 694.

This Court has held that to recover under the Eighth Amendment for insufficient medical care, a prisoner must prove that medical providers were "deliberately indifferent" to a "serious medical need." *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). This Court has described the deliberate indifference standard as requiring the establishment of a "culpable state of mind," and prison officials are only liable under the Eighth Amendment if they have knowledge of and disregard an excessive risk to an inmate's health or safety. *Farmer v. Brennan*, 511 U.S. 825, 837-38 (1994).

Establishing a "culpable state of mind" on the part of a governmental organization that does not simply represent the vicarious imposition of an employee's state of mind on the organization presents a distinct evidentiary challenge. It is also at the core of this case. In *Board of Commissioners of Bryan County v. Brown*, 520 U.S. 397 (1997), this Court observed that to establish municipal liability under *Monell*, it is critical to show that the conduct of the governmental employee

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[2] Corizon, a private entity that provided medical and mental health services to Indiana prisoners pursuant to a contract with the State of Indiana, acknowledges that it should be treated as a governmental entity for the purpose of § 1983.

about which a plaintiff complains actually flowed from either a formally-enacted "policy," or from an accepted or routine "custom" of the governmental entity, and was not merely the result of inadequate judgment or conduct by the employee himself or herself. *Brown*, 520 U.S. at 403-04. Further, merely identifying an official policy or widespread custom is insufficient. In addition, this Court required a causal link to be shown between the policy or custom and the alleged injury:

> The plaintiff must also demonstrate that, through its deliberate conduct, the municipality was the "moving force" behind the injury alleged. That is, a plaintiff must show that the municipal action was taken with the requisite degree of culpability and must demonstrate a direct causal link between the municipal action and the deprivation of federal rights.

Id. at 404.

In *Brown,* this Court acknowledged that in cases in which a single municipal decision led to a plaintiff's harm or injury, *Monell* liability could be established simply by proving that the municipality's decision was itself unconstitutional. *Id.* at 405-06, citing *Owen v. Independence*, 445 U.S. 662 (1980) (city council's censure and discharge of an employee without a hearing was actionable if its conduct were found unconstitutional); *Newport v. Fact Concerts, Inc.*, 453 U.S. 247 (1981) (city council's cancellation of a concert license was actionable if grounds for cancelation were unconstitutional). In *Owen* and *Newport*, the fault or culpability of the municipality was coextensive with the unconstitutional nature of its decision, and causation in both cases was "obvious." *Brown*, 520 U.S. 405-06.

The employee's discharge in *Owen* was a deliberate act which harmed the plaintiff; accordingly, the only question was whether the discharge itself was unconstitutional. The cancellation of the license in *Newport* was a deliberate decision which prevented the plaintiff from putting on the concert; the sole issue was whether the cancellation was unconstitutional. *See also Pembauer v. City of Cincinnati*, 475 U.S. 469, 480-81 (1986) (county prosecutor's instructions concerning obtaining personal service on recalcitrant grand jury witnesses led to violations of plaintiff's rights by court officers who complied with those instructions).

This Court also observed in *Brown* that *Monell* liability may arise in cases involving a municipal policy or custom that is not unconstitutional on its face, but nevertheless causes government employees to violate a plaintiff's constitutional rights. Such cases present "much more difficult problems of proof," however, than situations in which the conduct at issue is facially unconstitutional. *Brown*, 520 U.S. at 406. Cognizant of *Monell*'s elimination of *respondeat superior* as a permissible basis for municipal liability, in *Brown* this Court held that a plaintiff seeking to establish municipal liability on a theory that a facially lawful policy or custom led an employee to violate the plaintiff's rights "must demonstrate that the municipal action was taken with deliberate indifference as to its known or obvious consequences. A showing of simple or even heightened negligence [on the part of the municipality] will not suffice." *Id.* at 407.

In cases preceding *Brown*, this Court held that demonstrating a governmental entity's deliberate indifference to the known or obviously unconstitutional

consequences of a facially lawful policy or custom typically requires a showing that compliance with the challenged policy or custom has led to a *pattern* of unconstitutional conduct by employees which has injured others, in addition to the plaintiff. *E.g., City of Canton v. Harris*, 489 U.S. 378 (1989) (evidence of a pattern of tortious conduct by inadequately trained employees may establish that lack of proper training by the municipality, rather than an employee's negligence or factors peculiar to the particular incident, led to the plaintiff's injury); *City of Oklahoma City v. Tuttle*, 471 U.S. 808, 824 (1985) (Rehnquist, J., plurality op.) (where the policy is not itself unconstitutional, "considerably more proof than the single incident will be necessary in every case to establish both culpability or fault on the part of the municipality, and a causal connection between the "policy" and the constitutional deprivation.") A pattern of constitutional injuries resulting from the policy or custom puts the municipality on notice of the unconstitutional consequences of acting or failing to act, such that a jury may infer that failing to cease the policy or custom constitutes governmental deliberate indifference. As *Brown, City of Canton*, and *Tuttle* demonstrate, where a plaintiff advances only evidence of his or her *own* harm, this Court has generally found no basis for liability under *Monell*.

This Court has recognized that showing a pattern of tortious conduct, in addition to the plaintiff's own harm, is not necessarily the only way to establish *Monell* liability in a case involving a facially lawful policy or custom. In *Brown*, this Court hypothesized that a plaintiff who presents evidence of a single violation of federal rights, accompanied by evidence

that the municipality has failed to train its employees to handle recurrent circumstances that present "an obvious potential for such violation," could support *Monell* liability. 520 U.S. at 409. But this Court cautioned that such liability was available only in a "narrow range of circumstances" in which the evidence demonstrated a "high degree of predictability" that failing to train or equip employees to address certain circumstances would lead to constitutional injury. *Id.* at 409-410. Further, intrinsic to this Court's hypothesis in *Brown* is that there must still be *evidence* demonstrating that predictability, or otherwise satisfying the requirements of corporate culpability – *i.e.*, deliberate indifference to a known probability of harm – and a causal link between the inadequate policy or custom and constitutional harm to the plaintiff.

In sum, the decisions of this Court provide that to prevail on a claim under § 1983 alleging that a facially lawful policy or custom nonetheless causes governmental employees to violate a plaintiff's rights, a plaintiff must present some evidence of culpability on the part of the governmental entity in enacting, adopting, or allowing the policy or custom. The plaintiff must also present evidence of a causal link between the policy or custom and deprivation of the plaintiff's federal rights. And this Court has held unequivocally that if the plaintiff can point to only his or her own injury in support of a *Monell* claim, the claim ordinarily fails. *Brown*, 520 U.S. at 408.

B. At Most, The Evidence In This Case Supports An Inference That Corizon Did Not Implement A Policy Regarding Prisoners With Chronic Care Needs, And Mrs. Glisson Advanced No Evidence Of Culpability And No Evidence Of A Causal Link Between "The Lack Of A Policy" And Mr. Glisson's Death.

Mrs. Glisson contends that by not complying with the Health Care Services Directive concerning chronic health care needs in Mr. Glisson's case, Corizon "lacked a policy" with respect to prisoners with serious chronic health care needs.[3] This claim, along with Mr. Glisson's medical difficulties in prison and the fact of his death, comprise the only evidence Mrs. Glisson advanced in support of her *Monell* claim. Mrs. Glisson did not allege, and the Seventh Circuit did not conclude, that Corizon's alleged "lack of a policy" with

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[3] Corizon does not concede that its employees did not follow the Health Care Services Directive concerning chronic care in Mr. Glisson's case. On summary judgment and in its briefs on appeal, Corizon proffered substantial evidence that the protocols required by the Health Care Services Directive were implemented for Mr. Glisson. Significantly, the Health Care Services Directive does not require any specific diagnostic or treatment approach, and merely requires caregivers to identify chronic medical conditions and routinely document and update treatment plans. The Directive itself states, "The care itself should be consistent with community standards of practice in Indiana and in correctional settings around the United States."

respect to prisoners with serious chronic health care needs was facially unconstitutional.[4]

Assuming that Mrs. Glisson advanced sufficient evidence of a "lack of a policy," Mrs. Glisson was still required to present evidence showing that the alleged "lack of a policy" stemmed from a culpable state of mind, *i.e.* that Corizon persisted in "lacking a policy" with deliberate indifference to a demonstrated risk of constitutional injuries. *Brown*, 520 U.S. at 404. Further, Mrs. Glisson was obligated to present evidence that the alleged "lack of a policy" actually resulted in violations of Mr. Glisson's constitutional rights. This required Mrs. Glisson to present evidence that the alleged inadequacies in Mr. Glisson's prison medical care were the result of the "lack of a policy" for chronic health care needs, and not merely the result of medical negligence on the part of one or more individual employees. *Brown*, 520 U.S. at 403-04.

Mrs. Glisson presented no evidence that any other prisoner had ever been harmed by Corizon's alleged "lack of a policy" concerning chronic health care. Nor did she present evidence that merely providing care and treatment according to medical and nursing standards of care (Corizon's undisputed intent in Mr. Glisson's case), instead of implementing a specifically-articulated policy for prisoners with chronic health care needs, presents an "obvious potential" for

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[4] Noting that Mrs. Glisson claims that Corizon did not rely on any Health Care Services Directives in the course of treating Mr. Glisson, the *en banc* majority specifically stated, "That in itself, of course, does not describe an Eighth Amendment violation." (App. 14).

constitutionally insufficient medical care. Mrs. Glisson presented no evidence suggesting widespread deprivation of needed medical care to prisoners with chronic care needs as a result of Corizon's alleged "lack of a policy."

Mrs. Glisson was also required to present evidence that the "lack of a policy" concerning the treatment of chronic health conditions caused Corizon employees to deprive Mr. Glisson of constitutionally-required medical care.[5] Mrs. Glisson presented expert testimony that some of the individual physicians and nurses were negligent, but this Court has specifically held that evidence of negligence alone is insufficient to support the conclusion that Corizon's "lack of a policy" was the "motivating force" behind any particular aspect of Mr. Glisson's medical care. *Brown*, 520 U.S. at 403-04. Mrs. Glisson did not present evidence linking the alleged "lack of a policy" to any specific inadequacy in Mr. Glisson's care, much less any deprivation of Mr. Glisson's constitutional rights.

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[5] The district court found that neither Dr. Hermina nor Nurse Combs were deliberately indifferent to Mr. Glisson's medical needs. Mrs. Glisson did not appeal this conclusion.

C. Notwithstanding The Absence Of Evidence Of Institutional Fault Or Culpability, And Any Link Between The Alleged "Lack Of A Policy" And Mr. Glisson's Death, The Seventh Circuit Reversed And Remanded For Trial The Constitutional Claims Against Corizon.

The Seventh Circuit filled the evidentiary gap between the record presented to it and a record sufficient to permit Mrs. Glisson's *Monell* claim to survive summary judgment by stating:

> One does not need to be an expert to know that complex, chronic illness requires comprehensive and coordinated care. . . . A jury could further conclude that Corizon had actual knowledge that, without protocols for coordinated, comprehensive treatment, the constitutional rights of chronically ill inmates would sometimes be violated, and in the face of that knowledge it nonetheless "adopt[ed] a policy of inaction." [citation omitted]. Finally, that jury could conclude that Corizon, indifferent to serious risk such a course posed to chronically ill inmates, made a "deliberate choice to follow a course of action . . . from among various alternatives" to do nothing. [citation omitted].

(App. 20). These statements overlook the absence of evidence in the record from which such inferences could reasonably be drawn. The record contains no evidence supporting an inference that complex, chronic illnesses must be addressed by an explicit policy, over and above what is required by standards of medical and nursing care. The record is also barren of any evidence

supporting the conclusion that Corizon knew or should have known that the "lack of a policy" concerning chronic health care needs had led or would probably lead to constitutional violations. As the *en banc* dissent noted:

> No expert testified that the standard of care requires a corporate healthcare provider to promulgate formal protocols on this subject, so the record doesn't even clear the bar for simple negligence. *Monell* liability requires proof of culpability significantly *greater* than simple negligence.

(App. 37).

Moreover, the *en banc* majority did not identify any evidence linking the alleged "lack of a policy" for chronic health care needs to any particular inadequacy in Mr. Glisson's care, or to his death.

The *en banc* majority opinion departs substantially from the evidentiary threshold required by this Court in *Monell, Brown,* and *City of Canton* that is necessary to permit a jury to infer deliberate indifference on the part of a municipality, and to infer that a policy or custom caused the plaintiff's constitutional injury. The *en banc* majority incorrectly read out of this Court's decisions the requirements of institutional fault and causation. The *en banc* majority essentially concluded that because "everybody knows" that prisoners with a serious chronic illness require coordinated care, any evidence of lack of organization of medical care will permit a *Monell* claim to go to a jury. The decision improperly expands the scope of liability under *Monell*: a prisoner may avoid summary judgment merely by

presenting evidence of something other than rigorous adherence to policies and procedures, but no evidence of deliberate indifference to a known risk. Such a substantial departure from this Court's well-established precedent merits review.

II. THE SEVENTH CIRCUIT *EN BANC* MAJORITY HAS JOINED THE NINTH CIRCUIT AND THE THIRD CIRCUIT IN SUBSTANTIALLY DEPARTING FROM THE EVIDENTIARY REQUIREMENTS FOR *MONELL* CLAIMS RECOGNIZED BY THE REMAINING CIRCUITS, CREATING A SIGNIFICANT CONFLICT THAT WARRANTS CLARIFICATION AND RECONCILIATION BY THIS COURT.

The Seventh Circuit *en banc* majority opinion also represents an exceptional and significant departure in the application of *Monell* followed by all but two other federal appeals courts. Five circuits have adhered to the expectation expressed in *Brown* that "single-injury" cases will be very rare, and that plaintiffs are almost always required to demonstrate a pattern of constitutional injuries flowing from an allegedly inadequate policy or custom. Four other circuits have permitted *Monell* claims that do not necessarily present a pattern of injuries to support a jury verdict or survive summary judgment, but only where actual evidence demonstrates institutional knowledge of a risk of constitutional injury posed by the inadequate policy or custom, and evidence linking the policy or custom to the plaintiff's injury.

However, the Ninth and Third Circuits have departed from this Court's *Monell* jurisprudence in a

manner similar to the Seventh Circuit. The *en banc* majority relied on these decisions in eliminating the requirement of evidence of culpability and causation in a *Monell* case. This substantial conflict among the circuits warrants clarification and reconciliation by this Court.

A. The Fourth, Fifth, Sixth, Eighth, And Eleventh Circuits Have Consistently Required Evidence Of A Pattern Of Harm And Causation To Establish *Monell* Liability Based On A Facially Lawful Policy Or Custom.

The Fourth Circuit has explicitly held that a plaintiff "must point to a persistent and widespread practice of municipal officers, the duration and frequency of which indicate that policymakers (1) had actual or constructive knowledge of the conduct, and (2) failed to correct it due to their deliberate indifference." *Owens v. Baltimore City State's Attorney's Office*, 767 F.3d 379, 402 (4th Cir. 2014); *Spell v. McDaniel*, 824 F.2d 1380, 1386-91 (4th Cir. 1987). "Sporadic or isolated violations of rights will not give rise to *Monell* liability; only widespread or flagrant violations will." *Owens*, 767 F.3d at 402.

The Fifth Circuit has employed a similarly high standard. In *Valle v. City of Houston*, 613 F.3d 536 (5th Cir. 2010), the survivors of the victim of a police shooting alleged that the city was liable based in part on the alleged failure to train police in Crisis Intervention Team ("CIT") tactics. The Fifth Circuit analyzed the claim pursuant to a three-part test premised on *Brown* and *City of Canton*: A plaintiff must show that (1) the municipality's training policy or

procedure was inadequate; (2) the inadequate policy was a "moving force" in causing violation of the plaintiff's rights; and (3) the municipality was deliberately indifferent in adopting its training policy. *Valle*, 613 F.3d at 544, citing *Sanders-Burns v. City of Plano*, 594 F.3d 366, 381 (5th Cir. 2010), *Pineda v. City of Houston*, 291 F.3d 325, 332 (5th Cir. 2002).

In *Valle*, the Fifth Circuit acknowledged the "single incident exception" identified in *Brown*, where a plaintiff must prove that constitutional injury is a "highly predictable consequence" of a failure to train, but found that the plaintiffs had not presented sufficient evidence of such predictability. *Id.* at 549. Indeed, the lack of evidence of other constitutional violations stemming from the inadequate CIT training actually mitigated against an inference that the lack of training led to the constitutional violation at issue. *Id.* at 550.

In the Sixth Circuit, a plaintiff must show that the municipal policy at issue was representative of (1) a clear and persistent pattern of illegal activity, (2) which the municipality knew or should have known about, (3) yet remained deliberately indifferent about, and (4) that the municipality's custom was the cause of the deprivation of the plaintiff's constitutional rights. *Bickerstaff v. Lucarelli*, 830 F.3d 388, 402 (6th Cir. 2016); *Thomas v. City of Chattanooga,* 398 F.3d 426, 433 (6th Cir. 2005) (plaintiff may not rely on a single incident to infer a policy of deliberate indifference).

The Eighth Circuit in *Luckert v. Dodge County*, 684 F.3d 808 (8th Cir. 2012), considered a *Monell* claim against the county stemming from a pre-trial detainee's suicide in jail. The plaintiff presented evidence at trial

that the jail had a suicide intervention policy which was not consistently followed. However, the Eighth Circuit held that notwithstanding the evidence of flaws in the jail's practice, the plaintiff had not presented evidence of "the continuing, widespread, persistent pattern of constitutional misconduct" necessary to find the county liable. 684 F.3d at 820, citing *Jenkins v. Cnty. of Hennepin, Minn*, 557 F.3d 628, 634 (8th Cir. 2009), *Mettler v. Whitledge*, 165 F.3d 1197, 1204 (8th Cir. 1999).

The Eleventh Circuit has also explicitly required evidence of a pattern of constitutional injuries to establish *Monell* liability based on a facially lawful policy or custom. In *Craig v. Floyd County,* 643 F.3d 1306 (11th Cir. 2011), the Court considered a set of facts somewhat similar to those of the case at bar. The plaintiff, a pretrial detainee, sought to hold the private company that provided medical services at the county jail liable under *Monell* because of alleged inadequacies in the course of medical care provided to him during nine days in jail. Over nine days in jail, the plaintiff, like Mr. Glisson, was evaluated by various medical professionals. Eventually the plaintiff received a CAT scan of the head which showed injuries requiring surgery. 643 F.3d at 1308-09.

The detainee argued that because several medical employees who evaluated him failed to transfer him to a medical facility outside of the jail for additional treatment, their collective conduct demonstrated corporate deliberate indifference to his serious medical need. *Id.* at 1311. Citing *Tuttle* and *Connick v. Thompson*, 563 U.S. 51 (2011), the Eleventh Circuit disagreed. Because the plaintiff's proof rested on a

"single incident of alleged unconstitutional activity," and because the plaintiff's counsel could not point to another occasion when an alleged policy or custom contributed to or exacerbated an inmate's medical condition, the Court found the plaintiff's evidence insufficient to support *Monell* liability. *Id.* at 1311-12. *See also McDowell v. Brown*, 392 F.3d 1283, 1290-91 (11th Cir. 2004) (evidence that delay in transferring a detainee to the hospital in a timely fashion involved several jail employees did not establish an inadequate policy because delay was an "isolated incident").

It is almost certain that Mrs. Glisson's claim against Corizon would not have survived summary judgment in the Fourth, Fifth, Sixth, Eighth, and Eleventh Circuits. In these circuits, deliberate indifference may only be inferred from evidence of a pattern of constitutional injuries to others resulting from the alleged policy or custom, and the evidence must support an inference of causation to the plaintiff's own injury. Failure to clear these evidentiary hurdles is fatal to a *Monell* claim.

B. The First, Second, Tenth, And District of Columbia Circuits Have Permitted *Monell* Liability Without Evidence Of A Pattern Of Constitutional Injuries, But Only Where Extensive And Reliable Evidence Shows That Risk Of Constitutional Harm Stemming From The Policy Or Custom Was Known Or Obvious To The Municipality, And Only Where The Policy Or Custom Is Causally Linked To The Plaintiff's Injury.

The leading *Monell* case in the First Circuit is *Bordanaro v. McLeod*, 871 F.2d 1151 (1st Cir. 1989), in

which police officers brutally beat bar patrons after an altercation between an off-duty officer and another patron, leading to injuries and the deaths of some patrons. Although the First Circuit in *Bordanaro* did not explicitly insist on evidence of a pattern of constitutional injuries, the trial record contained extensive evidence of previous brutal conduct by the police which provided the foundation for the Court's conclusion that the events complained of were "standard operating procedure" in the department. The evidence gave rise to the strong inference that such conduct was known to, if not expected by, the ultimate policymaker. On such an extensive evidentiary record, *Monell* liability was well-grounded. 871 F.2d at 1158-1162.

More recently, the First Circuit has affirmed *Monell* liability in the absence of specific evidence of a pattern of constitutional injury, but only upon an evidentiary record showing that constitutional injury was an "obvious" risk or "highly predictable consequence" of a municipality's policy or custom. *Young v. City of Providence*, 404 F.3d 4 (1st Cir. 2005). The Court in *Young* acknowledged that liability without a pattern may be found where a violation of a federal right is a "highly predictable consequence of a failure to equip law enforcement officers with specific tools to handle recurring situations." 404 F.3d at 7, citing *Brown*, 520 U.S. at 409. Based on testimony at trial, the Court concluded that the evidence could support a jury finding that a friendly-fire shooting of an off-duty police officer was a "predictable consequence" of the department's failure to train, notwithstanding the absence of other shootings. *Id.*

With respect to causation, the Court noted that the jury found that one of the defendant officers acted in an objectively unreasonable fashion in connection with the shooting. This finding, alongside the evidence regarding the inadequacy of the officer's training, comprised sufficient evidence for the jury to conclude that appropriate training "would have made a difference here." *Id.* at 29.

The Second Circuit has also affirmed *Monell* liability on evidence that constitutional injury was an "obvious" risk or "highly predictable consequence" of a municipality's policy or custom. *Cash v. County of Erie*, 654 F.3d 324 (2d Cir. 2010), citing *Walker v. City of New York*, 974 F.2d 293, 297-98 (2d Cir. 1992). In *Cash*, the Second Circuit recognized that while a pattern of harm is usually required, the plaintiff's presentation of a report known to the sheriff concerning disputed sexualized interactions between a female detainee and jail staff, as well as plaintiff's presentation of an expert witness who testified that the report should have served as a "red light" that the county's policies were inadequate, comprised sufficient evidence to permit a jury to infer municipal deliberate indifference. *Cash*, 654 F.3d at 338.

Notwithstanding *Cash*, the Second Circuit has continued to subject *Monell* claims to a high standard of evidence, as demonstrated in its unpublished opinion in *Dickerson v. Prison Health Servs.*, 495 Fed. Appx. 154 (2d Cir. 2012) (prisoner's claim of sexual abuse by a prison physician rejected because the plaintiff "adduced no evidence that the City was alerted either to a general risk of sexual exploitation from having unchaperoned inmates of one sex examined by doctors

of another sex or to a specific risk associated with" the physician at issue, 495 Fed. Appx. at 157).

The Tenth Circuit has also affirmed *Monell* liability on the grounds that a risk of constitutional harm was "obvious," or known to policymakers "to a moral certainty," and that such knowledge could be established by evidence that is not necessarily limited to a pattern of constitutional injuries, but only upon an extensively-developed evidentiary record showing that governmental policymakers knew of risks of constitutional injury and took inadequate steps to address those risks. *Simpson v. Univ. of Colo. Boulder*, 500 F.3d 1170, 1181-1185 (10th Cir. 2007).

In *Smith v. District of Columbia*, 413 F.3d 86 (D.C. Cir. 2005), the District of Columbia Circuit held the District liable under *Monell* where it had failed to establish standards for selecting independent living programs for placement of at-risk youth, leading to a situation in which children "could be sent to totally inappropriate programs run by unqualified counselors and located in unsafe areas," risks that "were realized" when a substandard provider "failed to react to the murder of one youth and the armed robbery of another." Although the plaintiff did not show a pattern of other harms, she pointed to a licensure statute which required the District to implement certain policies for at-risk youth programs. The Court held that the statute placed the District on notice of the risk of harm associated with failure to comply with its provisions, and permitted an inference that failure to comply constituted deliberate indifference. *Id.* at 100.

More recently, however, the District of Columbia Circuit has reaffirmed that to establish *Monell* liability, there must usually be evidence of a pattern of constitutional harm. *Robinson v. Pezzat,* 818 F.3d 1 (D.C. Cir. 2016). In affirming summary judgment in favor of a police department under *Monell*, the Court held that a pattern of similar constitutional violations is ordinarily necessary to demonstrate deliberate indifference. 818 F.3d at 12.

These decisions demonstrate that while the First, Second, Tenth, and District of Columbia Circuits have found liability under *Monell* without specific evidence of a pattern of constitutional injuries, they nonetheless require actual evidence showing that the constitutional risk was "obvious" or "morally certain" to be known by municipal policymakers, and that the plaintiff's harm was a result of the policy or custom at issue. Because of the absence of such evidence in the case at bar, Mrs. Glisson's *Monell* claim would fail as a matter of law in these circuits as well.

C. The Ninth Circuit Has Affirmed *Monell* Liability Without Evidence Of Either A Pattern Of Constitutional Harm Or "Obvious" Constitutional Harm Posed By The Policy Or Custom.

The Ninth Circuit has permitted a *Monell* claim to go forward without evidence of either a pattern of constitutional harm or any "obvious" or "highly predictable" risk of constitutional harm which may be imputed to the municipal defendant. In *Long v. City of Los Angeles*, 442 F.3d 1178 (9th Cir. 2006), plaintiff's decedent died eighteen days into a 120-day jail sentence. His estate asserted municipal liability

against the county based on its alleged failure to implement certain medical policies. 442 F.3d at 1181. Reversing a grant of summary judgment for the county, the Ninth Circuit did not consider whether evidence of a pattern of constitutional injuries, or evidence showing that the risk of constitutional harm was "obvious" or "known to a moral certainty" to county policymakers, had been presented. Instead, the Ninth Circuit stated that plaintiff had presented declarations of experts who gave the opinion that jail nurses were not sufficiently trained, and that insufficiencies in various medical policies evidenced "deliberate indifference." *Id.* at 1189. Without detailing the facts that permitted a jury to infer municipal culpability, the Court concluded that the conclusory statements by experts created "triable issues" as to deliberate indifference. *Id.* at 1190. Similarly, without exploring or explaining how the inadequate custom or policy was a "moving force" behind the death, the Court found that there was a "triable issue" as to causation. *Id.* at 1191.

The Seventh Circuit *en banc* majority in this case relied in part on the *Long* opinion for the undisputed principle that a municipality may be held liable for "a policy of action or inaction." (App. 17). Unlike in *Long*, however, Mrs. Glisson presented no evidence from which a finder of fact could infer deliberate indifference from Corizon's purported lack of a policy addressing the treatment of chronic conditions.

