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RECOMMENDED FOR PUBLICATION
Pursuant to Sixth Circuit I.O.P. 32.1(b)

File Name: 23a0090p.06

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

KARLA HOWELL, AS ADMINISTRATRIX OF THE ESTATE OF CORNELIUS PIERRE HOWELL,

Plaintiff-Appellant,

v.

NAPHCARE, INC.; CHRISTINA JORDAN and PIERETTE ARTHUR, individually and in their official capacities; JIM NEIL, MATTHEW COLLINI, and DANIEL ERWIN, individually and in their official capacities in the Hamilton County Sheriff's Department; JUSTIN HUNT,

Defendants-Appellees.

No. 21-4132/22-3306

Appeal from the United States District Court for the Southern District of Ohio at Cincinnati. No. 1:19-cv-00373—Douglas Russell Cole, District Judge.

Argued: October 20, 2022

Decided and Filed: May 1, 2023

Before: SUTTON, Chief Judge; STRANCH, and DAVIS, Circuit Judges.

OPINION

JANE B. STRANCH, Circuit Judge. Cornelius Pierre Howell died of a sickle cell crisis while in pretrial custody at the Hamilton County Justice Center on December 9, 2018. Rather than transport a distressed Howell to a local hospital, nurses and jail personnel placed him in a restraint chair and put him in an observation room in the Jail's mental health unit. Howell remained strapped to the chair with minimal observation until jail personnel found him dead approximately four hours later. His Estate sued the nurses, their employer, NaphCare, Inc., the jail personnel, and Hamilton County for, as relevant to this appeal, deliberate indifference to his serious medical needs, excessive force, and failure to train, all in violation of the Fourteenth Amendment. The district court found that none of the Defendants violated Howell's constitutional rights and granted summary judgment. We AFFIRM IN PART, REVERSE IN PART, and REMAND for further proceedings.

I. Background

A. Factual Background

On December 2, 2018, Cornelius Pierre Howell was arrested and booked at Hamilton County Justice Center (the Jail). Over the course of the next week, Howell received two medical screenings from nurses employed by NaphCare, Inc., a private company that

contracts with the Jail to provide medical services. The nurses placed him on the "chronic care list" because of his charted diagnosis of sickle cell disease, and Howell informed them that he typically took Oxycodone for his sickle cell pain, which he stated had worsened during his incarceration.

Howell returned to the medical unit on December 9 after he started a fight with his cellmate. Video shows that two officers attempted to lead Howell down a hallway, but he immediately fell to the ground, requiring the officers to pick him up. Again, the officers attempted to assist Howell to an elevator, but he continued to fall to the ground. After leaning him against a wall, the officers placed Howell in a wheelchair and took him to the medical sallyport.

Nurse Christina Jordan first evaluated Howell's cellmate. Meanwhile, Howell exclaimed that he was in pain and "yell[ed], moan[ed], and groan[ed]" in an adjacent room—loud enough that those inside the sallyport could hear his cries. He also stated that he could not feel his legs. Once inside the medical sallyport, Howell continued with more of the same: he yelled, complained of pain in his back and legs, and rated his pain at ten-out-of-ten. Again, he "yell[ed] that his legs wouldn't work." Video shows that Howell continued to slide out of the wheelchair and was eventually left rolling around on the floor.

Jordan ultimately evaluated Howell in the medical sallyport with Officers Hunt and Erwin present. Although Howell refused to take a glucose tablet or provide a urine sample, the nurses did take Howell's vitals. NaphCare's medical director subsequently acknowledged that his respiratory rate of 22 was "abnormal." Jordan reviewed Howell's medical chart,

seeing Howell's sickle cell diagnosis and his medical history from previous incarcerations. Howell also told Jordan that he had sickle cell. On two prior occasions at the jail, at least one of which was memorialized in his medical chart, medical staff sent Howell to a local hospital due to sickle cell pain.

In previous jobs and during her time at the jail, Jordan had treated sickle cell patients, and she had received training about sickle cell disease. She knew that "pain [is] the primary symptom of sickle cell" and a sickle cell crisis can manifest as numbness in the legs. Jordan concluded Howell was in pain. But ultimately, she determined that Howell was experiencing "a psych[iatric] issue more than a sickle cell [issue], because [with] sickle cell . . . you're in too much pain to do anything," like moving or yelling. Accordingly, Jordan suggested that Jail officers transport Howell to the psychiatric department for evaluation.

Around 5:40 p.m., officers placed Howell in a restraint chair; at that time, Jordan recorded Howell's blood pressure as 90/56. The Defendants dispute whether the NaphCare Defendants or the Hamilton County Defendants ordered that Howell be placed in a restraint chair. But all Defendants concede that they did not object to that decision. Next, the officers transported Howell to the mental health unit, placed him in a cell that had a small window on its door, and attached the restraint chair to the wall.

Jail restraint-chair policy required jail officers to perform a "check" every ten minutes. Policy also required officers to consider removing the restrained detainee from the chair every hour, recommended at least ten minutes of limb rotations every two hours "to prevent blood clots," and required access to the

restroom and water. The medical staff relied on the officers to complete these checks and to report anything unusual with the restrained detainee. The officers had received some training at the officer academy and at orientation on how to perform observational checks on persons in restraint chairs. Alternatively, one sergeant explained that a "field training officer" conducted restraint-chair monitoring training after the academy. Additionally, the officers received "on-the-job" training, and the policy guidance was distributed with an encouragement to "read it" and "review it". The frequency of checks performed by the medical staff depended on who ordered the detainee to the chair. If medical personnel ordered a restraint chair, medical staff were required to perform a check every fifteen minutes; if jail personnel ordered the chair, medical staff were required to perform a check every two hours.

At approximately 6:06 p.m., Nurse Periette Arthur checked on Howell in the presence of Officers Collini and Erwin. Arthur stated that Howell was still yelling but decided that he did not need further medical treatment. After Arthur's initial check, no NaphCare employee checked on Howell again. From 6:23 p.m. to 8:03 p.m., Officers Collini and Erwin did not perform checks on Howell every 10 minutes; instead, they checked approximately every 20 minutes—six checks in total. Officer Collini performed one more check, approximately an hour later at 9:14 p.m.

The observations of Howell by Collini and Erwin consisted of looking through the "small little window" on the locked door—a view that provided only a side profile of Howell. But the Officers did not enter the cell, and they could not see Howell's eyes and could

not tell if he was alive. The Officers thought that Howell was sleeping. In reality, Howell may have already died. Collini and Erwin failed to consider Howell for removal every hour, rotate Howell's limbs every two hours, or provide Howell with water or the opportunity to use the restroom. Instead, the Officers falsified entries on the restraint chair log to appear to comply with the policy requiring a check every ten minutes. At 9:45 p.m., approximately four hours after being placed in the mental health unit, Officers, including Hunt, went to remove Howell from the restraint chair. The Officers found Howell dead.

Dr. Gretel Stephens, the Hamilton County Deputy Coroner, performed an autopsy the next day. She determined that Howell died from sickle cell crisis; "once the sickling began" Howell likely died within "minutes." The Estate's expert, Dr. Martin Steinberg, a sickle cell expert, determined that Howell died as a result of rhabdomyolysis, a common complication of sickle cell disease, onset by a "short period of intense exertion."[1] Dr. Steinberg opined that a transfer to a hospital "would more likely than not have prevented [] Howell's death."

B. Procedural History

Howell's sister, as administratrix of his estate, sued the NaphCare Defendants—NaphCare, Inc. and Nurses Arthur and Jordan—and the Hamilton County Defendants—Matthew Collini, Daniel Erwin, Justin Hunt, and Jim Neil—for injuries related to Howell's

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[1] The NaphCare Defendants' expert opined that Howell died from a sudden cardiac arrest, resulting from a prior chest stab wound that had required open heart surgery a year earlier.

death while he was in pretrial custody. Pursuant to 42 U.S.C. § 1983, the Estate claims all Defendants violated the Fourteenth Amendment through deliberate indifference to Howell's serious medical need and excessive force. Defendant Sheriff Neil was sued only in his official capacity for failure to train, inadequate supervision, and ratification. The operative complaint also includes state law claims for negligence, wrongful death, and survivorship against various Defendants.

The district court granted summary judgment for all Defendants on all federal claims and declined to retain jurisdiction over the remaining state law claims. The Estate appealed that decision[2] in November 2021 and in January 2022, moved for relief from judgment based on the district court's failure to consider our September 2021 decision in *Brawner v. Scott County*, 14 F.4th 585 (6th Cir. 2021) *cert. denied sub nom.*, *Scott County v. Brawner*, 143 S. Ct. 84 (2022), which changed the standard for deliberate indifference claims under the Fourteenth Amendment. The court denied the motion for relief, finding that under *Brawner*, Defendants were still entitled to summary judgment on the deliberate indifference claim. The Estate again appealed, and we consolidated the appeals.

II. Analysis

We review the district court's grant of summary judgment de novo. *Briggs v. Univ. of Cincinnati*, 11

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[2] The Estate brought its excessive force claim against all individual Defendants. On appeal, the Estate contests the district court's judgment on its excessive force claims only as to Nurse Jordan.

F.4th 498, 507 (6th Cir. 2021). Summary judgment should be granted if, viewing the record in the light most favorable to the nonmoving party, there is no genuine issue as to any material fact such that the movant is entitled to judgment as a matter of law. *Id.* (citing Fed. R. Civ. P. 56(c)). In our review, we draw all justifiable inferences in the nonmoving party's favor. *Id.* If there is sufficient evidence such that a jury could return a verdict for the nonmoving party, a genuine dispute of material fact exists, and summary judgment is improper. *Id.*

A. Deliberate Indifference Claim Against Individual Defendants

Both pretrial detainees, like Howell, and convicted prisoners have a constitutional right to be free from deliberate indifference to their serious medical needs. For a pretrial detainee, the right arises under the Fourteenth Amendment, while a prisoner's right comes from the Eighth Amendment. *Richmond v. Huq*, 885 F.3d 928, 937 (6th Cir. 2018). Until our decision in *Brawner*, this was a distinction without a difference: both groups' claims of deliberate indifference were analyzed under the test formulated by the Supreme Court in *Farmer v. Brennan*. 511 U.S. 825 (1994). *Farmer* requires a plaintiff to satisfy two components—one objective and one subjective. To satisfy the objective component, a plaintiff must show that the individual had an "objectively" serious medical need. *Id.* at 834. The subjective component requires a showing that "an official kn[ew] of and disregard[ed] an excessive risk to inmate health or safety; the official must both [have been] aware of facts from which the inference could be drawn that a substantial risk of harm exist-[ed], and he must also [have] draw[n] the inference."

Id. at 837. *Farmer*'s formulation of the subjective component adopted a standard akin to criminal-law recklessness and rejected a civil-law recklessness standard that would not require subjective knowledge. *Id.* at 836-37.

While *Farmer*'s criminal-law recklessness standard still governs a prisoner's Eighth Amendment deliberate indifference claim, *Brawner* changed the standard for pretrial detainees under the Fourteenth Amendment, adopting a civil-law recklessness standard that "calls a person reckless who acts or . . . fails to act in the face of an unjustifiably high risk of harm that is either known or so obvious that it should be known." *Id.* at 836. *Brawner* reasoned that this change was necessary in light of the Supreme Court's decision in *Kingsley v. Hendrickson*, 576 U.S. 389 (2015), which drew a distinction between claims brought by pretrial detainees and prisoners. *Brawner*, 14 F.4th at 596. In *Kingsley*, the Supreme Court held that for excessive force claims, a pretrial detainee need only show that the force used was objectively unreasonable, and it rejected a subjective unreasonableness inquiry. 576 U.S. at 392. Applying *Kingsley*'s reasoning, *Brawner* held that a pretrial detainee must make a showing (1) that he had an objectively serious medical need and (2) that each defendant "acted deliberately [and] also recklessly 'in the face of an unjustifiably high risk of harm that is either known or so obvious that it should be known.'"[3] *Brawner*, 14 F.4th at 596 (quoting *Farmer*, 511 U.S. at 836).

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[3] After *Brawner*, a panel of this court held that a pretrial detainee must satisfy a third element: that "the prison official knew that his failure to respond [to an excessive risk of harm] would pose a serious risk to the pretrial detainee and ignored

An objectively serious medical need includes conditions that have been "diagnosed by a physician as mandating treatment" or that are "so obvious that even a lay person would easily recognize the necessity for a doctor's attention." *Harrison v. Ash*, 539 F.3d 510, 518 (6th Cir. 2008) (quoting *Blackmore v. Kalamazoo County*, 390 F.3d 890, 897 (6th Cir. 2004)). We have "routinely held that a condition resulting in death is 'sufficiently serious' to meet the objective component." *Burwell v. City of Lansing*, 7 F.4th 456, 463 (6th Cir. 2021). In this case, Howell suffered a sickle cell crisis that, according to Dr. Stephens and Dr. Steinberg, caused his death.

After initially being taken from his cell, moreover, Howell continuously fell to the ground, seemingly unable to walk under his own power, complained about numbness and pain in his legs, complained about pain in his back, and rated his pain at ten-out-of-ten, evidencing an "obvious need for medical care." *Id.* at 464 (quoting *Blackmore*, 390 F.3d at 900). Howell's sickle cell crisis, pain, and death undoubtedly satisfy the objective prong.

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that risk." *Trozzi v. Lake County*, 29 F.4th 745, 757-58 (6th Cir. 2022). But that language is nearly identical in substance to *Farmer*'s subjective requirement for convicted prisoners: that an "official kn[ew] of and disregard[ed] an excessive risk to inmate health or safety; the official must both [have been] aware of facts from which the inference could be drawn that a substantial risk of harm exist[ed], and he must also [have] draw[n] the inference." 511 U.S. at 837. *Brawner* expressly departed from that standard. We agree with the panel in *Helphenstine v. Lewis County* that *Trozzi*'s "framing of the elements is irreconcilable with *Brawner*," and "[b]ecause *Brawner* was decided before *Trozzi*, *Brawner* controls." 60 F.4th 305, 316-17 (6th Cir. 2023).

Moving to the second prong, the Estate must show that the individual Defendants recklessly acted or recklessly failed to act where a reasonable official in their position would have recognized that Howell's serious medical need posed "an unjustifiably high risk of harm." *See Brawner*, 14 F.4th at 596-97 (quoting *Farmer*, 511 U.S. at 836). It is sufficient that the risk is known by the defendant or "so obvious that it should be known." *Id.* at 596 (quoting *Farmer*, 511 U.S. at 836). And the Estate must prove "more than negligence but less than subjective intent—something akin to reckless disregard." *Id.* at 598 (quoting *Castro v. County of Los Angeles*, 833 F.3d 1060, 1071 (9th Cir. 2016) (en banc)). We analyze each Defendant's liability individually. *Greene v. Crawford County*, 22 F.4th 593, 607 (6th Cir. 2022).

1. Individual NaphCare Defendants

The Estate claims a genuine dispute of material fact exists as to whether NaphCare Nurses Jordan and Arthur were deliberately indifferent to Howell's serious medical need— Jordan because she failed to send Howell to the emergency room after evaluation and Arthur because her monitoring of Howell in the mental health unit was inadequate.

a. Defendant Nurse Christina Jordan

There is no dispute that Jordan knew Howell had sickle cell disease. She saw it in Howell's chart, and he told her during her evaluation. Notably, Jordan had professional experience, "academic," and on-the-job training in treating patients with sickle cell, and she acknowledged that sickle cell crises can

manifest in extreme pain and numbness in the arms and legs. A reasonable inference can be drawn that based on her review of Howell's history in his medical chart, Jordan knew that Howell had been hospitalized during previous incarcerations due to sickle cell complications.

Jordan heard Howell's repeated complaints of leg and back pain, and it is reasonable to infer that she also heard Howell's complaints about not being able to feel his legs or that his "legs wouldn't work," because Howell was "yelling" them and other Defendants present heard these complaints. She witnessed Howell fall out of a wheelchair and roll around on the floor. Jordan took Howell's vitals, but there is a dispute of material fact regarding the irregularity of his respiratory rate and blood pressure. Most importantly, Jordan believed Howell was in pain; she did not think he was "faking" his anguish.

To be sure, there were other facts for Jordan to consider. She knew the officers brought Howell for evaluation after he uncharacteristically started a fight with his cellmate, and when reviewing his medical chart, she noticed a previous incident of drug use while incarcerated. Further, Howell refused a glucose tablet and hydration and refused to provide a urine sample.

Based on all these facts, Jordan ordered Howell to be put in a restraint chair and transported to a locked observation cell in the mental health unit; she then failed to check on him. She did nothing to treat Howell for a sickle cell crisis or for his excruciating pain. The Estate's expert opined that Howell's symptoms were well-known complications of sickle cell disease and that a detainee with sickle cell experiencing

bad pain represents a medical emergency: "A patient with sickle cell disease complaining of severe pain should never be ignored. . . . " The Estate's experts concluded that Jordan "should have immediately" sent Howell to the emergency department and "even a layperson" would have recognized the risk.

There is no dispute that Jordan subjectively believed Howell was experiencing a psychiatric episode. But after *Brawner*, subjective belief is not the end of the analysis. *Brawner* is satisfied if a jury could find that Jordan acted recklessly by failing to treat Howell's sickle cell disease when it was obvious that he faced an unjustifiably high risk of harm. A jury could make that finding here based on the following facts: (1) Jordan knew Howell had sickle cell; (2) she knew he had previously been transported to a local hospital for sickle cell complications while incarcerated; (3) she observed his inability to stand and saw him fall out of a wheelchair; (4) she heard his complaints about pain in his legs and back and numbness in his legs—common sickle-cell symptoms; (5) she read Howell's irregular vitals; and (6) as expert testimony established, a sickle cell patient complaining of severe pain represents a medical emergency that would have made it apparent to a layperson that Howell needed to go to the emergency department. Yet Jordan never took further action to rule out a sickle cell crisis. Accordingly, the district court erred in granting summary judgment to Nurse Jordan. *See Greene*, 22 F.4th at 613 (denying summary judgment to jail official that did not seek additional medical assistance); *see also LeMarbe v. Wisneski*, 266 F.3d 429, 437 (6th Cir. 2001) (denying summary judgment where risk "was extreme and obvious" to medical

professionals and "most lay people"); *Sours v. Big Sandy Reg'l Jail Auth.*, 593 F. App'x 478, 481, 485 (6th Cir. 2014) (reversing grant of summary judgment in favor of nurse who believed detainee who died of diabetic ketoacidosis was "probably detoxing").

Jordan argues she is entitled to summary judgment because she reasonably diagnosed Howell as experiencing a psychiatric episode, and a reasonable misdiagnosis does not subject her to liability. The district court granted summary judgment on that basis, holding that her misdiagnosis was not "clearly inconsistent" with Howell's symptoms. The record below reveals disputes of fact over whether and to what degree Howell's symptoms were inconsistent with a psychiatric episode and were instead consistent with a sickle cell crisis.

Under our caselaw, the simple fact that a medical professional misdiagnosed a patient does not rise to the level of deliberate indifference, *Griffith v. Franklin County*, 975 F.3d 554, 573 (6th Cir. 2020), and as a general matter, courts are "reluctant to second guess the medical judgment of prison medical officials," *Jones v. Muskegon County*, 625 F.3d 935, 944 (6th Cir. 2010). Medical officials, however, "may not entirely insulate themselves from liability under § 1983 simply by providing some measure of treatment." *Id.* (quoting *McCarthy v. Place*, 313 F. App'x 810, 814 (6th Cir. 2008)); *LeMarbe*, 266 F.3d at 439 ("A government doctor has a duty to do more than simply provide some treatment to a prisoner who has serious medical needs.")

