No. 18-337

IN THE
# Supreme Court of the United States

COUNTY OF ORANGE, CALIFORNIA, ET AL.,
*Petitioners*,

v.

MARY GORDON, INDIVIDUALLY AND AS SUCCESSOR IN INTEREST TO MATTHEW SHAWN GORDON, DECEASED,
*Respondent.*

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

## BRIEF OF INDIANA, HAWAII, AND TEXAS AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS


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## QUESTION PRESENTED

Whether a pretrial detainee's "inadequate medical care" claim pursuant to 42 U.S.C. § 1983 requires a showing of a jail professional's subjective intent in delivering care or whether an objective "unreasonableness" standard is sufficient.

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## INTEREST OF THE *AMICI* STATES[1]

The States of Indiana, Hawaii, and Texas respectfully submit this brief as *amici curiae* in support of Petitioners.

Although the responsibility for housing and providing medical care to pretrial detainees usually falls to counties and other municipal bodies, at least twenty States house pretrial detainees in state correctional facilities alongside convicted prisoners. Several States—Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont—have unified, state-run corrections systems in which the State houses all pretrial detainees and convicted prisoners. *See* Pew Charitable Trusts, *Prison Health Care: Costs and Quality* 58 (2017). Yet even in States without unified systems, comingling may occur under "safekeeper statutes," which authorize local jails to transfer detainees to state correctional facilities if the inmate is in danger or poses a danger to others in the local jail. *See, e.g.*, Cal. Penal Code § 4007; Idaho Code Ann. § 20-604; Ind. Code § 35-33-11-1; Iowa Code Ann. § 812.6(2)(a); Ky. Rev. Stat. Ann. § 441.540; Md. Code Ann., Corr. Servs. § 9-303; Mich. Comp. Laws Ann. § 801.55(g); Minn. Stat. Ann. § 243.91; Nev. Rev. Stat. Ann. § 209.311; N.H. Rev. Stat. Ann. § 21-H:8(VI); N.M. Stat. Ann. § 33-3-15; 61 Pa. Cons. Stat. Ann. § 1151(a); S.C. Code Ann. § 24-5-210(C); Va. Code

[1] Pursuant to Supreme Court Rule 37.2(a), counsel of record for all parties have received notice of the *Amici* States' intention to file this brief at least 10 days prior to the due date of this brief.

Ann. § 53.1-21. Only Florida categorically bars transferring pretrial detainees to state-run correctional facilities. Fla. Stat. Ann. § 944.17.

States accordingly have an interest in ensuring that prison officials and medical personnel operate under a clear and consistent constitutional standard regarding the provision of medical care. The Court has held that prison officials' deliberate indifference to the serious medical needs of a convicted prisoner violates the Eighth Amendment. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). To prevail on a deliberate-indifference claim, a convicted prisoner must prove that the defendant *actually* knew of and disregarded an objectively serious risk of substantial harm. *Farmer v. Brennan*, 511 U.S. 825, 837 (1994). The *amici* States, who share with local governments the substantial practical difficulties in caring for mixed inmate populations, urge the Court to adopt a substantially similar standard for addressing pretrial detainees' claims of constitutionally inadequate medical care.

## SUMMARY OF THE ARGUMENT

The Court has never squarely addressed the appropriate constitutional standard for pretrial detainees' challenges to their medical care. It has held that States must provide medical care to detainees, but it has declined to address whether detainees' claims alleging inadequate medical care are governed by the deliberate-indifference standard of *Estelle v. Gamble*, 429 U.S. 97 (1976), or some other standard.

Until recently, the circuits unanimously agreed that *Estelle*'s deliberate-indifference standard governs convicted prisoners' *and* pretrial detainees' claims of inadequate medical care. But in the past two years, three circuits have read *Kingsley v. Hendrickson*, 135 S. Ct. 2466 (2015)—an excessive-force case—to require, for *pretrial detainees'* claims, a less-demanding standard that turns exclusively on the objective reasonableness of the medical care. Four other circuits, meanwhile, have expressly rejected calls to modify or jettison the deliberate-indifference standard on the basis of *Kingsley*.

The Court should resolve the circuit split now. Employing a watered-down, objective-reasonableness standard to pretrial detainees' constitutional challenges to their medical care will exacerbate the toll on the States' thinly stretched resources. It will create incentives for inmates to bring more claims—a greater percentage of which will require substantial resources for expert testimony—the result of which may be deterrence of quality medical professionals from working in prisons and jails. In addition, a constitutionalized objective-reasonableness standard would place state medical negligence tort-reform measures at risk of becoming obsolete for pretrial detainees, as it would permit detainees to masquerade their ordinary medical-malpractice claims as federal due process claims immune to state tort-reform laws.