D. The Third Circuit Has Permitted *Monell* Liability Where There Is No Evidence Of A Pattern Of Constitutional Injuries And No Evidence, Other Than The Court's Own Judgment, That The Risk Of Constitutional Injury Was "Obvious."

In *Natale v. Camden Cnty. Corr. Facility*, 318 F.3d 575 (3rd Cir. 2003), the plaintiff, an insulin-dependent diabetic, did not receive his insulin while jailed and suffered a stroke two days later. 318 F.3d at 578. The plaintiff pursued a *Monell* claim against the prison medical provider, and the district court granted summary judgment based on the lack of evidence of a custom or practice of ignoring detainees' medication needs. *Id.* at 580. Reversing the district court, the Third Circuit relied on testimony from an employee nurse suggesting that the provider had no policy ensuring that an inmate having a need of medication for a serious medical condition would be given that medication during the first 72 hours of his incarceration. Based solely on this testimony, the Court held that a jury could reach a wide range of inferences on which the defendant could be found liable under *Monell*. *Id.* at 584-85.

The Third Circuit in *Natale* required no evidence that the provider knew, or had any reason to know, that the challenged practices had caused or were highly likely to cause constitutional injuries, as required by *Brown*, *City of Canton*, and *Tuttle*. The Court simply exercised its own judgment, in place of such evidence, to find that a policy that created the risk that detainees might not receive medications for up to 72 hours

permitted an inference that the provider was deliberately indifferent.

In adopting a similar approach in this case, the Seventh Circuit *en banc* majority rested its holding on *Natale*. (App. 17-18). Like the Third Circuit in *Natale*, the Seventh Circuit *en banc* majority expressed its own judgment about the "obvious" nature of the risk of lack of coordination in providing medical care to prisoners with chronic illness, instead of requiring Mrs. Glisson to present actual evidence of the risk of harm and Corizon's actual or imputed knowledge of that risk. This approach sets an improperly low evidentiary threshold for *Monell* claims.

E. Clarification Of The Evidentiary Requirements For Municipal Liability Under 42 U.S.C. § 1983 And The Eighth Amendment Under *Monell* And Reconciliation Of That Requirement Among The Federal Appellate Circuits Are Warranted.

The Seventh, Third, and Ninth Circuits have departed substantially from this Court's prior cases on the evidentiary threshold that must be met to advance a *Monell* claim past summary judgment. Such a claim alleging that a facially lawful policy or custom has caused an unconstitutional injury requires evidence that the municipality knew or should have known that its policy or custom would or had caused constitutional injury, and evidence that the plaintiff suffered a constitutional injury as a result of the policy or custom. Evidence supporting an inference that a governmental entity was deliberately indifferent to a risk of constitutional injury naturally requires evidence of

notice to the entity that such a risk exists. This Court in *City of Canton* specifically required that a governmental entity be "on notice":

> Without some form of notice to the city, and the opportunity to conform to constitutional dictates both what it does and what it chooses not to do, the failure to train theory of liability could engulf *Monell*, imposing liability without regarding to fault.

489 U.S. at 395. In *Tuttle*, this Court required more than a single incident. 471 U.S. at 821. This Court's precedents provide that injury without more is insufficient to prove fault and causation. A pattern of constitutional injuries traceable to a policy or custom is required. Only then can the inference arise that the governmental entity was "on notice" of the need to alter or amend its policy or custom.

As highlighted in the *en banc* dissent, the majority opinion deviates from this Court's precedents establishing that evidence demonstrating notice of the risk of constitutional injury and a causal connection between the policy or custom to the plaintiff's harm, is required before *Monell* liability attaches. (App. 28-30). Moreover, the survey above of federal appellate case law shows that when the Seventh Circuit *en banc* majority relied on the Third and Ninth Circuit cases described above, rather than authority from the remaining federal appellate circuits, the Seventh Circuit departed substantially from this Court's evidentiary requirements for municipal culpability. By doing so, the *en banc* majority opinion has abandoned the institutional fault and causation requirements of this Court's decisions in *Brown* and other *Monell* cases.

A liability standard for *Monell* cases – which effectively eliminates the requirements of notice, institutional fault, and causation – impermissibly blurs the distinction between corporate culpability and mere vicarious liability. *See en banc* dissent. (App. 38).

Given the large number of actions filed each year alleging *Monell* violations against governmental entities, the standard for liability in such cases should be clear and uniform. The *en banc* majority and dissenting opinions well ventilate the opposing arguments as to the liability standard, rendering this case an excellent vehicle for clarifying this important area of constitutional law.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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May 22, 2017

APPENDIX

APPENDIX

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APPENDIX A

IN THE
UNITED STATES COURT OF APPEALS
THE SEVENTH CIRCUIT

No. 15-1419

[Filed February 21, 2017]

ALMA GLISSON, Personal Representative of the Estate of NICHOLAS L. GLISSON, *Plaintiff-Appellant*,

v.

INDIANA DEPARTMENT OF CORRECTIONS, *et al.*, *Defendants-Appellees*.

Appeal from the United States District Court for the Southern District of Indiana, Indianapolis Division.
No. 1:12-cv-1418-SEB-MJD —
Sarah Evans Barker, *Judge*.

ARGUED SEPTEMBER 7, 2016 —
DECIDED FEBRUARY 21, 2017

Before WOOD, *Chief Judge*, and BAUER, POSNER, FLAUM, EASTERBROOK, KANNE, ROVNER, WILLIAMS, SYKES, and HAMILTON, *Circuit Judges*.

WOOD, *Chief Judge*. Nicholas Glisson entered the custody of the Indiana Department of Corrections on September 3, 2010, upon being sentenced for dealing in a controlled substance (selling one prescription pill to a friend who turned out to be a confidential informant). Thirty-seven days later, he was dead from starvation, acute renal failure, and associated conditions. His mother, Alma Glisson, brought this lawsuit under 42 U.S.C. § 1983. She asserts that the medical care Glisson received at the hands of the Department's chosen provider, Correctional Medical Services, Inc. (known as Corizon) violated his rights under the Eighth Amendment to the U.S. Constitution (made applicable to the states by the Fourteenth Amendment). A panel of this court concluded that Corizon was entitled to summary judgment in its favor. See *Glisson v. Indiana Dep't of Corr.*, 813 F.3d 662 (7th Cir. 2016). The court decided to rehear the case *en banc* in order to examine the standards for corporate liability in such a case. We conclude that Glisson presented enough evidence of disputed, material issues of fact to proceed to trial, and we therefore reverse the district court's judgment.

I

There is no doubt that Glisson had long suffered from serious health problems. He had been diagnosed with laryngeal cancer in 2003. In October of that year, he had radical surgery in which his larynx and part of his pharynx were removed, along with portions of his mandible (jawbone) and 13 teeth. He was left with a permanent stoma (that is, an opening in his throat), into which a tracheostomy tube was normally inserted. He needed a voice prosthesis to speak.

And that was not all. Glisson's 2003 surgery and follow-up radiation left his neck too weak to support his head; this in turn made his head slump forward in a way that impeded his breathing. Because physical therapy and medication for this condition were ineffective, he wore a neck brace. He also developed cervical spine damage. In 2008 doctors placed a gastrojejunostomy tube ("G-tube") in his upper abdomen for supplemental feeding. In addition to the problems attributable to the cancer, Glisson suffered from hypothyroidism, depression, and impairments resulting from his smoking and excessive alcohol use. Finally, there was some evidence of cognitive decline.

Despite all this, Glisson was able to live independently. He learned to clean and suction his stoma. With occasional help from his mother, he was able to use his feeding tube when necessary. He was able to swallow well enough to take his food and other supplements by mouth most of the time. His hygiene was fine, and he helped with household chores such as mowing the lawn, cleaning, and cooking. He also provided care to his grandmother and his dying brother.

The events leading up to Glisson's death began when a friend, acting as a confidential informant for the police, convinced Glisson to give the friend a prescription painkiller.[1] Glisson was charged and

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[1] It is not entirely clear from the record on appeal when this offense took place. Glisson's arrest record indicates that he was arrested for dealing in a controlled substance on July 31, 2007, and was released the same day on a $25,000 bond. The next entry is on August 31, 2010—the day he was sentenced and entered custody.

convicted for this infraction, and on August 31, 2010, he was sentenced to a period of incarceration and transferred to the Wayne County Jail. (All relevant dates from this point onward were in 2010.) Before sentencing, Dr. Richard Borrowdale, one of his physicians, wrote a letter to the court expressing serious concern about Glisson's ability to survive in a prison setting. Dr. Borrowdale noted Glisson's severe disabilities from cancer and alcohol dependence, his difficulty speaking because of the laryngectomy, his trouble swallowing, his severe curvature of the spine (kyphosis), and his problems walking. The conclusion of the letter was, unfortunately, prophetic: "This patient is severely disabled, and I do not feel that he would survive if he was incarcerated." Dr. William Fisher, another of Glisson's physicians, also warned that Glisson "would not do well if incarcerated."

Many of Glisson's disabilities were apparent at a glance, and his family tried to prepare him (and his custodians) for his incarceration. They brought his essential supplies, including his neck brace and the suction machine, mirror, and light that he used for his tracheostomy, to the Jail. When he was transferred on September 3 to the Reception Diagnostic Center of the Indiana Department of Corrections ("INDOC"), the Jail sent along his mirror, light, and neck brace. It is unclear what happened next to these items, but Glisson never received the neck brace, nor was he given a replacement.

The sentencing information sheet gives him one day's credit for jail time. It thus appears that the incarceration at issue in this case was based on this three-year-old arrest

At INDOC's Diagnostic Center, Glisson first came under Corizon's care, when upon his arrival Nurse Tim Sanford assessed his condition. Sanford recorded Glisson's account of his medication regimen and noted that Glisson appeared to be alert and able to communicate. Sanford noted that Glisson had a tracheostomy that had to be suctioned six times a day, and that Glisson had a feeding tube but that he took food through it only when he had difficulty swallowing. While Glisson was at the Diagnostic Center, medical personnel noted occasional problems with his blood pressure, pulse, and oxygen saturation level, as well as some signs of confusion and anger.

Several different medical providers saw Glisson while he was at the Diagnostic Center: Drs. Jill Gallien and Steven Conant (a psychiatrist); Nurses Rachel Johnson, Carla DeWalt, and Victoria Crawford; and mental health counselor Mary Serna. In addition, Health Services Administrator Kelly Kurtz contacted Glisson's mother to ask about his medical history and his behavior at home. Her inquiry was the only one that occurred throughout Glisson's incarceration, and there is no evidence that Mrs. Glisson's response (that Glisson did not behave oddly at home) was communicated to anyone else.

Ultimately the Diagnostic Center decided to place Glisson in INDOC's Plainfield Correctional Facility. Glisson was transferred there on September 17; an intake examination performed by Licensed Practical Nurse (LPN) Nikki Robinson revealed that he weighed 119 pounds and had normal vital signs. On September 21, Dr. James Mozillo ordered Glisson to be placed in the general population with a bottom-bunk pass.

Upon reaching Plainfield, Glisson's medical care—again furnished by Corizon—began to resemble the blind men's description of the elephant. A host of Corizon providers at Plainfield had a hand in Glisson's treatment. As far as we can glean from the record, they include the following: Drs. Malak Hermina (the lead physician at Plainfield), Mozillo, and Conant (again); Director of Nursing Rhonda Kessler; Registered Nurses (RNs) Mary Combs, Carol A. Griffin, Melissa Pearson, and Jennifer Hoffmeyer; LPNs Robinson, Allison M. Ortiz, and Paula J. Kuria; and mental health professional Catherine Keefer. Andy Dunnigan, Plainfield's Health Services Administrator, also played some part. We assume for the sake of argument here that none of these people, and none of the individual providers at the Diagnostic Center, personally did anything that would qualify as "deliberate indifference" for Eighth Amendment purposes. Most of them had so little to do with Glisson that such a conclusion is quite unlikely. The question before us is instead whether, because of a deliberate policy choice pursuant to which no one was responsible for coordinating his overall care, Corizon itself violated Glisson's Eighth Amendment rights.

Predictably, given the number of actors, Glisson's care over the first few weeks of his residence at Plainfield was disjointed: no provider developed a medical treatment plan, and thus no one was able to check Glisson's progress against any such plan. In fact, for his first 24 days in INDOC custody (including the time at the Diagnostic Center), no Corizon provider even reviewed his medical history. Granted, before Glisson arrived at Plainfield, Dr. Gallien had requested his medical history on September 10. But there is no

evidence that anyone responded to this request. Indeed, no one at the Center followed up, nor did anyone at Plainfield do anything until September 27, when Dr. Hermina saw Glisson and asked for the records; he received them within several hours.

At that visit, Dr. Hermina made an alarming observation about Glisson's weight. As we noted, when Glisson arrived at Plainfield he weighed only 119 pounds. On September 27, Dr. Hermina noted that Glisson appeared cachectic, which means undernourished to the point that the person has physical wasting and loss of weight and muscle mass—in a word, he is starving. See MedicineNet, Definition of Cachectic, http://www.medicinenet.com/script/main/art.asp?articlekey=40464 (last visited on February 21, as were all websites cited in this opinion). Although the medical personnel at the Diagnostic Center had ordered the nutritional supplement Ensure for Glisson, and apparently that order carried over to Plainfield, Dr. Hermina ordered a second nutritional supplement, Jevity. Remarkably, it appears that he did not weigh Glisson—at least, there is no record of a September 27 weight. He did, however, review Glisson's earlier lab work, which showed anemia and high creatinine (a sign of impaired kidney function). Later that day, Dr. Hermina reviewed the medical records he had just received and learned that Glisson suffered from (among other things) kyphosis and back pain (for which he was treated with the opioids OxyContin and Oxycodone), gastroparesis (partial paralysis of the stomach), neck pain, and several mental conditions (depression, poor memory, mild cognitive decline).

As time went on, along with the physical problems of cachexia, renal decline, and neck weakness (in part attributable to the fact that no one ever gave him his neck brace), Glisson's mental status was deteriorating. Dr. Hermina wondered if Glisson belonged in the psychiatric unit at a different prison, but he displayed no awareness of the fact that Dr. Conant had just conducted a mental-health evaluation on Glisson on September 23. Dr. Conant's findings were worrying, but no one connected them with any of the physical data on file, such as Glisson's tendency to have inadequate oxygen profusion and his cachexia. Dr. Conant found that Glisson was restless, paranoid, delusional, hallucinating, and insomniac. He placed Glisson under close observation and settled on a diagnosis of unspecified psychosis; he saw no need for medication. (This too is odd: Glisson was actually already on psychotropic medications; while at Plainfield he was abruptly switched from Effexor to Prozac without any evaluation, weaning, or monitoring. The two drugs work quite differently, and Dr. Diane Sommer, the expert retained by Glisson's estate, concluded that "[t]his abrupt change in medication contributed to [Glisson's] acute decline in function.")

Had Dr. Conant looked at something resembling a complete chart, he would have seen that Glisson had no history of psychosis, and he might have considered, as the post-mortem experts did, the more obvious possibility that lack of oxygen and food was affecting Glisson's mental performance. Dr. Conant noted that Glisson had been experiencing hallucinations, which the doctor thought were caused by morphine. This observation was reached in an information vacuum. In fact, as the medical records Dr. Hermina reviewed just

days later show, Glisson had been on narcotic medication without adverse effects for quite a while prior to his incarceration. Had Dr. Conant known of Glisson's medical history, he would have known that morphine was an unlikely cause for the hallucinations and he would have looked further.

The Corizon providers never took any steps to integrate the growing body of evidence of Glisson's malnutrition with his overall mental and physical health. The physical signs were clear even before he arrived at Plainfield. On September 4, Glisson's urinalysis results showed the presence of ketones and leukocytes. Dr. Sommer's report notes that "[k]etones suggest the presence of other medical conditions such as anorexia, starvation, acute or severe illness and hyperthyroidism to name a few." The Corizon staff at the Diagnostic Center did nothing to address either potential problem, even though a second urine sample taken on September 5 showed an increase in ketones and leukocytes. No physician reviewed either of those lab results, despite the fact that a note dated September 5 says that Glisson was not eating and seemed confused. Rather than probing the signs of infection, starvation, and dehydration further, the staff opted to put Glisson in the psychiatric unit under suicide watch.

The blood work at the Center continued to raise red flags. On September 9, it came back with signs of abnormal renal function. Although Glisson met with Dr. Gallien the next day, no one looked at the bloodwork until ten days after Glisson's transfer to Plainfield, at his September 27 visit with Dr. Hermina. At that point, Dr. Hermina ordered fasting labs for

September 28. When the results were returned on September 29, they showed acute renal failure—information that prompted Dr. Hermina to send Glisson immediately to Wishard Hospital. Taking the facts favorably to Glisson, the record indicates that he was already slipping into renal distress as early as September 4 or 9, and that the uncoordinated care Corizon furnished was a central cause for the increasing acuteness of his condition.

Glisson was discharged from Wishard and returned to Plainfield shortly after midnight on October 7. The discharge summary included the following diagnoses:

- Acute renal failure/acidosis/hyperkalemia on top of chronic kidney disease
- Acute respiratory insufficiency/pneumonia
- Tracheoesophageal voice prosthesis replacement
- Hypothyroidism
- Malnutrition
- Squamous cell carcinoma of left lateral tongue
- Hypertension
- Chronic pain
- Dementia/psychological disorder/depression
- Pressure wound on the sacrum

The morning after Glisson's return, Dr. Hermina saw him and reviewed the Wishard summary. He ordered the continuation of the medications prescribed at Wishard. RN Griffin saw him later that day, and the

next day both Dr. Hermina and several nurses saw him. LPN Ortiz noted that he did not eat any of his breakfast. In fact, Dr. Hermina had ordered G-tube feeding only (which does not seem to have happened), and so it is not clear why he had a tray.

On October 10, around 6:00 a.m., RN Combs was told that Glisson had been wandering about in a disoriented way. She tried to talk to him, but he apparently did not understand her. At 8:30 a.m., the staff notified RN Combs that Glisson was not moving and that there seemed to be blood in his bed. She found him unresponsive and called 911. The emergency team responded, and he was pronounced dead at 8:35 a.m.

The county coroner, Joseph Neuman, concluded that the cause of Glisson's death was complications from laryngeal cancer, with contributory chronic renal disease. He also observed that Glisson had extreme emaciation and cachexia. He then asked Dr. Steven Radentz, a forensic pathologist, to render a more detailed opinion. Dr. Radentz agreed with Neuman's overall assessment and added that Glisson's rapid-onset altered mental state could have resulted from hypoxia (insufficient oxygen saturation) and acute renal failure. Complications from laryngeal cancer include, Dr. Radentz said, aspiration pneumonia, acute renal failure, and hyperkalemia (elevated blood potassium, which can lead to cardiac arrest, see MedicineNet, Definition of Hyperkalemia, http://www.medicinenet.com/hyperkalemia/article.htm).

II

Alma Glisson filed this suit in state court in her capacity as Personal Representative of Glisson's Estate. She raised claims under both state law and 42 U.S.C. § 1983 against several of the doctors and nurses who were involved in Glisson's care, against INDOC, and against Corizon. The district court granted summary judgment in favor of the defendants on all of her federal claims, and it remanded the state-law claims to the state court. See *Glisson v. Indiana Dep't of Corr.*, No. 1:12-cv-1418-SEB-MJD, 2014 WL 2511579 (S.D. Ind. June 4, 2014). On appeal, Mrs. Glisson has limited her arguments to her claim against Corizon. As noted earlier, a panel of this court ruled that Mrs. Glisson failed to present enough evidence to defeat summary judgment in Corizon's favor. That conclusion rested on both a legal conclusion about what it takes to find an entity such as Corizon liable, as well as the characterization of the facts in the summary judgment record.

It is somewhat unusual to see an Eighth Amendment case relating to medical care in a prison in which the plaintiff does not argue that the individual medical provider was deliberately indifferent to a serious medical need. See *Estelle v. Gamble*, 429 U.S. 97 (1976); *Farmer v. Brennan*, 511 U.S. 825 (1994). But unusual does not mean impossible, and this case well illustrates why an organization might be liable even if its individual agents are not. Without the full picture, each person might think that her decisions were an appropriate response to a problem; her failure to situate the care within a broader context could be at worst negligent, or even grossly negligent, but not

deliberately indifferent. But if institutional policies are themselves deliberately indifferent to the quality of care provided, institutional liability is possible.

Ever since the Supreme Court decided *Monell v. New York City Dep't of Soc. Servs.*, 436 U.S. 658 (1978), the availability of entity liability under section 1983 has been established. This rule is not limited to municipal corporations, although that was the type of entity involved in *Monell* itself. As we and our sister circuits recognize, a private corporation that has contracted to provide essential government services is subject to at least the same rules that apply to public entities. See, *e.g.*, *Shields v. Illinois Dep't of Corr.*, 746 F.3d 782, 789–90 (7th Cir. 2014); *Iskander v. Vill. of Forest Park*, 690 F.2d 126, 128 (7th Cir. 1982); *Rojas v. Alexander's Dep't Store, Inc.*, 924 F.2d 406, 408–09 (2d Cir. 1990); *Harvey v. Harvey*, 949 F.2d 1127, 1129–30 (11th Cir. 1992) (citing cases); *Street v. Corr. Corp. of Am.*, 102 F.3d 810, 818 (6th Cir. 1996). (We questioned in *Shields* whether private corporations might also be subject to *respondeat superior* liability, unlike their public counterparts, see 746 F.3d at 790–92, but we have no need in the present case to address that question and we thus leave it for another day.)

The critical question under *Monell*, reaffirmed in *Los Angeles Cnty. v. Humphries*, 562 U.S. 29 (2010), is whether a municipal (or corporate) policy or custom gave rise to the harm (that is, caused it), or if instead the harm resulted from the acts of the entity's agents. There are several ways in which a plaintiff might prove this essential element. First, she might show that "the action that is alleged to be unconstitutional implements or executes a policy statement, ordinance,

regulation, or decision officially adopted and promulgated by that body's officers." *Humphries*, 562 U.S. at 35 (quoting *Monell*, 436 U.S. at 690). Second, she might prove that the "constitutional deprivation[] [was] visited pursuant to governmental 'custom' even though such a custom has not received formal approval through the body's official decisionmaking channels." *Monell*, 436 U.S. at 690–91. Third, the plaintiff might be able to show that a government's policy or custom is "made … by those whose edicts or acts may fairly be said to represent official policy." *Id.* at 694. As we put the point in one case, "[a] person who wants to impose liability on a municipality for a constitutional tort must show that the tort was committed (that is, authorized or directed) at the policymaking level of government … ." *Vodak v. City of Chicago*, 639 F.3d 738, 747 (7th Cir. 2011). Either the content of an official policy, a decision by a final decisionmaker, or evidence of custom will suffice.

The central question is always whether an official policy, however expressed (and we have no reason to think that the list in *Monell* is exclusive), caused the constitutional deprivation. It does not matter if the policy was duly enacted or written down, nor does it matter if the policy counsels aggressive intervention into a particular matter or a hands-off approach. One could easily imagine either kind of strategy for a police department: one department might follow a policy of zero-tolerance for low-level drug activity in a particular area, arresting every small-time seller; while another department might follow a policy of by-passing the lower-level actors in favor of a focus on the kingpins. The hands-off policy is just as much a "policy" as the 100% enforcement policy is.

Mrs. Glisson asserts that Corizon had a deliberate policy not to require any kind of formal coordination of medical care either within an institution (such as the Diagnostic Center or Plainfield) or across institutions for prisoners who are transferred. This is not the same as an allegation that Corizon was oblivious to the entire issue of care coordination. Read fairly, she is saying that Corizon consciously decided *not* to include this service, not that it had never thought about the issue and thus had nothing that could be called a policy.

In some cases, it may be difficult to tell the difference between inadvertence and a policy to omit something, but on the facts presented by Mrs. Glisson, this is not one of them. INDOC has Chronic Disease Intervention Guidelines, which explain what policies its health-care providers are required to implement. Healthcare Directive HCSD-2.06 states that each facility must adopt instructions for proper management of chronic diseases, and it spells out what those instructions should address. Among other things, it calls for "planned care in a continuous fashion" and care that is "organized and … consistent across facility lines." It specifically mandates a treatment plan for chronic cases—both an initial plan and one that is updated as care needs change. In the face of this directive, which appeared *seven years* before Glisson showed up in prison, Corizon consciously chose not to adopt the recommended policies—not for Glisson, not for anyone. As relevant to Glisson's case, it admitted that his care at INDOC was based only on general standards of medical and nursing care, not on any "written policies, procedures, or protocols." It relied on

none of the Health Care Service Directives in the course of his treatment.

That in itself, of course, does not describe an Eighth Amendment violation. Nothing in the U.S. Constitution required Corizon to follow INDOC's policies. The point is a more subtle one: the existence of the INDOC Guidelines, with which Corizon was admittedly familiar, is evidence that could persuade a trier of fact that Corizon consciously chose the approach that it took. That approach itself may or may not have led to a constitutional violation. Suppose, for instance, that the state guidelines call for a primary-care physician to coordinate all care, both basic and specialized, and a company such as Corizon decides to ignore the guidelines and instead to hire hospitalists to coordinate care. This would represent a conscious policy choice, but in all likelihood one that does not violate any inmate's constitutional rights. Moving closer to the facts of this case, it is also possible that a health-care provider's deliberate policy choice not to implement the state's guidelines does not lead to dire results. Some guidelines may be foolish or ineffective. A decision not to implement them would be a deliberate policy choice, but in such a case not one that gave rise to an Eighth Amendment violation.

Other courts have endorsed the distinction we are drawing in their decisions. For example, in *Long v. Cnty. of Los Angeles*, 442 F.3d 1178 (9th Cir. 2006), an elderly man reported to the county jail to begin serving a 120-day sentence. At that time, as his attorney informed the Director of the Jail Medical Services Division, he weighed more than 350 pounds and was suffering from congestive heart failure (among other

ailments). He had been under the care of a doctor affiliated with the Department of Veterans Affairs. During the ensuing 18 days, he received uncoordinated and inadequate care, was ultimately transferred to a hospital by ambulance, but died 14 hours later. The district court granted summary judgment for the county, but the Ninth Circuit reversed. It began by acknowledging that "[a] policy can be one of action or inaction." *Id.* at 1185. The plaintiff (the decedent's widow) attacked the county's "policies of inaction in the following areas: (1) its failure adequately to train MSB medical staff, and (2) an absence of adequate general policies to guide the medical staff's exercise of its professionally-informed discretion." *Id.* at 1190. With respect to the second ground, the court held that there was a triable issue on whether the county's failure to implement several policies amounted to deliberate indifference. *Id.*

The Third Circuit also encountered a similar case and resolved it in favor of the plaintiff: *Natale v. Camden Cnty. Corr. Facility*, 318 F.3d 575 (3d Cir. 2003). In that case a diabetic inmate brought a *Monell* suit in which he asserted that he suffered a stroke because New Jersey's Prison Health Service failed to provide him with insulin. Addressing Natale's claim against the Health Service itself, the court began with the common observation that "the Natales must provide evidence that there was a relevant PHS policy or custom, and that the policy caused the constitutional violation they allege." *Id.* at 583–84. It then recalled this point from *City of Canton, Ohio v. Harris*, 489 U.S. 378 (1989):

> But it may happen that in light of the duties assigned to specific officers or employees the need for more or different training is so obvious, and the inadequacy so likely to result in the violation of constitutional rights, that the policymakers of the city can reasonably be said to have been deliberately indifferent to the need. In that event, the failure to provide proper training may fairly be said to represent a policy for which the city is responsible, and for which the city may be held liable if it actually causes injury.