Our cases clarify the operation of these principles. In *Jones v. Muskegon County*, we determined that a doctor who misdiagnosed a detainee's cancer as con-

stipation was not deliberately indifferent in part because some of the detainee's symptoms were consistent with constipation. 625 F.3d at 945. We held that the doctor's merely negligent misdiagnosis did not rise to the level of "grossly inadequate" care. *Id.* at 945-46. As noted, however, the doctor in *Jones* also "scheduled various exams to determine more precisely what was affecting [the detainee] and transferred him to the hospital when it was apparent that his condition was worsening." *Id.* at 945. In *Rouster v. County of Saginaw*, we held that a nurse who misdiagnosed a detainee's perforated ulcer as alcohol withdrawal was not deliberately indifferent in part because "the majority of [the detainee's] symptoms were entirely consistent" with alcohol withdrawal. 749 F.3d 437, 451-52 (6th Cir. 2014). That opinion reasoned that the medical personnel,

> were ignorant of the single critical fact that might have caused them to interpret [the detainee's] symptoms in a different light: At no point did [the detainee] tell any member of the medical staff about his previous treatment for a perforated duodenal ulcer. Had [the medical staff] received full information regarding [the detainee's] medical history, we could easily conclude that [the medical staff defendants] were deliberately indifferent to [the detainee's] needs.

Id. at 453. In a recent unpublished opinion, *Britt v. Hamilton County*, a nurse misdiagnosed a detainee's endocarditis as heroin withdrawal. 2022 WL 405847, at *1-2 (6th Cir. Feb. 10, 2022). The *Britt* panel held that the nurse was not deliberately indifferent, noting that the detainee's symptoms were undisputedly con-

sistent with heroin withdrawal and the only facts before the nurse at the time of the misdiagnosis were a slightly elevated temperature and pulse rate that was "close to the typical range." *Id.* at *3. *Britt* explained that the nurse was "far less negligent than other conduct we have held did not create a triable issue of fact on deliberate indifference." *Id.*

The facts in Howell's case are readily distinguishable from these cases. It is undisputed that, unlike the medical staff in *Rouster*, Jordan knew the critical facts that should have caused her to interpret Howell's symptoms in a different light, 749 F.3d at 453; she knew Howell had sickle cell, heard him make repeated complaints synonymous with sickle cell illness, and the record provides a reasonable inference that Jordan knew about Howell's recent hospitalizations related to sickle cell. Moreover, unlike the medical professionals in *Jones* and *Britt*, Jordan was faced with multiple symptoms that were unrelated to the misdiagnosis and consistent with the proper diagnosis, yet she failed to undertake any additional evaluation, care, or treatment during or after the misdiagnosis.

Jordan is "not entirely insulate[d] . . . from liability under § 1983 simply" because she made some diagnosis. *Jones*, 625 F.3d at 944 (quoting *McCarthy v. Place*, 313 F. App'x at 814). This record and our precedent do not support the conclusion that a diagnosis as generic as "psychiatric episode," which could cover almost any physiological symptom, can serve as blanket insulation from liability. In the light most favorable to the Estate, a jury could find that Jordan was reckless by failing to act in the face of an obvious, unjustifiably high risk of harm, amounting

to deliberate indifference to Howell's serious medical need. We reverse the district court's grant of summary judgment to Nurse Jordan on the Estate's deliberate indifference claim.

b. Defendant Nurse Pierette Arthur

Nurse Arthur's exposure to Howell was far more limited than Nurse Jordan's. Arthur only interacted with Howell on one occasion when she checked on him immediately after the Officers brought him to the mental health unit in the restraint chair. She did not observe Howell's behavior in the medical sallyport, and the record does not support the inference that Arthur knew Howell had sickle cell disease. Based on Jordan's diagnosis, Arthur believed that Howell was in the restraint chair for a mental health evaluation.

The Estate argues that, given Arthur's knowledge of Howell's low blood pressure, her failure to call a doctor or perform further checks raises a genuine dispute of material fact whether she was deliberately indifferent. In contrast to Jordan, however, Arthur did not know any of the "critical fact[s]" that would have led a reasonable official to recognize the unjustifiably high risk Howell faced. *Rouster*, 749 F.3d at 453. She did not see Howell's demeanor in the medical sallyport or hear his complaints that would have tipped off a reasonable medical professional that he was experiencing a medical crisis. While the Estate is correct that policy dictated Arthur should have checked on Howell every fifteen minutes, and she only checked on him once in roughly 90 minutes, our caselaw states that a "'failure to follow internal policies, without more,' does not equal deliberate indifference." *Hyman v. Lewis*, 27 F.4th 1233, 1238

(6th Cir. 2022) (quoting *Winkler v. Madison County*, 893 F.3d 877, 891 (6th Cir. 2018)). There is not something "more" in this record that pushes Arthur's conduct beyond the level of negligence to deliberate indifference. *Griffith*, 975 F.3d at 570-71. The district court's grant of summary judgment to Arthur on the Estate's deliberate indifference claim is affirmed.

2. Individual Hamilton County Defendants

The Estate claims a genuine dispute of material fact exists whether Hamilton County Defendants Deputy Erwin, Deputy Collini, and Sergeant Hunt were deliberately indifferent to Howell's serious medical need by failing to adequately monitor and observe Howell while he was restrained in a locked cell in the mental health unit.

Our caselaw has recognized that generally "a non-medically trained officer does not act with deliberate indifference to an inmate's medical needs when he 'reasonably deferred to [a] medical professionals' opinions.'" *Greene*, 22 F.4th at 608 (quoting *McGaw v. Sevier County*, 715 F. App'x 495, 498 (6th Cir. 2017)). Such deference, however, may not be absolute or indefinite, particularly when officers are tasked with monitoring a detainee. *See, e.g.*, *Stojcevski v. Macomb County*, 827 F. App'x 515, 522 (6th Cir. 2020) (summarizing the relevant law that an officer can rely on a medical opinion for a "reasonable period of time after it is issued, absent circumstances such as the onset of new and alarming symptoms"). Moreover, "[a]t a certain point, bare minimum observation ceases to be constitutionally adequate." *Greene*, 22 F.4th at 609.

a. Defendant Deputy Daniel Erwin

Erwin first saw Howell in the medical sallyport, where he observed Howell "slumped over in the chair," then "sprawled out on the floor," and heard him "making noises." Other officers present heard Howell "moaning," and yelling that "his legs wouldn't work" and that he "could not feel his legs." Erwin overheard medical staff and officers debating whether Howell needed to go to the hospital, then he and other officers were ordered to place Howell in a restraint chair and transport him to the mental health unit for "safety and for observation." Erwin later stated that he thought Howell should have gone to the hospital.

It is undisputed that medical staff made the decision to send Howell to the mental health unit instead of the hospital, and Erwin reasonably deferred to that medical determination. But importantly, that medical determination relied on the understanding that officers would complete observational checks every ten minutes as required by policy and would alert the medical staff if they saw anything unusual. It is undisputed that Erwin completed only four checks after his initial check with Arthur at 6:06 p.m. and before Howell was found dead at 9:45 p.m. He did not complete a check after 8:03 p.m. Between Erwin and Collini, who was also responsible for observing Howell, only seven observational checks were performed during the approximately three-and-a-half-hour period. Policy specified that over 20 checks should have been performed. The Officers instead falsified entries to the restraint chair log, knowingly failing to comply with policy.

The infrequency of the observational checks violated policy. In addition, the methodology of the checks raises concerns. Erwin would "look in the . . . small little window . . . and observe [Howell]" from the left side. Collini testified that on two occasions he could not see Howell's eyes or tell if he was alive, which leads to the inference that Erwin could not either. Erwin never entered Howell's cell, despite having the discretion to do so and despite an abrupt change in Howell's demeanor. Nor did Erwin comply with the policy to offer Howell water and a chance to use the restroom.

The infrequency and inadequacy of Erwin's observational checks is compounded by the record evidence that he knew, or should have known, that Howell faced a high risk of harm. Erwin himself believed that Howell should have gone to the hospital after observing Howell's condition in the sallyport. He knew the medical staff considered sending Howell to the hospital prior to deciding that Howell would be restrained for further observation.

Considering these facts, a jury could find that Erwin's actions were the kind of "bare minimum observation" that "ceases to be constitutionally adequate." *Greene*, 22 F.4th at 609. In Erwin's case, there is "more" in the record beyond policy violations, *Hyman*, 27 F.4th at 1238, and a jury could determine that Erwin's actions crossed the line from negligence to reckless disregard. *See Speers v. County of Berrien*, 196 F. App'x 390, 397-98 (6th Cir. 2006) (denying summary judgment where officer heard of detainee's troubling symptoms but only observed the detainee through plexiglass and believed detainee was "sleeping"). The district court's grant of summary

judgment to Erwin on the Estate's deliberate indifference claim is reversed.

b. Defendant Deputy Matthew Collini

Unlike Hunt and Erwin, Collini was not present during Howell's evaluation in the medical sallyport; his first interaction with Howell was during Arthur's check around 6:06 p.m., after Howell had been placed in the restraining chair and brought to the mental health unit. He checked on Howell three times, once at 7:24 p.m., once at 7:40 p.m., and finally at 9:14 p.m., and he violated the same internal policies as Erwin during the observation period.

While Collini knew of the general risks a detainee faced in the restraint chair, he did not have the same knowledge as Erwin, who saw Howell's troubling symptoms in the sallyport and heard the medical staff's hospitalization discussion and their orders. While Collini did not see Howell's condition in the sallyport, he did see Howell's condition worsen while he was in the restraining chair, and he did nothing to alert the medical staff. For example, during his third check, Collini testified that Howell's head "was maybe a little more down. . . . More straight down, I guess." As explained, the medical staff relied on the officers to observe and alert them of these changes. Nonetheless, on this record, a jury could not find that a reasonable officer in Collini's position—without knowledge of what precipitated Howell's arrival in the mental health unit—would have recognized an unjustifiably high risk of harm to Howell. *See Brawner*, 14 F.4th at 597. Collini's failure to act and policy violations did not rise above the level of negligence. *See*

Hyman, 27 F.4th at 1238. The district court's grant of summary judgment to Collini on the Estate's deliberate indifference claim is affirmed.

c. Defendant Sergeant Justin Hunt

Hunt was present in the medical sallyport while Howell was evaluated. He saw Howell slide out of a chair onto the floor and heard him yell about pain and numbness in his legs and pain in his back. He heard the debate whether to send Howell to the hospital, heard the ultimate decision to keep Howell at the jail for "safety and for observation," and saw officers place Howell in the restraint chair and transport him from the medical sallyport. Hunt did not see Howell again until he came to remove Howell from the restraint chair and found him dead, approximately four hours later.

Like Erwin, Hunt reasonably deferred to the medical staff's judgment not to send Howell to the hospital. But unlike Erwin, Hunt was not responsible for performing the observational checks while Howell was restrained in the mental health unit. To be sure, approximately two hours into the observation period, Collini called Hunt to perform a limb rotation, which required a supervisor, and Hunt did not arrive until two hours later. The Estate faults Hunt for this failure to timely arrive and perform the limb rotation, but the jail's policy did not require a limb rotation, it merely recommended it. At the most, a jury could find that Hunt was negligent given that he reasonably deferred to the medical staff's judgment and was not personally responsible for observing Howell. *Griffith*, 975 F.3d at 570-71. The district court's grant of sum-

mary judgment to Hunt on the Estate's deliberate indifference claim is affirmed.

3. Qualified Immunity

In response to the deliberate indifference claim, the individual Hamilton County Defendants assert qualified immunity.[4] Qualified immunity operates to shield government officials from liability for their actions unless the officials are on notice that those actions are unlawful. *See Occupy Nashville v. Haslam*, 769 F.3d 434, 441-42 (6th Cir. 2014). To overcome the Officers' claims to qualified immunity, the Estate must show that (1) the Officers violated one of Howell's constitutional rights and (2) that right was clearly established. *Id.* at 442. As explained above, the Estate fails to carry its burden of showing a constitutional violation on the part of Deputy Collini and Sergeant Hunt, so they are entitled to qualified immunity. But because a jury could find that Deputy Erwin violated Howell's constitutional right to be free from deliberate indifference to his serious medical need, we analyze whether that right was clearly established in 2018. "For a right to be clearly established, the contours of the right must be sufficiently clear that a reasonable official would understand that what he is doing violates that right." *Burwell*, 7 F.4th at 476 (cleaned up). The illegality of the conduct must be apparent considering "pre-existing law, but we need not find a case in which the very action in question has previously been held unlawful." *Id.* at 476-77 (cleaned up).

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[4] Nurses employed by a private medical provider, like NaphCare, are not entitled to assert qualified immunity. *Harrison*, 539 F.3d at 524.

"As early as 1972, we stated that 'where the circumstances are clearly sufficient to indicate the need of medical attention for injury or illness, the denial of such aid constitutes the deprivation of constitutional due process.'" *Id.* at 477 (citing *Est. of Carter v. City of Detroit*, 408 F.3d 305, 313 (6th Cir. 2005)). "Furthermore, we reiterated in 2013 that it is clearly established that a prisoner has a right not to have his known, serious medical needs disregarded by a medical provider or an officer." *Helphenstine*, 60 F.4th at 327 (quoting *Greene*, 22 F.4th at 615). Under comparable circumstances, in *Phillips v. Roane County*, we denied qualified immunity to officers who inadequately monitored an inmate exhibiting signs of a serious medical condition. 534 F.3d 531, 540-41, 545 (6th Cir. 2008). The officers were tasked with monitoring the inmate in an observation room, observed her concerning symptoms, and disregarded prison protocols, ultimately leading to a failure to pursue further medical intervention. *Id.* at 540-41. The same is true in this case; Erwin observed Howell's condition, was tasked with monitoring him, and failed to follow policy in doing so, which a jury could find amounted to deliberate indifference. We hold that Erwin was sufficiently on notice that such conduct was unlawful and is not entitled to qualified immunity.

B. *Monell* Claims

The Estate also brought claims against NaphCare, Inc., and Hamilton County pursuant to *Monell v. Department of Social Services of the City of New York*, 436 U.S. 658 (1978). The Estate argues that NaphCare had a custom of authorizing its nurses to order restraint chairs, which practice led to Howell's inadequate medical care. As for the County, the

Estate contends it was deliberately indifferent in failing to train its officers on proper restraint-chair monitoring. The district court granted summary judgment to both Defendant entities.

1. Custom Claim Against NaphCare

A private corporation performing traditional state functions can be held directly liable under § 1983 if its customs, practices, or policies led to a constitutional deprivation. *Winkler*, 893 F.3d at 904. A custom that has not been formally approved may still serve as a basis for liability if "the relevant practice is so widespread as to have the force of law." *Bd. of Cnty. Comm'rs of Bryan Cnty. v. Brown*, 520 U.S. 397, 404 (1997). The Estate bears "a heavy burden in proving municipal liability, and [it] cannot rely solely on a single instance to infer a policy of deliberate indifference." *Thomas v. City of Chattanooga*, 398 F.3d 426, 433 (6th Cir. 2005).

The Estate argues that "there is evidence showing that nurses routinely ordered restraint chairs," and that custom "caused the denial of adequate medical care" to Howell. If such a custom existed, it violated jail policy that the "application of any clinically ordered restraints must be ordered by an advanced clinical provider." The Estate contends that this caused Howell's injury because if Jordan had complied with policy, a doctor would have been contacted and that doctor likely would have ordered Howell to the emergency room.

The Estate points to only one piece of deposition testimony that, according to a corrections officer, shows that it was "typical for nurses to be the ones who are authorizing the restraint chair." Notably,

this single piece of evidence does not make clear that it was "typical" for nurses to order restraint chairs without first receiving authorization from an advanced medical provider, which the policy permitted to be provided "in writing or via telephone consultation." That testimony alone is insufficient to show a genuine dispute of material fact as to whether there was a custom of nurses ordering restraints in violation of policy that was "so widespread as to have the force of law." *Brown*, 520 U.S. at 404.

The district court's grant of summary judgment to NaphCare on the Estate's *Monell* claim is affirmed.

2. Failure to Train Claim Against Hamilton County

The Estate sued Sheriff Neil in his official capacity under a failure-to-train theory, a claim that amounts to suit against Hamilton County itself. *Leach v. Shelby County*, 891 F.2d 1241, 1245-46 (6th Cir. 1989). A municipality may be liable under § 1983 for failure to train when it amounts to deliberate indifference. *City of Canton v. Harris*, 489 U.S. 378, 388-89 (1989). To succeed on a failure-to-train claim, a plaintiff must show: "(1) the training or supervision was inadequate for the tasks performed; (2) the inadequacy was the result of the municipality's deliberate indifference; and (3) the inadequacy was closely related to or actually caused the injury." *Ellis ex rel. Pendergrass v. Cleveland Mun. Sch. Dist.*, 455 F.3d 690, 700 (6th Cir. 2006). Regarding the second prong, a plaintiff most commonly demonstrates a municipality's deliberate indifference by pointing to a failure to act "in response to repeated complaints of constitutional violations by its officers." *Ouza v. City of Dearborn*

Heights, 969 F.3d 265, 287 (6th Cir. 2020) (quoting *Cherrington v. Skeeter*, 344 F.3d 631, 646 (6th Cir. 2003)). But a plaintiff can rely on a single incident to establish liability in a narrow range of circumstances "if the risk of the constitutional violation is so obvious or foreseeable" that it amounts to deliberate indifference for the municipality to fail to prepare its officers for it. *Id.* The Estate relies on this latter route to show the County's deliberate indifference.

The Estate initially argues that the County did not provide any training on restraint-chair monitoring, but ultimately argues that the County only provided limited on-the-job training that was inadequate. Three types of training regarding observation of inmates in restraint chairs were evinced by the record: training at correctional officer academy; training at orientation; and on-the-job training. One sergeant testified that training was offered by a "field training officer" after the academy.

Collini stated that he received training at the academy and received ongoing on-the-job training; Erwin received the same and showed an awareness and familiarity with the restraint chair policies. Based on the record, it is difficult to ascertain the substance of these trainings— formal or informal— and the Estate's expert only provides in conclusory terms that the County "failed to properly train and supervise" officers on the "proper supervision and careful observation of inmates" in restraint chairs.

To support its proposition that the County's training was inadequate, the Estate primarily relies on *Shadrick v. Hopkins County*, which held that a jail medical provider inadequately trained its nurses by providing only "some limited on-the-job-training."

805 F.3d 724, 740 (6th Cir. 2015). But *Shadrick* contained no indication that the nurses received "any type of ongoing training"; the only training provided appeared to be "some limited on-the-job training when beginning their employment, such as learning where supplies were kept." *Id.* They also did not receive any feedback or evaluations based on their performance. *Id.* Finally, none of the nurses, including their supervisor, could identify any of the requirements of the written policies that governed their work. *Id.* The record in *Shadrick* reveals that the "limited on-the-job training" offered at the beginning of the nurses' employment on housekeeping issues amounted to no training at all.