Certiorari is warranted also because the Ninth, Seventh, and Second Circuits erroneously premised their decisions on *Kingsley*, which is an excessive-force case, not a conditions-of-confinement case—let alone a medical-care case. There is no justification for

separate standards for detainees and convicted prisoners when it comes to the constitutional standard governing claims of inadequate medical care. The fact of confinement triggers the State's duty to provide medical care, and that duty has nothing to do with an inmate's more specific status as a detainee or a convict.

The Court has long rejected constitutionalizing medical malpractice standards for inmates, but the objective-reasonableness standard accomplishes exactly that. The Ninth Circuit attempts to avoid that outcome by incorporating from *Kingsley* the requirement that the defendant must have performed an intentional act. Yet while intentionality may be a meaningful issue in excessive-force cases, it will rarely if ever arise in medical-care cases. Correctional officers might accidentally trip and land on an inmate, but physicians and nurses do not inadvertently write prescriptions or issue medical orders.

The circuit split, the potential effects on the States within the Ninth, Seventh, and Second Circuits, and the infirmities in the Ninth Circuit's decision below, all justify the Court's prompt review.

## REASONS TO GRANT THE PETITION

### I. The Court Should Resolve the Split over the Proper Standard for Constitutionally Adequate Medical Care for Detainees

The Circuits are newly divided over the proper constitutional standard to apply when a pretrial detainee brings a claim under 42 U.S.C. § 1983 alleging constitutionally inadequate medical care. The division exists because the Court has declined to address

the appropriate standard for judging pretrial detainees' claims of constitutionally inadequate medical care and because several circuits have read *Kingsley v. Hendrickson*, 135 S. Ct. 2466 (2015), in sweeping terms unmoored from its context and constitutional rationale. The resulting uncertainty has yielded a patchwork of constitutional standards throughout the country in an area of law that, prior to *Kingsley*, was fairly uniform and stable. Consistency and stability in the standards for inmate medical care are particularly important owing to the costs and complexities associated with providing such care.

### A. The Court's competing lines of doctrine and reluctance to address the constitutional standard of medical care for detainees have sown confusion

1. In 1976, the Court held that prison officials' deliberate indifference to a prisoner's serious medical needs constitutes cruel and unusual punishment in violation of the Eighth Amendment. *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976). The nature of confinement, the Court explained, meant that the "inmate must rely on prison authorities to treat his medical needs; if the authorities fail to do so, those needs will not be met," which may result in unjustified pain and suffering or even "torture or lingering death." *Id.* at 103. Because "deliberate indifference to serious medical needs" effectively results in the "unnecessary and wanton infliction of pain," the Court held that such deliberate indifference violates the Eighth Amendment, "whether the indifference is manifested by prison doctors in their response to the prisoner's needs or by prison guards in intentionally denying or

delaying access to medical care or intentionally interfering with the treatment once prescribed." *Id.* at 104–05.

The Court, however, stressed that not "every claim by a prisoner that he has not received adequate medical treatment states a violation of the Eighth Amendment." *Id.* at 105. Neither accidents nor inadvertent failures to provide adequate care constitute "an unnecessary and wanton infliction of pain" or qualify as "repugnant to the conscience of mankind." *Id.* at 105–06. Simply put, "[m]edical malpractice does not become a constitutional violation merely because the victim is a prisoner." *Id.* at 106.

Although *Estelle* involved medical care, the Court soon extended it to other conditions that "may deprive inmates of the minimal civilized measure of life's necessities." *Rhodes v. Chapman*, 452 U.S. 337, 347 (1981); *see also Farmer v. Brennan*, 511 U.S. 825, 834–37 (1994); *Helling v. McKinney*, 509 U.S. 25, 35–36 (1993); *Wilson v. Seiter*, 501 U.S. 294, 303 (1991).

In *Farmer*, the Court held that a deliberate-indifference claim entails both an objective and a subjective element: the prisoner must prove (1) a medical condition or other condition of confinement that poses an objectively serious risk of substantial harm, and (2) prison officials' knowing disregard of that risk. 511 U.S. at 834–37. The Court rejected a purely objective standard because "an official's failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot under our cases be condemned as the infliction of punishment." *Id.* at 838. The Court stressed that negli-

gence—or even gross negligence—does not equal deliberate indifference because such conduct, even if it results in serious harm, does not constitute *punishment* and therefore does not fall within the scope of the Eighth Amendment. *Id.* at 835–36 & n.4.