Id. at 390. The Third Circuit applied that principle to the facts before it and concluded that "[a] reasonable jury could conclude that the failure to establish a policy to address the immediate medication needs of inmates with serious medical conditions creates a risk that is sufficiently obvious as to constitute deliberate indifference to those inmates' medical needs." *Natale*, 318 F.3d at 585; see also *Warren v. District of Columbia*, 353 F.3d 36, 39 (D.C. Cir. 2004) (ex-prisoner stated claim in *Monell* suit alleging that the District's policy or custom caused constitutional violations in prison conditions and medical care; "faced with actual or constructive knowledge that its agents will probably violate constitutional rights, the city may not adopt a policy of inaction").

We are not breaking new ground in this area; to the contrary, this court has recognized these principles for years. In *Sims v. Mulcahy*, 902 F.2d 524 (7th Cir. 1990), we observed that "in situations that call for procedures, rules or regulations, the failure to make policy itself may be actionable." *Id.* at 543 (citing *Avery*

v. Cnty. of Burke, 660 F.2d 111, 114 (4th Cir. 1981); *Murray v. City of Chicago*, 634 F.2d 365, 366–67 (7th Cir. 1980)). In the same vein, we said in *Thomas v. Cook Cnty. Sheriff's Dep't*, 604 F.3d 293 (7th Cir. 2010), that "in situations where rules or regulations are required to remedy a potentially dangerous practice, the County's failure to make a policy is also actionable." *Id.* at 303; see also *King v. Kramer*, 680 F.3d 1013, 1021 (7th Cir. 2012) (where municipality has "actual or constructive knowledge that its agents will probably violate constitutional rights, it may not adopt a policy of inaction").

Notably, neither the Supreme Court in *Harris*, nor the Ninth Circuit, nor the Third Circuit, said that institutional likability was possible only if the record reflected numerous examples of the constitutional violation in question. The key is whether there is a conscious decision not to take action. That can be proven in a number of ways, including but not limited to repeated actions. A single memo or decision showing that the choice not to act is deliberate could also be enough. The critical question under *Monell* remains this: is the action about which the plaintiff is complaining one of the institution itself, or is it merely one undertaken by a subordinate actor?

We reiterate that the question whether Corizon had a policy to eschew any way of coordinating care is not the only hurdle plaintiff faces: she must also prove that the approach Corizon took violated her son's constitutional rights. At trial, there is no reason why Corizon would not be entitled to introduce evidence of its track record, if it believes that this evidence will vindicate its decision not to follow the INDOC

guidelines. (If it does so, it presumably would also have to face less flattering news about its record. See, *e.g.*, David Royse, "Medical battle behind bars: Big prison healthcare firm Corizon struggles to win contracts," Modern Healthcare, April 11, 2015, at http://www.modernhealthcare.com/article/20150411/MAGAZINE/304119981; Matt Stroud, "Why Are Prisoners Dying in County Jail?" Bloomberg, June 2, 2015, at https://www.bloomberg.com/news/articles/2015-06-02/why-are-prisoners-dying-in-county-jail-. That issue, like the others we have identified, must await development at a trial.)

One does not need to be an expert to know that complex, chronic illness requires comprehensive and coordinated care. In *Harris*, the Court recognized that because it is a "moral certainty" that police officers "will be required to arrest fleeing felons," "the need to train officers in the constitutional limitations on the use of deadly force … can be said to be 'so obvious,' that failure to do so could properly be characterized as 'deliberate indifference' to constitutional rights." 489 U.S. at 390 n. 10. A jury could find that it was just as certain that Corizon providers would be confronted with patients with chronic illnesses, and that the need to establish protocols for the coordinated care of chronic illnesses is obvious. And in the final analysis, if a jury reasonably could find that Corizon's "policymakers … [were] deliberately indifferent to the need" for such protocols, and that the absence of protocols caused Glisson's death. *Id.* at 390.

A jury could further conclude that Corizon had actual knowledge that, without protocols for coordinated, comprehensive treatment, the

constitutional rights of chronically ill inmates would sometimes be violated, and in the face of that knowledge it nonetheless "adopt[ed] a policy of inaction." *Kramer*, 680 F.3d at 1021. Finally, that jury could conclude that Corizon, indifferent to the serious risk such a course posed to chronically ill inmates, made "a deliberate choice to follow a course of action … from among various alternatives" to do nothing. *Harris*, 489 U.S. at 389. *Monell* requires no more.

In closing, we reiterate that we are not holding that the Constitution or any other source of federal law required Corizon to adopt the Directives or any other particular document. But the Constitution does require it to ensure that a well-recognized risk for a defined class of prisoners not be deliberately left to happenstance. Corizon had notice of the problems posed by a total lack of coordination. Yet despite that knowledge, it did nothing for more than seven years to address that risk. There is no magic number of injuries that must occur before its failure to act can be considered deliberately indifferent. See *Woodward v. Corr. Med. Servs.*, 368 F.3d 917, 929 (7th Cir. 2004) ("CMS does not get a 'one free suicide' pass.").

Nicholas Glisson may not have been destined to live a long life, but he was managing his difficult medical situation successfully until he fell into the hands of the Indiana prison system and its medical-care provider, Corizon. Thirty-seven days after he entered custody and came under Corizon's care, he was dead. On this record, a jury could find that Corizon's decision not to enact centralized treatment protocols for chronically ill inmates led directly to his death. The judgment of the

district court is REVERSED and the case is REMANDED for further proceedings consistent with this opinion.

SYKES, *Circuit Judge*, with whom BAUER, FLAUM, and KANNE, *Circuit Judges*, join, dissenting. Today the court endorses *Monell* liability without evidence of corporate fault or causation. That contradicts long-settled principles of municipal liability under § 1983. The doctrinal shift is subtle but significant. The court rests its decision on the conceptual idea that a *gap* in official policy can sometimes be treated as an *actual* policy for purposes of municipal liability under *Monell v. Department of Social Services*, 436 U.S. 658 (1978). I have no quarrel with that as a theoretical matter. A municipality's failure to have a formal policy in place on a particular subject may represent its intentional decision *not* to have such a policy—that is, a policy *not* to have a policy—and that institutional choice may in appropriate circumstances form the basis of a *Monell* claim. The Supreme Court's cases, and ours, leave room for this theory of institutional liability under § 1983.

But identifying an official policy is just the first step in *Monell* analysis; it is not the whole ballgame. Evidence of an official policy or custom is a necessary but not sufficient condition to advance a *Monell* claim to trial. The plaintiff also must adduce evidence on two additional elements: (1) institutional fault, which in this context means the municipality's deliberate indifference to a known or obvious risk that its policy will likely lead to constitutional violations; and (2) causation. Because *Monell* doctrine applies to private corporations that contract to provide essential governmental services, *see Shields v. Ill. Dep't of Corr.*, 746 F.3d 782, 789–90 (7th Cir. 2014); *Iskander v. Village of Forest Park*, 690 F.2d 126, 128 (7th Cir. 1982), these requirements apply in full to Mrs. Glisson's claim against Corizon, Indiana's prison

healthcare provider, for the death of her son while in state custody.

But Mrs. Glisson produced no evidence to support the fault and causation elements of her claim. My colleagues identify none, yet they hold that a reasonable jury could find in her favor. I do not see how, without evidence on two of the three elements of the claim. The court's decision thus materially alters *Monell* doctrine in this circuit. With respect, I cannot join it.

To understand how the court's decision works a change in the law, it's helpful to begin with *Monell* itself. The familiar holding of the case is that § 1983 provides a remedy against a municipality for its *own* constitutional torts but not those of its employees or agents; the statute doesn't authorize vicarious liability under the common-law doctrine of *respondeat superior*. *Monell*, 436 U.S. at 691–92.

To separate direct-liability claims from vicarious-liability claims, the Supreme Court announced the now-canonical "policy or custom" requirement:

> Local governing bodies … can be sued directly under § 1983 for monetary, declaratory, or injunctive relief where, as here, the action that is alleged to be unconstitutional implements or executes a policy statement, ordinance, regulation, or decision officially adopted and promulgated by that body's officers. Moreover, although the touchstone of the § 1983 action against a government body is an allegation that official policy is responsible for a deprivation of rights protected by the Constitution, local

> governments, like every other § 1983 "person," by the very terms of the statute, may be sued for constitutional deprivations visited pursuant to governmental "custom" even though such a custom has not received formal approval through the body's official decisionmaking channels.

Id. at 690–91 (footnote omitted). Put more succinctly, *Monell* holds that when a plaintiff seeks to impose liability on a municipality under § 1983, he must have evidence that a municipal policy or custom—or the act of an authorized final policymaker, which amounts to the same thing—actually caused his constitutional injury.

But *Monell* sketched only the outlines of the doctrine; it took later decisions to fill in the details. Most pertinent here is *Board of County Commissioners of Bryan County v. Brown*, 520 U.S. 397 (1997). There the Court provided a primer for how to apply *Monell* doctrine in actual practice. But first the Court elaborated on the rationale for the policy-or-custom requirement:

> Locating a "policy" ensures that a municipality is held liable only for those deprivations resulting from the decisions of its duly constituted legislative body or of those officials whose acts may fairly be said to be those of the municipality. Similarly, an act performed pursuant to a "custom" that has not been formally approved by an appropriate decisionmaker may fairly subject a municipality to liability *on the theory that the relevant*

> *practice is so widespread as to have the force of law.*

Id. at 403–04 (emphasis added) (citation omitted).

The Court made it clear, however, that identifying an official policy or widespread custom is not sufficient to support a finding of liability:

> [I]t is not enough for a § 1983 plaintiff merely to identify conduct properly attributable to the municipality. The plaintiff must also demonstrate that, through its *deliberate* conduct, the municipality was the "moving force" behind the injury alleged. That is, *a plaintiff must show that the municipal action was taken with the requisite degree of culpability and must demonstrate a direct causal link between the municipal action and the deprivation of federal rights.*

Id. at 404 (second emphasis added). The culpability requirement—what I've referred to as "corporate fault" or "institutional fault"—must be tied to the specific alleged constitutional violation. *Id.* at 405. The causation element requires evidence that the municipality's *own* action *directly* caused the constitutional injury.

Brown involved a *Monell* claim by a plaintiff who was injured when a sheriff's deputy pulled her from a car and forced her to the ground during an arrest after a high-speed chase. *Id.* at 400–01. The deputy had amassed a criminal record before joining the sheriff's department—misdemeanor convictions for battery, resisting arrest, and public drunkenness—but the sheriff hadn't reviewed it closely before hiring him. *Id.*

at 401. The injured plaintiff sued the county under *Monell*, attributing her injury to the sheriff's lax hiring practices. *Id.*

The Court rejected the claim, holding that a single instance of excessive force—the plaintiff's own injury—wasn't enough to trigger municipal liability. *Id.* at 415. The Court began by tracing *Monell*'s basic requirements—an express policy or widespread custom, municipal fault, and causation—and then explained how these elements apply in different types of cases. First up were the obvious cases. The Court explained that when a *Monell* claimant alleges that "a particular municipal action *itself* violates federal law, … resolving … issues of fault and causation is straightforward." *Id.* at 404. "[P]roof that a municipality's legislative body or authorized decisionmaker has intentionally deprived a plaintiff of a federally protected right *necessarily* establishes that the municipality acted culpably." *Id*. at 405 (emphasis added). In the same way, when a legislative decision or an act of a final policymaker *itself* violates federal law, causation is clear and nothing more is needed; in that situation the act is *necessarily* the "moving force" behind the plaintiff's injury. *Id.*

Most *Monell* claims are more complicated, however, and Mrs. Glisson's claim is not in this straightforward category. She does not contend that Corizon's failure to promulgate formal protocols for chronically ill inmates *itself* violated the Constitution. My colleagues concede the point, acknowledging that Corizon's failure to adopt protocols for chronically ill inmates "does not [in itself] describe an Eighth Amendment violation." Majority Op. at p. 15. Where, as here, the challenged policy or

custom is not itself unlawful, something more is required to establish corporate culpability and causation.

Helpfully, *Brown* contains further instructions for *Monell* claims like this one that do *not* rest on allegations that a municipal policy on its face violates federal law. This part of *Brown* begins with a warning that's worth repeating here. The Court cautioned that *Monell* claims "not involving an allegation that the municipal action itself violated federal law … present much more difficult problems of proof." *Brown*, 520 U.S. at 406. Difficulties arise because claims of this type necessarily rest on the theory that a municipal policy or custom, though not itself unconstitutional, nonetheless led to constitutional torts by municipal employees acting in accordance with it. *Monell* claims in this category blur the line between municipal liability and *respondeat superior* liability; the Court worried that the line would collapse in actual practice. *Id.* at 407–08. To guard against that risk, the Court instructed the judiciary to "adhere to rigorous requirements of culpability and causation" when evaluating *Monell* claims of this kind. *Id.* at 415 ("Where a court fails to adhere to rigorous requirements of culpability and causation, municipal liability collapses into *respondeat superior* liability.").

More specifically, the Court held that

> a plaintiff seeking to establish municipal liability on the theory that a facially lawful municipal action has led an employee to violate a plaintiff's rights *must demonstrate that the municipal action was taken with deliberate indifference as to its known or obvious*

> *consequences.* A showing of simple or even heightened negligence will not suffice.

Id. at 407 (emphasis added) (citation omitted) (internal quotation marks omitted). For this holding the Court drew on principles announced in its earlier decision in *City of Canton v. Harris*, 489 U.S. 378 (1989), which involved a claim that shift supervisors at a city jail were inadequately trained to recognize an inmate's need for psychiatric intervention. *Brown* described *Harris*'s holding this way:

> We concluded [in *Harris*] that an "inadequate training" claim could be the basis for § 1983 liability in "limited circumstances." [489 U.S.] at 387. We spoke, however, of a deficient training "program," necessarily intended to apply over time to municipal employees. *Id.* at 390. Existence of a "program" makes proof of fault and causation at least possible in an inadequate training case. *If a program does not prevent constitutional violations, municipal decisionmakers may eventually be put on notice that a new program is called for.* Their continued adherence to an approach that they know or should know has failed to prevent tortious conduct by employees may establish the conscious disregard for the consequences of their action—the "deliberate indifference"—necessary to trigger municipal liability. … In addition, the existence of a pattern of tortious conduct by inadequately trained employees may tend to show that the lack of proper training, rather than a one-time negligent administration of the program or factors peculiar to the officer

> involved in a particular incident, is the "moving force" behind the plaintiff's injury.

Brown, 520 U.S. at 407–08 (emphasis added).

Harris, in turn, drew on *City of Oklahoma City v. Tuttle*, 471 U.S. 808 (1985). There a plurality of the Court observed that "where the policy relied upon is not itself unconstitutional, considerably more proof than the single incident will be necessary in every case to establish both the requisite fault on the part of the municipality, and the causal connection between the 'policy' and the constitutional deprivation." *Id.* at 824 (opinion of Rehnquist, J.) (footnotes omitted).

Together these decisions stand for the proposition that a *Monell* plaintiff's own injury, without more, is insufficient to establish municipal fault and causation. The plaintiff must instead present evidence of a pattern of constitutional injuries traceable to the challenged policy or custom—or at least more than one. Only then is the record sufficient to permit an inference that the municipality was on notice that its policy or custom, though lawful on its face, had failed to prevent constitutional torts. Put slightly differently, the plaintiff's own injury, standing alone, does not permit an inference of institutional deliberate indifference to a *known* risk of constitutional violations. "Nor will it be readily apparent that the municipality's action caused the injury in question, because the plaintiff can point to no other incident tending to make it more likely that the plaintiff's own injury flows from the municipality's action, rather than from some other intervening cause." *Brown*, 520 U.S. at 408–09.

In short, except in the unusual case in which an express policy (or an act of an authorized policymaker) is *itself* unconstitutional, a *Monell* plaintiff must produce evidence of a series of constitutional injuries traceable to the challenged municipal policy or custom; the failure to do so means a failure of proof on the fault and causation elements of the claim. *Brown* is unequivocal on this point: If the plaintiff can point *only* to his own injury, "the danger that a municipality will be held liable without fault is high" and the claim ordinarily fails. *Id.* at 408.

It's true that *Brown* and *Harris* do not foreclose the possibility that the requirement of pattern evidence might be relaxed in a narrow set of circumstances where the likelihood of recurring constitutional violations is an obvious or "highly predictable consequence" of the municipality's policy choice. *Id.* at 409–10. Addressing the inadequate-training context in particular, *Brown* acknowledged the "possibility" that "evidence of a single violation of federal rights, accompanied by a showing that a municipality has failed to train its employees to handle recurring situations presenting an obvious potential for such violation, could trigger municipal liability." *Id.* at 409. But the Court took great pains to emphasize the narrowness of this "hypothesized" exception:

> In leaving open [in *Harris*] the possibility that a plaintiff might succeed in carrying a failure-to-train claim without showing a pattern of constitutional violations, *we simply hypothesized that, in a narrow range of circumstances, a violation of federal rights may be a highly predictable consequence of a failure to equip law*

> *enforcement officers with specific tools to handle recurring situations*. The likelihood that the situation will recur and the predictability that an officer lacking specific tools to handle that situation will violate citizens' rights could justify a finding that [the] policymakers' decision not to train the officer reflected "deliberate indifference" to the obvious consequence of the policymakers' choice—namely, a violation of a specific constitutional or statutory right. The high degree of predictability may also support an inference of causation—that the municipality's indifference led directly to the very consequence that was so predictable.

Id. at 409–10.

Despite the contextual language, I see no reason to think that this hypothetical path to liability in the absence of pattern evidence is open *only* in failure-to-train cases. So I agree with my colleagues that evidence of repeated constitutional violations is not *always* required to advance a *Monell* claim to trial. But it's clear that this path to corporate liability is quite narrow. If the plaintiff lacks evidence of a pattern of constitutional injuries traceable to the challenged policy or custom, *Monell* liability is not possible *unless* the evidence shows that the plaintiff's situation was a recurring one (i.e., not unusual, random, or isolated) and the likelihood of constitutional injury was an obvious or highly predictable consequence of the municipality's policy choice. The Court's use of the terms "obvious" and "highly predictable" is plainly meant to limit the scope of this exception to those truly rare cases in which the policy or custom in question is

so certain to produce constitutional harm that inferences of corporate deliberate indifference and causation are reasonable even in the absence of any prior injuries—that is, in the absence of the kind of evidence normally required to establish constructive notice.

Our cases have always followed this understanding of *Monell* doctrine. We have held that a gap in municipal policy can sometimes support a *Monell* claim. *See, e.g.*, *Dixon v. County of Cook*, 819 F.3d 343, 348 (7th Cir. 2016); *Thomas v. Cook Cty. Sheriff's Dep't*, 604 F.3d 293, 303 (7th Cir. 2009); *Calhoun v. Ramsey*, 408 F.3d 375, 380 (7th Cir. 2005). But we have also recognized that claims grounded on the failure to have a policy must be scrutinized with great care. *Calhoun*, 408 F.3d at 380 ("At times, the absence of a policy might reflect a decision to act unconstitutionally, but the Supreme Court has repeatedly told us to be cautious about drawing that inference." (citing *Brown*, 520 U.S. at 409; *Harris*, 489 U.S. at 388)).

And in all cases we have consistently required *Monell* plaintiffs to produce evidence of more than one constitutional injury traceable to the challenged policy or custom (unless, of course, the policy or custom is itself unconstitutional, in which case the singular wrong to the plaintiffs is clearly attributable to the municipality rather than its employees). *See, e.g.*, *Chatham v. Davis*, 839 F.3d 679, 685 (7th Cir. 2016) (explaining that *Monell* claims "normally require evidence that the identified practice or custom caused multiple injuries"); *Daniel v. Cook County*, 833 F.3d 728, 734 (7th Cir. 2016) (explaining that a *Monell* plaintiff "must show more than the deficiencies specific

to his own experience" and allowing the claim to proceed based on a Department of Justice report documenting multiple instances of inadequate medical care in the jail); *Dixon*, 819 F.3d at 348–49 (same); *Calhoun*, 408 F.3d at 380 (explaining that a *Monell* claim ordinarily "requires more evidence than a single incident to establish liability"); *Palmer v. Marion County*, 327 F.3d 588, 596 (7th Cir. 2003) (same); *Gable v. City of Chicago*, 296 F.3d 531, 538 (7th Cir. 2002) (same); *Estate of Novack ex rel. Turbin v. County of Wood*, 226 F.3d 525, 531 (7th Cir. 2000) (A *Monell* plaintiff must show that "the policy itself is unconstitutional" or produce evidence of "a series of constitutional violations from which [institutional] deliberate indifference can be inferred.").

Finally, following the Supreme Court's lead in *Brown* and *Harris,* we have left open the possibility that a *Monell* claim might proceed to trial based on the plaintiff's injury alone, but only in rare cases where constitutional injury is a manifest and highly predictable consequence of the municipality's policy choice. *See Chatham*, 839 F.3d at 685–86; *Calhoun*, 408 F.3d at 381. So far, we've allowed recovery under this exception only once, in a case involving a jail healthcare provider's failure to ensure that its suicide-prevention protocols were scrupulously followed. *See Woodward v. Corr. Med. Servs. of Ill., Inc.*, 368 F.3d 917 (7th Cir. 2004).

To be more specific, in *Woodward* a jail's private healthcare provider had guidelines in place for inmate suicide risk identification and prevention. *Id.* at 921. An inmate committed suicide 16 days after he was booked into the jail; his estate sued the corporate

healthcare provider alleging a systemic failure to enforce compliance with the guidelines. *Id.* at 919–20. The evidence at trial established that the provider neither trained its employees on how to use the guidelines nor monitored their compliance with them, and in fact had long condoned widespread violations of the nominally mandatory procedures. *Id.* at 925–29. A jury returned a verdict for the estate and we affirmed. Although there was no evidence of prior suicides at the jail, we held that *Monell* liability was appropriate because inmate suicide is an obvious and highly predictable consequence of a jail healthcare provider's thoroughgoing failure to enforce its suicide-prevention program. *Id.* at 929.

This case is not at all like *Woodward*. While it's patently obvious that a systemic failure to enforce a jail suicide-prevention program will eventually result in inmate suicide, inmate death is not an obvious or highly predictable consequence of the alleged policy lapse at the center of this case. Mrs. Glisson claims that Corizon's failure to promulgate formal guidelines for the care of chronically ill inmates as required by INDOC Directive HCSD-2.06 caused her son's death. Everyone agrees that nothing in "the Constitution or any other source of federal law required Corizon to adopt the Directive[] or any other particular document." Majority Op. at p. 19. So *evidence* is needed to prove corporate culpability and causation; in the usual case, this means evidence of a series of prior similar injuries. But Mrs. Glisson presented no evidence that other inmates were harmed by the failure to have protocols in place as required by the Directive.

In the absence of prior injuries, Corizon was not on notice that protocols were needed to prevent constitutional torts. So Mrs. Glisson cannot prevail unless she can show that inmate death was an obvious or highly predictable consequence of the failure to promulgate formal protocols of the type specified in HCSD-2.06.

She has not done so. Her expert witness, Dr. Dianne Sommer, did not offer an opinion on the subject; the doctor's declaration states only that certain aspects of Nicholas Glisson's treatment fell below the standard of care. My colleagues insist that "[o]ne does not need to be an expert to know that complex, chronic illness requires comprehensive and coordinated care." Majority Op. at p. 18. Perhaps not, but it's conceptually improper to frame the issue at that level of generality.

This is a complicated medical-indifference case. It's far from obvious that formal protocols of the sort required by Directive HCSD-2.06 were needed to prevent constitutional torts of the kind allegedly suffered by Nicholas Glisson. The Directive itself is entirely nonspecific. It contains only the following instructions: (1) "[o]ffenders with serious chronic health conditions need to receive planned care in a continuous fashion"; (2) chronic conditions must be identified and "a treatment plan must be established"; and (3) the treatment plan "should be maintained current" and "[a]s care needs change, the treatment plan should be updated." In other words: Have a treatment plan and update it as needed.

During discovery Mrs. Glisson asked Corizon to produce "all policies, procedures, and/or protocols relied on in developing the course of treatment for Nicholas

Glisson." Corizon objected based on overbreadth and asked for a more targeted document request. Subject to the objection, Corizon gave this response: "Mr. Glisson's medical care and treatment at IDOC were based on standards of medical and nursing care, and generally were not dictated by written policies, procedures or protocols."

My colleagues do not explain how Corizon's adherence to professional standards of medical and nursing care amounts to deliberate indifference to a known or obvious risk of harm. More to the point, they do not explain how inmate death was an obvious or highly predictable consequence of Corizon's failure to promulgate protocols in compliance with the very loose and highly generalized instructions contained in Directive HCSD-2.06. Unlike the jail-suicide case, it is neither self-evident nor predictable—let alone *highly* predictable—that Corizon's reliance on professional standards of medical and nursing care (instead of HCSD-2.06-compliant protocols) would lead to constitutional injuries of the sort suffered by Nicholas Glisson.

My colleagues say that the absence of formal protocols for chronically ill inmates created "a well-recognized risk" and "Corizon had notice of the problems posed by a total lack of coordination." Majority Op. at p. 19. No evidence supports these assertions. No expert testified that the standard of care requires a corporate healthcare provider to promulgate formal protocols on this subject, so the record doesn't even clear the bar for simple negligence. *Monell* liability requires proof of culpability significantly *greater* than simple negligence. It also requires

evidence that Corizon's action—not the actions of its doctors and nurses—*directly* caused the injury. There is no such evidence here. Without the necessary evidentiary support, a jury cannot possibly draw the requisite inferences of corporate fault and causation. On this record, a verdict for Mrs. Glisson is not possible.

More broadly, by eliding the normal requirement of pattern evidence and relying instead on sweeping and unsubstantiated generalizations about the obviousness of the risk, my colleagues have significantly expanded a previously narrow exception to the general rule that a valid *Monell* claim requires evidence of prior injuries in order to establish corporate deliberate indifference and causation. The Supreme Court has instructed us to rigorously enforce the requirements of corporate culpability and causation to ensure that municipal liability does not collapse into vicarious liability. Today's decision does not heed that instruction.