On this record, we cannot say the same is true regarding the County's training on restraint-chair monitoring. The County offered initial training, and, while it did rely on on-the-job training, that training was ongoing. The Officers displayed knowledge of and familiarity with the relevant polices that governed restraint chairs, which the Estate's expert agreed were reasonable and appropriate. Finally, "failure-to-train liability is concerned with the substance of the training, not the particular instructional format." *Connick v. Thompson*, 563 U.S. 51, 68 (2011). Contrary to the Estate's argument, the County did not wholly fail to train its officers on restraint-chair monitoring. The Estate has failed to show a genuine dispute of fact regarding whether the training was deficient in substance. The Estate's failure-to-train claim against the County fails at prong one, and the district court's grant of summary judgment is affirmed.

C. Excessive Force Claim Against Nurse Jordan

The Estate brought an excessive force claim against Jordan, claiming that her use of the restraint chair violated Howell's Fourteenth Amendment rights. To succeed, the Estate must show "that the force purposely or knowingly used against [a pretrial detainee] was objectively unreasonable." *Kingsley*, 576 U.S. at 396-97. The reasonableness of the force turns on the facts and circumstances of the particular case, and "[a] court must make this determination from the perspective of a reasonable [official] on the scene, including what the [official] knew at the time, not with the 20/20 vision of hindsight." *Id.* at 397. Factors that may bear on the reasonableness analysis include:

> [T]he relationship between the need for the use of force and the amount of force used; the extent of the plaintiff's injury; any effort made by the officer to temper or to limit the amount of force; the severity of the security problem at issue; the threat reasonably perceived by the officer; and whether the plaintiff was actively resisting.

Id.

In the light most favorable to the Estate, Jordan ordered Howell into the restraint chair around 5:40 p.m., and it is undisputed that he remained in the chair for approximately four hours without any further check by Jordan. There is no evidence any force more than necessary was used to place Howell in the chair. Regarding the propriety of ordering a restraint chair based on Howell's symptoms, NaphCare's Health Services Administrator opined that "[y]elling, [falling]

on the floor, rolling around," and "non-complian[ce] with medical care" would not be grounds to place a detainee in a restraint chair, but "it depends on the events that led up to this [behavior]," and on "what was going on at that time."

Neither party cites authority from this court analyzing the failure to remove a detainee from a restraining chair in the context of an excessive force claim. The Estate relies on *Blackmon v. Sutton*, 734 F.3d 1237 (10th Cir. 2013), a case authored by then-Judge Gorsuch. *Blackmon* recognized that "the government may have a legitimate interest in ensuring the safety and order of the facilities where it houses pretrial detainees" and restraints can aid that interest even if they cause discomfort but noted that very harsh conditions might not be reasonably related to "any purpose except punishment." *Id.* at 1241 (quoting *Bell v. Wolfish*, 441 U.S. 520, 539 n. 20, 540 (1979)). In *Blackmon*, the defendants were denied summary judgment because on some occasions they restrained the plaintiff to a chair "without any legitimate penological purpose." *Id.* at 1242 (emphasis in original). This included occasions where the plaintiff had been restrained "for extensive periods after any threat of self-harm had dissipated." *Id.* The Estate argues that Jordan's initial order to place Howell in the restraint chair and the subsequent failures to check on Howell are analogous to the facts in *Blackmon*. It contends that, based on the record, a jury could find there was no legitimate purpose for putting Howell in the chair and Howell was left in the restraint chair long after "any threat . . . had dissipated."

Logic supports consideration of the Estate's excessive force claim as distinct from the inadequate-

medical-care claim. Excessive force raises the question of what harm Howell incurred based on Jordan's decision to place him in the restraint chair, instead of a decision that did not involve the force inherent in restraints, such as returning him to his cell or leaving him unrestrained in an observation room. Regarding the harm caused to Howell, the Estate's expert, Dr. Steinberg, concluded, "I don't think it was the restraint chair itself. I think it was . . . the lack of observation during this time." Indeed, the Estate did not contend that "the restraint chair killed Howell"; rather, that "Defendants killed Howell through their deliberate indifference to his serious medical condition while left alone in the chair." The record suggests that Howell's injury was caused by the failures to send him to the hospital and to properly monitor him. Whether those failures violated Howell's constitutional rights is properly analyzed in the Estate's deliberate indifference claim.

Given that Jordan determined Howell would not be sent to the hospital—again, a decision that is scrutinized in the inadequate-medical-care context—it was not objectively unreasonable to order Howell to a restraint chair for his safety and observation and for him to remain restrained for four hours. *Cf. Grinter v. Knight*, 532 F.3d 567, 573-74 (6th Cir. 2008) (holding that a convicted prisoner did not have a due process liberty interest in freedom from being restrained for four hours). Weighing the appropriate factors, the Estate has not shown a genuine dispute of material fact that Jordan used excessive force against Howell. *See Kinglsey*, 576 U.S. at 397. The district court's grant of summary judgment to Jordan on the excessive force claim is affirmed.

D. State Law Claims

In addition to the federal claims analyzed in this opinion, the Estate brought state law claims against the Defendants. After granting summary judgment in favor of Defendants on the Estate's § 1983 claims, the district court declined to retain supplemental jurisdiction over remaining state law claims. Because we reverse the district court's grant of summary judgment regarding Nurse Jordan and Deputy Erwin, we also reverse the district court's dismissal of the state law claims regarding those Defendants. *See, e.g.*, *Helphenstine*, 60 F.4th at 327. On remand, the district court should reconsider its decision to decline supplemental jurisdiction over these state law claims against Jordan and Erwin. *See id.*

III. Conclusion

The district court erred in granting summary judgment to Nurse Jordan and Deputy Erwin on the Estate's deliberate indifference claims, because, pursuant to *Brawner*, a reasonable jury could find that they recklessly failed to act to mitigate an unjustifiably high risk of harm to Howell that a reasonable official would have recognized. Erwin was not entitled to qualified immunity. Otherwise, the district court properly granted summary judgment on all other claims.

We therefore **REVERSE IN PART** and **AFFIRM IN PART** the district court's grant of summary judgment, and **REMAND** for further proceedings consistent with this opinion.

OPINION AND ORDER, U.S. DISTRICT COURT FOR THE SOUTHERN DISTRICT OF OHIO (MARCH 11, 2022)

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

_____

KARLA HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

_____

Case No. 1:19-cv-373

Before: Douglas R. COLE,
United States District Judge.

OPINION AND ORDER

This cause comes before the Court on a Motion for Relief from Judgment (the "Motion," Doc. 112), filed by Plaintiff Karla Howell, on behalf of the estate of Cornelius Pierre Howell (hereafter "Howell's estate"). Howell's estate argues that, based on a Sixth Circuit decision issued after briefing was complete, but before the Court issued its Order, the Court applied the wrong legal standard to the pending claims for deliberate indifference to serious medical need. The Court agrees. But because the Court would

have reached the same result under the new standard, the Court nonetheless DENIES the Motion (Doc 112).

FACTUAL BACKGROUND[1]

On December 2, 2018, Cornelius Pierre Howell ("Howell") was arrested and detained at the Hamilton County Justice Center (the "Jail"). (Guy Decl., Doc. 72, #868). Howell completed a medical intake with NaphCare, Inc. ("NaphCare"), the Jail's contracted medical provider, at which he disclosed that he had sickle cell disease. (Perdikakis Decl., Doc. 79-1, #1290). Howell received a medical screening on December 3, 2018, from a Licensed Practical Nurse employed by NaphCare who charted Howell's sickle cell disease and ADHD diagnosis. (*Id.* at #1282, 1290). Howell then had a chronic care visit with a nurse practitioner employed by NaphCare on December 7, 2018. (*Id.* at #1266-73). That practitioner noted that Howell reported taking Oxycodone for his sickle cell pain, which had worsened since his incarceration. (*Id.* at #1267).

On December 9, 2018, around 5:00 p.m., Howell had a fight with another inmate[2] housed at the Jail. (Hunt Dep., Doc. 69-8, #547). Guards brought Howell

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[1] This summary reproduces and abbreviates the Court's recounting of the facts of this case in its previous Opinion (Doc. 105) granting Defendants' Motions for Summary Judgment (Docs. 84, 85).

[2] This Opinion uses the term "inmate" generically to refer to all persons housed at the facility, the term "detainee" to refer to those inmates who are held in pretrial detention, and the term "prisoner" to refer inmates who have been convicted and are serving sentences.

to the medical unit in a wheelchair. (Guy Decl., Doc. 72, #873). Howell was yelling that he was in pain and at one point fell out of his wheelchair and rolled around on the floor. (Roettker Dep., Doc. 69-13, #720). Nurse Christina Jordan evaluated Howell. (Jordan Dep., Doc. 69-9, Ex. 33, #583). Jordan took several of Howell's vital signs but was unable to obtain his temperature. (*Id.*). Jordan was unconcerned by Howell's vital signs, which were generally within normal ranges. *(Id.* at #562). Jordan knew Howell had sickle cell disease from reviewing his electronic medical record. (*Id.* at #556). Howell also said so when Jordan examined him. (*Id.* at #583). Howell complained that he could not feel his legs. (Guy Decl., Doc. 72, #873). Jordan observed Howell rolling on the floor yelling with his eyes very wide open. (Jordan Dep., Doc. 69-9, #556).

Howell refused hydration and spit out a glucose tablet a nurse attempted to give him. (*Compare* NaphCare Proposed Undisputed Facts, Doc. 85-1, #1583, *with* Resp. to Proposed Undisputed Facts, Doc. 96-1, #1919). Howell also refused to provide a urine sample. (Jordan Dep., Doc. 69-9, #558, 568).

Nurse Jordan thought that Howell was likely having a psychiatric episode. (*Id.* at #557; *see also* Resp. to Proposed Undisputed Facts, Doc. 96-1, #1919). Based on that determination, she suggested that the Jail officers transport Howell to the psychiatric department. (Jordan Dep., Doc. 69-9, #569). Officers put Howell into a restraint chair around 5:40 p.m. (Hunt Dep., Doc. 69-8, #547). Howell did not resist placement in the chair. (Pierani Dep., Doc. 69-12, #652). Once he was in the chair, officers took Howell to the mental health unit.

Around 6:06 p.m., Licensed Practical Nurse Pierette Arthur, another NaphCare employee, observed Howell. (Surveillance Video G-21 #1 JC 265 5:45-6:45 p.m., Barth Dep., Ex. 12, Doc. 69-2, #288). Howell was yelling, and Arthur decided to walk away to allow Howell to calm down. (Arthur Dep., Doc. 78, #1196). Arthur later spoke to Jordan about Arthur's observations regarding Howell's condition before leaving work for the day, around 7:30 p.m. (*Id.* at #1200; *see also* NaphCare Proposed Undisputed Facts, NaphCare Mot. for Summ. J. Ex. 1, Doc. 85-1, #1586).

Officers Matthew Collini and Daniel Erwin were responsible for observing Howell during his time in the restraint chair. (Roettker Dep., Doc. 69-13, #714). Jail policy is that staff are normally expected to check on inmates in restraint chairs every ten minutes. (Neil Dep., Doc. 69-11, #621-22). Jail staff must also log the status of inmates in a restraint chair each time they check on the inmate. (Buchanan Dep., Doc. 69-3, #299). Inmates in restraint chairs are placed in one of two cells in the mental health department. (Hunt Dep., Doc. 69-8, #515). Inmates are positioned so they face a small window, which allows officers to see them from outside the cell. (*Id.*).

Officer Justin Hunt filled out the first two entries on the log concerning Howell's time in the restraint chair. (*Id.* at #524-25). Then, Collini and Erwin filled out numerous log entries for checks they purportedly conducted on Howell. Taken together, these entries showed that a check occurred approximately every ten minutes. (Roettker Dep., Ex. 6, Doc. 69-13, #714). It is now undisputed, however, that Erwin and Collini made false entries in the log; in fact, they conducted fewer than half of the checks

they recorded. (Collini Dep., Doc. 69-4, #349; Erwin Am. Disc. Resp., Doc. 71-2, #862). That being said, Collini testified he saw Howell alive and seated in the chair at 7:24 p.m. (Collini Dep., Doc. 69-4, #346).

At about 9:45 p.m., Hunt and another officer discovered Howell dead in the restraint chair when they arrived to evaluate him for release. (Guy Decl., Doc. 72, #874). The parties dispute the cause of Howell's death. The NaphCare Defendants say that Howell died of a sudden cardiac arrest, which they claim resulted, at least in part, from a prior chest stab wound that had required open heart surgery approximately a year earlier. (NaphCare Proposed Undisputed Facts, Doc. 85-1, #1587; Evans Decl., Doc. 79-2, #1305; Kiss Decl, Doc. 79-3, #1314-15). Howell's estate argues, by contrast, that, over the course of the roughly four hours he spent in the restraint chair, Howell died of rhabdomyolysis, a complication from sickle cell disease, and that this complication was triggered by Howell's fight with the other inmate. (Steinberg Expert Report, Doc. 87-3, #1693).

PROCEDURAL BACKGROUND

Howell's estate filed this suit on May 20, 2019. (Compl., Doc. 1). As relevant here, the Complaint alleges that Officers Erwin, Collini, and Hunt, and Hamilton County Sheriff Jim Neil (the "Hamilton County Defendants"), as well as Nurse Jordan, Nurse Arthur, and NaphCare (the "NaphCare Defendants"), violated the Fourteenth Amendment through deliberate indifference to Howell's serious medical need. (*Id.* at #10).

On March 15, 2021, both the Hamilton County Defendants and the NaphCare Defendants separately

moved for summary judgment on all of Howell's estate's claims. (Docs. 84, 85). As relevant here, all Defendants argued that Howell's estate created no genuine dispute as to whether any of them consciously disregarded Howell's serious medical need. (Hamilton Cnty. Mot. for Summ. J., Doc. 84, #1524, 1532). Briefing on those motions was completed on April 26, 2021. The Court heard oral argument on October 14, 2021.

The Court issued an Opinion (Doc. 105) on November 2, 2021. The Court granted summary judgment to all Defendants on all of Howell's estate's federal claims, including its deliberate indifference claims. But the Court's Opinion failed to consider the Sixth Circuit's then-recent decision in *Brawner v. Scott County, Tennessee*, 14 F.4th 585 (6th Cir. 2021), which stated that it was changing the legal standard that applies to deliberate indifference claims by pretrial detainees like Howell.[3] Under the pre-*Brawner* standard, which the Court applied in its Opinion, the Fourteenth Amendment standard for deliberate indifference claims by pretrial detainees was the same as the Eighth Amendment standard that applies when a postconviction prisoner advances a deliberate indifference claim. *See Brawner*, 14 F.4th at 591. Under that standard, such claims included a subjective component. That subjective component required the plaintiff to show that a defendant actually knew of a serious medical risk to the plaintiff and then consciously disregarded that risk. *Id.* In its previous Opinion, the Court's conclusion—that, as a matter of

[3] No party brought the case to the Court's attention, despite the fact that argument occurred in this case some three weeks after the Sixth Circuit decided *Brawner*.

law, the Defendants were not indifferent to Howell's serious medical need—relied on the absence of a genuine dispute as to the subjective component thus understood. (*See* Op., Doc. 105, #2008).

In *Brawner*, though, the Sixth Circuit opined that courts should apply a lower standard to Fourteenth Amendment deliberate indifference claims by pretrial detainees than the standard that applies to Eighth Amendment claims by postconviction inmates. *See Brawner*, 14 F.4th at 596. In particular, under *Brawner*, the Sixth Circuit abrogated (*see id.* at 594), or at least modified (*see id.* at 596; *see also Hyman v. Lewis*, No. 21-2607, 2022 WL 682543, at *2 (6th Cir. Mar. 8, 2022) ("under the modified second prong")), the subjective component that previously had applied to such claims. According to *Brawner*, a pretrial detainee need only show that a defendant "acted . . . recklessly in the face of an unjustifiably high risk of harm that is either known or so obvious that it should be known." *Brawner,* 14 F.4th at 596. (citation and internal quotation marks omitted).

On January 18, 2022, Howell's estate filed the instant Motion (Doc. 112), bringing *Brawner* to the Court's attention and asking the Court to set aside the judgment in favor of Defendants only as to Howell's estate's deliberate indifference claims. Both sets of Defendants opposed (Docs. 115, 116) Howell's estate's Motion (Doc. 112). Defendants argue, among other things, that the result in this case would be the same even under *Brawner*'s new, purportedly lower, recklessness standard. (*See* Hamilton Cnty. Resp. in Opp'n to Mot. ("Hamilton Cnty. Opp'n"), Doc. 115, #2189; NaphCare Resp. in Opp'n to Mot. ("NaphCare Opp'n"), Doc. 116, #2201). Howell's estate replied in

support (Doc. 118) of its Motion (Doc. 112) on February 22, 2022. The matter is now fully briefed and before the Court.

LEGAL STANDARD

Howell's estate moves for relief from judgment pursuant to Federal Rule of Civil Procedure 60(b)(6), a catch-all provision following an enumerated series of grounds for relief from judgment that permits a district court to set aside a judgment for "any other reason that justifies relief." According to the Sixth Circuit, Rule 60(b)(6) "vests courts with a deep reservoir of equitable power to vacate judgments 'to achieve substantial justice' in the most 'unusual and extreme situations.'" *Zagorski v. Mays*, 907 F.3d 901, 904 (6th Cir. 2018) (quoting *Stokes v. Williams*, 475 F.3d 732, 735 (6th Cir. 2007)). A court presented with a Rule 60(b)(6) motion should "intensively balance numerous factors, including the competing policies of the finality of judgments and the incessant command of the court's conscience that justice be done in light of all the facts." *Id.* (quoting *McGuire v. Warden*, 738 F.3d 741, 750 (6th Cir. 2013) (internal quotation marks omitted)).

Because the judgment Howell's estate seeks to set aside was entered pursuant to the Court's Opinion (Doc. 105) regarding Defendants' Motions for Summary Judgment (Docs. 84, 85), the legal standard for a motion for summary judgment is also relevant. Summary judgment is proper "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). The burden is on the moving party to conclusively show that no genuine

issue of material fact exists. *Lansing Dairy, Inc. v. Espy*, 39 F.3d 1339, 1347 (6th Cir. 1994). Once the movant presents evidence to meet its burden, the nonmoving party may not rest on its pleadings, but must come forward with significant probative evidence to support its claim. *Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986); *Lansing Dairy*, 39 F.3d at 1347.

Granting summary judgment depends upon "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *Amway Distribs. Benefits Ass'n v. Northfield Ins. Co.*, 323 F.3d 386, 390 (6th Cir. 2003) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 251-52 (1986)). In sum, the nonmoving party, at this stage, must present some "sufficient disagreement" that would necessitate submission to a jury. *See Moore v. Phillip Morris Cos., Inc.*, 8 F.3d 335, 340 (6th Cir. 1993) (quoting *Anderson*, 477 U.S. at 251-52). In making that determination, though, this Court must view the evidence in the light most favorable to the nonmoving party. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986); *Cox v. Ky. Dep't of Transp.*, 53 F.3d 146, 150 (6th Cir. 1995) ("In arriving at a resolution, the court must afford all reasonable inferences, and construe the evidence in the light most favorable to the nonmoving party.").