2. A parallel line of Eighth Amendment cases concerning excessive force developed alongside the deliberate-indifference cases. In *Whitley v. Albers*, the Court held that, to prevail on a claim of excessive force under the Eighth Amendment, a prisoner must prove that the defendant applied force "maliciously and sadistically for the very purpose of causing harm" and not merely as "a good faith effort to maintain and restore discipline." 475 U.S. 312, 320–21 (1986); *see also Hudson v. McMillian*, 503 U.S. 1, 6–7 (1992). *Whitley* refused to adopt the deliberate-indifference standard for excessive-force claims under the Eighth Amendment owing to the particular countervailing interests at stake when prison guards deploy force. 475 U.S. at 320; *see also County of Sacramento v. Lewis*, 523 U.S. 833, 849–51 (1998) (explaining that a deliberate-indifference standard "is sensibly employed only when actual deliberation is practical").

In short, excessive-force claims and medical-care claims are subject to entirely different standards.

3. Shortly after *Estelle*, the Court began to grapple with the similarities and differences between pretrial detainees and convicted prisoners. Pretrial detainees are *different* from convicted prisoners—and similar to free persons—in that detainees enjoy a presumption of innocence. But that presumption "has no application to a determination of the rights of a pretrial detainee during confinement before his trial has

even begun." *Bell v. Wolfish*, 441 U.S. 520, 533 (1979). More important, detainees are *similar* to convicted prisoners in that both groups have been lawfully confined by the State after receiving due process. *See id.* at 546 n.28; *see also id.* at 536. The fact of confinement means that detainees and convicts "simply do[] not possess the full range of freedoms of an unincarcerated individual." *Id.* at 546.

In *Bell* the Court held that "the proper inquiry" for determining the constitutionality of a pretrial detainee's conditions of confinement turns on "whether those *conditions amount to punishment* of the detainee." *Id.* at 535 (emphasis added); *see also Ingraham v. Wright*, 430 U.S. 651, 671–72 n.40 (1977). Not every restraint "imposed during pretrial detention amounts to 'punishment' in the constitutional sense"—once the State "has exercised its conceded authority to detain a person pending trial, it obviously is entitled to employ devices that are calculated to effectuate this detention." *Bell*, 441 U.S. at 537. Applying these principles, *Bell* held that double-bunking pretrial detainees in cells designed for single-bunking did not constitute punishment and so did not violate the Due Process Clause. *Id.* at 541–43.

4. Although the Court has held that the Due Process Clause requires States to provide medical care to detainees, it has never squarely addressed the appropriate constitutional standard for detainees' claims of inadequate medical care. *City of Revere v. Massachusetts Gen. Hosp.*, 463 U.S. 239, 244–45 (1983); *see also City of Canton v. Harris*, 489 U.S. 378, 388–89 n.8 (1989). In prior cases it has sufficed to say that the due process rights of a detainee are "at least as great

as the Eighth Amendment protections available to a convicted prisoner." *City of Revere*, 463 U.S. at 244.

In the absence of a definitive answer, the circuits at one time uniformly applied *Farmer*'s deliberate-indifference standard to pretrial detainees' inadequate-medical-care claims. *See, e.g.*, *Smith v. Sangamon Cnty. Sheriff's Dep't*, 715 F.3d 188, 191 (7th Cir. 2013); *Coscia v. Town of Pembroke*, 659 F.3d 37, 39 (1st Cir. 2011) (Souter, J.); *Clouthier v. County of Contra Costa*, 591 F.3d 1232, 1241–42 (9th Cir. 2010); *Martinez v. Beggs*, 563 F.3d 1082, 1088 (10th Cir. 2009); *Caiozzo v. Koreman*, 581 F.3d 63, 66, 69–72 (2d Cir. 2009); *Phillips v. Roane County*, 534 F.3d 531, 539–40 (6th Cir. 2008); *Butler v. Fletcher*, 465 F.3d 340, 344 (8th Cir. 2006); *Cook ex rel. Estate of Tessier v. Sheriff of Monroe County*, 402 F.3d 1092, 1115 (11th Cir. 2005); *Woloszyn v. County of Lawrence*, 396 F.3d 314, 319–20 (3d Cir. 2005); *Brown v. Harris*, 240 F.3d 383, 388 (4th Cir. 2001); *Hare v. City of Corinth*, 74 F.3d 633, 643 (5th Cir. 1996) (en banc).