Nicholas Glisson arrived in Indiana's custody suffering from complicated and serious medical conditions. Some of Corizon's medical professionals may have been negligent in his care, as Dr. Sommer maintains, and their negligence may have hastened his death. That's a tragic outcome, to be sure; if substantiated, the wrong can be compensated in a state medical-malpractice suit. Under traditional principles of *Monell* liability, however, there is no basis for a jury to find that Corizon was deliberately indifferent to a known or obvious risk that its failure to adopt formal protocols in compliance with HCSD-2.06 would likely lead to constitutional violations. Nor is there a factual basis to find that this alleged gap in corporate policy

caused Glisson's death. Accordingly, I would affirm the summary judgment for Corizon.

UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

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FINAL JUDGMENT

February 21, 2017

Before:
DIANE P. WOOD, Chief Judge
WILLIAM J. BAUER, Circuit Judge
RICHARD A. POSNER, Circuit Judge
JOEL M. FLAUM, Circuit Judge
FRANK H. EASTERBROOK, Circuit Judge
MICHAEL S. KANNE, Circuit Judge
ILANA DIAMOND ROVNER, Circuit Judge
ANN CLAIRE WILLIAMS, Circuit Judge
DIANE S. SYKES, Circuit Judge
DAVID F. HAMILTON, Circuit Judge

No. 15-1419	ALMA GLISSON, As Personal Representative of the Estate of NICHOLAS L. GLISSON, Plaintiff - Appellant v. INDIANA DEPARTMENT OF CORRECTIONS, et al., Defendants - Appellees

Originating Case Information:
District Court No: 1:12-cv-01418-SEB-MJD Southern District of Indiana, Indianapolis Division District Judge Sarah Evans Barker

The judgment of the district court is **REVERSED**, with costs, and the case is **REMANDED** for further proceedings consistent with this opinion. The above is in accordance with the decision of this court entered on this date.

form name: **c7_FinalJudgment**(form ID: **132**)

APPENDIX B

IN THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

No. 15-1419

[Filed February 17, 2016]

ALMA GLISSON, as Personal Representative of the Estate of NICHOLAS L. GLISSON, *Plaintiff-Appellant*,

v.

INDIANA DEPARTMENT OF CORRECTIONS, *et al.*, *Defendants-Appellees*.

Appeal from the United States District Court for the Southern District of Indiana, Indianapolis Division.
No. 1:12-cv-1418-SEB-MJD —
Sarah Evans Barker, *Judge*.

ARGUED OCTOBER 26, 2015 —
DECIDED FEBRUARY 17, 2016

Before WOOD, *Chief Judge*, and BAUER and SYKES, *Circuit Judges*.

BAUER, *Circuit Judge.* Plaintiff-appellant, Alma Glisson ("Appellant"), sued Correctional Medical

Services, Inc., also known as Corizon, Inc. ("CMS"), its employees Dr. Malaka G. Hermina ("Dr. Hermina"), Mary Combs, R.N. ("Nurse Combs"), and the Indiana Department of Corrections ("IDOC") (collectively "Appellees"), on behalf of her deceased son, Nicholas Glisson ("Glisson"). Glisson died while incarcerated at Plainfield Correctional Facility ("Plainfield") in Plainfield, Indiana. The lawsuit's federal claims arise under 42 U.S.C. § 1983 ("§ 1983"), specifically alleging that Appellees did not offer Glisson constitutionally adequate medical care, and that this failure violated his Eighth Amendment rights against cruel and unusual punishment. The district court granted summary judgment in favor of Appellees on all federal claims, and remanded the remaining state law claims. Appellant now only appeals the grant of summary judgment in favor of CMS, arguing that CMS's failure to implement a particular IDOC Health Care Service Directive (the "Directive") violated Glisson's Eighth Amendment rights. However, because Appellant has not produced legally sufficient evidence to demonstrate a genuine issue of material fact on this matter, we affirm summary judgment for CMS.

I. BACKGROUND

Glisson's medical history is tragic. Diagnosed with laryngeal cancer in 2003, he underwent surgery that removed his larynx and part of his pharynx. The surgery also removed portions of Glisson's mandible and thirteen teeth. The surgery left him with a permanent stoma, or opening in his throat, accompanied by a tracheostomy tube. He was later fitted with a voice prosthesis, and received postoperative radiation treatment. After the surgery,

he suffered from painful swallowing (dysphagia) and neck pain, both resulting from progressive neck instability. In 2008, doctors inserted a gastrojejunostomy tube ("G-tube") through his stomach to help with nutrition. In March 2010, a cancerous lesion was found on his tongue, but was successfully excised.

Exacerbating the effects of Glisson's cancer and surgery were ongoing memory issues, hypothyroidism, depression, smoking, and alcohol abuse. Despite these many health issues, Glisson lived independently and cared for himself; he even cared for his grandmother when she was sick and his brother when he was dying.

On August 31, 2010, Glisson was sentenced to incarceration for dealing in a controlled substance. He came into the custody of IDOC on September 3, 2010. IDOC housed him in its Reception Diagnostic Center from September 3 through September 17. During this time, CMS medical personnel noted spikes in Glisson's blood pressure, an occasional low pulse, and low oxygen saturation level. He also demonstrated signs of confusion and anger, and was at one point deemed a suicide risk. As a result, IDOC placed him in segregation and had him undergo a psychiatric evaluation.

IDOC transferred him from the Reception Diagnostic Center to Plainfield on September 17. At Plainfield, Glisson's condition further deteriorated. At Plainfield, he came under the medical care of Dr. Hermina and Nurse Combs. Plainfield personnel quickly determined that Glisson's medical issues were worsening. On September 29, he presented with symptoms suggesting acute renal failure. In response,

IDOC personnel transferred him to a local hospital, where he remained until October 7.

Upon returning to Plainfield, Glisson appeared stable. However, on the morning of October 10, Nurse Combs witnessed Glisson exhibiting strange behavior and transferred him to a medical isolation room. While isolated, Glisson was restless, moving from one side of the bed to the other. At 8:20 a.m., IDOC staff reported that Glisson was sitting upright in his bed, unresponsive. Emergency personnel arrived at 8:30 a.m., and pronounced Glisson dead at 8:35 a.m. The coroner concluded that Glisson died of natural causes, resulting from complications of laryngeal cancer with contributory renal failure. A pathologist agreed with these findings, and added that Glisson's various medical issues—diminished mental state, oxygen deficiency, and acute renal failure—were directly attributable to his throat cancer and laryngectomy.

After Glisson's death, Appellant sued Appellees in Indiana state court. She alleged that Dr. Hermina and Nurse Combs were deliberately indifferent to Glisson's medical needs. She also alleged, under *Monell v. Department of Social Services of City of New York*, 436 U.S. 658 (1978), and its progeny, that CMS's failure to implement the Directive led to this deliberate indifference. The Directive reads:

> Each facility must develop a site[-]specific directive that guides the management of the chronic disease management and clinics. Each site must have easily available a compilation of instructions for proper management [of] chronic diseases in the chronic disease clinic setting.

Related IDOC guidelines further note that the Directive is necessary because "[o]ffenders with serious chronic health conditions need to receive planned care in a continuous fashion" and that care provided to such inmates "should be organized and planned and should be consistent across [IDOC] facility lines."

CMS has argued throughout the litigation that it is not obligated to implement IDOC directives. It also admitted that it did not implement the Directive, stating instead that Glisson's care was "based on standards of medical and nursing care." CMS acknowledged that while IDOC "implement[s] Health Care Service Directives … generally none of those directives were relied on in rendering medical care and treatment to Mr. Glisson."

Appellant claims that because CMS did not adopt the Directive and did not create a centralized treatment plan for Glisson, his care was fractured and disorganized. She argues that CMS's *lack* of a policy of centralized care for inmates like Glisson led to the deliberate indifference of Dr. Hermina, Nurse Combs, and other CMS personnel. She specifically argues that CMS's failure to adopt any policy mandating coordinated care "prevent[ed] [CMS] medical personnel from communicating properly and ensuring appropriate continuity of care for inmates with serious medical problems," such as Glisson.

After Appellant filed the suit in Indiana court, Appellees removed the case to federal court, and then moved for summary judgment on the federal law claims. The district court granted summary judgment for Appellees, and remanded the remaining state law claims. In granting summary judgment, the district

court found that Dr. Hermina's and Nurse Combs's actions did not constitute deliberate indifference, and that as a result Glisson did not suffer any constitutional injury. Having determined that Glisson suffered no constitutional injury, the district court then held that Appellant could not prove a *Monell* claim against CMS as a matter of law.

Appellant appealed the district court's order.

II. DISCUSSION

Appellant only appeals the dismissal of her *Monell* claim against CMS. But this claim fails for want of necessary evidence. Specifically, Appellant has not presented evidence that CMS's failure to implement the Directive led to a widespread practice of deliberate indifference against not only Glisson, but other inmates as well.

We review the grant of summary judgment *de novo*, construing the facts in the light most favorable to the non-moving party—here, Appellant. *Rahn v. Bd. of Trustees of N. Ill. Univ.*, 803 F.3d 285, 287 (7th Cir. 2015) (citation omitted). Summary judgment is appropriate when there is no dispute of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(a); *Lalowski v. City of Des Plaines*, 789 F.3d 784, 787 (7th Cir. 2015). That is, at this stage, Appellant must have produced evidence that indicates a genuine issue of material fact. *See Armato v. Grounds*, 766 F.3d 713, 719 (7th Cir. 2014) (quotations and citations omitted). *See also Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986) (quoting Fed. R. Civ. P. 56(e) in holding that non-moving party must

"designate 'specific facts showing that there is a genuine issue for trial'").

Here, Appellant must produce evidence that CMS's failure to adopt the Directive led to deliberately indifferent medical care by CMS personnel. Government entities[1] "have an affirmative duty to provide medical care to their inmates." *Duckworth v. Ahmad*, 532 F.3d 675, 678–79 (7th Cir. 2008) (citing *Estelle v. Gamble*, 429 U.S. 97, 103 (1976)). Deliberate indifference to a prisoner's "serious medical needs … constitutes the 'unnecessary and wanton infliction of pain' and violates the Eighth Amendment's prohibition against cruel and unusual punishments." *Duckworth*, 532 F.3d at 679 (quoting *Estelle*, 429 U.S. at 104 (internal quotation and citation omitted)).

Here, Appellant has not produced the necessary evidence for a *Monell* claim against CMS. Private corporations like CMS cannot be liable in a § 1983 suit under *respondeat superior*.[2] *E.g., Iskander*, 690 F.2d at

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[1] Though a private corporation, CMS concedes that because it performs a government function—providing medical care to state prisoners—it may be liable as a government entity under § 1983. *E.g., Iskander v. Vill. of Forest Park*, 690 F.2d 126, 128 (7th Cir. 1982).

[2] Additionally, though CMS did not argue waiver on appeal, Appellant has nevertheless waived her right to recovery on a theory of *respondeat superior*. In the district court, she stated in her response to Defendants' Motion for Summary Judgment, "Plaintiff does not seek to impose liability on CMS under § 1983 based on *respondeat superior*." Yet Appellant now asks this Court to apply *respondeat superior* to private corporations like CMS. This is a new argument on appeal, and is thus waived. *See Brown v. Automotive Components Holdings, LLC*, 622 F.3d 685, 691 (7th

128; *Gayton v. McCoy*, 593 F.3d 610, 622 (7th Cir. 2010); *Maniscalco v. Simon*, 712 F.3d 1139, 1145 (7th Cir. 2013). Thus, even if Dr. Hermina and Nurse Combs were deliberately indifferent to Glisson's medical needs, a court cannot impute this liability to their employer, CMS. Rather, to survive summary judgment, Appellant must produce evidence of "the existence of an 'official policy' or other governmental custom that not only causes but is the 'moving force' behind the deprivation of constitutional rights." *Teesdale v. City of Chi.*, 690 F.3d 829, 833–34 (7th Cir. 2012) (quoting *City of Canton, Ohio v. Harris*, 489 U.S. 378, 388–89 (1989)). *See also Monell*, 436 U.S. at 694.

Further, where a plaintiff alleges that a *lack* of a policy caused a constitutional violation, she must produce "more evidence than a single incident to establish liability." *Calhoun v. Ramsey*, 408 F.3d 375, 380 (7th Cir. 2005) (citing *City of Okla. City v. Tuttle*, 471 U.S. 808, 822–23 (1985)). She must produce evidence of a "series of incidents" (*Hahn v. Walsh*, 762 F.3d 617, 638 (7th Cir. 2013), *cert. denied*, 135 S. Ct. 1419 (2015)), or a "widespread practice constituting custom and usage." *Phelan v. Cook Cnty.*, 463 F.3d 773, 789 (7th Cir. 2008) (a "widespread practice" argument "would focus on the application of the policy to many different individuals"). Evidence of a series of incidents permits the inference that "there is a true municipal policy at issue," and allows the factfinder "to understand what the omission means." *Calhoun*, 408 F.3d at 380. By presenting a series of incidents where "the same problem has arisen many times and the

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Cir. 2010) ("[a]rguments not raised in the district court are considered waived on appeal").

[government entity] has acquiesced in the outcome," a plaintiff has produced sufficient evidence that the lack of policy is in fact a *de facto* policy choice, not a discrete omission. *Id.* However, "[w]ithout evidence that a series of incidents brought the risk at issue to the attention of the policymaker, we cannot infer that the lack of a policy is the result of deliberate indifference." *Hahn*, 762 F.3d at 637–38 (citing *Calhoun*, 408 F.3d at 380).

Such is the case here. Appellant alleges that CMS failed to implement the Directive mandating a centralized care plan for inmates such as Glisson. Appellant therefore argues that CMS's lack of a policy was the "moving force" behind any deliberate indifference to Glisson's medical needs. Thus, to show that CMS's failure to implement the Directive amounted to a *de facto* policy, Appellant must have produced evidence that CMS staff had been deliberately indifferent to other inmates, and that a widespread practice of deliberate indifference flowed from the failure to implement the Directive. But Appellant has not done so. Instead, she has only produced evidence of alleged deliberate indifference towards Glisson, and admitted as much at oral argument.[3] This evidence alone is insufficient to

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[3] Appellant waived use of evidence of other incidents because she did not present such evidence before the district court. Her "Separate Appendix" includes a 2013 *Miami Herald* news article discussing various lawsuits brought by Florida prisoners against CMS (as Corizon), a 2012 expert report relating to a lawsuit against Corizon brought in federal court in Idaho, and a 2015 settlement order related to a lawsuit against Corizon in the Northern District of California. She argues in her appellate brief that this is evidence of a "pattern of constitutionally inadequate care." But she presented none of these three documents as

maintain a *Monell* claim against CMS. Absent evidence of a series of incidents or a widespread practice against other inmates, we cannot infer that CMS's failure to implement the Directive was the result of deliberate indifference. *See Hahn*, 762 F.3d at 637. Therefore, Appellant's claim fails as a matter of law, and summary judgment for CMS was appropriate.

III. CONCLUSION

For the foregoing reasons, we AFFIRM the judgment of the district court.

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evidence before the district court. Of course, she could not have presented the 2015 settlement order to the district court in this case, because the district court in this case ruled on summary judgment on June 4, 2014. However, the district court presiding over the Northern District of California settlement had denied summary judgment to Corizon on April 14, 2014, before the district court in this case ruled. *See M.H. v. Cnty. of Alameda*, 62 F. Supp. 3d 1049, 1087–88 (N.D. Cal. 2014). Thus, Appellant could have offered the denial of summary judgment in *M.H.* as supplemental authority for her argument before the district court. But she failed to do so, and has thus waived any argument relating to these three documents. *See Brown*, 622 F.3d at 691.

WOOD, *Chief Judge*, dissenting. Most cases in which a prisoner raises a claim about constitutionally inadequate medical care in the prison are brought against the doctor or other professional who actually delivered the services. In those cases, as *Estelle v. Gamble*, 429 U.S. 97 (1976), and *Farmer v. Brennan*, 511 U.S. 825 (1994), illustrate, the prisoner may prevail only if the providers exhibited deliberate indifference to a substantial risk of serious harm. The Eighth Amendment, after all, is about unconstitutional punishment, not about medical competence. But there is another theory that has been cognizable under 42 U.S.C. § 1983 ever since the Supreme Court decided *Monell v. Dep't of Social Servs.,* 436 U.S. 658 (1978). Overruling *Monroe v. Pape*, 365 U.S. 167 (1961), insofar as that case held that municipalities are immune from suit under section 1983, *Monell* drew a line between *respondeat superior* liability and direct liability for the municipal organization's own policies. It rejected the former, but it held that the latter was actionable. That latter theory is the one under which plaintiff Alma Glisson, acting as the personal representative of her deceased son, Nicholas L. Glisson, is seeking to recover damages against Correctional Medical Services, Inc. (Corizon), the company that was responsible for the deplorable medical care Glisson received in Indiana's Plainfield Correctional Facility. (Unless the context requires otherwise, my references to "Glisson" mean Nicholas, not Alma.)

In *Minix v. Canarecci*, 597 F.3d 824, 835 (7th Cir. 2010), this circuit confirmed that private corporations that contract with jails or prisons to provide medical services are treated the same as municipalities for purposes of liability under section 1983. That rule

applies to defendant Corizon. Alma Glisson asserts that Corizon maintained a policy that led directly to her son's death. My colleagues have concluded that she cannot prevail—indeed, that the paper record is so one-sided that it was proper for the district court to grant summary judgment in Corizon's favor. That conclusion can stand only if they have correctly depicted what it takes to prove that Corizon's policies violated the Eighth Amendment. They characterize this case as a complaint about the *lack* of a policy, and they assert that the plaintiff must therefore show a series of incidents or a widespread practice. Alma Glisson did not submit such evidence (at least not in a timely fashion), and so, they conclude, she fails. This syllogism assumes that policies are always affirmatively stated and that a decision *not* to regulate cannot also be a policy. Nothing in *Monell* or later cases, however, so holds. The relevant questions in all instances are (a) what is the policy at issue, and (b) whether that policy reflects deliberate indifference to a serious medical need. Taking the facts in the light most favorable to the plaintiff, a rational jury could find that Corizon deliberately structured the delivery of medical care in a way that lacked critical oversight. That policy in Glisson's case predictably had fatal results. I would reverse and send this case to trial.

I

Before turning to the legal analysis, it is helpful to review the facts in some detail. Although Glisson had suffered from bad health for many years, he was able to function on his own until he was taken into custody by the Indiana Department of Corrections (INDOC) on September 3, 2010 (following his conviction for giving

one prescription painkiller pill to a friend). Indeed, he not only lived independently, but he also provided care to his grandmother and his dying brother. After 41 days in custody, 37 of which were in INDOC's care, prison staff found him dead in his cell. The coroner concluded that Glisson died of "complications of laryngeal cancer." But that was not all he said. He also noted Glisson's "malnutrition," "extreme emaciation and cachexia [wasting away of tissue]." Consultant Dr. Stephen Radentz, a forensic pathologist, agreed with those conclusions, and added that Glisson suffered from acute renal failure with hyperkalemia (*i.e.* too much potassium in the blood), dehydration and volume depletion, acute respiratory insufficiency or pneumonia, and altered mental status. Finally, for purposes of this litigation, Glisson's estate retained Diane Sommer, M.D., who prepared a report finding "[w]ithin a high degree of medical certainty … that the health care [Glisson] received through out [*sic*] his brief incarceration lead [*sic*] to his early death."

No one disputes that Glisson's health was poor before he went to prison. He had been diagnosed with laryngeal cancer in 2003. In October of that year, he had radical surgery in which his larynx and part of his pharynx were removed, along with portions of his mandible (jawbone) and several teeth. He was left with a permanent stoma (that is, an opening in his throat), into which a tracheostomy tube was normally inserted. He needed a voice prosthesis to speak. Over the years, Glisson had additional treatments. Importantly for our case, the 2003 surgery and follow-up radiation left his neck too weak to support his head; this in turn made his head slump forward in a way that impeded his breathing. Because physical therapy and medication for

this condition were ineffective, he wore a neck brace. He also developed cervical spine damage. In 2008 doctors placed a gastrojejunostomy tube in his upper abdomen for supplemental feeding. Finally, there was some evidence of cognitive decline.

Despite all this, Glisson was able to care for himself in the home. He learned to clean and suction his stoma independently. With occasional help from his mother, he was able to use his feeding tube when necessary. He was still able to swallow well enough to take his food and other supplements by mouth most of the time. His hygiene was fine, and he helped with household chores such as mowing the lawn, cleaning, cooking, and caring for his brother.

The events leading up to Glisson's death began when a friend, acting as a confidential informant for the police, convinced Glisson to give the friend a prescription painkiller. Glisson was charged and convicted for this infraction, and on August 31, 2010, he was sentenced to a period of incarceration and transferred to the Wayne County Jail. Before sentencing, Dr. Borrowdale, one of his physicians, wrote a letter to the court expressing serious concern about Glisson's ability to manage in a prison setting. Dr. Borrowdale noted Glisson's severe disabilities from cancer and from alcohol dependence, his difficulty speaking because of the laryngectomy, his trouble swallowing, his severe curvature of the spine (kyphosis), and his problems walking. The conclusion of the letter was prophetic: "This patient is severely disabled, and I do not feel that he would survive if he was incarcerated." Dr. Fisher, another of Glisson's

physicians, also warned that Glisson "would not do well if incarcerated."

Glisson's family brought his essential supplies to the Wayne County Jail, including his neck brace and the suction machine, mirror, and light that he used for his tracheostomy. When he was transferred on September 3 to INDOC's Reception Diagnostic Center, the Jail sent along his mirror, light, and neck brace, but it is unclear what happened to these items. Glisson never received the neck brace while he was at Plainfield, nor was he given a replacement.

At the Diagnostic Center, Nurse Tim Sanford assessed Glisson's condition, accurately as far as one can tell. Sanford recorded Glisson's account of his medication regimen, and noted that Glisson appeared to be alert and able to communicate. Sanford noted that Glisson had a tracheostomy that had to be suctioned six times a day, and that Glisson had a feeding tube but that he took food through it only when he had difficulty swallowing. After that evaluation, Glisson was placed in the general population.

From this point on, Glisson's care began to resemble the blind men's description of the elephant. Different people took steps that were never coordinated or supervised by a single responsible medical provider. No provider furnished a comprehensive investigation of his medical condition. On September 5, staff reported that Glisson was angry and throwing candy out of his cell. (Glisson disputes this, and so this fact cannot be taken as established for summary judgment purposes.) Nurse Rachel Johnson tried to take his blood pressure, but could not. She recorded a pulse of 60 and an oxygen saturation level of 84%, which was low. (The record

includes evidence indicating that normal oxygen saturation ranges between 95 and 100%; saturation below 90% is a sign of respiratory distress.) Some staff thought that Glisson seemed confused, but Johnson found him to be alert and oriented. The staff told her that Glisson had consumed only milk in the past two days and that he was not cooperating with their efforts to handcuff him for a clinic visit. They tested his oxygen saturation again and found it to be fluctuating between 84% and 94%. At that point, they took him to the clinic and allowed him to use his suction machine. Also, for reasons that are largely unclear, they identified him as a suicide risk and transferred him to segregation.

Glisson's care over the next couple of weeks was disjointed: no provider developed a medical treatment plan, and thus no one was able to check Glisson's progress against any such plan. In fact, for his first 24 days in INDOC custody, no Corizon provider even reviewed his medical history. Dr. Gallien requested his medical history on September 10. But there is no evidence that anyone responded to his request, and no one followed up on that request until September 27, when Dr. Malaka G. Hermina asked for the records and received them within several hours. Except for one instance on September 10, no Corizon provider ever tried to contact Glisson's mother or any other relative for information. During this time, Glisson's oxygen saturation rate bounced up and down, occasionally reaching troubling lows: On September 5 it fluctuated between 84% and 94%; it rose to 96% when he was allowed to use his suction machine; it sank back to 86% on September 6 before suctioning restored it to 94%; it was back down at 84% on September 8, and so on.

Glisson's weight, never high, was also deteriorating. On September 9 a psychiatrist, Dr. Conant, recorded that he had lost weight; later that day a nurse practitioner ordered that Glisson be given the nutritional supplement Ensure. No one kept any daily account of how much—if any—Ensure Glisson consumed.

When Glisson was transferred from the holding facility to Plainfield on September 17, 2010, he weighed 119 pounds. There is no record of anyone's monitoring his weight, although on September 27 Dr. Hermina noted that Glisson appeared cachectic, which means undernourished to the point that the person has physical wasting and loss of weight and muscle mass. See MedicineNet.com, Definition of Cachectic, http://www.medicinenet.com/script/main/art.asp?articlekey=40464. Dr. Hermina ordered a second nutritional supplement, Jevity, but he did not make any recording of Glisson's weight. As noted above, the coroner also noted Glisson's emaciation.

During this time, Glisson's mental status was also deteriorating. Dr. Sommer's report charts that process and notes at various points how the deterioration could have been halted if a qualified medical professional had been evaluating the full picture. Such an evaluation would have shown, Dr. Sommer said, a clear correlation between Glisson's underlying medical problems and his mental state. Her report comments on the drugs Glisson was taking. He was switched from Effexor to Prozac without any evaluation; worse, he was not monitored or weaned off Effexor while the Prozac was started. The two drugs work quite differently, the report notes, and it concludes that

"[t]his abrupt change in medication contributed to [Glisson's] decline in function."

While Glisson was in custody, he had numerous episodes of altered mental status. Despite this fact, Dr. Gallien (again operating on the basis of incomplete information) noted on September 10 that Glisson had "no real mental health issues." Yet at roughly the same time, Health Services Administrator Kelly Kurtz called Glisson's mother to ask whether he had any abnormal behavioral issues, such as spitting on the floor. Alma Glisson said no. There is no record that Kurtz told anyone about this, or that any Corizon provider could or did take this information into account in structuring Glisson's treatment.

Dr. Conant did conduct a mental health evaluation on Glisson on September 23. His findings were worrying, but no one connected them with any of the physical data on file, such as Glisson's tendency to have inadequate oxygen profusion and his cachexia. Dr. Conant found that Glisson was restless, paranoid, delusional, hallucinating, and insomniac. He placed Glisson under close observation and settled on a diagnosis of unspecified psychosis; he saw no need for medication. Had he looked, he would have seen that Glisson had no history of psychosis, and he might have considered (as the post-mortem experts did) the possibility that lack of oxygen and food was affecting Glisson's mental performance. Dr. Conant noted that he thought that Glisson's hallucinations were caused by morphine. This observation, too, was reached in an information vacuum. In fact, Glisson had been on narcotic medication for some time prior to his incarceration. Had Dr. Conant known of Glisson's

medical history, he would have known that morphine was an unlikely cause and he would have looked further.

The Corizon providers never took any steps to integrate the growing body of evidence of Glisson's malnutrition with his overall mental and physical health. On September 4, Glisson's urinalysis results showed the presence of ketones and leukocytes. Dr. Sommer's report notes, without contradiction in the record, that "[k]etones suggest the presence of other medical conditions such as anorexia, starvation, acute or severe illness and hyperthyroidism to name a few." "Leukocytes," it said, "are a sign of possible infection." The medical staff did nothing to address either potential problem, even though a second urine sample taken on September 5 showed an increase in ketones and leukocytes. There is no evidence in the record that a physician reviewed either of those lab results. That is so even though the record includes a note saying that on September 5 Glisson "had not been eating and seemed confused." Rather than probing the signs of infection and dehydration further, the staff opted to put Glisson in the psychiatric unit under suicide watch.