LAW AND ANALYSIS

In *Brawner*, the Sixth Circuit stated it was adopting a new standard for deliberate indifference claims involving pretrial detainees. Rather than meeting the subjective component that applies to an Eighth Amendment deliberate indifference claim, a

detainee need only show that a defendant "acted deliberately (not accidentally), [and] recklessly in the face of an unjustifiably high risk of harm that is either known or so obvious that it should be known." *Brawner*, 14 F.4th at 596. To be sure, "[m]ere negligence is insufficient." *Id.* But a pretrial detainee need not prove "subjective intent," but rather "something akin to reckless disregard." *Id.* (citations and internal quotation marks omitted).

Howell says that this standard is different from the one that the Court applied to his claim, and that the different standard requires a different result on summary judgment in his case. As to the former, though, the Court is not convinced that *Brawner* actually changed things much. But more importantly, as to the latter, the Court is convinced that the new *Brawner* standard (to the extent that it is new) does not change the appropriate outcome here.

To be sure, *Brawner* suggests that it changed the standard so that the test that applies to detainees' deliberate indifference claims is now solely objective. But the test for recklessness that the *Brawner* court adopted—failure to act in the face of an unjustifiably high risk of harm that is known or so obvious that it should have been known—still seems to include what amounts to a subjective component. That is, the first way to meet the test (*i.e.*, showing that the risk was "known") is, of course, a subjective question, and the latter path (*i.e.*, the obviousness of the risk) had been deemed, even pre-*Brawner*, as one way to inferentially prove actual knowledge, as the dissent in *Brawner* noted. *See Brawner*, 14 F.4th at 604 (Readler, J., dissenting) (citing cases). Thus, *Brawner*'s recklessness standard, whether labeled a "subjective component"

or not, still seems to require a showing similar to what had been required under the subjective component of the pre-*Brawner* test for deliberate indifference claims, as the *Brawner* dissent also noted. *See id.* at 610 ("in terms of the proof necessary to make out such a claim, it is not entirely clear how this objective reasonableness standard differs from our traditional subjective indifference standard").

Perhaps not surprisingly then, even under this reformulated test, the Court still concludes that Howell's claim fails as a matter of law. To see why, start with *Brawner* itself. The facts there certainly provide no help to Howell here. In *Brawner*, jail officials prevented a detainee from taking her prescribed anti-seizure medications for her known epilepsy over a period of almost a week despite her experiencing at least a dozen seizures. *Id.* at 589-90. Nothing like that happened here.

And given *Brawner*'s recency, only three subsequent Sixth Circuit decisions have applied its civil recklessness standard. None of those cases helps Howell either.

First, in *Greene v. Crawford*, 22 F.4th 593 (6th Cir. 2022), the Sixth Circuit held that some jail officials were deliberately indifferent when they failed to provide medical care during a period of about four days in which a pretrial detainee experienced severe symptoms of alcohol withdrawal, including two days where he displayed symptoms of delirium tremens such as hallucinations, extremely erratic behavior, and sleeplessness. *Greene*, 22 F.4th at 601-04. The detainee had a very high blood alcohol content at the time of booking, and the officials expected him to experience alcohol withdrawal and correctly interpreted

his symptoms as manifesting that condition. *Id.* But even though the officials understood that he was going through alcohol withdrawal, they neither sent him for outside medical care, nor provided him any medical attention within the jail, until about four days after he began experiencing symptoms of alcohol withdrawal, and two days after he began experiencing delirium tremens. *Id.* at 601. Instead, jail officials sought only a mental health evaluation of the detainee, on the basis of which they concluded that he did not need medical care because he was having a mental episode. *Id.* at 603. As a result, the jail officials did not seek any medical attention for the detainee until after he experienced acute respiratory failure, whereupon they transported him to the hospital. *Id.* at 603-04. The detainee died four days later. *Id.*

In the second case, *Britt v. Hamilton County*, Case No. 21-3424, 2022 WL 405847 (6th Cir. Feb. 10, 2022), a divided Sixth Circuit panel concluded in an unpublished opinion that the defendants (who included both Hamilton County and NaphCare) were entitled to summary judgment on claims that they were deliberately indifferent to a pretrial detainee's serious medical need. In *Britt*, the detainee initially exhibited normal vital signs and disclosed to NaphCare nurses that he was a heroin user who had last used the previous day. *Id.* at *1. For the next several days, the detainee continued to exhibit normal vital signs, but also began to display symptoms consistent with heroin withdrawal, such as nausea, vomiting, and diarrhea. *Id.* A few days later, however, he was found unconscious. *Id.* at *2. After rousing the detainee back to consciousness, the nurses determined that he did not need outside medical care because his vital signs con-

tinued to be within a normal range, he appeared alert, and he told the nurses he was feeling better. *Id.* Two days later, officers found the detainee acting lethargic with vomit and urine on the floor, abnormal coloration, and an extremely elevated pulse. *Id.* At that point, he was transported to the emergency room and eventually diagnosed with endocarditis, an infection in the lining of the heart. *Id.* He died about three weeks later. *Id*.

Finally, in *Hyman*, a united panel affirmed a grant of summary judgment to an officer and municipal defendants on the deliberate indifference claims of a detainee's estate. *Hyman*, 2022 WL682543, at *1. Police arrested a detainee on a felony warrant and took him to the Detroit Detention Center. *Id.* Officers searched the detainee for contraband. *Id*. They also asked the detainee whether he was under the influence of any drugs or alcohol, and he said he was not. *Id.* About an hour after the detainee's arrest, officers put the detainee in a "video-arraignment room," a room with transparent, glass walls designed to hold multiple detainees awaiting arraignment. *Id.* A police officer responsible for making rounds that night looked at the detainees through the glass but did not physically enter the room to check on the detainees, although jail policy required such physical entry. *Id.* About two hours after his arrest, the detainee slid onto the floor of the room, where he remained motionless for several hours during the night. *Id.* When a jail employee found the detainee unresponsive several hours after that, the detainee was transported to the hospital, which discovered narcotics concealed in the detainee's rectum. *Id.* The detainee had died of an accidental drug overdose. *Id.*

Greene, *Britt*, and *Hyman* provide substantial guidance as to issues pertinent to resolution at the summary judgment stage of Howell's estate's claims under the post-*Brawner* civil recklessness standard. First, *Greene* shows that at least one pre-*Brawner* rule—that jail staff who are not medical personnel may rely on the medical opinions of professionals—remains good law in the Sixth Circuit. *See Greene*, 22 F.4th at 608 (quoting *McGaw v. Sevier Cnty., Tenn.*, 715 F. App'x 495, 498-99 (6th Cir. 2017) (when "an officer responds to a substantial risk of serious harm by asking for and following the advice of a professional the officer believes to be capable of assessing and addressing that risk, then the officer commits no act of deliberate indifference in adhering to that advice")). *Greene* did not suggest that *Brawner* changed anything about this general principle, which *Greene* cited approvingly. Instead, the problem in *Greene* was that jail officials apparently relied on a mental health counselor, who was not a medical professional, to conclude that a detainee did not need medical care. *Id.*

Again, nothing like *Greene*'s facts occurred here. Rather, in this case, the Hamilton County Defendants relied on the conclusion from trained NaphCare nurses that Howell did not need immediate medical care. (*See* Op., Doc. 105, #2004). For the reasons explained at length in the Court's previous Opinion (*id.*), the "general principle that an officer may rely on the judgments of medical personnel concerning a detainee's need for medical care"—a principle that apparently remains valid under *Brawner*'s civil recklessness standard—entitles the individual Hamilton County Defendants to summary judgment. The Hamil-

ton County Defendants did not act recklessly in relying on the NaphCare Defendants' determination that Howell was having a psychiatric episode. At the very least, they are entitled to qualified immunity, because it was not clearly established that following the recommendation of medical personnel could have amounted to deliberate indifference under such circumstances. *Cf. Greene*, 22 F.4th at 615.

Second, *Hyman* illustrates that *Brawner*'s recklessness standard should not change the Court's conclusion that the individual Hamilton County Defendants are entitled to summary judgment even though they failed to check on Howell as frequently as jail policy required while Howell was in the restraint chair. *See Hyman*, 2022 WL 682543, at *3 (quoting *Winkler v. Madison Cnty.*, 893 F.3d 877, 891 (6th Cir. 2018) ("'failure to follow internal policies, without more,' does not equal deliberate indifference")). As the Court noted, on the record before it, "serious medical risk to an inmate in a restraint chair is very much the exception rather than the norm." (Op., Doc. 105, #2006). Thus, "a jury could not reasonably infer that [placement in a restraint chair] created an objective risk of serious harm." (*Id.*). For the same reason, a reasonable jury could not conclude that it was reckless to fail to check on Howell more frequently during the at most four hours that Howell was alive in the restraint chair. And given the NaphCare Defendants' determination that Howell was not experiencing a physiological medical episode that required outside care, a reasonable jury could not conclude that any medical risk to Howell was "so obvious that it should be known" to the Hamilton County Defendants during the time after Howell's placement in the

restraint chair. *Brawner*, 14 F.4th at 596; (*see also* Op., Doc. 105, #2001-02 ("to the extent that Erwin and Collini may ever have become aware of any serious medical need on Howell's part, they did not consciously disregard that need, but rather sought medical attention for Howell in the sallyport")).

Third, *Britt* reaffirmed the validity of yet another principle on which the Court relied in granting summary judgment to the individual NaphCare Defendants. As this Court put it in the previous decision, "when nursing staff did not know that [an individual] suffered from a serious medical ailment, and they instead interpreted his symptoms as indicating a different condition, for which they provided appropriate treatment, they were not deliberately indifferent to his serious medical needs." (Op., Doc. 105, #2021-22 (quoting *Rouster v. Cnty. of Saginaw,* 749 F.3d 437, 453 (6th Cir. 2014) (internal quotation marks omitted))). *Britt* used almost identical language in affirming a grant of summary judgment under the post-*Brawner* standard: "[the nurse's] care could have risen to deliberate indifference only if [the detainee's] symptoms had been clearly inconsistent with heroin withdrawal and she had failed to confirm that his symptoms were not indicative of a different and more serious condition." *Britt*, 2022 WL 405847, at *3 (citing *Rouster*, 749 F.3d at 451) (internal quotation marks and modification omitted). In other words, *Brawner*'s civil recklessness standard does not require nurses to correctly diagnose a pretrial detainee's condition. To the contrary, a mistaken diagnosis will not amount to deliberate indifference unless it is both "clearly inconsistent" with the detainee's symptoms and

reflective of a failure to rule out other explanations. *See Britt*, 2022 WL 405847, at *3.

For example, in *Britt*, the nurses operated on the belief that the detainee was not experiencing any condition more serious than heroin withdrawal. *See Britt*, 2022 WL 405847, at *3. That belief was ultimately mistaken, but it was not "clearly inconsistent" with the symptoms the nurses perceived at the time. *Id.* By contrast, the jail officials in *Greene* understood from the beginning that the detainee was experiencing alcohol withdrawal, a condition of which delirium tremens is a well-known life-threatening complication. *See Greene*, 22 F.4th at 598, 601. Given that awareness, their failure to secure any medical attention at all for the detainee over a period of four days could have constituted recklessness. *Id.* at 609. Importantly, the jail officials did not mistakenly diagnose the detainee in *Greene*; they could not have diagnosed him at all, mistakenly or otherwise, because they were not medical professionals. Instead, the jail officials sought no medical attention for the detainee, even though they were aware that he was experiencing alcohol withdrawal and severe symptoms including hallucinations.

For the reasons explained at length in the Court's Opinion (Doc. 105, #2022- 32), the principle that nurses are not deliberately indifferent when they provide treatment pursuant to a diagnosis consistent with the detainee's symptoms, even if that diagnosis is ultimately mistaken, entitles the individual NaphCare Defendants to summary judgment as to Howell's estate's deliberate indifference claims. Howell's symptoms were not "clearly inconsistent" with a psychiatric episode. *Britt*, 2022 WL 405847, at *3. Moreover,

the individual NaphCare Defendants took steps to "confirm that [Howell's] symptoms were not indicative of a different and more serious condition," including checking Howell's vital signs, which were normal, and offering him hydration, a glucose tablet, and a urine test, all of which he refused. *Id*. The fact that the NaphCare Defendants may have ultimately been incorrect about Howell's condition is insufficient to establish recklessness. Instead, the NaphCare Defendants are entitled to summary judgment because they understood Howell to be experiencing a psychiatric episode on the basis of symptoms not "clearly inconsistent" with that diagnosis, and because of their efforts to rule out "a different and more serious condition." *See Britt*, 2022 WL 405847, at *3.

Fourth, and relatedly, an expert's opinion that a nurse's care was "grossly negligent" and fell "below the standard of care," while undoubtedly relevant to medical malpractice claims, is insufficient to create a genuine dispute as to recklessness for purposes of a constitutional deliberate indifference claim. *See Britt*, 2022 WL 405847, at *3. Instead, the fact that a detainee's symptoms were "consistent" with a nurse's ultimately erroneous diagnosis defeats a claim for deliberate indifference, as discussed above. So do the nurses' efforts to "confirm that [the detainee's] symptoms were not indicative of a different and more serious condition." *Id.* Accordingly, and for the reasons discussed in the Court's Opinion (Doc. 105, #2025-26), Howell's estate's expert evidence does not create a genuine dispute as to the individual NaphCare Defendants' deliberate indifference to Howell's medical need.

Finally, *Greene*, *Britt*, and *Hyman* all illustrate that it matters how long a detainee goes without receiving medical attention, both initially and as his condition worsens. In *Greene*, the detainee did not receive any medical attention during four days of confinement despite displaying symptoms of delirium tremens for two of those four days and of alcohol withdrawal during the entire period. *See Greene*, 22 F.4th at 601, 607. In *Britt*, by contrast, even though the nurses found the detainee unconscious a few days before they ultimately sent him to the hospital, and thus arguably did not recognize and react to the seriousness of his condition as promptly as they could have, the nurses still examined the detainee at least once per day. *See Britt*, 2022 WL 405847, at *1, 3. In *Hyman*, the detainee was dead at most seven hours after his arrest, and nothing about his observable condition at the time of booking suggested that he was likely to need urgent medical attention within the next several hours. *See Hyman*, 2022 WL 682543, at *1. In the instant case, Howell received medical attention almost immediately after his fight with the other inmate, and he died about four hours after receiving that medical attention. The relatively short duration of time that Howell went without receiving medical care, combined with the absence of symptoms or other circumstances that would have made a need for urgent medical care apparent, does not support a finding of deliberate indifference.

Indeed, as this Court noted in reference to the district court's opinion in *Britt* (*see* Op., Doc. 105, #2030-31 (citing *Britt v. Hamilton Cnty.*, 531 F. Supp. 3d 1309 (S.D. Ohio 2021))), the case for deliberate indifference here is substantially weaker than on the

facts of *Britt*. Howell experienced symptoms for, at most, a few hours, rather than days, and those symptoms would have appeared much less extreme to the Defendants here than those exhibited by the detainee in *Britt*. The Court acknowledges that *Britt* is an unpublished decision with a dissent, but still considers the case to be the most closely applicable guidance from the Sixth Circuit regarding application of *Brawner*'s new civil recklessness standard to the facts of this case. Moreover, *Britt*'s reasoning relies on, and is consistent with, other established principles in the Sixth Circuit regarding deliberate indifference to serious medical need, principles on which the Court also relied in its previous Opinion (Doc. 105). Under those principles, the Court concludes that its disposition of this case should not change under *Brawner*'s recklessness standard. Assuming that the post-*Brawner* standard is in fact substantively different from the pre-*Brawner* standard, rather than essentially the same test applied under a different label, there may be cases where the precise contours of that difference could be outcome determinative, but, as *Greene*, *Britt*, and *Hyman* aptly illustrate, this case is not one of them.

CONCLUSION

Howell's death was a tragedy. But on the facts here, it does not give rise to a viable deliberate indifference claim, even under *Brawner*. Accordingly, for the reasons set forth above, the Court DENIES Howell's estate's Motion for Relief from Judgment (Doc. 112).

SO ORDERED.

/s/ Douglas R. Cole
United States District Judge

March 11, 2022
DATE

OPINION AND ORDER, U.S. DISTRICT COURT FOR THE SOUTHERN DISTRICT OF OHIO (NOVEMBER 2, 2021)

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

KARLA HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

Case No. 1:19-cv-373

Before: Douglas R. COLE,
United States District Judge.

OPINION AND ORDER

This cause comes before the Court on two Motions for Summary Judgment, one by Defendants Matthew Collini, Daniel Erwin, Justin Hunt, and Jim Neil (the "Hamilton County Defendants"), the other by Defendants NaphCare, Inc. ("NaphCare"), Pierette Arthur, and Christina Jordan (the "NaphCare Defendants"). (Docs. 84, 85). For the reasons that follow, the Court GRANTS both Motions with respect to all of Howell's federal claims against both sets of Defendants. The Court also DENIES AS MOOT Howell's

estate's Motion to Strike (Doc. 95) a sentence from Hunt's Declaration (Doc. 82). Given the Court's disposition of the federal-law claims of Howell's estate, the Court declines to exercise jurisdiction over the state-law claims against the NaphCare Defendants. Accordingly, the Court DISMISSES Howell's federal claims against both the Hamilton County Defendants and the NaphCare Defendants WITH PREJUDICE. The Court also DISMISSES Howell's state-law negligence claim and attendant wrongful death and survivorship claims against the NaphCare Defendants WITHOUT PREJUDICE.

FACTUAL BACKGROUND

On December 2, 2018, Cornelius Pierre Howell was arrested and detained at the Hamilton County Justice Center (the "Jail").[1] (Guy Decl., Doc. 72, #868). Howell completed a medical intake with NaphCare, the Jail's contracted medical provider, at which he disclosed that he had sickle cell disease. (Perdikakis Decl., Doc. 79-1, #1290). Howell received a medical screening on December 3, 2018, from a Licensed Practical Nurse employed by NaphCare who charted Howell's sickle cell disease and ADHD diagnosis. (*Id.* at #1280, 1282). Howell then had a chronic care visit with a nurse practitioner employed by NaphCare on December 7, 2018. (*Id.* at #1266-73). That practitioner noted that Howell reported taking Oxycodone for his sickle cell pain, which had worsened since his incarceration. (*Id.* at #1267).

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[1] The parties use different surnames for the decedent. To avoid confusion, the Court refers to him as "Howell" and the plaintiff in this action as "Howell's estate."

On December 9, 2018, around 5:00 p.m., Howell had a physical altercation with another Jail inmate. (Hunt Dep., Doc. 69-8, #547). Guards brought Howell to the medical unit in a wheelchair. (Guy Decl., Doc. 72, #877). Howell was yelling that he was in pain and at one point fell out of his wheelchair and rolled around on the floor. (Roettker Dep., Doc. 69-13, #720). Nurse Christina Jordan evaluated Howell. (Jordan Dep., Doc. 69-9, Ex. 33, #583). Jordan took several of Howell's vital signs but was unable to obtain his temperature. (*Id.*). Jordan was unconcerned by Howell's vital signs, which she understood to be within normal ranges. *(Id.* at #562). Jordan knew Howell had sickle cell disease from reviewing his electronic medical record. (*Id.* at #556). Howell also said so when Jordan examined him. (*Id.* at #583). Howell complained that he could not feel his legs. (Guy Decl., Doc. 72, #873). Jordan observed Howell rolling on the floor yelling with his eyes very wide open. (Jordan Dep., Doc. 69-9, #556). Howell refused hydration and spit out a glucose tablet a nurse attempted to give him. (*Compare* NaphCare Prop. Undisp. Facts, Doc. 85-1, #1583 *with* Resp. to Prop. Undisputed Facts, Doc. 96-1, #1919). Howell may also have refused to provide a urine sample. (Jordan Dep., Doc. 69-9, #568).