But that consensus has recently been undermined owing to several circuits' misreading of *Kingsley*. In *Kingsley* the Court held that an excessive-force claim brought by a pretrial detainee does not require inquiry into the defendant's subjective state of mind—the detainee need only show that the defendant purposefully or knowingly used force against him and that the force was objectively unreasonable. 135 S. Ct. at 2472–73. The Court said that eliminating inquiry into the defendant's subjective reason for applying the force was consistent with *Bell*, for actions not rationally related to legitimate nonpunitive governmental purposes may constitute "punishment" forbidden by

the Due Process Clause regardless of the defendant's mental state. *Id.* at 2473–74. *Whitley* and *Hudson*, the Court said, were not applicable because they involved convicted prisoners, who unlike detainees may be punished up to a point. *Id.* at 2475.

Since *Kingsley*, the Fifth, Eighth, Tenth, and Eleventh Circuits have continued to apply *Farmer*'s deliberate-indifference standard to inadequate-medical-care claims brought by pretrial detainees, rejecting calls to jettison the subjective inquiry. *See Clark v. Colbert*, 895 F.3d 1258, 1267–69 (10th Cir. 2018); *Whitney v. City of St. Louis*, 887 F.3d 857, 860 & n.4 (8th Cir. 2018); *Dang v. Sheriff, Seminole County Fla.*, 871 F.3d 1272, 1279 & n.2 (11th Cir. 2017); *Alderson v. Concordia Parish Correctional Facility*, 848 F.3d 415, 419 & n.4 (5th Cir. 2017) (per curiam). These circuits have reasoned that *Kingsley* involved a claim of excessive force and not one of deliberate indifference, so *Kingsley* did not overrule inadequate-medical-care precedents. *See, e.g.*, *Whitney*, 887 F.3d at 860 n.4; *see also Miranda-Rivera v. Toledo-Davila*, 813 F.3d 64, 74–75 (1st Cir. 2016) (continuing to apply *Estelle* and *Farmer* without addressing *Kingsley*). They have thus acknowledged the doctrinal differences between excessive-force claims and inadequate-medical-care (or other conditions-of-confinement) claims. *See Whitley*, 475 U.S. at 320.

Yet three other circuits have read *Kingsley* broadly to apply not only to excessive-force claims but also to conditions-of-confinement claims, including those about medical care. *See* App. 13–14; *Miranda v. County of Lake*, 900 F.3d 335, 353–54 (7th Cir. 2018), *reh'g en banc denied*; *Darnell v. Pineiro*, 849 F.3d 17,

34–35 (2d Cir. 2017); *Castro v. County of Los Angeles*, 833 F.3d 1060, 1069–71 (9th Cir. 2016) (en banc); *Bruno v. City of Schenectady*, 727 F. App'x 717, 720 (2d Cir. 2018).

The Ninth Circuit has led the charge. In *Castro*, it held that a purely objective standard applies to detainees' failure-to-protect claims, 833 F.3d at 1068–70, and in this case extended *Castro* to detainees' medical claims, *see* App. 13–14. Acknowledging that excessive-force claims differ from conditions-of-confinement claims, the Ninth Circuit nevertheless determined that the same standards should apply because both claims arise under the Fourteenth Amendment and the *Kingsley* majority wrote in broad language. App. 12–14; *Castro*, 833 F.3d at 1069–70.

In a nominal effort to avoid imposing section 1983 liability merely for the lack of due care, the Ninth Circuit adopted a purported multi-part standard. *See* App. 14. But all the court really did was rephrase the ordinary negligence standard and add the requirement that the defendant's action must be intentional and not inadvertent. The detainee need only prove that the defendant "made an intentional decision" about treatment, yet failed to "take reasonable available measures" to decrease a reasonably apparent "substantial risk of harm," which in turn "caused the plaintiff's injuries." *Id.*

The Second Circuit joined the Ninth when it held that a pretrial detainee's challenges to several conditions of confinement turned on the objective reasonableness of those conditions. *Darnell*, 849 F.3d at 30–36; *see also Bruno*, 727 F. App'x at 720 (remanding

inadequate-medical-care claim for application of objective standard). According to the Second Circuit, "an official can violate the Due Process Clause . . . without meting out any punishment." 849 F.3d at 35. Like the Ninth Circuit, the Second Circuit incorrectly suggested that its standard will exclude ordinary negligence claims because the detainee would need to "prove that an official acted intentionally or recklessly, and not merely negligently." *Id.* at 36.