The blood work continued to raise red flags. On September 9, it came back with signs of abnormal renal function. Although Glisson met with Dr. Gallien the next day, no one looked at the bloodwork until September 27. At that point, Dr. Hermina ordered fasting labs for September 28. When the results were returned on September 29, they showed acute renal failure–information that prompted Dr. Hermina to send Glisson immediately to Wishard Hospital. A jury could easily conclude that Glisson was already slipping

into renal distress as early as September 4 or 9, but that the uncoordinated care Corizon furnished allowed his condition to become acute. Recall that Dr. Radentz listed acute renal failure as a cause of his death.

Last, anyone with a good overall knowledge of Glisson's health problems would have realized that he was at high risk for aspiration pneumonia because he had undergone major surgery that had disrupted his swallowing mechanism, he had a stoma and feeding tube, and he had a cervical-spine problem that caused laxity in his neck. Whether or not his neck brace was transferred from the jail to the prison is beside the point: the record shows that he never received it, and it was not replaced. The only care he received for his neck and throat was suctioning, and then only after he was already hypoxic. Someone lost his voice prosthesis too. It was not replaced, despite the fact that there is evidence in the record to support a finding that its absence greatly increased the potential of aspiration and pneumonia, and that those were listed as contributing causes of death.

II

It was not Alma Glisson's burden ultimately to convince the district court that Corizon's policy violates the Constitution; she needed only to show that there are genuine issues of material fact and that a rational jury could so conclude. In my view, the more complete account of the facts provided above leaves room for no other outcome. Two questions are critical: first, whether Corizon is automatically entitled to judgment if its staff committed no constitutional violation; and if the answer is no, then second, whether a jury could find that Corizon's failure to formulate protocols to

guide care for chronically ill inmates violates the Eighth Amendment.

A

There are two points on which I agree with my colleagues in the majority. We all accept that under the law as it presently exists, there is no *respondeat superior* liability in a case under section 1983 even for a private corporation such as Corizon. This court noted in *Shields v. Illinois Dep't of Corrections*, 746 F.3d 782, 789–96 (7th Cir. 2014), that there may be some question about that proposition, but we went no further, and so for now the applicability of *Monell*'s rule to private entities such as Corizon remains established. In addition, we all understand that Glisson did not need to prove that the individual providers' care was deliberately indifferent in order to prevail. We squarely held in *Thomas v. Cook Cnty. Sheriff's Dep't*, 604 F.3d 293 (7th Cir. 2010), that "we find unpersuasive the County's argument that it cannot be held liable under *Monell* because none of its employees were found to have violated [plaintiff's] constitutional rights." *Id.* at 304. Sometimes the nature of the constitutional violation, the theory of municipal liability, and the defenses will cause a *Monell* claim to fail because of the lack of any underlying violation, but sometimes it will not. Our case falls in the latter category. Individual medical providers may act within constitutional boundaries, both objectively and subjectively, but if there is an unconstitutional policy at the corporate level, the corporation must answer for it.

B

This takes me to the essence of my disagreement with the majority. My colleagues read Glisson's complaint as alleging only that it was Corizon's failure to implement INDOC's Health Care Service Directive that violated the Eighth Amendment, rather than as presenting a broader argument attacking Corizon's decision not to require centralized monitoring of inmates with complex medical conditions. Certainly if Corizon had implemented the state's Directive, quoted *ante* at 5, no policy would have stood in the way of adequate care for prisoners (such as Glisson) with chronic diseases. INDOC guidelines recognize the need for "planned care in a continuous fashion," and it is obvious that Glisson received nothing of the kind. My colleagues see this as a complaint about the *lack* of a policy, *ante* at 9, and they then conclude that in this situation a plaintiff must present evidence of a series of incidents or a widespread practice constituting custom and usage. That is not Glisson's claim. Even if it were, I see no support for the final step of the majority's line of reasoning.

The Supreme Court's decision in *Los Angeles Cnty. v. Humphries,* 562 U.S. 29 (2010), unanimously reaffirms that the key holding of *Monell* is that a municipal policy or custom must be at stake, no matter what type of relief is sought. 562 U.S. at 31. *Monell*'s requirement of a policy or custom is meant to ensure that a municipality is held liable only in situations where its "*deliberate* conduct" is the "moving force" causing the injury—that is, the deprivation results "from the decisions of … those officials whose acts may fairly be said to be those of the municipality." *Board of*

County Commissioners of Bryan County v. Brown, 520 U.S. 397, 403–04 (1997) (emphasis in original).

The Court has enumerated several ways to demonstrate that the municipality's own conduct is at stake, not that of its employees or agents. First, it has held that "[l]ocal governing bodies ... can be sued directly under § 1983 ... where ... the action that is alleged to be unconstitutional implements or executes a policy statement, ordinance, regulation, or decision officially adopted and promulgated by that body's officers." *Humphries*, 562 U.S. at 36 (quoting *Monell*, 436 U.S. at 690-91). A municipality can also be sued for "deprivations visited pursuant to governmental 'custom' even though such a custom *has not received formal approval* through the body's official decisionmaking channels." *Id.* (emphasis added).

In other words, either the content of an official policy, a decision by an official decisionmaker, or evidence of custom will suffice. It is true that a plaintiff must show multiple incidents to prove a custom or practice that has not been "officially adopted and promulgated." *Id.* But if she seeks to establish municipal liability by either of the other two methods—proving that the unconstitutional action resulted from a policy or a *decision* by the entity's "authorized decisionmakers"—she need not show multiple incidents. *Pembaur v. City of Cincinnati*, 475 U.S. 469, 481 (1986). In such cases, "the municipality is equally responsible whether that action is to be taken only once or to be taken repeatedly." *Id.*

The choice the majority has framed—written policy versus lack of written policy—is therefore a false one. The majority assumes that because Glisson attacks

Corizon's failure to enact certain protocols, he is alleging the absence of a policy. Not at all. Glisson alleges that Corizon had a deliberate policy that eschewed coordinated care: in essence, a policy not to have a policy and instead to rely on each provider's isolated decisions. And even if Glisson *were* alleging only the absence of a written policy, it does not follow that he must prove a custom. Glisson's allegations—and his evidence—fit comfortably within the "authorized decisionmaker" route, which does not require proof of multiple incidents. *Id.* Nowhere does Glisson allege that Corizon has an informal *custom* of not creating a protocol for centralized treatment plans. He alleges instead that it made an affirmative, official *decision* not to do so. Policymakers make decisions to act and not to act; there is no reason why an official decision not to act should be any less culpable—or any less official—under section 1983 than one to act. Corizon was well aware of the INDOC Directive. After seven years, it is reasonable to infer that Corizon's decision not to enact the required protocols was deliberate and was made by persons within Corizon with decisionmaking authority. (Indeed, it is hard to infer anything else.)

Even if Glisson's claim fits awkwardly into the methods mentioned in *Monell*, that is not a problem unless one reads *Monell* as providing an exhaustive, not an illustrative, list. But nothing in *Monell* or later cases supports such a mechanistic approach. *Monell*'s methods of proof are not ends; they are *means*. They suggest three paths to the same place: proof that "the municipal action was taken with the requisite degree of culpability." *Brown*, 520 U.S. at 404. *Monell* was about the conditions necessary to attribute conduct to

the municipal "person" under section 1983: that is, whether the action in question can properly be considered the municipality's "deliberate conduct." *Id*. The harm itself—or the number of harms—is irrelevant for this purpose. Where there is strong evidence of official culpability—as there is in this case—a court need not worry about which path the plaintiff takes to proving that the municipality is culpable. What matters is that the proof point to the municipality's own act.

The essential prerequisite to deliberateness—and thereby culpability—is knowledge of the risk at issue. In policy-omission cases, it is the plaintiff's burden is to present "evidence that there is a true municipal policy at issue, not a random event." *Calhoun v. Ramsey*, 408 F.3d 375, 380 (7th Cir. 2005). Such evidence is "necessary to understand what the omission means:" it could reflect nothing more than the municipality's ignorance of the problem's existence or gravity or its preference for another permissible course. *Id.* ("No government has, or could have, policies about virtually everything that might happen."). To be attributed to the municipality as a "policy," a course of action must be "consciously chosen from among various alternatives;" therefore, evidence must "be adduced which proves that the inadequacies resulted from conscious choice—that is, proof that the policymakers deliberately chose a ... program which would prove inadequate." *Id.* (quoting *City of Oklahoma City v. Tuttle*, 471 U.S. 808, 823 (1985)). When they lack evidence from which a conscious choice can be inferred, plaintiffs may prove that the municipality had a custom or practice of dealing with incidents in a certain way; in other words, they may use circumstantial

evidence to show an unspoken policy. Common sense says that one incident cannot constitute a custom. But where a plaintiff *does* present evidence from which the municipality's knowledge and choice can be inferred, there is no reason why proving multiple incidents should be necessary.

That is why we have stated that, where a municipal entity has "actual or constructive knowledge that its agents will probably violate constitutional rights, it may not adopt a policy of inaction." *King v. Kramer*, 680 F.3d 1013, 1021 (7th Cir. 2012) (alteration omitted) (quoting *Warren v. District of Columbia*, 353 F.3d 36, 39 (D.C. Cir. 2004)). It is why we have noted that a policymaker may be directly liable where he has actual knowledge of a risk but nonetheless ignores it. See *Steidl v. Gramley*, 151 F.3d 739, 741 (7th Cir. 1998) ("If the warden were aware of 'a systematic lapse in enforcement' of a policy critical to ensuring inmate safety, his 'failure to enforce the policy' could violate the Eighth Amendment.") (quoting *Goka v. Bobbitt*, 862 F.2d 646, 652 (7th Cir. 1988)). It is why we have held that where a situation calls for procedures, rules or regulations, the "failure to make a policy is also actionable." *Thomas*, 604 F.3d at 303 (citing *Sims v. Mulcahy*, 902 F.2d 524, 543 (7th Cir. 1990)).

For the same reason, the Supreme Court has noted that even where there is *no* evidence of actual notice, deliberateness may be inferred where a risk is sufficiently obvious. For example, in its failure-to-train cases, the Court has said that where, "in light of the duties assigned to specific ... employees the need for more or different training is so obvious, and the inadequacy so likely to result in the violation of

constitutional rights, … the policymakers of the city can reasonably be said to have been deliberately indifferent to the need." *City of Canton, Ohio v. Harris*, 489 U.S. 378, 390 (1989).

Here, Glisson has presented evidence that supports a reasonable inference that Corizon made "a deliberate choice to follow a course of action … from among various alternatives," and therefore may be held liable as a municipality under section 1983. *Harris*, 489 U.S. at 389 (quoting *Pembaur*, 475 U.S. at 483–84 (plurality opinion)). The Indiana Department of Corrections saw fit to promulgate Health Care Services Directive 2.06 on "Chronic Disease Intervention Guidelines." The Guidelines say that "[e]ach facility must establish a site specific directive that guides the management of chronic disease management and clinics." They instruct that this directive should ensure that "[c]are provided to [inmates with chronic illnesses] should be organized and planned and should be consistent across facility lines." They add other essential criteria for the care of the chronically ill, including the need for an individualized treatment plan that includes objectives for care and is kept current.

This Directive squelches any possible argument Corizon might have about a lack of awareness of the risk of not having protocols for the care of inmates with chronic illnesses. Timing is not on Corizon's side either. *Seven years* after the Directive appeared, Corizon had yet to make any policy change with regard to the comprehensive treatment of chronically ill inmates. In its responses to Glisson's interrogatories, Corizon admitted that it was aware of the Directive's existence and that it had done nothing to comply with its

dictates. The most plausible inference—if not the only one—is that Corizon consciously chose, without medical justification, simply not to enact protocols for managing the care of these vulnerable inmates.

One does not need to be an expert to know that complex, chronic illness requires comprehensive and coordinated care. In *Harris*, the Court recognized that because it is a "moral certainty" that police officers "will be required to arrest fleeing felons," "the need to train officers in the constitutional limitations on the use of deadly force … can be said to be 'so obvious,' that failure to do so could properly be characterized as 'deliberate indifference' to constitutional rights." 489 U.S. at 390 n.10. It was just as certain that Corizon providers would be confronted with patients with chronic illnesses. The need to establish protocols for the coordinated care of chronic illnesses is obvious, just as is the recklessness exhibited by failing to do so. On the record here, a jury could reasonably find that Corizon's "policymakers were deliberately indifferent to the need" for such protocols, and that the absence of protocols caused Glisson's death. *Id.* at 390.

Indeed, it is not necessary to rely on the obviousness of these risks, because the Directive provided all the information Corizon needed. Through it, Corizon was "aware of 'a systematic lapse in enforcement" of the directive, a policy critical to ensuring inmate safety.'" *Steidl*, 151 F.3d at 741. It had actual knowledge that, without protocols for coordinated, comprehensive treatment, the constitutional rights of chronically ill inmates would sometimes be violated, and nonetheless it "adopt[ed] a policy of inaction." *Kramer*, 680 F.3d at 1021. A jury could conclude that Corizon, indifferent to

the serious risk such a course posed to chronically ill inmates, made "a deliberate choice to follow a course of action ... from among various alternatives" to do nothing. *Harris*, 489 U.S. at 389. *Monell* requires no more.

In closing, it is important to stress that I am not arguing that the Constitution or any other source of federal law required Corizon to adopt the Directive or any other particular document. But the Constitution does require it to ensure that a well-recognized risk for a defined class of prisoners be competently addressed and not deliberately left to happenstance. Corizon had notice of the problems posed by a total lack of coordination. Yet despite that knowledge, it did nothing for more than seven years to address that risk. There is no magic number of injuries that must occur before its failure to act can be considered deliberately indifferent. See *Woodward v. Correctional Medical Services*, 368 F.3d 917, 929 (7th Cir. 2004) ("CMS does not get a 'one free suicide' pass.").

Nicholas Glisson may not have been destined to live a long life, but he was managing his difficult medical situation successfully until he fell into the hands of the Indiana prison system and its medical-care provider, Corizon. Forty-one days after he entered custody, he was dead. On this record, a jury could find that Corizon's obdurate failure to enact centralized treatment protocols for chronically ill inmates led directly to his death. I would reverse the judgment below and remand for a trial.

UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

Everett McKinley Dirksen United States Courthouse
Room 2722 - 219 S. Dearborn Street
Chicago, Illinois 60604

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FINAL JUDGMENT

February 17, 2016

Before: DIANE P. WOOD, Chief Judge
WILLIAM J. BAUER, Circuit Judge
DIANE S. SYKES, Circuit Judge

No. 15-1419	ALMA GLISSON, As Personal Representative of the Estate of NICHOLAS L. GLISSON, Plaintiff - Appellant v. INDIANA DEPARTMENT OF CORRECTIONS, et al., Defendants - Appellees
Originating Case Information:	
District Court No: 1:12-cv-01418-SEB-MJD Southern District of Indiana, Indianapolis Division District Judge Sarah Evans Barker	

The judgment of the District Court is AFFIRMED, with costs, in accordance with the decision of this court entered on this date.

APPENDIX C

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

No. 1:12-cv-01418-SEB-MJD

[Filed February 13, 2015]

NICHOLAS GLISSON (Estate of) Alma Glisson, Personal Representative of Estate,

Plaintiff,

vs.

INDIANA DEPARTMENT OF CORRECTION, CORRECTIONAL MEDICAL SERVICES, INC., MALAKA G. HERMINA Dr., MARY COMBS nurse,

Defendants.

ORDER DENYING PLAINTIFF'S MOTION TO ALTER OR AMEND JUDGMENT AND RECONSIDER SUMMARY JUDGMENT RULING

This cause is now before the Court on Plaintiff's Motion to Alter or Amend Judgment and Reconsider

Summary Judgment Ruling [Docket No. 94], filed on June 17, 2014, pursuant to Federal Rule of Civil Procedure 59(e). In order to prevail on a Rule 59 motion, a party must "clearly establish" that: "(1) the court committed a manifest error of law or fact, or (2) that newly discovered evidence precluded entry of judgment." *Cincinnati Life Ins. Co. v. Beyrer*, 722 F.3d 939, 954 (7th Cir. 2013) (quoting *Blue v. Hartford Life & Accident Ins. Co.*, 698 F.3d 587, 598 (7th Cir. 2012)). A party cannot show that the court committed a "manifest error of law" simply by recapitulating its previously unsuccessful arguments; rather, it must demonstrate that the court's ruling exhibited "wholesome disregard, misapplication, or failure to recognize controlling precedent." *Oto v. Metro. Life. Ins. Co.*, 224 F.3d 601, 606 (7th Cir. 2000) (quotation marks and citation omitted).

Plaintiff requests that we reconsider only one part of our June 4, 2014 summary judgment order, specifically, our grant of summary judgment in favor of Defendant Correctional Medical Services, Inc. ("CMS") on Plaintiff's *Monell* claim, brought pursuant to 42 U.S.C. § 1983. Plaintiff's *Monell* claim against CMS was based on the allegation that CMS policies "prevent[] its medical personnel from communicating properly and ensuring appropriate care for inmates with serious medical problems," which policies Plaintiff claimed exhibited deliberate indifference to the serious medical needs of inmates and led to Mr. Glisson's death. Dkt. No. 68 at 31.

In denying Plaintiff's *Monell* claim, we determined that Mr. Glisson had received constitutionally sufficient care from the individual defendants named

in the lawsuit. Thus, we held that because Plaintiff "has not established that a constitutional injury occurred, a 'custom or policy' claim stemming from this notional injury fails as a matter of law." *Glisson v. Ind. Dep't of Correction*, No. 1:12-cv-01418-SEB-MJD, 2014 WL 2511579, at *26 (S.D. Ind. June 4, 2014) (citing *Ray v. Wexford Health Sources, Inc.*, 706 F.3d 864, 866 (7th Cir. 2013) ("It is unnecessary to decide what the [corporate defendant]'s policy may be, since [plaintiff] has not established a constitutional problem with his treatment and thus did not suffer actionable injury from the policy he attributes to the corporation.")).

Plaintiff claims that we erred in our analysis in tying our finding that the individual defendants were not deliberately indifferent to Mr. Glisson's serious medical needs to Plaintiff's *Monell* claim against CMS. Plaintiff concedes that if we made an explicit finding that Mr. Glisson received constitutionally adequate treatment overall, it would then compel a finding that CMS was not liable under *Monell*. However, because our holding in her view was limited to whether the individual defendants acted with deliberate indifference, she maintains that CMS could still be liable if it were established that: "(1) Mr. Glisson's medical care was provided pursuant to a CMS practice/policy; (2) that practice/policy was deliberately indifferent to inmates' serious medical needs; (3) that practice/policy prevented any individual medical provider from forming the subjective state of mind required for Eighth Amendment liability; and (4) the

practice/policy caused Mr. Glisson's death."[1] Pl.'s Mem. at 5.

In support of her contention, Plaintiff cites the Seventh Circuit's decisions in *Thomas v. Cook County Sheriff's Department*, 604 F.3d 293 (7th Cir. 2010) and *Shields v. Illinois Department of Corrections*, 746 F.3d 782 (7th Cir. 2014).[2] In *Thomas*, the Seventh Circuit held that "a municipality can be held liable under *Monell*, even when its officers are not, unless such a finding would create an *inconsistent* verdict." *Thomas*,

---

[1] Alternatively, Plaintiff argues that we should find CMS liable under a *respondeat superior* theory, citing the Seventh Circuit's recent expression of disfavor in *Shields v. Illinois Department of Corrections*, 746 F.3d 782 (7th Cir. 2014) for the unavailability of *respondeat superior* liability for private corporations that have contracted to provide essential government services such as health care for prisoners. *Id.* at 786, 789-96 (observing that the court "may need to reconsider" whether the *Monell* standard extends from local governments to private corporations "if and when we are asked to do so"). However, because the Seventh Circuit has not yet had occasion to reconsider this issue, we follow the current precedent in our circuit under which *respondeat superior* is not a viable theory of liability for private corporations like CMS. Thus, we need not address Plaintiff's argument based on a *respondeat superior* theory further.

[2] The Seventh Circuit's decision in *Shields* was decided after the motion for summary judgment in our case was fully briefed, and thus, was not available at the time Plaintiff filed her response. Although the Seventh Circuit's decision in *Thomas* had been issued when the summary judgment motion was briefed, Plaintiff contends that she did not include this authority in her response to CMS's motion for summary judgment because the issue the Court found determinative was not raised by CMS in its opening brief or reply, and thus, Plaintiff had no reason to cite such authority at that time.

604 F.3d at 305 (emphasis in original). To determine whether a municipality's liability is dependent on its officers, courts are to "look to the nature of the constitutional violation, the theory of municipal liability, and the defenses set forth." *Id.* In *Thomas*, the court held that it was not inconsistent for the jury to have found that the individual defendants were not deliberately indifferent to the plaintiff's serious medical need, but that the county defendant was nonetheless liable under *Monell* because the jury could have found that the individual defendants "simply could not respond adequately because of the well-documented breakdowns in the [county defendant's] policies for retrieving medical request forms." *Id.*

Similarly, in *Shields*, the Seventh Circuit indicated that a private medical contractor's practices or policies can give rise to *Monell* liability. There, the court observed that, although the plaintiff was "the victim of serious institutional neglect of, and perhaps deliberate indifference to, his serious medical needs," the medical service contractor (also a defendant) had "diffused responsibility" for the plaintiff's medical care so widely that the plaintiff was unable to identify a particular person responsible for his care and that, as a result, "[n]o one doctor knew enough that a jury could find that he both appreciated and consciously disregarded" the plaintiff's serious medical needs. 746 F.3d at 785, 786. The *Shields* Court ultimately found in favor of the defendant medical contractor, however, because the plaintiff had failed to offer evidence of an express policy, instead attempting to show a practice or custom through a series of bad acts. The plaintiff had evidence only of isolated incidents that the court determined were insufficient to establish a custom or practice that

was deliberately indifferent to inmates' serious medical needs. *Id.* at 796.

We view the case at bar as distinguishable from *Thomas* and *Shields*. In both of those cases, the court found specifically that a constitutional injury had occurred, to wit, that the respective plaintiffs had received constitutionally deficient care despite the fact that the individual defendants in each case were shown not to have the requisite mental state to be found deliberately indifferent. In contrast, in denying Plaintiff's *Monell* claim against CMS, we indicated that our ruling was based on our finding that Mr. Glisson had suffered no constitutional injury, and thus, any analysis of CMS's policies was unnecessary. Plaintiff maintains that we did not adequately flesh out our analysis to make clear that we not only found that the individual defendants were not deliberately indifferent to Mr. Glisson's serious medical needs but also that Mr. Glisson received constitutionally adequate care overall. Assuming we did not make it sufficiently clear in our summary judgment order, we do so now: The undisputed evidence clearly establishes that the care Mr. Glisson received was in no way constitutionally deficient and there is no evidence that his death was caused by any unconstitutional infirmity in any policy or practice of CMS regarding the coordination of care for chronically ill offenders.

Unlike the situations presented in *Thomas* and *Shields*, Mr. Glisson received extensive treatment for his physical and mental health needs while housed at the Indiana Department of Correction ("IDOC") as fully detailed in the factual background section of our summary judgment order. In *Thomas*, the reverse was

true: for example, there was evidence that the defendant ignored numerous requests by the plaintiff for medical treatment and that there were systemic problems related to the delivery of medical care, understaffing, and infrequent checks by medical personnel. 604 F.3d at 298-99. Similarly, in *Shields*, the court found that the plaintiff was the "victim of serious institutional neglect or, and perhaps deliberate indifference to, his serious medical needs." 746 F.3d at 785.

There is no evidence of such deficiencies in CMS's policies and practices. Plaintiff alleges that CMS failed to enact a policy to ensure effective communication and continuity of care among its medical professionals, which Plaintiff contends resulted in a lack of awareness of Mr. Glisson's treatments, a failure to take personal responsibility, and various communication breakdowns on the part of CMS personnel in connection with Mr. Glisson's care, the combination of which deficiencies led to his death. We are not so persuaded: the fact that multiple medical providers participated in Mr. Glisson's care without more is insufficient to establish a constitutional violation. Although Plaintiff makes much of the fact that CMS-affiliated providers failed to cite specific provisions of the IDOC's Health Care Services Directives that they followed in providing Mr. Glisson's care, that alone is also insufficient to establish constitutionally inadequate care, particularly given that the evidence adduced clearly demonstrates that the care provided by CMS-affiliated providers complied with the substance of these directives, including the requirements that medical personnel identify a patient's chronic health

conditions, include conditions listed on a master problem list, and establish a treatment plan.

Within one week of his arrival at IDOC, psychiatrist Dr. Steven Conant, M.D. assessed Mr. Glisson's condition, identifying his chronic problem of depressive disorder for which he formulated a treatment plan of medication. Mr. Glisson was seen the next day by physician Dr. Jill Gallien, M.D., who diagnosed chronic problems of hypertension, acquired hypothyroidism, neoplasm of unspecified nature of digestive system, and skin disorder. Dr. Gallien documented a treatment plan for Mr. Glisson which included medications as well as labwork and x-rays. The evidence shows that Mr. Glisson's chronic problems identified by Dr. Conant and Dr. Gallien consistently appeared in his electronic medical records and subsequent care providers documented changes to his treatment plans as necessary. We need not reiterate the salient details of the care received by Mr. Glisson while incarcerated because those facts are all clearly outlined in our summary judgment order, but those undisputed facts clearly establish that Plaintiff failed to meet her burden to establish that at any point Mr. Glisson's medical care fell below constitutional standards.

Given the undisputed evidence before us, even if certain deficiencies existed in CMS's policies addressing the coordination of care for chronically ill inmates (which we have not found), Plaintiff has failed to establish that any such deficiency subjected Mr. Glisson to any constitutional deprivation which caused

his death. For these reasons, Plaintiff's motion for reconsideration is DENIED.[3]

IT IS SO ORDERED.

Date: 2/13/2015 /s/Sarah Evans Barker
SARAH EVANS BARKER, JUDGE
United States District Court
Southern District of Indiana

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[3] On February 3, 2015, Plaintiff filed a Motion for Status Conference [Docket No. 99]. Because that request was made solely to address this motion to reconsider, Docket No. 99 is DENIED AS MOOT.

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APPENDIX D

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF INDIANA
INDIANAPOLIS DIVISION

No. 1:12-cv-01418-SEB-MJD

[Filed June 4, 2014]

NICHOLAS GLISSON (Estate of) Alma Glisson, Personal Representative of Estate,

Plaintiff,

vs.

INDIANA DEPARTMENT OF CORRECTION, CORRECTIONAL MEDICAL SERVICES, INC., MALAKA G. HERMINA Dr., MARY COMBS nurse,

Defendants.