Jordan thought that Howell was likely having a psychiatric episode. (*Id.* at #557; *see also* Resp. to Prop. Undisp. Facts, Doc. 96-1, #1919). Based on that determination, she suggested that the Jail officers transport Howell to the psychiatric department. (Jordan Dep., Doc. 69-9, #569). Officers put Howell into a restraint chair around 5:40 p.m. (Hunt Dep., Doc. 69-8, #547). The NaphCare Defendants and the Hamilton County Defendants each say that the other

was responsible for the decision to put Howell into the restraint chair. (*Compare* Hunt Dep., Doc. 69-8, #547, *with* Jordan Dep., Doc. 69-9, #547). They agree, however, that, whoever raised the idea, no one in either group of Defendants objected to it. (*See* Jordan Dep., Doc. 69-9, #569; Hunt Dep., Doc. 69-8, #521). Howell did not resist placement in the chair. (Pierani Dep., Doc. 69-12, #652). Once he was in the chair, officers took Howell to the mental health unit.

Around 6:06 p.m., Licensed Practical Nurse Pierette Arthur, another NaphCare employee, observed Howell. (Surveillance Video G-21 #1 JC 265 5:45-6:45 p.m., Barth Dep., Ex. 12, Doc. 69-2, #288). Howell was yelling, and Arthur decided to walk away to allow Howell to calm down. (Arthur Dep., Doc. 78, #1196). Arthur later spoke to Jordan about her observations of Howell's condition before leaving work for the day, around 7:30 p.m. (*Id.* at #1200).

Officers Collini and Erwin were responsible for observing Howell during his time in the restraint chair. (Roettker Dep., Doc. 69-13, #714). Jail policy is that staff are normally expected to check on inmates in restraint chairs every ten minutes. (Neil Dep., Doc. 69-11, #621-22). Jail staff must also log the status of inmates in a restraint chair each time they check on the inmate. (Buchanan Dep., Doc. 69-3, #299). Inmates in restraint chairs are placed in one of two cells in the mental health department. (Hunt Dep., Doc. 69-8, #515). Inmates are positioned so they face a small window, which allows officers to see them from outside the cell. (*Id.*).

Hunt filled out the first two entries on the log concerning Howell's time in the restraint chair. (*Id.* at #524-25). Then, Collini and Erwin filled out

numerous log entries for checks they purportedly conducted on Howell. Taken together, these entries showed that a check occurred approximately every ten minutes. (Roettker Dep., Ex. 6, Doc. 69-13, #744). It is now undisputed, however, that Erwin and Collini made false entries in the log; in fact, they conducted fewer than half of the checks they recorded. (Collini Dep., Doc. 69-4, #349; Erwin Am. Disc. Resp., Doc. 71-2, #862). That being said, Collini testified he saw Howell alive and seated in the chair at 7:24 p.m. (Collini Dep., Doc. 69-4, #346).

At about 9:45 p.m., Hunt and another officer discovered Howell dead in the restraint chair when they arrived to evaluate him for release. (Guy Decl., Doc. 72, #874). The parties dispute the cause of Howell's death. The NaphCare Defendants say that Howell died of a sudden cardiac arrest, which they claim resulted, at least in part, from a prior chest stab wound that had required open heart surgery approximately a year earlier. (NaphCare Prop. Undisp. Facts, Doc. 85-1, #1587; Evans Decl., Doc. 79-2, #1305; Kiss Decl, Doc. 79-3, #1315). Howell's estate argues, by contrast, that, over the course of the roughly four hours he spent in the restraint chair, Howell died of rhabdomyolysis, a complication from sickle cell disease, and that this complication was triggered by Howell's fight with the other inmate. (Steinberg Export Rep., Doc. 87-3, #1693). The coroner's report contains elements consistent with each version. (Stephens Decl., Doc. 73, #941). Like Howell's estate, the coroner identified the cause of death as "[s]ickle cell crisis following physical altercation." (*Id.*). More in keeping with the NaphCare Defendants' version, though, the coroner identified the interval between

onset of the crisis and death as "minutes," which would be consistent with a sudden cardiac event. (*Id.*).

Both an internal affairs investigation and a criminal investigation into Howell's death occurred. (Neil Dep., Doc. 69-11, #616). The internal investigation concluded that there were no violations of Jail policy and that officers checked on Howell every ten minutes. (Guy Decl., Doc. 72, #869). As discussed above, all parties now agree that this was not the case. The internal investigation reached this erroneous conclusion in part because investigators failed to review the video footage that eventually established that Erwin and Collini had conducted fewer than half of the checks indicated on the forms they completed. (*See* Hamilton County Mot. for Summ. J., Doc. 84, #1544). The criminal investigation did not result in any charges.

PROCEDURAL BACKGROUND

Karla Howell filed this suit on behalf of Howell's estate on May 20, 2019. (Compl., Doc. 1). The Complaint alleges that both (1) the Hamilton County Defendants, and (2) the NaphCare Defendants, violated 42 U.S.C. § 1983. More specifically, the Complaint alleges that all of these defendants violated the Fourteenth Amendment through deliberate indifference to serious medical need, failure to protect,[2] and excessive force.

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[2] In the context of this case, where the danger that caused harm to Howell took the form of a medical crisis, the Court considers that a claim for deliberate indifference to serious medical need is really a subspecies of claim for failure to protect. Howell's estate does not argue, for example, that there is a separate claim for failure to protect arising out of Howell's

(*Id.* at ¶ 68, #10). The Complaint separately includes a state-law claim for negligence, which it asserts against the NaphCare Defendants only. (*Id.* at #11). The Complaint names all natural-person defendants in both their individual and their official capacities, except for Jim Neil, who is the Hamilton County Sheriff. Neil is sued only in his official capacity. Against him, the Complaint asserts claims for failure to train, inadequate supervision, and ratification of the alleged violations of Howell's constitutional rights through failure to investigate them. (*Id.* at #11-14). Finally, the Complaint includes a state-law wrongful death claim against all defendants. (*Id.* at #14).

The Hamilton County Defendants and the NaphCare Defendants both filed separate Answers on July 19, 2019. (Docs. 11, 12). On August 27, 2019, Judge Dlott, who was then assigned to this case, referred the matter to Magistrate Judge Bowman. On March 6, 2020, Howell's estate filed its Amended Complaint, the operative complaint in this action, asserting the same causes of action as the original Complaint but adding a survivorship action and official-capacity claims for inadequate supervision against Hunt and Buchanan. (Doc. 27, #94, 97). But on April 6, 2021, the parties jointly moved to dismiss

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initial scuffle with his cell-mate. Accordingly, the Court's discussion of deliberate indifference to serious medical need is also applicable to any claim for failure to protect. *See Farmer v. Brennan*, 511 U.S. 825, 835 (1994) (citing *Estelle v. Gamble*, 429 U.S. 97, 104 (1976)) (adopting deliberate indifference standard from context of inmate medical treatment to failure-to-protect context). The excessive force claim is distinct from the other two claims because it arises from somewhat different facts and is subject to a different legal standard, as discussed in more detail below.

all claims against Buchanan without prejudice (Doc. 97), and the Court granted that motion on April 12, 2021 (4/12/21 Notation Order Granting Mot. to Dismiss Claims Against Brad Buchanan).

On March 15, 2021, both the Hamilton County Defendants and the NaphCare Defendants separately moved for summary judgment. (Docs. 84, 85). The Hamilton County Defendants argue that Howell's estate creates no genuine dispute as to whether any of them consciously disregarded Howell's serious medical need or used excessive force or whether there was a policy that caused a violation of Howell's constitutional rights. (Hamilton County Mot. for Summ. J., Doc. 84, #1524, 1532). In the alternative, the Hamilton County Defendants say they are entitled to qualified immunity and Ohio statutory immunity. (*Id.* at #1535, 1546). The NaphCare Defendants similarly argue that none of them were deliberately indifferent to Howell's serious medical need. (NaphCare Mot. for Summ. J., Doc. 85, #1560). They also argue that Howell's negligence claim should fail because Howell presents insufficient evidence to create a genuine dispute as to whether any breach of the standard of care by the NaphCare Defendants proximately caused injury to Howell. (*Id.* at #1573). Briefing on those motions was completed on April 26, 2021. The Court heard oral argument on October 14, 2021.

LEGAL STANDARD

Summary judgment is proper "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). The burden

is on the moving party to conclusively show that no genuine issue of material fact exists. *Lansing Dairy, Inc. v. Espy*, 39 F.3d 1339, 1347 (6th Cir. 1994). Once the movant presents evidence to meet its burden, the nonmoving party may not rest on its pleadings, but must come forward with significant probative evidence to support its claim. *Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986); *Lansing Dairy*, 39 F.3d at 1347.

This Court is not obliged to search the record sua sponte for genuine issues of material fact. *Betkerur v. Aultman Hosp. Ass'n*, 78 F.3d 1079, 1087 (6th Cir. 1996); *Guarino v. Brookfield Twp. Trs.*, 980 F.2d 399, 404-06 (6th Cir. 1992). Instead, the nonmoving party must "designate specific facts or evidence in dispute." *Jordan v. Kohl's Dep't Stores, Inc.*, 490 F. App'x 738, 741 (6th Cir. 2012) (quotation omitted). If the nonmoving party fails to make the necessary showing for an element upon which it bears the burden of proof, then the moving party is entitled to summary judgment. *Celotex Corp.*, 477 U.S. at 323.

Granting summary judgment depends upon "whether the evidence presents a sufficient disagreement to require submission to a jury or whether it is so one-sided that one party must prevail as a matter of law." *Amway Distribs. Benefits Ass'n v. Northfield Ins. Co.*, 323 F.3d 386, 390 (6th Cir. 2003) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 251-52 (1986)). In sum, the nonmoving party, at this stage, must present some "sufficient disagreement" that would necessitate submission to a jury. *See Moore v. Phillip Morris Cos., Inc.*, 8 F.3d 335, 340 (6th Cir. 1993) (quoting *Anderson*, 477 U.S. at 251-52). In making that determination, though, this Court must view the evidence in the light most favorable to the

nonmoving party. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986); *Cox v. Ky. Dep't of Transp.*, 53 F.3d 146, 150 (6th Cir. 1995) ("In arriving at a resolution, the court must afford all reasonable inferences, and construe the evidence in the light most favorable to the nonmoving party.").

LAW AND ANALYSIS

Section 1983 does not create any substantive rights. Rather, it provides a vehicle for remedying violations of other substantive rights. More specifically, § 1983 allows a party to bring "an action at law, suit in equity, or other proper proceeding for redress," against any "person who, under color of [state law]" deprives the party of any rights "secured by the Constitution and [federal] laws." 42 U.S.C. § 1983. In other words, to succeed in a § 1983 action, the plaintiff must show that a defendant violated a right bestowed on the plaintiff by federal law, and that the defendant did so while acting "under color of" state law.

A plaintiff can sue a defendant under § 1983 in that defendant's individual capacity, official capacity, or both. As the label suggests, an individual-capacity claim is directed against the person him or herself, and the liability for the conduct extends only to that person. An official-capacity claim against a public employee under § 1983, by contrast, is really a claim against the individual's employer. *Curtis v. Breathitt Cnty. Fiscal Ct.*, 756 F. App'x 519, 525 (6th Cir. 2018) ("An official capacity claim filed against a public employee generally represents another way of pleading an action against the public entity that agent represents.") (citing *Kentucky v. Graham*, 473 U.S. 159, 165 (1985)). So, for example, if a plaintiff were to sue

a county law-enforcement officer in the officer's official capacity, that is for all intents and purposes a suit against the county itself. *Graham*, 473 U.S. at 166 ("[A]n official-capacity suit is, in all respects other than name, to be treated as a suit against the entity.").

A. The Hamilton County Defendants Did Not Consciously Disregard a Known Serious Medical Risk to Howell

Howell's estate attempts to hold the Hamilton County Defendants liable in their individual capacities under § 1983. To survive summary judgment on those claims, Howell's estate "must set forth facts that, when construed favorably to [it], establish (1) the deprivation of a right secured by the Constitution or laws of the United States (2) caused by a person acting under the color of state law." *Phillips v. Roane Cnty.*, 534 F.3d 531, 538 (6th Cir. 2008) (quoting *Sigley v. City of Parma Heights*, 437 F.3d 527, 533 (6th Cir. 2006)). The Hamilton County Defendants do not dispute that they were acting under color of state law. That is not surprising. They are Hamilton County Justice Center employees who were carrying out their official duties in connection with the alleged events, and thus constitute state actors for the purposes of § 1983. So that means Howell's estate need only show that the Hamilton County Defendants violated Howell's constitutional rights as a pre-trial detainee in order to succeed on these claims.[3]

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[3] Because Howell was a pretrial detainee, his claims arise under the Fourteenth Amendment rather than the Eighth Amendment. *See Ford v. Cnty. of Grand Traverse,* 535 F.3d 483, 495 (6th Cir. 2008) ("The Eighth Amendment, by its terms,

"[T]he treatment a prisoner receives in prison and the conditions under which he is confined are subject to scrutiny under the Eighth Amendment." *Helling v. McKinney*, 509 U.S. 25, 31 (1993). In addition to requiring officials to provide "humane" conditions of confinement, the Eighth Amendment also "imposes duties" on prison officials, such as requiring them to "take reasonable measures to guarantee the safety of the inmates." *Farmer v. Brennan*, 511 U.S. 825, 832 (1994) (quoting *Helling*, 509 U.S. at 31-32). This includes a right to medical care for serious medical needs. *See Estelle v. Gamble,* 429 U.S. 97, 103-04 (1976). But not every failure to provide medical treatment results in liability. Instead, "the Eighth Amendment prohibits mistreatment only if it is tantamount to 'punishment,'" and courts therefore impose liability only when jail officials are "so deliberately indifferent to the serious medical needs of prisoners as to unnecessarily and wantonly inflict pain." *Perez v. Oakland Cnty.,* 466 F.3d 416, 423 (6th Cir. 2006) (quoting *Horn v. Madison Cnty. Fiscal Ct*., 22 F.3d 653, 660 (6th Cir. 1994)). Howell's claim thus turns on whether his estate can show a genuine dispute of material fact as to whether the Hamilton County Defendants acted with that deliberate indifference.

To establish deliberate indifference, a plaintiff must clear two hurdles—one objective and one sub-

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applies . . . to post-conviction inmates."). The substantive standard for deliberate indifference to serious medical need under the Eighth and Fourteenth Amendments is identical, however. Thus, the Court interchangeably refers to cases interpreting the Eighth or Fourteenth Amendments to establish the legal standard for Howell's claims. *See Blackmore v. Kalamazoo Cnty.*, 390 F.3d 890, 895 (6th Cir. 2004).

jective. As to the former, the deprivation that the plaintiff alleges "must be, objectively, 'sufficiently serious.'" *Farmer*, 511 U.S. at 834 (quoting *Wilson v. Seiter*, 501 U.S. 294, 298 (1991)). In other words, the plaintiff must show that, as a matter of fact, "he [was] incarcerated under conditions posing a substantial risk of serious harm." *Id.* In cases alleging failure to provide medical treatment, the plaintiff must identify a serious medical need, which is one "that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention." *Martin v. Warren Cnty., Ky.*, 799 F. App'x 329, 338 (6th Cir. 2020) (quoting *Jones v. Muskegon Cnty.*, 625 F.3d 935, 941 (6th Cir. 2010)).

The second hurdle requires a showing that the jail official acted with "a 'sufficiently culpable state of mind.'" *Farmer*, 511 U.S. at 834 (quoting *Wilson*, 501 U.S. at 302). That subjective state of mind occurs when a jail official "knows of and disregards an excessive risk to inmate health or safety." *Id.* at 837. And where a detainee-plaintiff seeks to show such knowledge by inference, the plaintiff ultimately must establish that the jail official is "both . . . aware of facts from which the inference could be drawn that a substantial risk of serious harm exists," and that the jail official "also dr[e]w the inference." *Id.* Thus, to mount a successful deliberate indifference claim based on inferred knowledge, the plaintiff must "show that the official being sued subjectively perceived facts from which to infer substantial risk to the prisoner, that he did in fact draw the inference, and that he then disregarded that risk." *Comstock v. McCrary*,

273 F.3d 693, 703 (6th Cir. 2001) (citing *Farmer*, 511 U.S. at 837).

Another way of viewing the issue is that deliberate indifference's subjective element turns on the official's state of mind during the alleged constitutional violation. For instance, "[a] prison official is deliberately indifferent when he acts with criminal recklessness, a state of mind that requires he act with a conscious disregard [*i.e.*, the subjective element] to a substantial risk [*i.e.*, the objective element] of harm to the prisoner." *Love v. Taft*, 30 F. App'x 336, 338 (6th Cir. 2002) (citing *Farmer*, 511 U.S. at 837). When evaluating the official's subjective mindset, the "standard is not whether there is something easy that the [defendant], with the benefit of hindsight, could have done," but instead the Court is to assess the defendant's "actions based on the information that was available . . . at the time." *Burwell v. City of Lansing*, 7 F.4th 456, 466 (6th Cir. 2021) (first quoting *Williams v. Mehra*, 186 F.3d 685, 692 (6th Cir. 1999) (en banc) and then quoting *Rouster v. Cnty. of Saginaw*, 749 F.3d 437, 453 (6th Cir. 2014)). What is more, even when officials fail to remedy "an obvious risk of which they should have known but did not," that does not amount to deliberate indifference. *Garretson v. City of Madison Heights*, 407 F.3d 789, 797 (6th Cir. 2005). Putting that all together, an official must act with a state of mind akin to criminal recklessness in response to a known risk, given the information available during the incident, in order to exhibit

deliberate indifference and thus violate the Constitution.[4]

Importantly, to make the necessary showing on deliberate indifference, plaintiffs bringing claims on behalf of a detainee must satisfy both the objective and subjective elements. *Alspaugh v. McConnell*, 643 F.3d 162, 169 (6th Cir. 2011) ("A deliberate indifference claim has both objective and subjective components."). Failure on either front prevents a plaintiff from imposing liability on jail officials for harm the detainee suffered while incarcerated. On the other hand, while the plaintiff must make those showings to succeed at trial, here the matter is before the Court on summary judgment. At this stage, the plaintiff need only show that there are sufficient record facts, when viewed in the light most favorable to the plaintiff, from which a reasonable jury could conclude that both of these elements are present. But, given that the plaintiff must show both the objective and subjective components, if the plaintiff fails to show sufficient facts as to either,

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[4] True, there is some question about whether the Supreme Court's decision in *Kingsley v. Hendrickson*, 576 U.S. 389 (2015), has lowered the bar such that plaintiffs "need only prove that the officers should have known" about the risk of harm to an inmate when mounting a deliberate indifference claim. *Burwell*, 7 F.4th at 465. But, as in the Sixth Circuit's recent opinion in *Burwell*, Howell's estate did not raise that argument here. *See id.* at 466. Thus, the Court declines to consider whether it should depart from the subjective analysis for deliberate indifference, as articulated in *Burwell* and other Sixth Circuit cases, when neither party has raised that issue. The Court also notes that at least one other court in this district has considered the question and concluded that it should still apply the two-prong test elaborated above. *See Britt v. Hamilton Cnty.*, Case No. 1:17-cv-724, 2021 WL 1184057, at *7-8 (S.D. Ohio Mar. 30, 2021).

summary judgment would be warranted on the Fourteenth Amendment deliberate indifference claim.