The Seventh Circuit recently followed suit and held that pretrial detainees' claims of inadequate medical care are to be judged without reference to the subjective mindset of the defendant officials or medical professionals. *Miranda*, 900 F.3d at 353–54. Instead, "medical-care claims brought by pretrial detainees under the Fourteenth Amendment are subject only to the objective unreasonableness inquiry identified in *Kingsley*." *Id.* at 352. Under the Seventh Circuit's approach, so long as the defendant medical professional undertakes a purposeful, knowing, or even reckless act, a jury can find that the act violates the Due Process Clause if that act was objectively unreasonable. *Id.* at 352–54.

***

The circuit split has unsettled what for a time constituted fairly stable and uniform law regarding the applicable standard to pretrial detainees' section 1983 claims alleging inadequate medical care. One group of circuits continues to apply the deliberate-indifference standard of *Estelle* and *Farmer* to such claims. Another group of circuits has read *Kingsley*'s holding regarding excessive-force cases to mean that a uniform objective-reasonableness standard applies

to all claims brought by pretrial detainees, including claims alleging constitutionally inadequate medical care. The Court should resolve the split and restore uniformity and predictability.

### B. States need stability, certainty, and uniformity in the constitutional standard governing the provision of medical care to persons who are in state custody

1. This Court has long recognized that "[r]unning a prison is an inordinately difficult undertaking." *Turner v. Safley*, 482 U.S. 78, 84–85 (1987); *see also Procunier v. Martinez*, 416 U.S. 396, 404–05 (1974) (explaining "that the problems of prisons in America are complex and intractable, and, more to the point, they are not readily susceptible of resolution by decree," and thus "courts are ill equipped to deal with the increasingly urgent problems of prison administration and reform").

Providing medical care to convicted prisoners in state correctional facilities is a gargantuan task. On any particular day, state prisons confine more than 1.3 million people. Pew Charitable Trusts, *Prison Health Care: Costs and Quality* 1, 92 (2017). Prisoners have a high incidence of chronic and infectious diseases, such as hypertension, HIV, hepatitis C, and mental illness, which are costly to treat. *See id.* at 7, 24; Pew Charitable Trusts & MacArthur Foundation, *State Prison Health Care Spending* 9 (2014).

Overall, roughly 20% of total state prison expenditures go toward paying for inmates' medical care. Pew, *Prison Health Care*, *supra*, at 3. In 2012, for example, States spent a total of $38.6 billion on prisons,

$7.6 billion of which was for inmate health care. *Id.* at 126 n.4. And in 2015, state departments of correction spent approximately $8.1 billion on prison health care services. *Id.* at 3. Nearly half the States (twenty-one) spent $100 million or more on prison health care in 2015, with California topping that list at more than $2.3 billion. *See id.* at 90–91. Three more—Connecticut, Indiana, and Massachusetts—fell just short of $100 million, spending between $93 million and $97 million. *Id.* And thirty-one States spent more than $5,000 per inmate. *See id.* at 94–95.

The Federal Bureau of Prisons, which as of June 2017 had responsibility for about 188,000 inmates, similarly spent nearly $1.2 billion of its $6.9 billion appropriation on health care for inmates in 2016, at a per-inmate cost of $8,602. U.S. Gov't Accountability Office, GAO-17-379, *Bureau of Prisons: Better Planning and Evaluation Needed to Understand and Control Rising Inmate Health Care Costs* 1, 6, 17 (2017); *see also id.* at 15 (reporting health-care expenditures of $9 billion from 2009 through 2016).

In addition to the roughly 1.3 million people housed by state prisons on any given day, county and local jails house more than 740,000 inmates. Zhen Zeng, U.S. Dep't of Justice, *Jail Inmates in 2016*, at 1 (2018); *see also* Pew, *Prison Health Care*, *supra*, at 57–58 (excluding inmates in local custody from figures concerning state prison medical expenditures). During 2015, local jails booked more than 10.9 million people into jail. Pew Charitable Trusts, *Jails: Inadvertent Health Care Providers* 3 (2018); *see also Florence v. Bd. of Chosen Freeholders*, 566 U.S. 318, 326 (2012).