ORDER ON PENDING MOTIONS

This cause is before the Court on the Motions for Summary Judgment filed by Defendants Correctional Medical Services, Inc., Malaka G. Hermina, M.D., and Mary Combs [Docket No. 40] and by the Defendant Indiana Department of Correction [Docket No. 57] on

September 10, 2013 and November 27, 2013, respectively. Plaintiff, Alma Glisson, has brought this action as Personal Representative of the Estate of Nicholas Glisson, pursuant to 42 U.S.C. § 1983, alleging that Defendants were deliberately indifferent to Mr. Glisson's serious medical needs, which constituted cruel and unusual punishment in violation of his rights under the Eighth Amendment to the United States Constitution. For the reasons detailed below, we GRANT IN PART the CMS Defendants' Motion for Summary Judgment as to all federal claims brought pursuant to § 1983 and REMAND the remaining state law claims to Marion Superior Court.[1]

Factual Background[2]

Mr. Glisson's Physical Health Issues Prior to Incarceration

This action arises out of the death of Mr. Glisson on October 10, 2010, at the age of fifty while he was incarcerated at Plainfield Correctional Facility. Mr. Glisson had several longstanding, chronic medical conditions upon entering into custody at the Indiana Department of Correction on September 3, 2010. His

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[1] All pending motions to limit or exclude expert testimony filed by Defendants [Docket Nos. 51, 52, 79, 83, and 85] are DENIED AS MOOT because the testimony Defendants seek to exclude does not alter our determination that Plaintiff's federal claims cannot survive summary judgment.

[2] Because Plaintiff has indicated that she does not dispute any of the specific factual assertions in Defendants' statements of facts, we have drawn heavily from Defendants' factual recitations, incorporating additional facts alleged by Plaintiff where applicable.

medical difficulties stemmed primarily from a diagnosis of laryngeal cancer in 2003, which required extensive surgery performed on October 17, 2003, by Richard Borrowdale, M.D., to remove his larynx and part of his pharynx. During that surgery, Mr. Glisson also had a tracheoesophageal puncture for voice restoration. Dr. Borrowdale extracted portions of Mr. Glisson's mandible and thirteen teeth and performed bilateral modified neck dissections at that time as well. As a result of the surgery, Mr. Glisson was left with a permanent stoma, or opening in his throat, with placement of a tracheostomy tube. Mr. Glisson was given training on how to care for the stoma and tracheostomy tube, which involved keeping the area clean using saline solution and using a suction machine to clear saliva and mucous secretions from the stoma when necessary.

On October 28, 2003, Dr. Borrowdale performed a follow-up examination of Mr. Glisson, noting that Glisson had been fitted for a voice prosthesis and opining that Glisson would require postoperative radiation treatment to further treat the cancer. After Mr. Glisson's radiation therapy concluded, Dr. Borrowdale examined him on April 1, 2004, with particular attention to a mass that had developed on the left side of his neck. Fortunately, a biopsy established that the mass was merely granulation tissue and not cancerous.

On June 3, 2004, Mr. Glisson returned to Dr. Borrowdale with complaints of dysphagia or difficulty swallowing. Mr. Glisson was also diagnosed with hypothyroidism as a result of his radiation therapy. To treat Mr. Glisson's swallowing difficulty, Dr.

Borrowdale performed a direct esophagoscopy and a blind dilation of Glisson's esophagus, and ordered him to return in six weeks for a follow-up examination. Mr. Glisson's swallowing problems persisted, which led Dr. Borrowdale on December 20, 2004 to again attempt a direct esophagoscopy using a rigid scope. Because Mr. Glisson was experiencing swelling and was unable to flex his head, the scope could not be passed through directly, requiring Dr. Borrowdale to dilate the esophagus using dilators.

Mr. Glisson continued to have difficulty swallowing during the months and, indeed, years following his surgery. On June 24, 2005, Dr. Borrowdale performed an esophagoscopy which revealed a mucosal irregularity at the lower portion of the pharynx above Mr. Glisson's voice prosthesis. Dr. Borrowdale obtained a specimen of this irregularity for biopsy, finding it to be non-cancerous. Dr. Borrowdale again treated Mr. Glisson for dysphagia on September 1, 2005, at which point he noted a mucosal superficial lesion which was also biopsied. On January 16, 2005, Dr. Borrowdale used an esophagoscope to dilate Mr. Glisson's esophagus. On that same date, Dr. Borrowdale made note of the fact that Glisson was a chronic alcoholic.

Dr. Borrowdale again examined Mr. Glisson on June 9, 2006, following which he noted that Mr. Glisson had some leukoplakia, or white patches on his tongue, and erythoplakia, or red lesions in his mouth. Dr. Borrowdale further observed that after nearly three years post-surgery, Mr. Glisson still had a nonhealing area around his stoma and experienced continued difficulty swallowing. On June 26, 2006, Dr.

Borrowdale dilated Mr. Glisson's esophagus to excise the anterior floor of his mouth lesion.

Mr. Glisson returned to Dr. Borrowdale on January 26, 2007 with facial swelling and dysphagia. Dr. Borrowdale again performed an esophagoscopy and advised Mr. Glisson to return in six months for further follow up examination.

On May 1, 2007, Mr. Glisson presented to Dr. Borrowdale with complaints of contracture of the neck with pain in the occipital area, along with right shoulder and arm pain. Dr. Borrowdale noted that there was no evidence of disease or cancer, but he was concerned that Mr. Glisson might have some cervical spine disease. Thus, he referred him to neurologist Katherine T. Kobza, M.D., who saw Mr. Glisson on July 6, 2007. Dr. Kobza noted that he had developed progressive problems with neck pain over the previous several years. His neck slumped forward and he had trouble holding his head up, which affected his ability to use his voice prosthesis. Dr. Kobza opined that Mr. Glisson's case was very complicated due to his extensive surgery and post-surgical radiation.

Mr. Glisson returned to see Dr. Kobza on July 25, 2007, after having a CT scan of the cervical spine, which showed a mildly compressed T1 vertebral body and changes throughout the neck region. A nerve study also showed right C7 radicular changes with left C6 and bilateral carpal tunnel. Dr. Kobza's impressions were probable cervical radiculopathy and significant scar tissue. She told Mr. Glisson that there would be limitations on how much capacity could be regained and suggested physical therapy for strengthening and

stretching. Dr. Kobza instructed Mr. Glisson to return to see her in four to six weeks.

However, Mr. Glisson did not return to see Dr. Kobza until February 15, 2008, more than six months later. At that time, he continued to have pain and difficulty with his neck. He was wearing a neck brace some of the time during the day to help him hold his head up, although he still had considerable difficulty doing so, especially toward the end of the day. Dr. Kobza noted that Mr. Glisson had tried an injection and physical therapy without definite improvement and that she had little other treatment protocols to suggest or provide.

On March 25, 2008, Derron K. Wilson, M.D. of the Indianapolis Neurosurgical Group examined Mr. Glisson. Mr. Glisson told Dr. Wilson that he had noticed over the previous two years that his head was falling forward. Dr. Wilson reviewed a March 12, 2008 cervical MRI which showed mild cervical spondylosis, abnormal signal intensity of uncertain origin, and findings possibly suggestive of metatastic lesions. Dr. Wilson was also concerned about Mr. Glisson's report of a recent ten-pound weight loss. Dr. Wilson prescribed Valium as needed for muscle spasms and referred Mr. Glisson to Alexander Yeh, M.D., a radiation oncologist who had managed Mr. Glisson's chemotherapy.

Dr. Yeh examined Mr. Glisson on March 31, 2008, and requested another MRI. Mr. Glisson was subsequently hospitalized at St. Vincent Hospital in Indianapolis from May 28, 2008 to June 4. 2008. Mr. Glisson's discharge summary was completed by Salvatore Grimaldi, M.D., who noted Glisson's history

of cancer with surgery, and recent radiologic films and MRI which revealed a cervical spine abnormality. Mr. Glisson continued to suffer from progressive dysphagia with weight loss, and flexion of the neck so severe that it made it difficult for him to clean his tracheal stoma and use his voice prosthesis. During his hospitalization, Mr. Glisson had a gastrojejunostomy tube, also referred to as a "G-tube," place in his upper abdomen to permit nutritional support via tube feeding. No cancerous cells were identified during Mr. Glisson's hospitalization. Mr. Glisson was discharged with home health care and nutrition care to be provided at home.

On August 5, 2008, Mr. Glisson was examined by Dr. Gregory Hellwarth of Orthopedic Spine & Surgery, LLC, who noted that Mr. Glisson had severe neck pain with C1-2 anterior sublaxation, a history of laryngeal carcinoma with extensive irradiation to the anterior neck, chronic nicotine dependency (and still smoking), and malnutrition. Dr. Hellwarth opined that surgery to address Mr. Glisson's neck problems would be a major undertaking and would carry a huge risk of severe complications. He recommended a CT scan to define the process of the upper cervical spine better. Dr. Hellwarth saw Mr. Glisson again on August 21, 2008, after the CT scan and reiterated his belief that corrective surgery for Mr. Glisson's neck was beyond the scope of what could be offered. Dr. Hellwarth referred Mr. Glisson for further consultation by Dr. Rick Sasso.

On May 5, 2009, Mr. Glisson was examined by neurologist Jay Bhatt, M.D. for evaluation of severe anterocollis, or anterior neck flexion. Dr. Bhatt noted

that Mr. Glisson continued to have difficulty swallowing. Dr. Bhatt concluded that Mr. Glisson's anterocollis was due to radiation therapy and recommended botulinum toxin injections. He cautioned, however, that if the flexion was due to fibrosis, the injections would not help. Dr. Bhatt further observed that Mr. Glisson's G-tube would be helpful if he continued to have trouble swallowing. On May 20, 2009, Mr. Glisson underwent an initial set of botulinum injections, but Dr. Bhatt continued to be suspicious that Glisson had contractures and scar tissue in his neck.

On June 17, 2009, Mr. Glisson was examined by Dr. Stacey L. Halum of University Otolaryngology Associates, Inc. In addition to his prior health issues, Mr. Glisson reported that he recently experienced leaking of his voice prosthesis. Dr. Halum observed an area of red, thickened mucosa at the left soft palate which she found concerning, and recommended a biopsy. Dr. Halum also discussed options for addressing and revising Mr. Glisson's stoma. However, because Mr. Glisson had fungal colonization on his voice prosthesis at that time, Dr. Halum recommended a course of antibiotics before changing the prosthesis or revising the stoma.

Mr. Glisson was admitted to Clarian Health on July 20, 2009, for surgical release of neck contractures, esophageal dilation, revision of his tracheoesophageal puncture, an esophagoscopy, a laryngoscopy and biopsy of the left soft palate lesion, and placement of a new voice prosthesis. Mr. Glisson received physical and occupational therapy during his hospitalization and was fitted with a modified cervical collar designed to

hold his neck in a more natural and less-flexed position. Mr. Glisson was advised to wear the cervical collar as often as possible, preferably at all times while awake. He was discharged on July 24, 2009.

On August 6, 2009, Mr. Glisson saw Dr. Hallum for a follow-up examination. She noted that his speech was very good and that he was holding his head much higher. In response to Mr. Glisson's desire to adjust his neck brace, he was scheduled to meet with a physical therapist, who would assist in modifying the brace. On September 3, 2009, Mr. Glisson returned to Dr. Hallum at which point she placed a new voice prosthesis that allowed him to drink water with no evidence of leaking.

On September 23, 2009, Mr. Glisson was examined by Dr. Borrowdale who reviewed the results from Glisson's June 17, 2009 biopsy of the left soft palate lesion. The results of the biopsy showed squamous cell carcinoma requiring surgical recision, which Dr. Borrowdale performed on October 8, 2009. Dr. Borrowdale again examined Mr. Glisson on December 18, 2009, and noted that he continued to be in very poor health.

At a March 23, 2010 examination of Mr. Glisson, Dr. Borrowdale noted a lesion on his left lateral tongue which was suspicious for carcinoma. Dr. Borrowdale obtained a specimen for biopsy and ordered a PET scan. The lesion was cancerous and Dr. Borrowdale excised it on April 28, 2010. In a follow-up visit on June 24, 2010, Dr. Yeh noted that Mr. Glisson was improving but that he continued to suffer from severe fibrosis causing neck retraction and pain.

Mr. Glisson's Cognitive and Mental Health Issues Prior to Incarceration

On October 1, 2009, Mr. Glisson complained to Dr. Fisher of poor memory. On October 2, 2009, Mr. Glisson's attorney contacted Dr. Borrowdale's office and requested that Glisson's memory issues be evaluated by a neurologist to determine what effect his medication regime had on his brain.

On January 14, 2010, Dr. Kozba, a neurologist, examined Mr. Glisson. Dr. Kozba had previously seen Mr. Glisson in November 2009 and thereafter was given an MRI and neuropsychological testing. At the January 14 appointment, Dr. Kozba noted that Mr. Glisson was struggling with memory and depression. A December 11, 2009 MRI of his brain was normal, but neuropsychological testing performed on December 14, 2009 showed a mild neurocognitive decline with difficulties related to attention span, processing speeds, verbal fluency, and memory, along with signs of significant depression. Dr. Kozba observed:

> Mr. Glisson's neuropsychological evaluation did demonstrate some mild cognitive impairment. This is likely multifactorial both from his ongoing illness, alcohol consumption but the overwhelming finding was that of significant depression as well. At this point, this has not been addressed or treated and I think he definitely deserves treatment. I worry about his psychological status in terms of plans to testify in court in the next several weeks and I think that maybe this needs to be carefully thought out whether he is able to handle this. I will institute some therapy with Celexa today to see

> if we can get some symptoms under control but this will not take effect for 4 to 6 weeks.

Defs.' Exh. 37.

Mr. Glisson's Alcohol Issues

At some point prior to Mr. Glisson's throat cancer diagnosis in 2003, he participated in a twelve-step program through Alcoholics Anonymous ("AA") to address his alcoholism. However, on August 12, 2006, Mr. Glisson was examined by his primary care physician, William Fisher, M.D., who noted that Mr. Glisson's main problem was that he continued to be a heavy consumer of alcohol. Dr. Fisher advised Mr. Glisson to return to an AA program and to quit both drinking and smoking. Dr. Fisher also noted concern regarding Mr. Glisson's compliance with the medication Synthroid, which he took to address his chemotherapy-induced hypothyroidism. When Mr. Glisson returned on August 15, 2008 for refills of Oxycodone and Oxycontin, Dr. Fisher noted that Mr. Glisson continued to use alcohol. On January 19, 2009, Mr. Glisson again visited Dr. Fisher for treatment of blisters on his heels. At that appointment, Dr. Fisher noted that Mr. Glisson smelled of alcohol.

Mr. Glisson's Ability to Care for Himself

Despite his significant health issues, from 2003 to 2010, Mr. Glisson was able to take care of his stoma and suctioning independently, without assistance. Plaintiff Alma Glisson, Mr. Glisson's mother, testified by deposition that although both she and Mr. Glisson's sister were present when he was taught how to perform the cleaning and suctioning of his tracheostomy/stoma

vent shortly after his 2003 surgery, he would not allow them to help him and insisted on doing it himself.

Plaintiff testified that she did help Mr. Glisson with certain other tasks at times, such as assisting him with his feeding tube and keeping it clean as well as helping to make sure he took the right medication at the right time. However, she also testified that Mr. Glisson used the feeding tube only occasionally and that he generally took food or nutritional supplements like Ensure or Boost through his mouth. According to Plaintiff, Mr. Glisson ate well and took Ensure or Boost six times per day as prescribed, unless he ate a sufficient amount of other food so that he did not require as many supplements.

Mr. Glisson lived alone, except for brief periods of time when he stayed with his family to help care for his sick grandmother and dying brother. Plaintiff testified that she was never aware of any problems with his hygiene. To the contrary, he kept clean, took regular baths, and washed his own laundry. Plaintiff testified that, during the week or so before he was incarcerated in August 2010, Mr. Glisson came to her house to mow the lawn, clean her French doors, do some cooking, and help care for his brother. According to Plaintiff, although Mr. Glisson had health issues, he was able to live with them. She testified that: "[H]e had no voicebox, no thyroid, neck breather, and that was the condition he was in. But he got along very well with it, very well for what happened to him." Pl.'s Exh. C at 122. Plaintiff did not believe that Mr. Glisson's condition was deteriorating before his incarceration.

Physicians Express Concern for Mr. Glisson's Condition Prior to Incarceration

On April 30, 2010, Dr. Borrowdale wrote a letter expressing concern regarding incarcerating Mr. Glisson, stating:

> Nick Glisson is a 50-year-old male who has been a cancer patient of mine for at least the last 15 years. He is severely disabled from his cancer and from alcohol. He is severely alcoholic. He is unable to speak because of his laryngectomy and has problems with dysphagia. He is also very kyphotic and has problems ambulating. The patient has also had a cancer of the soft palate and just recently, of his tongue. This patient is severely disabled, and I do not feel that he would survive if he was incarcerated.

Defs.' Exh 38.

On July 1, 2010, Mr. Glisson's voice prosthesis was changed after it had fallen out. On August 26, 2010, Dr. Fisher wrote a letter stating:

> Nicholas [Glisson] is an unfortunate gentleman with many health problems needing daily observation for monitoring of these problems. He has had surgery for throat cancer and has a permanent tracheostomy. He has severe DJD of his cervical spine with deformity of his neck/unable to lift his head, difficulty swallowing and talking. He is unable to be away from his home by himself. He would not do well if incarcerated.

Defs.' Exh. 40.

Mr. Glisson's Last Examination by Dr. Fisher Prior to Incarceration

Dr. Fisher last saw Mr. Glisson on August 19, 2010. At that examination, Dr. Fisher observed that Mr. Glisson was stable. In particular, he was fully able to take care of himself, clean his tracheostomy, and take food through a feeding tube when necessary. Dr. Fisher also observed that, while Mr. Glisson still had trouble swallowing and talking, he had managed to care for himself throughout the six years following his surgery. According to Dr. Fisher, he never had end-of-life discussions with Mr. Glisson and he had not considered any such medical planning for Glisson.

Mr. Glisson's Incarceration at Wayne County Jail

On August 31, 2010, Mr. Glisson was sentenced to a period of incarceration and taken to the Wayne County Jail. His attorney, David Jordan, wrote a letter to the Wayne County Sheriff stating that Mr. Glisson had very serious medical conditions, including throat cancer, and that he had a feeding tube, voice box, and other issues that required daily attention. A Booking Screening Form signed by Mr. Gleason on August 31, 2010, noted that Mr. Glisson had a "trache" and that he looked unsteady and was unable to raise his head.

On that same day, Michelle Cruse, a nurse at the Wayne County Jail, noted that she had spoken with Plaintiff Alma Glisson and that Ms. Glisson planned to bring supplies to the jail that Mr. Glisson needed to treat his medical conditions. There is no evidence that Nurse Cruse performed an assessment of Mr. Glisson on August 31, but she did note on September 1, 2010, that she had spoken to Mr. Glisson and that he had not

told her the previous day that he had a G-tube. There is no indication that Mr. Glisson received any other medical or nursing examination at the Wayne County Jail.

According to Plaintiff, she and Mr. Glisson brought a number of instruments that Glisson used to care for himself and his tracheostomy to the Wayne County Jail when he was taken there on August 31, 2010. The medical equipment they brought included the machine Mr. Glisson used to suction his tracheostomy, a mirror and light he used to help him clean his tracheostomy, and his neck brace. According to Plaintiff, Mr. Glisson was prescribed a neck brace to help him hold his head up because he had developed problems doing so after his surgeries. By wearing the neck brace, Mr. Glisson could more easily hold his head up, which improved his breathing and speech, and reduced the pain in his neck.

Mr. Glisson's Transfer to the Indiana Department of Correction and Initial Evaluation

On September 3, 2010, Mr. Glisson was transferred from the Wayne County Jail to the Indiana Department of Correction's ("IDOC") Reception Diagnostic Center ("RDC"). His transfer documentation included a summary of County Jail Medical Records and attached documentation prepared by Donna Roberts, RN, of the Wayne County Jail. The summary noted that Mr. Glisson had a history of throat cancer, hypothyroidism, throat surgery with a tracheostomy and a G-tube. The summary also identified ongoing treatment, including: using suction; G-tube feedings; soft foods; and Boost, a nutritional supplement. A list of medications was attached that included

Levothyroxine, Omeprazole, Oxycontin, Rampiril, Effexor, Veramyst, and Flexeril. Documentation attached to the summary indicated that Mr. Glisson used his suction machine as needed to suction his stoma, that he used an antiseptic oral rinse, and that he had swabs for stoma care.

When Mr. Glisson was transported to IDOC's RDC, personnel at the Wayne County Jail gave the transport officers Glisson's equipment to be transported with him. However, there is no record of who at RDC (e.g., whether it was a DOC employee or a CMS employee) received this equipment. Plaintiff contends that this equipment was never provided to Mr. Glisson after he arrived at RDC nor was it returned to Plaintiff after Glisson's death.

On the same day he was transferred to IDOC, Mr. Glisson was assessed by Tim P. Sanford, RN, at Reception Diagnostic Center. Nurse Sanford noted Mr. Glisson's self-reported medication regimen included Levothyroxine, Effexor, Omeprazole, Flexeril, Oxycontin, and Altace, which is another name for Ramipril. Nurse Sanford described Mr. Glisson as alert and able to make his needs known using his voice prosthesis and noted that he had a tracheostomy that was suctioned approximately six times per day, and that his G-tube was used only when he had difficulty swallowing. According to Nurse Sanford's notes, Mr. Glisson would receive Levothyrozine Sodium, Lisinopril, Clonidine HCL, Oxycontin, Prilosec, and Flexeril.

Mr. Glisson's Health Condition from September 4, 2010 to September 10, 2010

On September 4, 2010, Mr. Glisson performed his own tracheostomy care and cleaned his stoma. Pamela E. England, RN, noted that Mr. Glisson was permitted to be fed in his cell, and that he could use a bandana to cover his tracheostomy.

On the evening of September 5, 2010, Mr. Glisson was identified as a suicide risk by IDOC custody staff and transferred from general population to segregation. Custody staff members reported to Rachel M. Johnson, RN, that Mr. Glisson was angry and throwing candy out of his cell. Nurse Johnson evaluated Mr. Glisson in his cell, but because of security measures, she was unable to take his blood pressure. She was able to determine that Mr. Glisson had a pulse of 60 and an oxygen saturation level of 84%, which was quite low. Mr. Glisson stated that he was angry with the custody officers for not listening to him and that he had not been trying to hurt himself. Staff members on the day shift had told Nurse Johnson that Mr. Glisson had seemed confused, but when Nurse Johnson evaluated him, he was alert and oriented. Custody officers relayed to Nurse Johnson that Mr. Glisson had consumed only milk for two days and that he was not eating. They further advised her that Mr. Glisson could not be brought to the medical clinic area because he refused to be handcuffed. Nurse Johnson and Carla DeWalt, RN, went to the segregation cell to assess Mr. Glisson further. His oxygen saturation level was at that time fluctuating between 84% and 94% with breathing and position changes. Mr. Glisson told Nurse Johnson that he had not used his suction machine to

clear secretions from his tracheostomy that day. He was eventually brought to the medical clinic where he was allowed to use his suction machine, at which point his oxygen saturation improved to 96%. However, according to the nurses' notes, he still appeared confused and was taken back to the segregation area on suicide watch.

The next morning, September 6, 2010, Mr. Glisson was again brought to the medical clinic area to suction his tracheostomy. He was alert and oriented with normal vital signs, including temperature of 98.3 degrees, blood pressure of 122/82, a pulse of 92, a respiratory rate of 20, and an oxygen saturation of 98%. Victoria M. Crawford, RN, instructed custody staff to notify medical staff if Mr. Glisson became confused or disoriented.

Later that day, Tina M. Burger, LPN, was summoned to the segregation area because Mr. Glisson was not responding to questions from the custody staff. Nurse Burger noted that he had been placed in a wheelchair but would not sit up. Mr. Glisson was brought to the medical clinic for further observation. His breath sounds were clear and regular, but his blood pressure was elevated to 159/107. Nurse Burger administered Clonidine to address his elevated blood pressure and continued to monitor his vital signs. Mr. Glisson remained unresponsive until Nurse Crawford performed a corneal touch at which point he awoke completely and became alert and oriented.

Mr. Glisson returned to the medical clinic from segregation again later that evening for suctioning and monitoring of his vital signs. His vital signs were normal except for his oxygen saturation level, which

was 86%. After Mr. Glisson performed his tracheostomy care, his oxygen saturation improved to 94%, but he continued to be somewhat disoriented as to time and place.

On September 7, 2010, Nurse Crawford noted that Mr. Glisson refused to be brought from segregation to the medical clinic. Nurse Crawford visited Mr. Glisson in his cell, observing him to be alert and oriented, but agitated. Mr. Glisson stated that he did not need to be suctioned. His vital signs were normal, with a 99% oxygen saturation level. Mr. Glisson was also assessed that same day by licensed mental health counselor Mary J. Serna. At that assessment, Mr. Glisson reported fair support and adjustment to prison life. He stated that he had a history of blackouts possibly due to "spinal injuries" and also acknowledged drinking alcohol and the use of marijuana.

Mr. Glisson returned to the medical clinic on September 8, 2010, after IDOC officers had taken his bandana from him because he was "making underwear out of it, then applying it to his neck." Nurse Johnson noted that he was extremely aggravated with the custody officers. Mr. Glisson's oxygen saturation was 84% and it remained low even after he was suctioned. Nurse Johnson asked the custody officers to step back and give Mr. Glisson space, and she instructed Glisson to close his eyes and take deep breaths. His oxygen saturation level then rose to 97%. Nurse Johnson also noted that Mr. Glisson had a small skin tear on his left forearm, so she added him to the wound care list.

On September 9, 2010, Mr. Glisson had an initial psychiatric evaluation with Dr. Steven G. Conant. Dr. Conant learned that Mr. Glisson was divorced with two

adult children and that he had at that point been on social security disability for about five years. Dr. Conant also noted Mr. Glisson's history of gastroesophageal reflux disease, hypertension, previous throat surgery and throat reconstruction. Mr. Glisson acknowledged previous heavy alcohol use, and that he had been diagnosed with depression, for which Effexor seemed to help. Mr. Glisson stated that his weight was down but that his appetite was "OK." He agreed to a trial of Prozac in place of Effexor to treat his depression. Also on September 9, 2010, Mr. Glisson was assessed by nurse practitioner Samuel Kobba, who wrote an order permitting Glisson to be given the Ensure supplemental nutrition drink that he brought with him from the Wayne County Jail.

The next day, on September 10, 2010, Mr. Glisson was assessed by Jill Gallien, MD. Dr. Gallien noted Mr. Glisson's chronic health problems and observed that he appeared thin and had decreased breath sounds, but that his feeding tube and trach site both looked good. She further noted that he sat with his neck in constant flexion, complained of neck pain, and that he seemed somewhat confused. Dr. Gallien prescribed Morphine Sulfate, Ensure through December 2010, and a four-day course of Vicodin to treat Mr. Glisson's pain. On that same day, requests for Mr. Glisson's medical records were sent to Methodist Hospital, Dr. Kobza, CENTA, and Dr. Fisher. Kelley Kurtz, a Health Services Administrator with IDOC, also contacted Plaintiff by telephone to inquire about Mr. Glisson's medical history as well as behaviors at home, such as whether he spit on the floor when he lived at home. According to Plaintiff, she told Ms. Kurtz that he did

not, and Ms. Kurtz responded that she did not think Mr. Glisson was acting right.