Howell's estate seeks to hold Officers Erwin, Collini, and Hunt liable for Howell's death. Howell's estate argues that the record evidence, read in Howell's favor, suffices for summary judgment purposes to show the Hamilton County Defendants knew that: (1) Howell was exhibiting symptoms including wide eyes, slumping over in his chair, complaining of pain, rolling around on the floor, sweating, and a bleeding lip after his altercation; and (2) inmates confined to a restraint chair require frequent monitoring; but that, despite awareness of both of those factors, the Hamilton County Defendants nevertheless (3) not only failed to check on Howell with the requisite frequency, but (4) faked a majority of their log entries to show that they had done so. All of that together, according to Howell's estate, shows both (1) that the Hamilton County Defendants exposed Howell to a substantial risk of serious harm, thereby satisfying the objective element, and (2) that the Hamilton County Defendants knew about that risk when they placed Howell in the restraint chair instead of sending him to the hospital (or at least knew of the risk when they failed to check on him with the required frequency), and yet consciously chose to disregard the risk, thereby satisfying the subjective element.

1. Howell's Estate Fails to Show a Genuine Dispute of Material Fact as to Whether Erwin or Collini Acted With Deliberate Indifference

Start with the subjective prong and Officers Erwin and Collini. Howell's estate argues that both

officers were aware that Howell was facing a substantial risk of serious harm. Specifically, Howell's estate asserts that Erwin was present in the medical sallyport where Jordan evaluated Howell and witnessed Howell slumped over, falling out of his chair, and rolling around on the floor. (Resp. in Opp. to Mots. for Summ. J. ("Resp. in Opp."), Doc. 96, #1891). While Collini was not present in the sallyport, Howell's estate argues that the fact that Howell was in a restraint chair put Collini on notice of a need to monitor Howell for Howell's safety. (*Id.* at #1893). Howell's estate faults both men at length for failing to conduct checks on Howell every ten minutes and falsifying many of the checks they logged. (*Id.* at #1892, 1894). Howell's estate further faults both men for their lack of candor about their conduct during disciplinary investigations and in the course of this action. (*Id.*). Howell's estate points to the expert report of Anthony Callisto (Doc. 87-9), which concludes that Erwin's and Collini's failures to monitor Howell breached the standard of care.

In analyzing the arguments of Howell's estate, the Court starts from the proposition that deliberate indifference is a far higher standard than mere negligence. *See Love*, 30 F. App'x at 338 (characterizing standard as more akin to "criminal recklessness"). It is not deliberate indifference if Erwin and Collini failed to address even "an obvious risk of which they should have known but did not." *Garretson*, 407 F.3d at 797. Rather, Howell's estate must produce evidence that Collini and Erwin were in fact subjectively aware of a serious risk to Howell's health or safety but consciously disregarded that risk. *See Farmer*, 511 U.S. at 837 (official must both be "aware of facts

from which the inference could be drawn that a substantial risk of serious harm exists" and in fact "draw that inference").

Here, there is insufficient record evidence to create a genuine dispute as to whether Erwin and Collini consciously disregarded a serious medical risk to Howell of which they were subjectively aware. The principal record evidence to which Howell's estate points concerning subjective awareness of Howell's serious medical need is the fact that Erwin (but not Collini) was in the medical sallyport with Howell and observed his symptoms and behavior. It is far from clear that Howell's wide eyes, bleeding lip, complaints of pain, yelling, slumping in his chair, and rolling around on the floor would have been sufficient to make it "obvious" to Erwin that Howell was experiencing a serious physiological medical emergency. *Martin*, 799 F. App'x at 338. But even assuming this were the case, to the extent that Erwin or Collini may ever have become aware of any serious medical need on Howell's part, they did not consciously disregard that need, but rather sought medical attention for Howell in the sallyport. In other words, after Howell's fight with another inmate, Howell may well have been in need of care. But the corrections officers arranged for him to receive such care. More specifically, corrections officers took Howell to see the health care professionals in the facility. And, once they had done so, the Court agrees with the Hamilton County Defendants that Erwin, Collini, and the other Hamilton County Defendants were entitled to rely on the judgment of medical personnel that Howell was experiencing a psychiatric episode rather than a physiological medical emergency. *See Spears v. Ruth*,

589 F.3d 249, 255 (6th Cir. 2009) ("Officer [] was entitled to rely on the EMTs' and the jail nurse's medical assessments that [the inmate] did not need to be transported to the hospital.").

Howell's estate asserts that is not the case, arguing that "reliance on medical personnel poses questions of fact" (Resp. in Opp., Doc. 96, #1897), and citing *McKinney v. Lexington-Fayette Urban County Government*, 651 F. App'x 449, 451 (6th Cir. 2016). But *McKinney* by no means stands for the broad proposition that reliance on medical personnel is an inappropriate basis on which to grant summary judgment to non-medical jail employees on claims of deliberate indifference to serious medical need. Rather, the relevant holding of *McKinney* was only that the Sixth Circuit lacked jurisdiction to consider an interlocutory appeal of a district court's denial of summary judgment because the officers' argument was premised on factual disputes rather than questions of law. *Id.* at 458. The district court had considered the officers' argument about reliance on medical personnel and found only that it did not entitle them to summary judgment on the facts of that case. *Id.*

In any event, the factual situation in *McKinney* is inapposite to the instant case. In *McKinney*, the officers used force to restrain and subdue an inmate who was having a seizure and spitting blood out of his mouth. *Id.* at 452. Arguing they were entitled to summary judgment on the plaintiff's excessive force and deliberate indifference claims, the officers noted that medical personnel were present and did not try to stop them from using the techniques they employed. *Id.* at 460 n.6. Thus, in *McKinney*, it was the officers who made the original decision to use force, a correc-

tional rather than a medical decision, and then argued that the mere acquiescence of the medical personnel was enough to relieve them of responsibility for that decision. Here, by contrast, it was the NaphCare Defendants who made the decision at issue (which was a medical rather than a correctional decision), namely that Howell did not need to be transported to the hospital. Thus, *McKinney* provides no basis to hold the Hamilton County Defendants responsible for the medical decisions that the NaphCare Defendants made in this case. In the same vein, even if Erwin at some point thought that Howell should go to the hospital (Resp. in Opp., Doc. 96, #1891), the Constitution did not require Erwin to overrule the judgment of the NaphCare Defendants that Howell did not need to do so. Likewise, even if Collini or Erwin at some point heard that Howell had sickle cell disease, that general knowledge did not obligate them to second-guess the NaphCare Defendants' determination that Howell was experiencing a psychiatric episode that did not require transport to the hospital.

In sum, Howell's estate points the Court to no legal authority for the proposition that the Constitution requires officers to overrule the judgments of medical personnel as to a detainee's medical-care needs. To be sure, there may be some conceivable circumstance where such a requirement could perhaps arise. But the Court sees nothing in the record here to warrant a departure from the general principle that an officer may rely on the judgments of medical personnel concerning a detainee's need for care. Thus, the record would not allow a reasonable jury to conclude that Erwin and Collini consciously disregarded a serious

medical risk to Howell based on their transport of Howell to the medical sallyport and reliance on the NaphCare Defendants' analysis of Howell's symptoms.

Howell's estate separately argues that Erwin and Collini were deliberately indifferent to a known serious medical risk to Howell during the period of time after Howell received care in the sallyport and was placed in the restraint chair. In that regard, Howell's estate makes much of Erwin and Collini's failures to check on Howell at ten-minute intervals, combined with their falsification of documents indicating that they did so. The Court does not doubt that this conduct was blameworthy. But again, the issue here is not whether Erwin and Collini failed to do all they could or should have done for Howell, or even whether they failed to address "an obvious risk of which they should have known but did not." *Garretson*, 407 F.3d at 797. The issue is whether Erwin and Collini were subjectively aware of a serious risk to Howell that they consciously disregarded. *Farmer*, 511 U.S. at 837.

Moreover, the inquiry is not whether Erwin and Collini violated a Jail policy, but whether they violated the Constitution, which does not include or incorporate the policies of the Hamilton County Justice Center. Just as an officer's conduct might conform to a jail policy but violate the Constitution, it is also possible that conduct may violate a jail policy without violating the Constitution. Viewed by reference to the relevant constitutional legal standard, rather than the Jail policies, Howell's estate does not explain how Erwin and Collini's failure to check on Howell at ten-minute intervals supports the inference that Erwin and Collini were subjectively aware of a serious med-

ical risk to Howell. To be sure, if other evidence showed that the officers were aware of a serious medical risk to Howell from being seated in the restraint chair, their failure to check frequently might support an inference that they were deliberately indifferent to that risk. (Although, even on that front, the Court is not sure that failing to check every ten minutes would amount to "deliberate indifference.") But the point here is merely that the failure to check on Howell is not evidence that these officers were aware of the risk. Indeed, if anything, their failure to check suggests the opposite conclusion, namely that Erwin and Collini believed that Howell was not at a serious medical risk. (The Court is not suggesting that this evidence would compel a conclusion that the officers believed Howell was not at serious risk, but only that it is not evidence supporting the conclusion that they were.)

In spite of these facts, Howell's estate seems to argue that Howell's placement in a restraint chair, in and of itself, was enough to put Erwin and Collini on notice of a serious medical risk to Howell, such that their conduct in failing to check on Howell amounted to conscious disregard of that subjectively known risk. (*See* Resp. in Opp., Doc. 89, #1891, 1894). The Court disagrees. Howell's estate fails to support the factual premise that an inmate's confinement in a restraint chair in and of itself justifies an inference of subjective knowledge that the inmate is at serious physiological medical risk. The record evidence suggests that, while there may be some risks associated with the use of restraint chairs, serious medical risk to an inmate in a restraint chair is very much the exception rather than the norm. For example, Nurse Pierette

Arthur testified without contradiction that, although she has observed and assessed inmates in restraint chairs on a near-daily basis over more than ten years working at the Jail, she has never encountered a situation, apart from this case, where such an inmate suffered an adverse medical event while in the restraint chair. (*See* Arthur Dep., Doc. 78, #1183). Nor has Howell's estate identified any other evidence suggesting a basis upon which any of these Defendants would have known of the alleged risk of harm. Given the absence of any evidence to suggest that placement in restraint chairs routinely, or even sometimes, puts inmates in serious medical danger, a jury could not reasonably infer that this placement created an objective risk of serious harm, let alone reasonably infer that placement in a restraint chair created actual subjective knowledge on the part of the corrections officers of a serious danger to that inmate. Thus, there is insufficient record evidence to support the inference that Erwin and Collini were subjectively aware of a serious medical risk to Howell simply because they knew that he was in a restraint chair.

Howell's estate's reliance on *Phillips v. Roane County, Tennessee*, 534 F.3d 531 (6th Cir. 2008), to try to argue otherwise is off base. There, the inmate had originally been found unconscious, and then exhibited severe symptoms over a period of more than two weeks, "including nausea, vomiting of blood, swelling, lethargy, and chest pains." *Id.* at 540. Nevertheless, when another inmate told correctional officers of the need for medical attention, "[t]hey would not listen, but instead, just walked on by." *Id.* at 541. Here, all parties agree that Howell's medical crisis lasted, at most, hours rather than weeks, and

he did not display anything close to the symptoms in *Phillips*. Moreover, Erwin and Collini did not just "walk on by"—after Howell received treatment at the medical sallyport, the two officers checked on Howell periodically while he was in the restraint chair, albeit less frequently than required by Jail policy.

Howell's estate's corrections expert Anthony Callisto's report is replete with references to breaches of the "standard of care" by Erwin and Collini. (*See, e.g.*, Callisto Rep., Doc. 87-9, #1728, 1745). But that provides little assistance to Plaintiff here. Those opinions, while they might constitute evidence of negligence, do not create a genuine dispute as to deliberate indifference under the Eighth and Fourteenth Amendments. Even "gross negligence," referenced more sparsely in Callisto's report, is not enough. (*See id.* at #1731, 1735). And while Callisto's report states generally that Erwin and Collini were deliberately indifferent to Howell's medical needs (*see id.* at #1728), that bare legal conclusion is unavailing and possibly inadmissible without some specific explanation of how the record shows that each element of deliberate indifference was met. *See Berry v. City of Detroit*, 25 F.3d 1342, 1353 (6th Cir. 1994) (excluding conclusory testimony that defendant was deliberately indifferent).[5] What Callisto does

[5] The Court notes Howell's estate's own Motion to Strike (Doc. 95) Hunt's Declaration (Doc. 82) on the grounds that it expresses a legal conclusion. As discussed below, the Court need not and does not rely on this declaration for its conclusory statement that Hunt was not deliberately indifferent to Howell's serious medical needs. But by the same token, Howell's estate also cannot rely on an expert's conclusory assertions of deliberate indifference to survive summary judgment.

not, and probably could not, do in his expert report is substantiate that Erwin and Collini were subjectively aware of facts from which they could draw the inference that Howell was experiencing a serious medical need, and, as also required for deliberate indifference, that they actually did draw that inference but consciously disregarded the need. Any attempt to establish these factual predicates through expert testimony alone would necessarily risk crossing the line between competent evidence and speculation. *Cf. Boyd v. Baeppler*, 215 F.3d 594, 603 (6th Cir. 2000) ("The speculation of plaintiff's expert is not sufficient evidence to create a genuine issue of material fact."). Therefore, Callisto's report does not, and probably could not, help Howell's estate establish the subjective component of deliberate indifference with respect to Erwin and Collini.

In sum, the record evidence provides no basis from which a reasonable jury could conclude that Erwin and Collini were subjectively aware of a serious medical risk to Howell that they consciously disregarded. Therefore, the Court GRANTS summary judgment to Erwin and Collini on Howell's estate's § 1983 claims based on deliberate indifference to serious medical need.

2. Howell's Estate Fails to Show a Genuine Dispute of Material Fact as to Whether Hunt Acted With Deliberate Indifference

As for Officer Hunt, Howell's estate argues that deliberate indifference can be inferred from Hunt's presence in the medical sallyport, possible responsibility for ordering the restraint chair for Howell, and failure to consider Howell for release from the restraint

chair until four hours after Howell's placement therein. (Resp. in Opp., Doc. 96, #1895). This argument fails for many of the same reasons as noted above. Hunt's observation of Howell, or awareness that Howell was in a restraint chair, provides no basis for charging Hunt with subjective awareness of a serious medical risk to Howell that he consciously disregarded.

To be sure, Hunt did observe Howell after his altercation with the other inmate and during his trip to the sallyport. Thus, Hunt likewise observed Howell's complaints of pain, his wide-open eyes, and the fact that he was sliding out of his chair and rolling around on the floor. But, putting aside for the moment whether these facts would be a sufficient basis for a jury to conclude that Hunt was aware that Howell needed medical care, the fact is that Hunt did help ensure that Howell received some medical care. He took Howell to the sallyport for examination. And, once again, even if Hunt at some point believed or was aware that Howell faced a serious medical risk, Hunt was entitled to rely on the expertise of the NaphCare Defendants and their determination that Howell did not require transport to the hospital.[6]

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[6] At oral argument, Howell's estate suggested that Hunt was not bound by the NaphCare Defendants' assessment of the situation and had independent authority to order inmates transferred to receive outside medical care. But, as before, the question is whether the Constitution required Hunt to disregard Nurse Jordan's conclusion that Howell was experiencing a psychiatric episode that did not necessitate transfer to outside medical care. This record does not contain evidence from which a reasonable jury could conclude that Howell's medical needs were so obvious that Hunt's acquiescence in the NaphCare Defendants' determinations amounted to deliberate indifference. *Cf. Spears*, 589 F.3d at 255.

Hunt's possible role in ordering the restraint chair and his failure to consider Howell for release earlier will be addressed in more detail below in connection with the excessive force claim. But insofar as Howell's estate argues that the delay in considering Howell for release is evidence that Hunt was subjectively aware of a risk, the Court again notes that this fact, if anything, is evidence of the opposite conclusion, namely that Hunt did not subjectively believe, or it simply did not occur to him, that Howell was facing a medical emergency, even if Hunt should have known this was the case. Again, the Court is not saying that the evidence proves that fact, but merely that Howell's estate cannot rely on this evidence to meet its burden on the subjective awareness element (although, once again, if other evidence established subjective awareness of a risk, Plaintiffs could perhaps point to the failure to check earlier as deliberate indifference to that risk). Finally, Callisto's expert report cannot establish a genuine dispute of material fact with conclusory assertions of subjective awareness and deliberate indifference. Because there is no genuine dispute of material fact as to whether Hunt was deliberately indifferent to Howell's serious medical needs, the Court GRANTS summary judgment for Hunt on the § 1983 claims based on deliberate indifference to serious medical need.

Notably, in reaching this conclusion about the absence of any genuine dispute of material fact as to Hunt's lack of deliberate indifference to Howell's serious medical need, the Court need not, and does not, rely on Hunt's own self-serving testimony at issue in Howell's estate's Motion to Strike (Doc. 95) a portion of Hunt's Declaration (Doc. 82). Howell's estate

argues, in one paragraph, that a single sentence in Hunt's Declaration should be stricken because it expresses a legal conclusion. (Mot. to Strike, Doc. 95, #1860 (citing Hunt Decl., Doc. 82, #1494 ("At no time on December 9, 2018 or at any time during Mr. Howell's incarceration was I deliberately indifferent to any serious medical condition or substantial risk of harm to Mr. Howell's well-being."))). Because the Court does not find it necessary to rely on Hunt's conclusory statement about his lack of deliberate indifference to Howell's serious medical need given the absence of evidence in the record to create a genuine dispute of material fact as to this issue, the Court DENIES AS MOOT the Motion to Strike (Doc. 95).

B. The Hamilton County Defendants Did Not Use Excessive Force

In addition to deliberate indifference to serious medical need, Howell's estate also argues that the Hamilton County Defendants used excessive force against Howell, both by putting Howell into the restraint chair to begin with and by leaving him there after Howell had ceased exhibiting behaviors that justified use of the restraint chair. (Resp. in Opp., Doc. 96, #1906). Although Howell's estate does not argue that putting Howell into the restraint chair contributed to Howell's death apart from the failure to send him to outside medical care, and although there is no separate injury attributable to the decision to put Howell into the chair, Howell's estate nevertheless argues that, but for the decision to place Howell into the restraint chair, combined with the failure to consider removing him until over four hours later,

Howell would have survived because someone would have noticed his deteriorating condition before it was too late. (*Id.* at #1908).