The costs of providing health care to pretrial detainees and others housed in jails are similarly massive. *See, e.g.*, Pew, *Jails*, *supra*, at 7 (noting that Cook County, Illinois, spent almost $100 million on jail-inmate health care in 2016); Christian Henrichson et al., Vera Inst. of Justice, *The Price of Jails: Measuring the Taxpayer Cost of Local Incarceration* 14 (2015) (noting that King County, Washington, spent $29 million, roughly twenty percent of its budget, on inmate health care in 2014). The Department of Justice has estimated that localities spent more than $22 billion on jails in 2011, Tracey Kyckelhahn, U.S. Dep't of Justice, *Local Government Corrections Expenditures, FY 2005–2011*, at 3 tbl.2 (2013), yet that figure is misleadingly low because in some localities other agencies pay for inmate health care and other expenses. Henrichson, *supra*, at 4–5, 14. The high costs are hardly surprising—detainees, like prisoners, have a high incidence of chronic and infectious disease as well as mental illness. Pew, *Jails*, *supra*, at 3. Indeed, some jails have unwittingly become substitutes for now-shuttered public mental health hospitals. *Id.* at 5.

2. Owing to the vast sums of taxpayer money already at issue, it is critical for States, localities, and courts to have a clear, uniform, and predictable constitutional standard. Inmate suits alleging constitutionally inadequate medical care are already ubiquitous. Paying damages awards and attorney fees or implementing injunctive relief drains resources. Uncertainty over something as fundamental as the applicable constitutional standard only complicates matters.

The costs of inmate litigation are not measured solely in paying out or implementing judgments. Every minute a physician spends in a deposition is a minute away from providing care to another inmate, which requires States and localities to spend yet more to hire additional medical professionals. At the same time, however, the omnipresent threat of inmate litigation in federal court deters some medical professionals from providing care in jails and prisons, making it difficult to recruit quality medical personnel. These professionals are, after all, asked to go into undesirable places and provide care to some of the most difficult persons in society.

The costs and consequences of this sort of litigation stand to grow dramatically if inmates are no longer required to satisfy *Estelle*'s and *Farmer*'s deliberate-indifference standard. By requiring plaintiffs to establish subjective recklessness, the deliberate-indifference standard reduces the number of cases in which federal courts rely on medical experts to determine the constitutionality of incarcerated individuals' medical care. But removing the defendant's subjective state of mind from the equation leaves nothing but objective reasonableness, a matter usually informed by expert testimony.

The potential need for expert testimony in the mine run of detainee-medical-treatment cases stands to increase the costs of litigation and to draw out the process, thereby clogging federal dockets, distracting medical professionals from treating detainees, and draining scarce public resources. Moreover, imposing a lower standard than deliberate indifference suggests that detainees will succeed in more cases,

whether by settlement or judgment, encouraging more suits. The serious economic impact of these types of claims makes the issue presented one of critical importance to the States.

3. Again, in adopting the deliberate-indifference standard in *Estelle*, the Court cautioned that it was not constitutionalizing the law of negligence. 429 U.S. at 106. Similarly, "liability for negligently inflicted harm is categorically beneath the threshold of constitutional due process." *Lewis*, 523 U.S. at 849; *see also, e.g.*, *Daniels v. Williams*, 474 U.S. 327, 328 (1986) (holding "that the Due Process Clause is simply not implicated by a *negligent* act of an official causing unintended loss of or injury to life, liberty, or property").

Yet the Ninth Circuit's reasonableness standard, by requiring proof of nothing more than negligence, effectively constitutionalizes the common-law negligence standard. The Ninth and Seventh Circuits have disclaimed as much on the grounds that *Kingsley* requires inquiry into whether the defendant intended to take the act at issue. *See* App. 13–14; *Miranda*, 900 F.3d at 353–54; *Castro*, 833 F.3d at 1071. That requirement, however, stems from Fourth Amendment cases, where no seizure occurs absent intentional use of force. *See Lewis*, 523 U.S. at 843–44 (discussing *California v. Hodari D.*, 499 U.S. 621, 626 (1991), and *Brower v. County of Inyo*, 489 U.S. 593, 596–97 (1989)). But *all* medical-care claims are accompanied by intentional acts, such that even something as basic as writing a prescription for ibuprofen rather than acetaminophen for a detainee who then suffers gastric bleed becomes a due process claim upon proof that the

physician acted unreasonably in the choice of medication.