Mr. Glisson's Health Condition from September 17, 2010 to September 26, 2010

One week later, on September 17, 2010, Mr. Glisson was transferred from the Reception Diagnostic Center to Plainfield Correctional Facility. A Prisoner Health History form signed by Mr. Glisson noted that he took with him a suction machine and glasses. Nikki J. Robinson, LPN, conducted an intake assessment, noting that Mr. Glisson's weight was 119 pounds and that he had normal vital signs. He was placed in the infirmary upon his arrival. On September 18, 2010, Carol A. Griffin, RN, noted that Mr. Glisson continued to be self-sufficient with his tracheostomy care. Three days later, on September 21, 2010, Dr. James Mozillo ordered that Mr. Glisson be released from the infirmary and housed in general population, with a 90-day bottom bunk pass. Allison M. Ortiz, LPN, assessed Mr. Glisson that same day and noted that he was alert and oriented and that his vital signs were within normal limits. Mr. Glisson was officially discharged from the infirmary at 12:30 p.m. on September 22, 2010.

Mental health professional Catherine Keefer assessed Mr. Glisson the next day (September 23, 2010) at the request of Health Services Administrator Andy Dunnigan. Mr. Dunnigan's concern was based on the fact that Mr. Glisson's cell was unclean and in disarray, and Glisson was sitting on the bottom bunk with his jumpsuit unbuttoned. A piece of plastic tubing and a pill card were on the floor of the cell and Mr. Glisson had scabs and sores on his arms and neck. Mr.

Glisson's cell mate reported that Glisson had been picking his scabs, that he was restless and had not slept in twenty-four hours, and that he complained of "children" trying to hurt him. Upon further consultation with Mr. Dunnigan and Director of Nursing Rhonda Kessler, Mr. Glisson was placed on close observation, with fifteen minute intermittent observation, until he could be assessed further the next day by Dr. Conant. Ms. Keefer also noted that Mr. Glisson would be considered for transfer to the psychiatric unit at New Castle Correctional Facility.

On September 24, 2010, Dr. Conant examined Mr. Glisson and opined that Glisson's condition had deteriorated from when he last examined Glisson on September 9, 2010. Mr. Glisson was not adequately caring for himself and his hygiene was poor. Dr. Conant observed water and food on the floor. Although Mr. Glisson was mostly able to follow Dr. Conant's questions, he appeared disoriented and cognitively unaware. Dr. Conant noted that Mr. Glisson had been started on Morphine on September 10, 2010, and opined that it was possible he was being oversedated. Dr. Contant advised that Mr. Glisson remain in the infirmary as long as he could be adequately managed there.

On the afternoon of September 24, 2010, Mr. Glisson was transferred from the disciplinary unit to the infirmary at Plaintifield Correctional Facility in response to Dr. Conant's recommendation. The level of care provided to offenders in the infirmary at Plainfield Correctional Facility approximates that provided in nursing home care, in that nursing staff is available to

offenders at any time and they are regularly monitored by physicians.

Mr. Glisson was assessed in the infirmary by Defendant Mary Combs, RN, on the morning of September 25, 2010. At that point, Mr. Glisson's records identified chronic problems of hypertension, unspecified psychosis, acquired hypothyroidism, depressive disorder, neoplasm of unspecified nature of the digestive system, and unidentified disorders of the skin and subcutaneous tissue. Mr. Glisson was cooperative with the assessment and Nurse Combs noted that Glisson was at that time able to provide care for his tracheostomy and to bring up secretions himself using his suction device, and that he was alert and able to communicate his needs, but that his speech was difficult to understand at times. Nurse Combs further observed that Mr. Glisson's gait was steady, meaning that he was able to stand and walk. Mr. Glisson's temperature was 97.4 degrees, his blood pressure was 100/60, his pulse was 68, his respiration rate was 16, and his oxygen saturation was 90%. All but the oxygen saturation level were within the normal range; oxygen saturation was low.

On September 26, 2010, Nurse Griffin assessed Mr. Glissin in the infirmary. Nurse Griffin noted that: Mr. Glisson was alert and "oriented times three" (a normal finding); he was ambulating in his room; and he was breathing on room air with unlabored respirations. However, she also noted that he had diminished breathing sounds and transient wheezing which cleared when he coughed. Nurse Griffin observed that Mr. Glisson was able to suction secretions himself, could tolerate food intake and fluids well by mouth, and

was able to drink Ensure supplements. Mr. Glisson's temperature was 98 degrees, his blood pressure was 98/58, his pulse was 64, his respiration rate was 16, and his oxygen saturation was 97%. All of these vital signs were within the normal range.

First Examination by Defendant Malak Hermina, M.D.

Defendant Malak Hermina, M.D., the lead physician in the infirmary at Plainfield Correctional Facility, first examined Mr. Glisson on the morning of September 27, 2010.[3] Dr. Hermina noted that Mr. Glisson had a history of hypertension, psychiatric disorder, a tracheostomy that had been necessitated by throat cancer, and a history of hypertension. During his examination, Dr. Hermina observed that Mr. Glisson was not communicating properly which Dr. Hermina attributed to his tracheostomy and to dementia. Mr. Glisson also appeared cachectic, or undernourished. Dr. Hermina noted that Mr. Glisson had previous labwork performed on September 9, 2010, which showed anemia and high creatinine. Because Dr. Hermina had not previously examined Mr. Glisson and it was not clear whether there had been further workup following those lab results, he directed that records be obtained from Glisson's previous medical providers so that the medical staff in the infirmary could further assess and understand his medical conditions. Dr. Hermina also noted that the origin and status of Mr.

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[3] In September 2010, Dr. Hermina's typical work hours were Monday to Friday from approximately 6:00 a.m. until early afternoon. He was also available to the infirmary's nursing staff via telephone twenty-four hours a day.

Glisson's mental condition was not clear, but that it was possible that he would be an appropriate candidate for transfer to the psychiatric unit at New Castle Correctional Facility once his medical conditions and treatment plan were clarified.

To address Mr. Glisson's issues related to poor nourishment, Dr. Hermina ordered Jevity, a nutritional supplement, in addition to the Ensure that Glisson was already taking. Dr. Hermina also ordered a complete red blood count to monitor Mr. Glisson's anemia as well as a white blood count with differential to monitor for infection. Mr. Glisson was also scheduled for a thyroid-stimulating hormone test to monitor his hypothyroidism. To assess whether Mr. Glisson had chronic kidney disease or whether his prior lab results were more suggestive of an acute renal problem, Dr. Hermina ordered fasting labs to be drawn on September 28, 2010, and processed on a "stat" basis, so that results would be available within twenty-four hours of the labs being drawn. Dr. Hermina observed that Mr. Glisson had a skin rash which he noted was suggestive of poor personal cleaning habits, but reported that Glisson's hypertension seemed to be under control. Finally, Dr. Hermina noted that Mr. Glisson had a systolic heart murmur which may have been the result of anemia or hyperdynamic circulation, and ordered that Glisson be monitored further to determine whether he might need an echocardiogram or other testing if the condition persisted.

At 10:35 a.m. on September 27, 2010, requests for Mr. Glisson's prior medical records were faxed to Dr. Fisher, whose office faxed back nine pages of records at 2:47 p.m. that same afternoon. Those records contained

notes prepared by Dr. Fisher between July 22, 2010 and September 27, 2010; a procedure note from St. Vincent Hospital from May 29, 2008, reflecting that Dr. Daryl F. Daugherty had performed an esophagogastroduodenoscopy on Mr. Glisson on that date; a letter from Dr. Fisher on July 31, 2009, appealing restrictions on Mr. Glisson's dosage of Oxycontin imposed by "Silverscript PA"; an assessment of Mr. Glisson by Dr. Gregory Hellwarth on August 21, 2008, for severe neck pain and deformity; a report on Mr. Glisson from Dr. Katherine Kobza of Josephson Wallack Munshower Neurology on January 14, 2010; and an assessment of Mr. Glisson performed by Dr. Hellwarth on August 5, 2008.

Dr. Hermina testified that he learned the following information regarding Mr. Glisson's medical history from those records:

- Per Dr. Fisher's notes and letter, Mr. Glisson suffered from kyphosis and back pain which was primarily treated with Oxycontin and Oxycodone, two narcotic pain relief medications.
- Per Dr. Daugherty's May 29, 2008 note, Mr. Glisson suffered from gastroparesis, or partial paralysis of the stomach preventing normal digestion of food, which likely contributed to his poor nourishment.
- Per Dr. Hellwarth's records, Mr. Glisson suffered from neck pain with instability at the first and second levels of the cervical spine, for which he was not a candidate for surgery given his medical history, malnourishment and nicotine dependency. The extent of Mr. Glisson's

further workup and treatment for this problem after 2008 was not communicated to me.

- Per Dr. Kobza's report, Mr. Glisson had a history of depression and poor memory, with neuropsychological testing on December 14, 2009, confirming mild neurocognitive decline, contributed to by his ongoing medical conditions, alcohol consumption and depression.

Exh. 68 (Hermina Aff.).

Melissa Pearson, RN, assessed Mr. Glisson in the infirmary on the afternoon of September 27, 2010. She noted that he was alert and oriented times three and that he was able to make his needs known. He had a regular heartbeat. His breath sounds were clear and his respirations were even and nonlabored. Nurse Pearson did note that Mr. Glisson had difficulty moving, that he had kyphosis of the neck, and that he was emaciated. Mr. Glisson's temperature was 98.2 degrees, his blood pressure was 100/64, his pulse was 76, his respiratory rate was 16, and his oxygen saturation was 96%. All of these vital signs were within normal limits. Mr. Glisson stated that he had pain at a level of two on a scale of one to ten. Nurse Pearson noted that the plan for Mr. Glisson's care would be continued.

Jennifer C. Hoffmeyer, RN, assessed Mr. Glisson in the infirmary in the early morning of September 28, 2010. She noted that Mr. Glisson was disorganized and did not always follow the conversations. White mucous was suctioned from Mr. Glisson's tracheostomy, and he returned to sleep without distress. Later that morning, Nurse Pearson assessed Mr. Glisson, noting that he

was alert and oriented times three and able to make his needs known. Nurse Pearson noted a red, raised rash on Mr. Glisson's chest, but he did not complain of itching or pain. She also noted multiple lesions over his upper and lower extremities. Mr. Glisson had a regular heartbeat and clear but somewhat diminished breath sounds. Although his gait was unsteady, he was able to ambulate without assistance. Mr. Glisson's temperature was 98.2 degrees, his blood pressure was 100/78, his pulse was 68, his respiratory rate was 18, and his oxygen saturation was 92%. All of these vital signs were within normal limits.

The next morning, on September 29, 2010, Dr. Hermina again assessed Mr. Glisson. At this time, Dr. Hermina was still waiting on results from the lab tests he had ordered on September 27, 2010. He noted that Mr. Glisson was being considered for transfer to the psychiatric unit at New Castle Correctional Facility and that Glisson had a history of neck surgery due to cancer of the larynx and a history of hypothyroidism. Mr. Glisson related that he had a history of alcohol abuse. Dr. Hermina observed that Mr. Glisson was not communicating properly and continued to appear cachectic. Dr. Hermina noted that Mr. Glisson was difficult to understand and that he engaged in behavior consistent with dementia, such as defecating on the floor and neglecting his personal care. Following his assessment, Dr. Hermina concluded that Mr. Glisson's cachexia would be further addressed by determining whether there had been a recurrence of cancer and continuing to provide him with Jevity and Ensure nutritional supplements. Dr. Hermina also suggested that, once assessment of Mr. Glisson's other health concerns was completed, a CT scan and orthopedic

follow-up would be appropriate to further investigate his neck problems.

Later that day, Nurse Combs assessed Mr. Glisson while Dr. Hermina was making rounds. As Dr. Hermina had indicated in his assessment, Nurse Combs noted that Mr. Glisson was alert but not communicating well. His temperature was 97.4 degrees; blood pressure was 98/60; pulse was 72; respiratory rate was 16; and oxygen saturation was 90%. With the exception of his oxygen saturation level, which was low, Mr. Glisson's remaining vital signs were all normal.

Around 1:30 p.m. that same day, Dr. Hermina retrieved Mr. Glisson's lab results that had been placed in his mailbox at the nurses' station in the infirmary. The results showed that Mr. Glisson's potassium level was over seven, his blood urea nitrogen ("BUN") level was 167, and his creatinine was 6.7, all of which were suggestive of acute renal failure. Dr. Hermina's expectation had been that the lab that performed the tests would immediately inform the prison medical staff of any critical lab results. However, the lab, which is not affiliated with Defendant Correctional Medical Services, Inc., faxed the results to the prison without specific attention being drawn to the critical results and without immediately informing Dr. Hermina or other prison medical staff of the serious findings. The lab report indicates that the results were available by 7:52 a.m. on September 29, 2010, but Dr. Hermina did not receive them until the early afternoon.

Immediately upon receiving Mr. Glisson's lab results, Dr. Hermina ordered an albuterol nebulizer, monitoring of input and output, administration of

fluids and insulin along with a concentrated dextrose solution called D50, and an urgent EKG. Dr. Hermina also directed that an ambulance be summoned to transfer Mr. Glisson to the hospital. Mr. Glisson was transferred to Wishard Hospital at 2:20 p.m., accompanied by a copy of his infirmary medical records. Mr. Glisson remained hospitalized for seven days.

At 12:17 a.m. on October 7, 2010, Mr. Glisson returned to the infirmary at Plainfield Correctional Facility from Wishard Hospital. His discharge report contained the following conditions and treatment information:

- Acute renal failure/acidosis/hyperkalemia on top of chronic kidney disease. The medical staff at the hospital [was] unable to identify a clear origin for Mr. Glisson's kidney difficulty, and concluded that the likely causes were his psych medications, including Prozac, and volume depletion. Mr. Glisson received intravenous fluids and bicarbonate and his normal kidney function was restored.

- Acute respiratory insufficiency/pneumonia treated with antibiotics.

- Tracheoesophageal voice prosthesis evaluation. Mr. Glisson had a voice prosthesis which had apparently been lost two weeks previously. He did not report loss of the prosthesis to Dr. Hermina or to any other medical staff. The medical staff at Wishard Hospital noted that Mr. Glisson had been coughing secretions from his

tracheostomy. A new voice prosthesis was placed during his hospitalization.

- Hypothyroidism, for which Mr. Glisson was re-started on thyroxin. His TSH, which measures his thyroid level, had been assessed via labwork on September 27, 2010, and had been normal.
- Malnutrition, for which the Jevity Dr. Hermina had ordered in the infirmary, in addition to ensure, was continued.
- Squamous cell carcinoma of the left lateral tongue, which was to be followed up on with an ear, nose, and throat specialist as an outpatient.
- Hypertension, for which Mr. Glisson was continued on Lisinopril.
- Chronic pain, for which Mr. Glisson was to continue receiving narcotic pain medication.
- Dementia/psych disorder/depression. Mr. Glisson did not demonstrate any agitation during his stay at Wishard, but a CT scan of his head confirmed cerebral volume loss and patch hypodensities within deep subcortical and perventricular white patter consistent with mild dementia and the presence of microvascular disease of the brain. At Wishard, Mr. Glisson was continued on the Prozac he had been receiving in prison.
- A pressure wound on the sacrum which developed during Mr. Glisson's seven-day hospitalization.

Defs.' Exh. 68, ¶ 18; Defs.' Exh. 79.

Upon his return to the prison infirmary, Mr. Glisson was assessed by Nurse Hoffmeyer. She noted that he was alert and oriented, that his respirations were even and unlabored, and that his lung sounds were coarse throughout. Mr. Glisson was able to get into bed without assistance. His temperature was 98.7 degrees; his blood pressure was 140/100; his pulse was 88; his respiratory rate was 16; and his oxygen saturation was 97%. All of these vital signs were within normal limits.

Dr. Hermina examined Mr. Glisson later that morning and documented the plan to comply with all of the orders Mr. Glisson received upon discharge from Wishard Hospital, including follow up with an ear, nose, and throat specialist within four weeks; continuing Jevity and Ensure for nutritional support; continuation of Lisinopril for hypertension, Santyl for the pressure wound he acquired at the hospital; a multivitamin; Valium, Vicodin, and the antibiotic Flagyl; and obtaining a walker to assist him with ambulation. To continue monitoring Mr. Glisson's cachexia, anemia, hypothyroidism, and kidney function, Dr. Hermina ordered follow-up labwork to be obtained on November 1, 2010. In his notes, Dr. Hermina also made mention of the systolic heart murmur he had previously documented, but noted that Mr. Glisson had been assessed at Wishard Hospital with no indication that the murmur was indicative of any further problem, and thus, did not designate any follow-up measures to address the murmur.

Nurse Griffin examined Mr. Glisson in the infirmary later that same day. He complained of pain at a level of five on a scale of one to ten, and she administered pain medication via his gastronomy tube.

Nurse Griffin noted that Mr. Glisson had wheezing that cleared when he coughed, and that he had productive sputum from his tracheostomy. Mr. Glisson's suction machine was set up at his bedside for use in clearing his tracheostomy.

The next day, on October 8, 2010, Paula J. Kuria, LPN, assessed Mr. Glisson in the early morning. She noted that Mr. Glisson was in bed but that he had been somewhat restless through the night. Mr. Glisson reported that he was not in pain. Nurse Kuria noted that Mr. Gisson's tracheostomy site was suctioned as needed.

Later that morning, Dr. Hermina again examined Mr. Glisson. Dr. Hermina noted that Mr. Glisson was awake and responded properly, but that he was difficult to understand. Because Mr. Glisson appeared to be having difficulty with oral intake, Dr. Hermina ordered that he be provided nutrition and medication only through his gastronomy tube until he could have an outpatient speech therapy evaluation performed at Wishard Memorial Hospital, which Dr. Hermina ordered occur on an urgent basis. Dr. Hermina did not examine or treat Mr. Glisson again after October 8, 2010.

Later that same day, Allison M. Ortiz, LPN, assessed Mr. Glisson and noted that he was alert and oriented with some periods of confusion, but that he was able to make his needs known. Nurse Ortize further noted that Mr. Glisson seemed somewhat confused and upset, and did not eat any breakfast from his tray. Mr. Glisson's temperature was 98.4 degrees, his blood pressure was 116/76, his pulse was 91, his respiratory rate was 18, and his oxygen saturation was

96%. These vital signs were all within a normal range. On that afternoon, Mr. Glisson participated in a physical therapy session.

The next morning, on October 9, 2010, Nurse Combs assessed Mr. Glisson, observing that he was easily able to bring up thick secretions from his tracheostomy himself using his suction machine. She noted that Mr. Glisson's temperature was 97.4 degrees, his blood pressure was 110/64, his pulse was 81, his respiratory rate was 16, and his oxygen saturation was 93%. These vital signs were all within normal limits.

At the 6:00 a.m. shift change the next morning, on October 10, 2010, Nurse Combs noted that staff coming off shift at that time reported to her that Mr. Glisson had been up in the hallways wandering through the infirmary night shift. When Nurse Combs went to check on Mr. Glisson, she found that he was in another patient's bed grabbing his lower extremities as the other patient woke up. Based on this behavior, Nurse Combs transferred Mr. Glisson to a medical isolation room. At 7:48 a.m., Nurse Combs noted that Mr. Glisson was in bed in the medical isolation room, and that he was restless and moving from one side of the bed to the other. Nurse Combs observed that Mr. Glisson was able to bring up secretions by suctioning his trach stoma and noted: "All equipment will be accessible in hallway outside of room and this patient's grasp for safety issues. Numerous attempts to tell this patient what was done and reason for the different occurrences without evidence of understanding the information being given." Defs.' Exh. 87.

Nurse Combs noted at 8:20 a.m. that she had been alerted by Indiana Department of Correction custody

staff that Mr. Glisson appeared not to be moving, and that it was possible that there was blood on the bed. Nurse Combs observed Mr. Glisson sitting upright on the bed with a large ring of brown fluid on the bed under his left shoulder. He was unresponsive; his skin was cold to the touch; he had no bilateral carotid reflexes, and he had bilateral fixed dilated pupils. Nurse Combs called 911, and by 8:30 a.m. EMS had arrived at Plainfield Correctional Facility. Mr. Glisson was pronounced dead by Dr. Andrew Alaimo at 8:35 a.m.

The Hendricks County Coroner investigated Mr. Glisson's death and noted his history of laryngeal cancer with surgical resection in 2004 resulting in tracheostomy, squamous cell carcinoma of tongue with partial glossectomy, feeding tube placement, respiratory insufficiency, hypertension, chronic kidney disease with episodes of acute renal failure and hyperkalemia, hypothyroidism, and alcohol-induced dementia. The coroner also observed that Mr. Glisson had extreme emaciation and cachexia. Without performing an autopsy, the coroner concluded that Mr. Glisson died of natural causes, specifically, that his death resulted from complications of laryngeal cancer, with contributory chronic renal disease. Mr. Glisson's estate sought a copy of the coroner's file. This request was originally denied but was eventually turned over following an order from this Court on December 20, 2012.

The Hendricks County Coroner subsequently provided Mr. Glisson's medical records to pathologist Steven S. Radentz, M.D. to review. Dr. Radentz concluded that Mr. Glisson's rapid onset altered mental

status could have resulted from hypoxia and acute renal failure-type acid-base/electrolyte abnormalities, and the hypoxia could be secondary to a number of potential problems involving his stoma, including aspiration pneumonia, a tracheoesophageal fistula with chemical pneumonitis or collapse/malfunction of the stoma whereby the stomavent became dislodged or partially dislodged. Dr. Radentz observed that the large amount of light brown fluid from Mr. Glisson's stoma suggested a pulmonary process or tracheoesophageal fistula, and that acute renal failure could have been precipitated by volume depletion or dehydration in conjunction with chronic renal failure. Dr. Radentz agreed with the coroner that all of these issues were directly related to Mr. Glisson's throat cancer and laryngectomy.

Legal Analysis

I. Standard of Care

Summary judgment is appropriate when the record shows that there is "no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). Disputes concerning material facts are genuine where the evidence is such that a reasonable jury could return a verdict for the non-moving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). In deciding whether genuine issues of material fact exist, the court construes all facts in a light most favorable to the non-moving party and draws all reasonable inferences in favor of the non-moving party. *See id.* at 255. However, neither the "mere existence of some alleged factual dispute between the parties," *id.*, 477 U.S. at 247, nor

the existence of "some metaphysical doubt as to the material facts," *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986), will defeat a motion for summary judgment. *Michas v. Health Cost Controls of Ill., Inc.*, 209 F.3d 687, 692 (7th Cir. 2000).

The moving party "bears the initial responsibility of informing the district court of the basis for its motion, and identifying those portions of [the record] which it believes demonstrate the absence of a genuine issue of material fact." *Celotex*, 477 U.S. at 323. The party seeking summary judgment on a claim on which the non-moving party bears the burden of proof at trial may discharge its burden by showing an absence of evidence to support the non-moving party's case. *Id.* at 325.

Summary judgment is not a substitute for a trial on the merits, nor is it a vehicle for resolving factual disputes. *Waldridge v. Am. Hoechst Corp.*, 24 F.3d 918, 920 (7th Cir. 1994). Therefore, after drawing all reasonable inferences from the facts in favor of the non-movant, if genuine doubts remain and a reasonable fact-finder could find for the party opposing the motion, summary judgment is inappropriate. *See Shields Enterprises, Inc. v. First Chicago Corp.*, 975 F.2d 1290, 1294 (7th Cir. 1992); *Wolf v. City of Fitchburg*, 870 F.2d 1327, 1330 (7th Cir. 1989). But if it is clear that a plaintiff will be unable to satisfy the legal requirements necessary to establish his or her case, summary judgment is not only appropriate, but mandated. *See Celotex*, 477 U.S. at 322; *Ziliak v. AstraZeneca LP*, 324 F.3d 518, 520 (7th Cir. 2003). Further, a failure to prove one essential element "necessarily renders all other facts immaterial." *Celotex*, 477 U.S. at 323.

A plaintiff's self-serving statements, which are speculative or which lack a foundation of personal knowledge, and which are unsupported by specific concrete facts reflected in the record, cannot preclude summary judgment. *Albiero v. City of Kankakee*, 246 F.3d 927, 933 (7th Cir. 2001); *Stagman v. Ryan*, 176 F.3d 986, 995 (7th Cir. 1999); *Slowiak v. Land O'Lakes, Inc.*, 987 F.2d 1293, 1295 (7th Cir. 1993).

II. Section 1983 Claims

Plaintiff's core federal claims in this lawsuit are that Dr. Hermina and Nurse Combs were deliberately indifferent to Mr. Glisson's serious medical needs in violation of the Eighth Amendment's prohibition against cruel and unusual punishment and that CMS is liable for having in place a practice or policy that caused Mr. Glisson constitutional injury. We address these claims in turn below.

A. Individual Defendants

The Eighth Amendment's prohibition against cruel and unusual punishment protects inmates "against a lack of medical care that 'may result in pain and suffering which no one suggests would serve any penological purpose.'" *Rodriguez v. Plymouth Ambulance Serv.*, 577 F.3d 816, 828 (7th Cir. 2009) (quoting *Estelle v. Gamble*, 429 U.S. 97, 103 (1976)). Accordingly, under Seventh Circuit law, a governmental officer may be held individually liable under Section 1983 if he exhibits "deliberate indifference to serious medical needs" of an inmate, such as intentionally denying or delaying access to medical care or intentionally interfering with prescribed treatment. *Id.* at 828-29. However, mere

negligence in the provision of medical care is not a constitutional violation. *Id.* at 829. "Rather, 'a plaintiff must show both: (1) an objectively serious medical condition to which (2) a state official was deliberately, that is subjectively, indifferent.'" *Id.* (quoting *Duckworth v. Ahmad*, 532 F.3d 675, 679 (7th Cir. 2008)).

The objective prong requires that "the illness or injury for which assistance is sought is sufficiently serious or painful to make the refusal of assistance uncivilized." *Gutierrez v. Peters*, 111 F.3d 1364, 1372 (7th Cir. 1997) (quoting *Cooper v. Casey*, 97 F.3d 914, 916 (7th Cir. 1996)). Under Seventh Circuit law, "[a]n 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.'" *Gayton v. McCoy*, 593 F.3d 610, 620 (7th Cir. 2010) (quoting *Hayes v. Snyder*, 546 F.3d 516, 522 (7th Cir. 2008)). To satisfy the subjective component of the test and prove deliberate indifference, a plaintiff must demonstrate that the individual defendants "intentionally disregarded the known risk to inmate health or safety." *Collins v. Seeman*, 462 F.3d 757, 762 (7th Cir. 2006). In other words, "[t]he officials must know of and disregard an excessive risk to inmate health; indeed, they must 'both be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists' and 'must also draw the inference.'" *Greeno v. Daley*, 414 F.3d 645, 653 (7th Cir. 2005) (quoting *Farmer v. Brennan*, 511 U.S. 825, 837 (1994)).