Unlike the standard for deliberate indifference to serious medical need applied in the above discussion, the legal standard for excessive force varies depending on whether the inmate is a pretrial detainee or a postconviction offender. *Kingsley v. Hendrickson*, 576 U.S. 389, 400-01 (2015). While a postconviction inmate under the Eighth Amendment must show that officers used force "maliciously and sadistically," a pretrial detainee need only satisfy the Fourth Amendment's objective reasonableness requirement applicable to searches and seizures. *Id.* Because Howell was a pretrial detainee, in this case, Howell's estate would only need to show that the force used against Howell was objectively unreasonable. *Id.* at 397-98. Unlike claims based on failure to provide medical treatment (and unlike postconviction excessive force claims) there is no subjective component to an excessive force claim for a pretrial detainee. *Id.* at 403-04. On the other hand, objective reasonableness should be considered from the perspective of a reasonable officer on the scene at the time, rather than with the benefit of hindsight. *Id.* at 397.

Numerous district courts in this Circuit have had occasion to consider excessive force claims arising out of the use of restraint chairs. *See, e.g., Lister v. Pickaway Cnty. Sheriff's Office*, No. 2:14-cv-269, 2015 WL 671997 (S.D. Ohio Feb. 17, 2015); *Wade v. Montgomery Cnty., Ohio*, Case No.: 3:17-cv-051, 2018 WL 6329831 (S.D. Ohio Dec. 4, 2018); *Degolia v. Kenton Cnty.*, 381 F. Supp. 3d 740 (E.D. Ky. 2019); *Rodriguez*

Ortiz v. Jefferson Cnty., Tenn., Nos. 3:17-cv-00401, 2019 WL 5932757 (E.D.

Tenn. Nov. 12, 2019). A few principles emerge from these cases that guide the Court's inquiry here. First, restraint chairs have a proper purpose to protect the inmate or others, or to prevent violence at the facility. *Lister*, 2015 WL 671997, at *5 (noting restraint chairs can be properly used); *Degolia*, 381 F. Supp. 3d at 760 (use of restraint chair to avoid "another violent confrontation" did not violate Constitution). Second, an officer's failure to follow the facility's policies regarding use of restraint chairs is insufficient, in and of itself, to establish a constitutional violation. *Wade*, 2018 WL 6329831, at *3 (inmate restrained longer than two-hour period established by jail policy); *Degolia*, 381 F. Supp. 3d at 760 n.16 ("That Defendants allegedly violated KC Detention center policies by using the restraint chair does not change the outcome."); *Rodriguez Ortiz*, 2019 WL 5932757, at *11 ("As for placement in the restraint chair beyond the two hours permitted [by policy] and without the requisite monitoring, this claim does not rise to the level of a constitutional violation."). Third, although there is no mechanical rule for how long is too long, courts have often granted summary judgment to defendants on excessive force claims arising out of the use of restraint chairs where an inmate was restrained for a period of only a few hours. *Rodriguez Ortiz*, 2019 WL 5932757, at *11 (about two and a half hours) (citing *Grinter v. Knight*, 523 F.3d 567, 574 (6th Cir. 2008) (four hours)); *Degolia*, 381 F. Supp. 3d at 759 ("just over two [] hours").

Applied to this case, these principles inescapably lead to the conclusion that the Hamilton County Defendants did not use excessive force against Howell. Begin with their initial placement of Howell into the restraint chair.[7] It is undisputed that Howell got into a fight with his cellmate about forty minutes prior to his placement in the restraint chair. (*Compare* NaphCare Prop. Undisp. Facts, Doc. 85-1, #1582 *with* Resp. to Prop. Undisp. Facts, Doc. 96-1, #1918). It is also undisputed that Howell yelled and rolled around on the floor during his examination at the medical sallyport. (*Compare* NaphCare Prop. Undisp. Facts, Doc. 85-1, #1582 *with* Resp. to Prop. Undisp. Facts, Doc. 96-1, #1918-19). Howell spit out a glucose tablet and was otherwise uncooperative with the medical examination. (*Compare* NaphCare Prop. Undisp. Facts, Doc. 85-1, #1583 *with* Resp. to Prop. Undisputed Facts, Doc. 96-1, #1919). Moreover, Nurse Jordan told the officers who were present in the sallyport that her opinion was that Howell was experiencing a psychiatric episode. (Jordan Dep., Doc. 69-9, #557). Notably, Howell did not resist placement into the restraint

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[7] In separately discussing each group of defendants, the Court assumes for purposes of summary judgment that the decision to order Howell into the restraint chair was made by a member of that group. Thus, here, the Court assumes that it was Hunt or another Hamilton County Defendant who ordered Howell into the chair. In its discussion below of Howell's estate's claim of excessive force against the NaphCare Defendants, the Court instead assumes that it was Jordan who ordered Howell into the chair. Because the use of the restraint chair did not amount to excessive force, regardless of who ordered it, the dispute about who ordered Howell into a restraint chair does not constitute a genuine dispute of material fact that precludes summary judgment.

chair, so doing so required very little if any force. (Resp. in Opp., Doc. 96, #1874).

Under these circumstances, adopting the perspective of a reasonable officer present at the time, it was not objectively unreasonable for the Hamilton County Defendants to use minimal, if any, force to place Howell into a restraint chair with a view to preventing him from harming himself or other cellmates. *Compare Degolia*, 381 F. Supp. 3d at 760 (inmate placed in restraint chair was uncooperative, yelling, and cursing); *Rodriguez Ortiz*, 2019 WL 5932757, at *2 (inmate yelled incessantly and pushed computer off desk); *Wade*, 2018 WL 6329831, at *6 (wrist manipulation incidental to putting uncooperative inmate in restraint chair not unreasonable after inmate struck head against wall). If anything, placing Howell in the restraint chair was an appropriate reaction to the Hamilton County Defendants' perception that Howell was at risk of harming himself or others, especially given that Nurse Jordan understood Howell to be experiencing an acute psychiatric episode.

Leaving Howell in the restraint chair for at most four hours before he died also did not constitute excessive force. Howell's estate argues that Howell had ceased exhibiting behaviors to justify placement in the restraint chair. (Resp. in Opp., Doc. 96, #1907). But it is undisputed that around 6:06 p.m., Howell was still "belligerent, yelling obscenities and threatening staff." (*Compare* NaphCare Prop. Undisp. Facts, Doc. 85-1, #1585 *with* Resp. to Prop. Undisp. Facts, Doc. 96-1, #1920). And, as noted above, courts in this circuit have repeatedly declined to find a decision to leave an inmate in a restraint chair for a few hours

objectively unreasonable. *Wade*, 2018 WL 6329831, at *3; *Degolia*, 381 F. Supp. 3d at 759; *Rodriguez Ortiz*, 2019 WL 5932757, at *8. To be sure, there is no bright-line rule, and the Court does not doubt that, under some circumstances, confinement in a restraint chair for several hours or even a shorter period might constitute an objectively unreasonable use of force. But the Court concludes that the circumstances of this case do not warrant such a finding. In particular, the Court declines to hold that the Constitution requires officers to wake a detainee who is actually or apparently sleeping peacefully in order to remove that detainee from a restraint chair. Howell's estate points the Court to no authority, and the Court is aware of none, for this proposition, which would place a significant burden on both jail staff and detainees wherever restraint chairs are involved. Indeed, if anything, the lack of visible distress counts against any finding of excessive force. If a restraint chair occupant was clearly experiencing great pain as a result of the placement there, questions about excessive force might naturally arise. But when a detainee appears to be resting peacefully, the opposite inference is warranted.

The Court also considers that there must be some reasonable interval between an inmate's cessation of behaviors justifying use of the restraint chair and the detainee's release from the chair. Here, at most four hours elapsed between Howell's placement in a restraint chair and his death. The interval between the time Howell stopped exhibiting disruptive behaviors, which could have been no earlier than 6:06 p.m., and his death must have been even shorter. Like other courts to consider use of a restraint chair

under similar circumstances, this Court holds that the Hamilton County Defendants did not use objectively unreasonable force by keeping Howell in a restraint chair for at most four hours, with Howell not in any visible distress, before he died.

Howell's estate does not really contest any of the above legal or factual propositions. Instead, Howell's estate again focuses on ways that the Hamilton County Defendants allegedly violated Jail policies applicable to use of restraint chairs. (Resp. in Opp., Doc. 96, #1906). As discussed above, the constitutional inquiry into the objective reasonableness of force does not depend on whether the officer followed the applicable policies. *Wade*, 2018 WL 6329831, at *3; *Degolia*, 381 F. Supp. 3d at 760 n.16; *Rodriguez Ortiz*, 2019 WL 5932757, at *11. Again, the Constitution does not include within its text the Hamilton County Justice Center's policies, nor does the right the Constitution affords a pretrial detainee to be free from excessive force tacitly incorporate those policies. Indeed, as already noted, an officer's conduct might be fully consistent with a jail's policies and yet violate the Constitution. But the reverse is also true—violating Jail policies does not, in and of itself, show a constitutional violation. Thus, evidence that the Hamilton County Defendants violated Jail policies, either in their initial placement of Howell into the chair, or in their failure to consider him for release earlier, does not create a genuine dispute of material fact as to whether the Hamilton County Defendants' use of force was objectively reasonable.

Moreover, the Court notes that Callisto's expert report does not explicitly state that the Hamilton County Defendants' use of force in placing and keeping

Howell in the restraint chair was objectively unreasonable. (*See* Callisto Rep., Doc. 87-9). To the extent that Howell's estate relies on Callisto's characterization of the decision to place Howell into a restraint chair as "a breach of the reasonable standard of care," the Court again notes that "the reasonable standard of care" is not the same as the constitutional standard for excessive force. (*See* Resp. in Opp., Doc. 96, #1906 (citing Callisto Rep., Doc. 87-9, #1728)). As a result, Callisto's opinion that, under the applicable standard of care, the restraint chair was a "less appropriate" option than sending Howell to the hospital does not carry the day on the excessive force inquiry. In determining whether the Hamilton County Defendants used excessive force, the Court must evaluate the reasonableness of the actions that the Hamilton County Defendants did in fact take, in contrast to Howell's previously discussed claims based on medical treatment, which can rest on actions the Hamilton County Defendants could have taken, but did not, in response to Howell's medical needs. (*See* Resp. in Opp., Doc. 96, #1907 (citing Callisto Dep., Doc. 80-1, #1434)).

All in all, viewing events from the perspective of a reasonable officer at the time, a reasonable jury could not conclude that the Hamilton County Defendants used excessive force against Howell when they placed him in the restraint chair and allowed him to remain there, apparently resting calmly, for at most four hours before he died. Accordingly, the Court GRANTS the Hamilton County Defendants' Motion

for Summary Judgment (Doc. 84) with respect to the excessive force claims.[8]

C. The Complaint Does Not Include Any State-Law Claims Against the Hamilton County Defendants

The Hamilton County Defendants note that the operative Complaint in this action does not appear to contain any state-law claims against them. (*See* Hamilton County Mot. for Summ. J., Doc. 84, #1545 ("Plaintiff's claims for survivorship and wrongful death likely relate to the claims of medical negligence against co-Defendants NaphCare, Jordan, and Arthur.") (citing Am. Compl., Doc. 27, #93)). Howell's estate does not address this issue in its briefing. (*See* Resp. in Opp., Doc. 96, #1916). Under the Federal Rules of Civil Procedure, any claim for relief must contain "a short and plain statement of the claim showing that the pleader is entitled to relief. . . . " Fed. R. Civ. P.

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[8] For the same reasons that the Hamilton County Defendants did not violate Howell's constitutional rights, they are also entitled to qualified immunity. "For a plaintiff to avoid summary judgment for the defendant based on qualified immunity, the plaintiff must show that the defendant (1) violated a constitutional right and (2) 'the violated right was clearly established when [the defendant] acted.'" *Banas v. Hagbom*, 806 F. App'x 439, 441 (6th Cir. 2020) (quoting *Shanaberg v. Licking County*, 936 F.3d 453, 455 (6th Cir. 2019)). Here, the Court has concluded that the Hamilton County Defendants did not violate Howell's constitutional rights. Moreover, even if the Hamilton County Defendants did violate Howell's constitutional rights, Howell's estate has pointed the Court to no legal authority that would support the clearly-established nature of those rights at the requisite level of specificity. *See Brosseau v. Haugen*, 543 U.S. 194, 198 (2004) (qualified immunity depends on specific context of case rather than broad general proposition).

8(a)(2); *see also Liberty Mut. Ins. Co. v. Wetzel*, 424 U.S. 737, 743 (1976) (complaint "advanced a single legal theory which was applied to only one set of facts" despite request for several different types of relief). Applying this standard, the Court agrees with the Hamilton County Defendants that the Amended Complaint does not contain any state-law claims against the Hamilton County Defendants.

The correct reading of the Amended Complaint is that Counts VI and VII against the Hamilton County Defendants pursue wrongful death and survivorship damages pursuant to the § 1983 claims, the only other claims against the Hamilton County Defendants contained in the Complaint. This interpretation is strengthened by the fact that the Complaint does contain allegations of medical malpractice, a form of negligence, against the NaphCare Defendants but not the Hamilton County Defendants. Because the Court determines that the Hamilton County Defendants are entitled to summary judgment on the § 1983 claims, the Court does not reach the survivorship and wrongful death claims against the Hamilton County Defendants.

But even if the Court were to determine that the survivorship and wrongful death claims constituted separate state-law causes of action against the Hamilton County Defendants independent of the § 1983 claims, the implications for this lawsuit would be the same. That is because, as explained more fully below in connection with the negligence claim against the NaphCare Defendants, the Court would in any event decline to exercise jurisdiction over any state-law claims against the Hamilton County Defendants and therefore would dismiss such claims without pre-

judice. Thus, either way, there would be no state-law claims against the Hamilton County Defendants before this Court. For that reason, the Court need not and does not reach the issue whether the Hamilton County Defendants are entitled to statutory immunity under Ohio Rev. Code § 2744.02. One way or another, there are no state-law claims against the Hamilton County Defendants before this Court to which such immunity could be applicable.

D. The NaphCare Defendants Did Not Consciously Disregard a Known Serious Medical Risk to Howell

Having concluded that the Hamilton County Defendants in their individual capacities are entitled to summary judgment on all claims against them in this lawsuit, the Court now turns to the claims against the NaphCare Defendants. The same general legal standards discussed at length above in connection with the Hamilton County Defendants also apply to Howell's constitutional claims against the NaphCare Defendants for deliberate indifference to his serious medical needs and for excessive force. Courts applying the general standards for deliberate indifference to serious medical needs have discussed their application to health care personnel specifically. For example, the Sixth Circuit has stated that "[n]egligence or medical malpractice alone cannot sustain an Eighth Amendment claim, absent a showing of deliberate indifference." *Perez v. Oakland Cnty.*, 466 F.3d 416, 423 (6th Cir. 2006) (citing *Estelle*, 429 U.S. at 105-06). Thus, just as deliberate indifference is a higher standard than ordinary negligence for defendants who are not medically trained, it is also a higher standard than would be required to make out a tort

claim of medical malpractice against a health care worker. In particular, negligence in diagnosing a medical condition is not a sufficient basis for liability under § 1983. *Sanderfer v. Nichols*, 62 F.3d 151, 154 (6th Cir. 1995) (citing *Estelle*, 429 U.S. at 106).

Moreover, the Sixth Circuit distinguishes between cases where an inmate alleges a complete denial of medical care and cases where the allegation is that the treatment was inadequate. *Westlake v. Lucas*, 537 F.2d 857, 860 n.5 (6th Cir. 1976). Where an inmate has received some treatment, mere disagreement among medical professionals regarding the appropriateness of that treatment is insufficient to survive summary judgment under a deliberate indifference standard. *Hill v. Jones*, 211 F.3d 1269 (Table), 2000 WL 571948, at *3 (6th Cir. May 3, 2020). Instead, a constitutional claim requires that the medical treatment at issue fail to satisfy "contemporary standards of decency" or constitute an "unnecessary and wanton infliction of pain." *Stevens v. Gooch*, 615 F. App'x 355, 360 (6th Cir. 2015) (citations and internal quotation marks omitted). Of particular relevance, when "nursing staff did not know that [an individual] suffered from a serious medical ailment, and they instead interpreted his symptoms as indicating a different condition, for which they provided appropriate treatment, they were not deliberately indifferent to his medical needs." *Rouster v. Cnty. of Saginaw*, 749 F.3d 437, 453 (6th Cir. 2014).

1. Howell's Estate Fails to Show a Genuine Dispute of Material Fact as to Whether Jordan Acted With Deliberate Indifference

As discussed above, deliberate indifference to serious medical need has a subjective as well as an objective prong. To survive summary judgment on the subjective prong with respect to Jordan, the nurse who examined Howell in the medical sallyport, Howell's estate must create a genuine dispute as to whether Jordan subjectively knew facts from which she could draw the inference of a serious medical risk to Howell, actually drew that inference, and consciously disregarded the risk. *Comstock*, 273 F.3d at 703. Although this question is a closer call for Jordan than for any of the other Defendants in this case, the Court still concludes that there is no genuine dispute as to whether Jordan was deliberately indifferent to Howell's serious medical need.

Howell's estate argues that a reasonable jury could infer deliberate indifference from Jordan's knowledge that Howell suffered from sickle cell disease combined with her observations of Howell's symptoms in the medical sallyport, which included his complaints of pain, sweating, wide eyes, bleeding lip from the fight, and sliding out of the wheelchair and rolling around on the ground. (Resp. in Opp., Doc. 96, #1900; NaphCare Mot. for Summ. J., Doc. 85, #1566 (citing Jordan Dep., Doc. 69 9, #556)). But these facts are only a sufficient basis for an inference of deliberate indifference if, at a minimum, Jordan could and did subjectively understand them to indicate a serious medical risk to Howell. While Jordan may have had some prior experience with sickle cell crisis, her tes-

timony suggests that, if anything, she subjectively, even if mistakenly, understood the symptoms of that condition as inconsistent with the behaviors Howell exhibited. Specifically, Jordan testified that in her understanding, "with sickle cell . . . [y]ou just don't even have the energy to be verbally aggressive or anything." (Jordan Dep., Doc. 69-9, #558). For present purposes, it is beside the point whether this view was mistaken. What matters is that Howell's estate points the Court to no evidence to suggest that Jordan mischaracterized her own subjective understanding of sickle cell disease. Jordan's understanding of sickle cell disease as inconsistent with the symptoms Howell exhibited leaves no basis in the record for the inference that Jordan was subjectively aware of a serious physiological medical risk to Howell. Perhaps she should have been (the Court expresses no opinion on that topic), but there is no evidence that she in fact was.

Further confirming this result, Jordan's uncontradicted testimony, the only direct record evidence of her mental state, points to a conclusion at odds with deliberate indifference to serious medical need. Specifically, Jordan testified that she believed that Howell's behavior and symptoms were explicable as the result of a psychiatric episode. (*Id.* at #557). Jordan further testified that she was aware Howell had a history with narcotics and therefore hoped Howell would provide a urine sample, which Howell refused. (*Id.* at #558, 568). And there is no record evidence that substantially contradicts Jordan's testimony that Howell's vital signs gave no cause for serious concern. (*Compare id.* at #562 *with* Steinberg Dep., Doc. 69-15, #783).