This implication of the objective reasonableness test is important not only because it contravenes *Estelle*, but also because it undermines state tort-reform efforts in the context of medical malpractice. Many States have statutes governing the procedures and damages available for medical negligence claims. *See, e.g.*, Ind. Code § 34-18-1-1 *et seq.*; Am. Med. Ass'n, *Medical Liability Reform—Now!* 14–22 (2018 ed.); Jean Macchiaroli Eggen, *Medical Malpractice Screening Panels: An Update and Assessment*, 6 J. Health & Life Sci. L. 1, 8 & n.21 (2013); F. Patrick Hubbard, *The Nature & Impact of the "Tort Reform" Movement*, 35 Hofstra L. Rev. 437, 517–22 (2006); Scott H. Moulton, USLAW Network, *Compendium of Law: 50-State Analysis of Liability Damages Cap* (2017). The purpose of those statutes is to control medical negligence liability, promote talent retention, and preserve and promote access to health care. Permitting pretrial detainees to bootstrap medical negligence claims into constitutional claims would permit circumvention of med-mal tort reform efforts. It would also put federal courts in the middle of interpreting and applying ordinary state medical negligence standards in the process.

The Court should decide whether the Due Process Clause requires such an intrusion on the States' traditional regulation of tort law.

## II. The Decision Below Is Wrong

The decision below—and similar decisions of the Seventh and Second Circuits—extending the purely objective test of *Kingsley v. Hendrickson*, 135 S. Ct. 2466 (2015), to pretrial detainees' inadequate-medical-care claims is wrong. The decision is unmoored from the justification for a constitutional duty to provide medical treatment to inmates—and indeed suggests (contrary to precedent) that States are permitted, up to a point, to "punish" convicted prisoners with subpar medical treatment. It also ignores well-established doctrinal differences between excessive-force and conditions-of-confinement claims and (again contrary to precedent) attempts to fashion a one-size-fits-all standard from the Due Process Clause.

### A. No constitutional or logical reason justifies different standards for inadequate-medical-care claims brought by convicted prisoners and pretrial detainees

1. Both the Eighth Amendment and the Due Process Clause impose on States a duty to provide adequate medical care to confined individuals. *See City of Revere v. Massachusetts Gen. Hosp.*, 463 U.S. 239, 244 (1983); *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). When the State has affirmatively restrained an individual's liberty and "render[ed] him unable to care for himself," it must "provide for his basic human needs." *DeShaney v. Winnebago Cnty. Soc. Servs. Dep't*, 489 U.S. 189, 200 (1989); *see also County of Sacramento v. Lewis*, 523 U.S. 833, 851 (1998)*; Estelle*, 429 U.S. at 103–04.

The Constitution does not require different standards for evaluating inadequate-medical-care claims brought by pretrial detainees and those brought by convicted prisoners. The Due Process Clause bars the State from inflicting "punishment" on a pretrial detainee. *Kingsley*, 135 S. Ct. at 2475; *Bell v. Wolfish*, 441 U.S. 520, 536–37 (1979). And the Court's Eighth Amendment cases hold that while disregarding a serious medical risk of which the defendant is *subjectively* aware constitutes punishment, objectively unreasonable conduct that is *not* accompanied by subjective awareness is *not* punishment; it is nothing more than medical malpractice. *See Farmer v. Brennan*, 511 U.S. 825, 838 (1994) (reasoning that "an official's failure to alleviate a significant risk that he should have perceived but did not, while no cause for commendation, cannot under our cases be condemned as the infliction of punishment"); *Wilson v. Seiter*, 501 U.S. 294, 300 (1991) ("If the pain inflicted is not formally meted out *as punishment* by the statute or the sentencing judge, some mental element must be attributed to the inflicting officer before it can qualify."); *Estelle*, 429 U.S. at 105–06. In the context of providing medical care to confined inmates, it is the defendant's subjective recklessness—*i.e.*, conscious disregard of a known substantial risk of harm—that distinguishes between "punishment" and medical malpractice, irrespective of the inmate's status as a detainee or a convict.

In other words, the critical event triggering the States' duty to provide medical care is confinement, not conviction. The State must provide medical care to any inmate, regardless of the reason for confine-

ment or the constitutionally permissible level of punishment, because by locking up the inmate the State has prevented self-care. And regardless of whether the inmate is a convicted prisoner or a pretrial detainee, in order to violate the Eighth Amendment *or* the Due Process Clause the provision of medical care must constitute *punishment*.