When the state actor is a medical professional, the law imposes a more specific threshold for

constitutionally actionable misconduct. A doctor or other practitioner's "deliberate indifference may be inferred when 'the medical professional's decision is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible did not base the decision on such a judgment.'" *King v. Kramer*, 680 F.3d 1013, 1018-19 (7th Cir. 2012) (quoting *Estate of Cole by Pardue v. Fromm*, 94 F.3d 254, 261-62 (7th Cir. 1996)). Thus, while a prisoner "is not required to show that he was literally ignored" by a medical professional, it is insufficient to allege mistake or medical malpractice; the course of treatment must be "so blatantly inappropriate" that a reasonable fact-finder could infer subjective indifference to the prisoner's needs. *See Greeno*, 414 F.3d at 653-54 (7th Cir. 2005).

Here, there is no dispute that Mr. Glisson suffered from an objectively serious medical condition, and thus satisfies the objective prong of the Eight Amendment standard. Accordingly, the only issue in dispute is the subjective component of the standard, to wit, whether Dr. Hermina or Nurse Combs exhibited deliberate indifference to Mr. Glisson's known medical needs. We address the facts relevant to each defendant in turn below.

1. Dr. Hermina

Plaintiff contends that, although Dr. Hermina did not ignore Mr. Glisson's medical needs entirely, his treatment nevertheless fell below the level required to pass constitutional muster. Specifically, Plaintiff faults Dr. Hermina for ignoring acute changes in Mr. Glisson's mental health and failing to search for a physical cause of Glisson's rapid mental decline while

incarcerated; ignoring the fact that on several occasions Glisson had below-normal oxygen saturation, which signaled possible health problems, such as pneumonia; and failing to communicate with medical providers at Wishard, which complicated their ability to properly diagnose and treat Glisson.

However, it is abundantly clear from a review of the record, even when viewed in the light most favorable to Plaintiff as we are required to do at this stage of the litigation, that Dr. Hermina's treatment of Mr. Glisson was neither consciously reckless nor substantially below the standards of his profession. Accordingly, it did not rise to the level of being a violation of Mr. Glisson's Eighth Amendment rights. Dr. Hermina first became responsible for Mr. Glisson's care on September 27, 2010, when he initially assessed Mr. Glisson in the jail infirmary, approximately three days after Glisson was transferred there. Dr. Hermina's assessment included consideration of Mr. Glisson's history of hypertension, psychiatric disorder, throat cancer with tracheosomy and hypothyroidism. Based on the results of previous labwork dated September 9, 2010, which showed anemia and high creatinine suggestive of a renal problem, Dr. Hermina ordered that follow-up labwork be performed on Mr. Glisson to determine whether the issue was a chronic or acute condition.

At the initial examination, Dr. Hermina also observed that Mr. Glisson suffered from cachexia or malnourishment and ordered that Glisson be given the nutritional supplement Jevity in addition to the supplement he was already receiving to address the problem. Dr. Hermina noted that the extent of Mr.

Glisson's mental condition was still being assessed,[4] but that he might eventually be a candidate for transfer to the psychiatric unit at the New Castle Correctional Facility. Dr. Hermina opined that Mr. Glisson's hypertension appeared to be under control, but ordered a TSH test to monitor Glisson's hypothyroidism. Dr. Hermina also observed a systolic heart murmur that he noted would be monitored further to determine whether the condition persisted and necessitated an echocardiogram or other testing. Following Dr. Hermina's initial examination of Mr. Glisson, he arranged for a prompt review of Glisson's prior medical records to develop a further understanding of his medical history, reviewing the records on the afternoon of the same day on which he conducted Glisson's initial assessment.

When Dr. Hermina next examined Mr. Glisson on the morning of September 29, 2010, he opined that, once assessment of Glisson's other health concerns was complete, a CT scan and orthopedic follow-up would be appropriate to further address his chronic neck problems. Upon receipt of Mr. Glisson's labwork that same afternoon, Dr. Hermina immediately recognized that Glisson was in renal failure and ordered an albuterol nebulizer, monitoring of input and output, administration of fluids and insulin along with a concentrated dextrose solution called D50, and an urgent EKG. Dr. Hermina also directed that an

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[4] Dr. Conant, a psychiatrist, examined Mr. Glisson on September 24, 2010, and was the medical professional who advised that Glisson be transferred to the infirmary based on the deterioration Dr. Conant observed in Glisson's mental condition since he had last examined Glisson on September 9, 2010.

ambulance be called to transfer Mr. Glisson to the hospital. The ambulance arrived within minutes and Mr. Glisson was immediately transferred to Wishard Hospital for treatment. When Mr. Glisson returned to the jail infirmary from the hospital on October 7, 2010, Dr. Hermina implemented every order and intervention recommended by Glisson's discharge summary. Dr. Hermina again examined Mr. Glisson on October 8, 2010, and noted that Glisson appeared to be having difficulty swallowing. To address the issue, Dr. Hermina ordered that Mr. Glisson be provided nutrition and medication only through his gastronomy tube until he could have an outpatient speech therapy evaluation, which Dr. Hermina ordered be done on an urgent basis. That was the last time Dr. Hermina examined Mr. Glisson before his death on October 10, 2010.

Despite the extensive treatment provided by Dr. Hermina during the very limited time period when he was responsible for Mr. Glisson's care, Plaintiff nevertheless contends that Dr. Hermina's treatment fell below the standard required by the Eighth Amendment. In support of her contention that Dr. Hermina was deliberately indifferent to Mr. Glisson's serious medical needs, Plaintiff cites the Eleventh Circuit's decisions in *McElligot v. Foley*, 182 F.3d 1248 (11th Cir. 1999) and *Carswell v. Bay County*, 854 F.2d 454 (11th Cir. 1988). However, not only are these cases not binding on this court, they are clearly factually distinguishable.

In *McElligott*, the first case cited by Plaintiff, the evidence established that despite complaining of abdominal pain, nausea, and vomiting, the plaintiff

was not physically examined by the prison physician until thirty days after entering the jail and then did not receive a follow-up examination for seven weeks despite the plaintiff reporting severe pain. The physician then prescribed medications to relieve the plaintiff's pain but did not examine plaintiff again for another six weeks, despite pleas from the plaintiff to be seen. The plaintiff continued to lose weight over the next two months, but the jail physician did not alter the course of treatment. Finally, while the plaintiff was briefly hospitalized, he was discharged to return to the jail based not on a determination that his medical condition had improved, but rather because of cost concerns after the jail nurse calculated the potential expense of ongoing hospitalization. Similarly, in *Carswell*, the other case cited by Plaintiff, the inmate plaintiff made requests for medical attention at the jail for over eleven weeks, all of which were ignored. During those eleven weeks, when he still had not been examined by a physician, the plaintiff lost fifty-three pounds, until his weight dropped to a mere ninety-two pounds. Despite being informed by multiple members of the jail staff as well as the public defender that he needed medical attention, the defendants in *Carswell* "did nothing significant" to ensure that the plaintiff – who turned out to be suffering from undiagnosed diabetes – received the medical care he needed until almost three months after entering the jail.

No such neglect, never mind such a pattern of neglect existed here. As described above, Dr. Hermina examined Mr. Glisson within three days of Glisson's transfer to the infirmary, set out treatment plans for each of the conditions he diagnosed, and then continued to monitor Glisson's condition, examining

him on four additional occasions while he was in the infirmary to assist in the management of his care. Dr. Hermina promptly sent Glisson to the hospital when lab results showed he was experiencing acute renal failure, and upon Mr. Glisson's return to the prison infirmary from the hospital, Dr. Hermina implemented all of the hospital staff's instructions. When Dr. Hermina examined Mr. Glisson on October 8, 2010, and he demonstrated difficulty swallowing, rather than ignoring the issue, Dr. Hermina ordered that Glisson be provided nourishment and medication through his gastrostomy tube until an urgent outpatient speech therapy evaluation could be performed. The prompt and frequent attention paid to Mr. Glisson's medical issues by Dr. Hermina clearly differs from the indifference exhibited by the defendants in *McElligot* and *Carswell*. Indeed, Dr. Hermina's treatment of Mr. Glisson was not remotely similar to that of the physician in *Carswell*.

Plaintiff maintains that although Dr. Hermina did not entirely ignore Mr. Glisson, he improperly focused on Glisson's chronic health problems, while ignoring acute changes in Glisson's condition that occurred during his incarceration. To support this contention, Plaintiff first points to the sharp decline in Mr. Glisson's mental status while incarcerated as an example of an acute change ignored by Dr. Hermina. Specifically, Plaintiff argues that Dr. Hermina failed to investigate whether Mr. Glisson's deteriorating mental condition was caused by physical problems. According to Plaintiff's expert, Dr. Diane Sommer, a decline in mental status can be caused by physical issues, such as dehydration, infection, or malnourishment.

It is undisputed that Mr. Glisson demonstrated a marked deterioration in his mental condition while incarcerated, and that deterioration is in fact what initially prompted psychiatrist Dr. Steven Conant to transfer Mr. Glisson to the IDOC infirmary. But the evidence does not support the conclusion that Dr. Hermina ignored this change in Mr. Glisson's mental health or failed to investigate whether a physical problem was causing the mental decline. In fact, Dr. Hermina ordered lab work including a complete blood count ("CBC") when he first examined Mr. Glisson on September 27, 2010, which assists physicians in identifying evidence of infection, one of the possible physical causes of mental decline cited by Plaintiff's expert. Dr. Hermina also took note of Mr. Glisson's malnourishment during that same examination (another possible cause of mental decline cited by Dr. Sommer) and ordered an increase in nutritional supplements to help address the problem. These facts do not support a conclusion that Dr. Hermina failed to address Mr. Glisson's mental decline.

Plaintiff next argues that because Dr. Hermina was aware that Mr. Glisson had abnormal urinalysis results on September 4 and 5, 2010, exhibited evidence of renal failure on September 9, 2010, had abnormal thyroid function on September 13, 2010, and had dropped from 122 pounds on admission to 119 pounds by September 17, 2010, Dr. Hermina should have acted more quickly to address these issues when Glisson first came under his care on September 27, 2010, rather than waiting until he had received the labwork evidencing renal failure on September 29, 2010. Specifically, Plaintiff's expert, Dr. Sommer, testified that Mr. Glisson's condition warranted a "rapid

evaluation"; that the labwork to check his renal functioning should have been ordered STAT; and that he should have been given a head CT scan to rule out trauma, stroke, and metastatic disease.

But the undisputed facts establish that, with the exception of the head CT scan,[5] Dr. Hermina addressed the concerns raised by Plaintiff's expert when he assessed Mr. Glisson on September 27, 2010. Dr. Hermina examined Mr. Glisson only three days after he was transferred to the infirmary, and immediately ordered labwork to be performed STAT to test Glisson's renal functioning. At that time, he also made specific orders to address Mr. Glisson's malnutrition and ordered a CBC to assist in identifying infection, both of which are concerns that Dr. Sommer identified as possibly being related to the abnormal urinalyses on September 4 and 5. Additionally, although Mr. Glisson had lost three pounds from the time he was admitted to IDOC to September 17, 2010, he did not lose any more weight by September 27, 2010, when Dr. Hermina examined him. Accordingly, there was no additional weight loss to be addressed. Given these facts, we cannot conclude that Dr. Hermina ignored any acute changes, either mental or physical, in Mr. Glisson's health. Nor is there any indication that Dr. Hermina persisted with ineffective treatment in the face of Mr. Glisson's mental and physical deterioration as Plaintiff claims. As Defendants point out, the medical providers at Wishard Hospital apparently felt

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[5] Mr. Glisson was given a head CT while he was hospitalized at Wishard and it showed no evidence of the possible health concerns raised by Dr. Sommer in her expert report, such as trauma, stroke, or metastatic disease.

Dr. Hermina's treatment plan was effective because they kept in place the same treatments for Mr. Glisson's hypothyroidism, hypertension, malnutrition, chronic pain, and depression that Dr.Hermina had ordered.

Plaintiff also contends that Dr. Hermina exhibited deliberate indifference to Mr. Glisson's serious medical needs by ignoring the fact that Glisson had low oxygen saturation levels on several occasions while incarcerated, which, according to Dr. Sommer, could have signaled pneumonia or another serious physical condition. The undisputed evidence is that Mr. Glisson's oxygen saturation levels were low between September 5 and September 8, 2010, approximately three weeks before he was transferred to the infirmary and first came under Dr. Hermina's care, and that his levels were moderately below normal on two occasions while in the infirmary, to wit, on September 25 and September 29, 2010. However, Mr. Glisson's oxygen level routinely improved with suctioning of his trach,[6] and, on September 25th, two days before Dr. Hermina first examined him, although Mr. Glisson's oxygen saturation level was moderately low at 90%, his other vital signs were normal, he was cooperative with the assessment, was able to provide care for his tracheostomy and to bring up secretions himself using

[6] Plaintiff points to September 8, 2010 as an example of a time when Mr. Glisson's oxygen saturation level did not improve with suctioning. However, on that occasion, after suctioning did not improve Mr. Glisson's saturation level, a nurse instructed Mr. Glisson to close his eyes and take deep breaths at which point it rose to 97% after initially being measured at 84%.

his suction device, and was alert and able to make his needs known.

The only time that Mr. Glisson's oxygen saturation level was low while he was in Dr. Hermina's care was on September 29, 2010, when it measured 90% at 9:43 a.m. as recorded by Nurse Combs; all other vital signs were normal at that time. Although Dr. Hermina made no special note about the moderately low oxygen saturation level that afternoon when he saw Mr. Glisson, it is undisputed that, by that point, Dr. Hermina had just received Glisson's labwork indicating he was in renal failure and was at that time arranging for emergency attention to that clearly more serious medical need. Other than the occasions described above, Mr. Glisson's oxygen saturation was measured at normal levels while in the infirmary. Significantly, upon Mr. Glisson's return from Wishard Hospital on October 7, 2010, his oxygen saturation levels remained above 90% until his death on October 10, 2010. Accordingly, there were no low oxygen saturation levels for Dr. Hermina to have ignored during the three days between when Mr. Glisson returned from the hospital and his death.

Plaintiff's expert, Dr. Sommer, suggests that Dr. Hermina's failure to specifically address Mr. Glisson's low oxygen saturation levels exhibited deliberate indifference to the possibility that Glisson was suffering from pneumonia. When Mr. Glisson was transferred to Wishard Hospital, he was diagnosed with pneumonia and given an antibiotic to treat the pneumonia, which Dr. Hermina continued to administer upon his return to the IDOC infirmary, up to the time of his death. However, given that Mr.

Glisson's low saturation levels generally improved with suctioning, coupled with the fact that he exhibited normal saturation levels on September 26 and again on September 27, 2010 when Dr. Hermina initially examined him, we cannot find that Dr. Hermina's failure to suspect or diagnose pneumonia before Glisson was admitted to Wishard Hospital was so consciously reckless or such a substantial departure from professional standards that it violated Mr. Glisson's Eighth Amendment rights. While in hindsight, Dr. Hermina may have missed possible signs of pneumonia, there is no indication that he displayed a subjective indifference to a serious medical need at the time he was treating Mr. Glisson as required to run afoul of the Constitution.

Finally, Plaintiff faults Dr. Hermina for failing to adequately communicate with the medical staff at Wishard Hospital when Mr. Glisson was transferred on September 29, 2010. However, there is no evidence that any provider at Wishard felt he or she had insufficient information in the course of treating Mr. Glisson or that his treatment suffered because of a lack of communication. It is undisputed that Mr. Glisson's medical records accompanied him to Wishard Hospital and that he received treatment there for acute renal failure, acute respiratory insufficiency/pneumonia, hypothyroidism, malnutrition, squamous cell carcinoma of the left tongue, chronic pain and dementia, and that he was evaluated for a new voice prosthesis. It is not clear how additional information from Dr. Hermina would have affected the medical care Mr. Glisson received at Wishard Hospital. Dr. Sommer theorizes that if Dr. Hermina would have communicated with Wishard staff regarding Mr.

Glisson's condition, "the feasibility of his return to the facility could have been evaluated" and that he might have been transferred out of prison to a "nursing home setting or sub-acute setting." Sommer Report at 7. However, the extent of Dr. Hermina's authority with regard to transferring Mr. Glisson outside of IDOC was to summon an ambulance and order he be taken to the hospital. Beyond that, it is undisputed that Dr. Hermina did not have the authority to direct or arrange for permanent placement of Mr. Glisson outside of prison. In short, there is no basis for finding that Dr. Hermina was deliberately indifferent to Mr. Glisson's serious medical needs by failing to communicate with Wishard staff.

For the foregoing reasons, Plaintiff has failed to establish that Dr. Hermina was at any point or in any fashion deliberately indifferent to Mr. Glisson's serious medical needs. Accordingly, Plaintiff's § 1983 claim brought against Dr. Hermina cannot survive summary judgment.

2. Nurse Combs

Plaintiff contends that Nurse Combs exhibited deliberate indifference to Mr. Glisson's serious medical needs by ignoring the evidence of his rapid deterioration and failing to alert a physician when she saw inappropriate vital signs, as well as in her handling of him on the day of his death, October 10, 2010. We address these arguments in turn.

On September 25 and 29, 2010, Nurse Combs assessed Mr. Glisson during her rounds in the infirmary and, on both occasions, measured his oxygen saturation level at 90%. Plaintiff argues that, while in

a normal patient, these moderately low readings may not have been cause for significant concern, considering Mr. Glisson's previous low oxygen saturation readings and his high risk for pneumonia, oxygen saturation readings of 90% should have caused Nurse Combs to perform further evaluation or alert a physician. However, it is undisputed that, on September 25th, other than the 90% oxygen saturation level, all of Mr. Glisson's vital signs were normal, he was alert and able to communicate his needs, his gait was steady, and he was able to perform his tracheostomy care. Nurse Combs also recorded a 90% oxygen saturation level for Mr. Glisson on September 29, 2010, but again, all of his other vital signs were normal. Given the fact that Mr. Glisson's vital signs were otherwise normal and there were no other warnings of distress, there is no indication on either occasion that Nurse Combs was subjectively aware of an immediate serious medical need of Mr. Glisson's that she deliberately ignored.[7] *See Dale v. Poston*, 548 F.3d 563, 569 (7th Cir. 2008) ("The deliberate indifference test … has both objective and subjective prongs, the former requiring a grave risk and the latter requiring actual knowledge of that risk."). Accordingly, Nurse Combs's failure to consult a physician regarding Mr. Glisson's moderately low oxygen saturation level on September 25 and

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[7] Although Plaintiff faults Nurse Combs for failing to call a physician on September 29th, the undisputed facts establish that Dr. Hermina saw Glisson twice that day – once in the morning before Nurse Combs took his vital signs and then again in the afternoon when he ordered Glisson's transfer to the hospital based solely on lab results that came in after Nurse Combs's examination.

September 29, 2010 did not run afoul of the Constitution.

Nor can we find that Nurse Combs's actions on October 10, 2010, constitute deliberate indifference. That morning, while performing her 6:00 a.m. morning rounds, Nurse Combs was alerted to the fact that Mr. Glisson was in another patient's bed, engaging in irrational behavior. At that point, she put Mr. Glisson alone in a medical observation cell and placed his suction machine outside of the room for what she believed were safety reasons. Although she told him what she was doing and why, she noted that it was unclear whether he understood her. At 7:48 a.m., Nurse Combs noted that Mr. Glisson was restless in bed in the isolation room. Approximately thirty minutes later, at 8:20 a.m., Nurse Combs was alerted by prison staff that Mr. Glisson did not appear to be moving, at which point she immediately responded, and, when she found him unresponsive, she called 911. EMS responded by 8:30 a.m. and Mr. Glisson was pronounced dead at 8:35 a.m.

Clearly, once Nurse Combs was told that Mr. Glisson was not moving, she acted promptly and undertook reasonable actions to address his obvious need for immediate medical attention. Accordingly, the only issue in dispute is whether her actions leading up to that point comported with constitutional requirements. Plaintiff argues that by placing Mr. Glisson in the isolation room and failing to immediately alert a physician or transfer him to the hospital upon first observing his irrational behavior, Nurse Combs acted with deliberate indifference to his serious medical needs. We disagree. The undisputed evidence

in the record leads to no other conclusion than that Nurse Combs made a good-faith effort to address Mr. Glisson's irrational behavior in a manner she believed was calculated to balance concerns regarding his condition with safety concerns, by separating him from the other prisoners in an observation room where he could be monitored. After Mr. Glisson was placed in the medical isolation room, Nurse Combs and prison staff continued to monitor him, as evidenced by Nurse Combs's notes at 7:48 a.m. that he appeared restless in bed and the prison staff's subsequent report approximately thirty minutes later that Mr. Glisson appeared not to be moving. Although more conservative options may have been available upon discovery of Mr. Glisson's odd behavior on the morning of October 10th, the Eighth Amendment does not require that prisoners receive the "best" care available and even negligence, which would constitute medical malpractice, does not violate a prisoner's constitutional right to adequate health care as long as subjective indifference to a serious medical need is not demonstrated. *See King*, 680 F.3d at 1019; *Johnson v. Doughty*, 433 F.3d 1001, 1013 (7th Cir. 2006). There simply is no such evidence in the record here that Nurse Combs's treatment of Mr. Glisson was either consciously reckless or a substantial departure from professional standards such that it violated the Eighth Amendment. Accordingly, Plaintiff's § 1983 claim against Nurse Combs must be dismissed.

B. Defendant Correctional Medical Services, Inc.

CMS is a private corporation that acts under color of state law by contracting to perform a government

function, i.e., providing medical care to correctional facilities. As such, CMS is treated as a government entity for purposes of claims brought pursuant to § 1983. It is well-established that there is no respondeat superior liability under § 1983. *See Horwitz v. Bd. of Educ. of Avoca Sch. Dist. No. 37*, 260 F.3d 602, 619-20 (7th Cir. 2001). A "private corporation is not vicariously liable under § 1983 for its employees' deprivations of others' civil rights." *Iskander v. Vill. of Forest Park*, 690 F.2d 126, 128 (7th Cir. 1982) (citations omitted). Rather, to maintain a viable § 1983 action against a government agent such as CMS, "a plaintiff must demonstrate that a constitutional deprivation occurred as the result of an express policy or custom promulgated by that entity or an individual with policymaking authority." *Gayton*, 593 F.3d at 622 (citing *Latuszkin v. City of Chicago*, 250 F.3d 502, 504 (7th Cir. 2001)).

Here, Plaintiff maintains that CMS has a policy that "prevents its medical personnel from communicating properly and ensuring appropriate continuity of care for inmates with serious medical problems" which "exhibits deliberate indifference to [inmates'] serious medical needs …." Pl.'s Resp. at 31. However, our conclusion as to the § 1983 claims brought against Dr. Hermina and Nurse Combs dictates that Plaintiff's claim against CMS likewise must fail. Where, as here, a plaintiff has not established that a constitutional injury occurred, a "custom or policy" claim stemming from this notional injury fails as a matter of law. *See Ray v. Wexford Health Sources, Inc.*, 706 F.3d 864, 866 (7th Cir. 2013) ("It is unnecessary to decide what the [corporate defendant]'s policy may be, since [plaintiff] has not

established a constitutional problem with his treatment and thus did not suffer actionable injury from the policy he attributes to the corporation"). Accordingly, Plaintiff's § 1983 claim brought against CMS cannot survive summary judgment.

III. State Law Claims

Having determined that all of Plaintiff's federal claims must be dismissed, we turn to the question of whether we should exercise supplemental jurisdiction over the remaining claims in this case, all of which arise under Indiana law. "When all federal claims in a suit in federal court are dismissed before trial, the presumption is that the court will relinquish federal jurisdiction over any supplemental state-law claims." *Al's Serv. Ctr. v. BP Prods. N. Am., Inc.*, 599 F.3d 720, 727 (7th Cir. 2010). Although the presumption is rebuttable, "it should not be lightly abandoned, as it is based on a legitimate and substantial concern with minimizing federal intrusion into areas of purely state law." *RWJ Management Co., Inc. v. BP Prods. N. Am., Inc.*, 672 F.3d 476, 479 (7th Cir. 2012) (citation omitted). The Seventh Circuit has identified the following three situations in which a court should retain jurisdiction over supplemental claims even though all federal claims have been dismissed: where the statute of limitations would bar the refiling of the supplemental claims in state court; where substantial federal judicial resources have already been expended on the resolution of the supplemental claims; or where it is obvious how the claims should be decided. *Williams Elec. Games, Inc. v. Garrity*, 479 F.3d 904, 906-07 (7th Cir. 2007) (citation omitted).

Upon review of the relevant factors, we find that the presumption in favor of remanding state claims is not overcome here. This case was originally filed in state court and Defendants removed it on the basis of the complaint's federal claims brought pursuant to § 1983. Remanding the state law claims as opposed to dismissing them with prejudice will address any concerns related to statute of limitations issues. *See Carnegie-Mellon Univ. v. Cohill*, 484 U.S. 343, 351-52 (1988) (observing that remand may be preferable to dismissal without prejudice "when the statute of limitations on the plaintiff's state-law claims has expired before the federal court has determined that it should relinquish jurisdiction"). Although this remand comes relatively close to the scheduled trial date, this fact alone is insufficient to overcome the presumption in favor of remand. *See Myers v. Cnty. of Lake Ind.*, 30 F.3d 847, 848 (7th Cir. 1994) ("[D]ismissal of the federal claim on the eve of trial is not by itself sufficient to justify resolving the remaining claims in federal court."). Throughout the past seventeen months that this case has pended on our docket, there have been no substantive rulings made on the state-law claims nor have significant judicial resources been otherwise dedicated specifically to their resolution. Finally, while the state law claims in this case are not unusually complex, their resolution is not sufficiently obvious to justify resolving them in federal court. Accordingly, having now disposed of all federal claims in this litigation, pursuant to pursuant to 28 U.S.C. § 1367(c), we relinquish supplemental jurisdiction over all claims under state law and remand these claims to the Marion Superior Court, where this suit began.

IV. Conclusion

For the reasons detailed above, the CMS Defendants' Motion for Summary Judgment is GRANTED IN PART as to the federal claims brought pursuant to 42 U.S.C. § 1983 and all pending motions to limit or exclude expert testimony filed by Defendants [Docket Nos. 51, 52, 79, 83, and 85] are DENIED AS MOOT. Having dismissed all federal claims in this litigation, we relinquish supplemental jurisdiction over all remaining state law claims, which are hereby REMANDED to Marion Superior Court. The Clerk of Court is hereby directed to effect this remand under cause number 49D05-1208-CT-034526 as promptly as possible.

IT IS SO ORDERED.

Date: 6/4/2014 /s/Sarah Evans Barker
SARAH EVANS BARKER, JUDGE
United States District Court
Southern District of Indiana

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