Indeed, because the Court has never condoned *any* medical deprivation as a permissible form of punishment, the objective standard adopted by the Ninth, Seventh, and Second Circuits logically runs straight into *Estelle* and *Farmer*. If objectively unreasonable medical care constitutes "punishment" with regard to a detainee—the critical inquiry in evaluating a detainee's due process claim, *see Kingsley*, 135 S. Ct. at 2473; *Bell*, 441 U.S. at 535—then it necessarily constitutes punishment with regard to a convicted prisoner. *See Wilson*, 501 U.S. at 301–02 ("An intent requirement is either implicit in the word 'punishment' or is not; it cannot be alternately required and ignored as policy considerations might dictate."). Yet *Estelle* and *Farmer* clearly and definitively say that medical treatment—even objectively unreasonable treatment—for which there is no subjective recklessness is *not* punishment under the Eighth Amendment. *Estelle*, 429 U.S. at 104–06; *see also Farmer*, 511 U.S. at 838; *Wilson*, 501 U.S. at 300.

2. The Ninth Circuit (along with the Seventh and Second Circuits) deemed *Estelle* and *Farmer* inapplicable and instead embraced the theory that a pretrial detainee must in all cases have greater rights than a convicted prisoner. *See* App. 12–14. Yet for purposes of medical care, detainees and convicts are identically

situated. The State equally confines inmates of both groups and thereby equally prevents them from securing their own medical care. *Cf. Bell*, 441 U.S. at 546 (explaining that the principles limiting the scope of convicts' constitutional rights "applies equally to pretrial detainees"). Nor, unlike with excessive force claims, can a *Fourth Amendment* standard apply to medical care, which in no way further "seizes" someone already confined. *See, e.g.*, *DeShaney*, 489 U.S. at 200. Just as it would have been "nonsensical" to apply the medical deliberate-indifference standard to excessive-force claims, *see Whitley*, 475 U.S. at 320–21, so too is it nonsensical to extend the *Kingsley* standard to the medical-care context.

The upshot is that the Court's precedents do not treat excessive force and deprivation of medical care in tandem. The Ninth Circuit's reliance on *Kingsley* to fashion a new rule of constitutional law for inadequate-medical-care claims is misplaced and ignores the principle that "[r]ules of due process are not . . . subject to mechanical application in unfamiliar territory." *Lewis*, 523 U.S. at 850. The constitutional foundation underlying the State's duty to provide medical care to those it has confined does not turn on the status of the person confined. It is about furnishing those who cannot help themselves with life's basic necessities.

### B. The deliberate-indifference standard is appropriate for evaluating pretrial detainees' inadequate-medical-care claims

Unlike the Ninth Circuit's objective-reasonableness standard, the deliberate-indifference standard accounts for the constitutional basis for the State's duty to provide medical care, which in no way turns on whether a confined person has been convicted. *See, e.g.*, *DeShaney*, 489 U.S. at 200; *cf. Farmer*, 511 U.S. at 839 (explaining that "a subjective approach isolates those who inflict punishment"); *Bell*, 441 U.S. at 536–37 (holding that a jail may subject a detainee to restrictions and conditions that "do not amount to punishment").

The deliberate-indifference standard is also consistent with the "shocks the conscience" standard applicable to substantive due process claims. *See Lewis*, 523 U.S. at 849; *see also Rochin v. California*, 342 U.S. 165, 172 (1952). Conscience-shocking activity by its nature requires a particular mental state. Merely substandard medical care does not shock the conscience, but subjectively reckless medical care might.

Finally, the deliberate-indifference standard also reflects the reality that "courts are ill equipped to deal with the increasingly urgent problems of prison administration." *Procunier v. Martinez*, 416 U.S. 396, 405 (1974). States and localities are tasked not only with providing medical care to all inmates but also with supplying adequate shelter, nutrition, clothing, and safety. *Farmer*, 511 U.S. at 832. Imposing section 1983 liability on officials and medical providers with-

out a showing of at least subjective recklessness implies that while the Constitution does not require *comfortable* prisons and jails, *see Rhodes v. Chapman*, 452 U.S. 337, 349 (1981); *Bell*, 441 U.S. at 537–43, it requires *perfectly run* prisons and jails. That has never been the law.

In creating a new constitutional standard for judging detainee medical-care claims the Ninth Circuit detached *Kingsley* from its constitutional footing and ignored the basis for the States' constitutional duty to provide adequate medical care to inmates, whether convicted or not.

## CONCLUSION

The Petition should be granted.

Respectfully submitted,

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