Under these circumstances, Jordan's interpretation of Howell's behavior and symptoms in terms of a psychiatric episode would preclude any reasonable inference that she consciously disregarded a serious medical need of which she was subjectively aware. First, Jordan's belief that Howell was experiencing a psychiatric episode would have appeared to her as a sufficient explanation for his symptoms and behavior, leaving no factual basis for the inference that Jordan also subjectively understood Howell's symptoms to be signs of a serious physiological medical emergency. Second, given Jordan's understanding of Howell's situation in terms of a psychiatric episode, Jordan did not consciously disregard any serious (psychiatric) risk of which she may have been aware, but instead either ordered or acquiesced in a response congruent with her understanding of the situation, including actions such as asking Howell what he meant when he said he was "sorry" and using a restraint chair so that Howell could "calm down." (Jordan Dep., Doc. 69-9, #556, 561). Again, the point is not to determine whether these steps would have been the medically correct reaction to a psychiatric episode. Rather, the point is that Jordan's behavior indicated that she did not consciously disregard the risk of which she was subjectively aware, namely a risk of harm to Howell due to the psychiatric episode Jordan believed him to be experiencing.

Thus, Jordan's subjective, even if mistaken, belief that Howell was experiencing a psychiatric episode, rather than a serious physiological medical emergency, precludes a finding that Jordan was deliberately indifferent to Howell's medical needs. Nor does there appear to be any dispute that Jordan believed Howell

was experiencing a psychiatric episode—Howell's estate admits it. (*Compare* NaphCare Prop. Undisp. Facts, Doc. 85-1, #1584 ("Ultimately, Nurse Jordan felt that Howell was likely experiencing an acute psychological issue.") *with* Resp. to Prop. Undisputed Facts, Doc. 96-1, #1919 ("Admit that Jordan believed Pierre was having psychological issue. . . . ")). That being said, the Court need not, and does not, rely only on this admission from Howell's estate's Response to NaphCare's Proposed Undisputed Facts. Instead, the Court agrees with the NaphCare Defendants that the record contains no evidence from which a reasonable jury could conclude, based on a preponderance of the evidence, that Jordan lacked a sincere, even if mistaken, belief that Howell was experiencing a psychiatric episode rather than a physiological emergency. Given this belief, Jordan's conduct does not amount to deliberate indifference as a matter of law.

Notably, Howell's estate's nursing expert Lori Roscoe does not offer any conclusion as to whether either Jordan herself, or a nurse in Jordan's situation, would have subjectively understood Howell to be at substantial risk of a serious physiological medical emergency. (*See generally* Roscoe Rep., Doc. 87-6). Instead, Roscoe's report focuses on alleged violations of the "standard of care," including Jordan's failure to send Howell for outside medical treatment, her possible role in ordering the restraint chair for Howell, and her decision that Arthur, a Licensed Practical Nurse, would provide an evaluation of Howell's condition despite Arthur's lack of qualifications to do so (according to Roscoe). (*Id.* at #1706, 1707, 1708). Put another way, Roscoe's report focuses on what it says Jordan "should have" done. (*Id.* at #1706, 1708).

While such arguments may be the bread and butter of a negligence or medical malpractice claim, as discussed above, they do not establish a genuine dispute as to whether Jordan was subjectively aware of a serious medical risk to Howell that she consciously disregarded.

Nor does Howell's estate's medical expert Martin Steinberg's report contribute any evidence that Jordan subjectively understood that Howell was facing a serious physiological medical emergency. (*See generally* Steinberg Rep., Doc. 87-3). Rather, Steinberg only concludes generally that "[a]n alert medical staff should have recognized that Mr. Howell, known to have [sickle cell] disease, was extremely ill and implement [sic] hydration by any means necessary while arranging his emergent transfer to a medical facility for treatment." (*Id.* at #1692). Again, while this opinion about what "should have" happened might constitute evidence of negligence, it falls short of what would be necessary to establish deliberate indifference to serious medical need.

As before, Howell's estate does not really contest any of the factual or legal predicates for the Court's determination that Jordan did not consciously disregard a known serious medical risk to Howell. Instead, Howell's estate once more focuses on murky allegations of policy violations that it vaguely insinuates support a conclusion of deliberate indifference. For example, in its briefing, Howell's estate reasons thus:

> . . . Jordan and Arthur have testified in this case that nurses cannot order an inmate into a restraint chair, in direct contradiction of the handful of Jail employees who have testified that it happens commonly. It is at

> least a reasonable inference that Jordan and Arthur have denied Jordan gave the order because it would otherwise be an implicit recognition that Jordan saw a medical need for the restraint chair placement and Arthur was aware of Jordan's assessment.

(Resp. in Opp., Doc. 96, #1901). This chain of logic is flawed on multiple levels. First, giving Howell's estate the benefit of disputed factual questions, the possibility that Jordan ordered Howell into the restraint chair in violation of a policy does not mean that Jordan has violated the Constitution through deliberate indifference to Howell's serious medical needs. Second, the fact that nurses or other NaphCare staff who were not doctors "commonly" ordered inmates into restraint chairs would if anything constitute evidence against the proposition that a restraint chair equals recognition of a serious medical need, especially given the record evidence that countless inmates have spent hours or longer in restraint chairs without any serious medical emergency resulting. Third, even if Jordan "saw a medical need for the restraint chair placement" (*id.*), this fact would, if anything, tend to weaken the argument that Jordan consciously disregarded a serious medical risk to Howell. Rather, even under Howell's estate's strained logic, ordering the restraint chair would have constituted a response to Howell's serious medical need, albeit a misguided one in the view of Howell's estate. Thus, while the summary judgment record itself suffices to support the Court's conclusion that Jordan was not deliberately indifferent to Howell's serious medical need, the self-defeating arguments contained in the briefing further confirm

that Howell's estate has not met its burden to point this Court to a genuine dispute of material fact.

As legal authority in support of its argument that its deliberate indifference claims against Jordan should survive summary judgment, Howell's estate cites *Sours v. Big Sandy Regional Jail Authority*, 593 F. App'x 478 (6th Cir. 2014). But the contrast between the facts of *Sours* and those of the instant case illustrate why Jordan was not deliberately indifferent to Howell's serious medical need. In *Sours*, the Sixth Circuit held that there was a genuine dispute as to deliberate indifference where a nurse who was herself diabetic knew that an inmate (1) was diabetic, (2) exhibited rising blood sugar and other symptoms of ketoacidosis (a complication from diabetes) such as nausea, vomiting, and confusion, and (3) might not have taken insulin in the recent past. *Id.* at 485. The nurse did nothing to obtain or administer insulin for the inmate over a period of two days. *Id.*

The NaphCare Defendants rightly note that the Sixth Circuit listed nine facts in support of its conclusion in *Sours* that there was a genuine dispute as to deliberate indifference, only some of which even arguably pertain in this case. (NaphCare Reply in Supp. of Mot. for Summ. J., Doc. 102, #1972). In particular, the Court considers that three distinctions between *Sours* and the instant case go to the heart of the deliberate indifference inquiry.

First, there was ample record evidence in *Sours* to support the inference that the nurse in that case would have subjectively connected one or more specific symptoms (especially high blood sugar) with a specific underlying serious medical condition (diabetes) that in turn called for a specific treatment (insulin). Facts

supporting this inference included the fact that the nurse herself was diabetic, that the nurse knew the inmate had diabetes and needed insulin, that the nurse was aware that the inmate might not have taken insulin as recently as necessary, and that the nurse was aware that the inmate was exhibiting symptoms including high blood sugar, nausea, vomiting, and confusion. *Sours*, 593 F. App'x at 485. Nothing similar could be said of the instant case—as discussed above, no one contends that Jordan subjectively recognized or should have recognized Howell's behaviors or symptoms as signs of a specific complication from sickle cell disease. Rather, Howell's estate only argues generally that Jordan should have recognized some serious medical need requiring outside treatment.

Second, and relatedly, the nurse in *Sours* proffered no specific alternative explanation as to what she subjectively believed was causing the inmate's condition, but only implausibly denied knowing that Sours had diabetes in spite of substantial record evidence to the contrary. *See id.* at 485. As discussed above, in the instant case, Jordan's explanation that she subjectively believed Howell was experiencing a psychiatric episode is not only uncontradicted by the record but also apparently conceded by Howell's estate.

Third, the failure to provide medical treatment lasted two days in *Sours*, as opposed to at most hours here. *Id.*

A recent decision in this district provides a much closer parallel to the facts here. *See Britt v. Hamilton Cnty.*, Case No. 1:17-cv-724, 2021 WL 1184057 (S.D. Ohio Mar. 30, 2021). In *Britt*, a detainee initially

exhibited normal vital signs and disclosed to NaphCare nurses that he was a heroin user who had last used earlier that day. *Id.* at *2. For the next several days, the detainee continued to exhibit normal vital signs but also began to display symptoms consistent with heroin withdrawal such as nausea, vomiting, and diarrhea. *Id.* A few days later, however, the detainee was found unconscious. *Id.* at *3. The nurses successfully used an ammonia inhalant to rouse the detainee back to consciousness, but determined that the detainee did not need outside medical care because his vital signs continued to be within a normal range, he appeared alert, and he told the nurses he was feeling better. *Id.* The detainee was placed in a restraint chair for two or three hours. *Id.* at *4. Two days later, officers found the detainee acting lethargic with vomit and urine on the floor, abnormal coloration, and an extremely elevated pulse. *Id.* At that point, the detainee was transported to the emergency room and eventually diagnosed with endocarditis, an infection in the lining of the heart. *Id.* The detainee died about three weeks later. *Id.* at *1. Based on these facts, the court determined that there was no genuine dispute as to whether the nurses were deliberately indifferent to the detainee's serious medical needs because there was no record evidence that they could have or did infer that the detainee was suffering from anything more serious than heroin withdrawal when they made the relevant determinations. *Id.* at *10, 12.

Here, Jordan likewise subjectively believed that Howell was experiencing a psychiatric episode rather than a serious physiological medical event. She was not aware of any specific reason to connect Howell's

symptoms to his sickle cell disease, but instead understood those symptoms to be inconsistent with sickle cell crisis. If anything, the evidence for deliberate indifference is even weaker in the instant case than in *Britt* because Howell exhibited symptoms for at most hours rather than days. Howell also was never unconscious, vomiting, or exhibiting abnormal coloration. As in *Britt*, the nurses' course of conduct in the instant case, including their use of a restraint chair, was consistent with their understanding of Howell's condition, however incorrect that understanding turned out to be in hindsight. Under relevant Sixth Circuit precedent, that is enough to defeat the claim that they were deliberately indifferent to Howell's serious medical need. *Cf. Rouster*, 749 F.3d at 453 (nurses who believed inmate was suffering from alcohol withdrawal not deliberately indifferent for failure to seek medical care for inmate's complaints of severe abdominal pain). Accordingly, the Court GRANTS summary judgment to Jordan on Howell's estate's claims of deliberate indifference to serious medical need.

2. Howell's Estate Fails to Show a Genuine Dispute of Material Fact as to Whether Arthur Acted With Deliberate Indifference

Most of the above discussion is even more strongly applicable to Arthur. Arthur interacted with Howell only once, when she went to check on him at Jordan's instruction, observed him yelling, and decided to walk away to allow him to calm down. Notably, there is no record evidence that Arthur knew Howell had sickle cell disease. Howell's estate nevertheless argues that Arthur knew Howell was in a restraint chair and therefore was on notice of a serious medical need. (Resp. in Opp., Doc. 96, #1900). As discussed

above in connection with Hamilton County Defendants Erwin and Collini, this argument fails because nothing about placement in a restraint chair alone indicated that an inmate faced a substantial risk of serious harm. There is no evidence from which a reasonable jury could infer that Arthur was subjectively aware of a serious medical need of Howell's that she consciously disregarded. Therefore, the Court GRANTS summary judgment to Arthur on Howell's claims of deliberate indifference to serious medical need.

E. The NaphCare Defendants Did Not Use Excessive Force

Howell's estate argues that if Jordan ordered Howell placed in the restraint chair, that decision was objectively unreasonable. (Resp. in Opp., Doc. 96, #1906). Howell's estate does not appear to argue that it was the NaphCare Defendants' responsibility to consider Howell for release from the restraint chair. In any event, for the reasons discussed at length above in connection with the Hamilton County Defendants, it was not excessive force to place Howell into the restraint chair and keep him there for at most four hours before his death. This conclusion does not depend on whether it was Jordan or any of the Hamilton County Defendants who ordered that Howell be placed in the chair. Accordingly, the Court GRANTS summary judgment to the NaphCare Defendants on Howell's excessive force claim.

F. Howell's Estate's Official-Capacity and *Monell* Claims Fail

As described above, official-capacity § 1983 claims amount to claims against an official's employer. To

mount a successful § 1983 claim against a sub-state-level governmental entity, such as a county employer here, the plaintiff must show both that the entity acted "with the requisite degree of culpability" and that the action had a "causal link" to the alleged injury. *Bd. of Cnty. Comm'rs of Bryan Cnty., Okl. v. Brown*, 520 U.S. 397, 404 (1997). Here, the Court's conclusion that neither the individual Hamilton County Defendants nor the individual NaphCare Defendants violated Howell's constitutional rights largely eliminates the need to discuss these further claims. True, the Sixth Circuit has not foreclosed the possibility that a municipality could be found liable even if none of its employees were liable in their individual capacities. *Winkler v. Madison Cnty.*, 893 F.3d 877, 899-903 (6th Cir. 2018). But at a minimum, Howell's estate would then instead need to establish that Sheriff Neil or NaphCare themselves acted with deliberate indifference to Howell's serious medical needs. *Id.* at 901; *North v. Cuyahoga Cnty.*, 754 F. App'x 380, 391 (6th Cir. 2018) ("Here, however, because [plaintiff] has not demonstrated that any individual jail employee violated his Eighth Amendment right to adequate medical care by acting with deliberate indifference, he must show that the municipality itself, through its acts, policies, or customs, violated his Eighth Amendment rights by manifesting deliberate indifference to his serious medical needs."). Howell's estate has not addressed in its briefing how any policy that the County, or Neil, or NaphCare adopted evinced deliberate indifference, much less pointed the Court to evidence sufficient to create a genuine dispute as to this issue. Howell's estate likewise fails to argue or create a genuine dispute as to whether the alleged failure to train or inadequate supervision evinced

deliberate indifference. *See Shadrick v. Hopkins Cnty., Ky.*, 805 F.3d 724, 739 (6th Cir. 2015) (applying deliberate indifference standard to claim of failure to train). Finally, Neil's alleged ratification of the Hamilton County Defendants' actions could not have caused any violation of Howell's constitutional rights because the alleged ratification necessarily occurred after the alleged violations and because there is no record evidence of failure to investigate earlier incidents (which failure presumably could have created an environment that caused a violation of Howell's constitutional rights). *See Wright v. City of Euclid*, 962 F.3d 852, 882 (6th Cir. 2020) (considering whether "failure to investigate and punish" officers "led in any way" to constitutional violation). Accordingly, the Court GRANTS summary judgment to Neil and NaphCare as to Howell's estate's § 1983 official-capacity and *Monell* claims.

G. The Court Declines to Exercise Jurisdiction Over Howell's Estate's State-Law Negligence Claim Against the NaphCare Defendants

The Court's foregoing discussion disposes of all federal claims in this matter. Thus, Howell's estate's only remaining claim is its state-law claim for negligence against the NaphCare Defendants (and attendant claims for wrongful death and survivorship damages). Under such circumstances, the Sixth Circuit has indicated that the district court ordinarily should not reach the state-law claims. *See Britt*, 2021 WL 1184057, at *22 (citing *Rouster*, 749 F.3d at 454). This general practice accords with principles of federalism and comity insofar as it avoids federal courts needlessly deciding state-law issues. *Id.* Here, the

Court sees no reason to depart from the general practice. Although considerations of judicial economy might favor further litigation of the state-law claims in federal court given the development of an extensive summary judgment record through discovery, the Court finds that interests in comity outweigh this consideration, as is generally the case according to the Sixth Circuit. *See id.* The parties have not briefed the issue, and the Court is aware of no special circumstances here that would support retention of the state-law claims in this case. Accordingly, the Court declines to exercise jurisdiction over Howell's estate's negligence claim against the NaphCare Defendants (and attendant wrongful death and survivorship claims) and therefore DISMISSES those claims WITHOUT PREJUDICE.

CONCLUSION

For the foregoing reasons, the Court **GRANTS** the Hamilton County Defendants' Motion for Summary Judgment (Doc. 84) and **DISMISSES WITH PREJUDICE** Howell's estate's claims against the Hamilton County Defendants. The Court **DENIES AS MOOT** Howell's estate's Motion to Strike (Doc. 95) a sentence from Hunt's Declaration (Doc. 82). The Court also **GRANTS** the NaphCare Defendants' Motion for Summary Judgment (Doc. 85) as to all federal claims and **DISMISSES** those claims **WITH PREJUDICE.** The Court declines to exercise jurisdiction over Howell's estate's state-law negligence claim against the NaphCare Defendants or the attendant wrongful death and survivorship claims and therefore **DISMISSES** those claims **WITHOUT PREJUDICE.** The Court therefore **DIRECTS** the

Clerk to enter judgment and **TERMINATE** this case on its docket.

SO ORDERED.

/s/ Douglas R. Cole
United States District Judge

November 2, 2021
DATE

ORDER DENYING REHEARING, U.S. COURT OF APPEALS FOR THE SIXTH CIRCUIT (JUNE 2, 2023)

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

KARLA HOWELL, AS ADMINISTRATRIX OF THE ESTATE OF CORNELIUS PIERRE HOWELL,

Plaintiff-Appellant,

v.

NAPHCARE, INC.; CHRISTINA JORDAN and PIERETTE ARTHUR, individually and in their official capacities; JIM NEIL, MATTHEW COLLINI, and DANIEL ERWIN, individually and in their official capacities in the Hamilton County Sheriff's Department; JUSTIN HUNT,

Defendants-Appellees.

No. 21-4132/22-3306

Before: SUTTON, Chief Judge; STRANCH, and DAVIS, Circuit Judges.

ORDER

The court received two petitions for rehearing en banc. The original panel has reviewed the petitions for rehearing and concludes that the issues raised in the petitions were fully considered upon the original

submission and decision of the cases. The petitions then were circulated to the full court. No judge has requested a vote on the suggestion for rehearing en banc.

Therefore, the petitions are denied.

ENTERED BY ORDER OF THE COURT

/s/ Deborah S. Hunt
Clerk

AMENDED RESPONSES OF DEFENDANT DANIEL ERWIN TO PLAINTIFF'S FIRST SET OF INTERROGATORIES, REQUEST FOR PRODUCTION OF DOCUMENTS AND REQUESTS FOR ADMISSION (MARCH 12, 2021)

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

KARLA HOWELL, AS ADMINISTRATRIX OF THE ESTATE OF CORNELIUS PIERRE HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

Case No. 1:19-cv-00373

Before: Douglas R. COLE, United States District Judge, Stephanie K. BOWMAN, Magistrate Judge.

---

1. Identify all persons who participated in responding to these Interrogatories, Document Requests, and Requests for Admission.

ANSWER: In addition to counsel, Deputy Daniel Erwin.

2. Identify all persons whom You intend to call as lay witnesses in this case.

ANSWER: Lay witnesses to be called at trial have yet to be determined. Such will be identified and disclosed as discovery progresses.

3. Identify all persons whom You intend to identify as expert witnesses in this case along with the subject matter of their opinions.

ANSWER: Expert witnesses to be called at trial have yet to be determined. Such will be identified and disclosed as discovery progresses and/or pursuant to the discovery schedule.

4. Produce any and all expert reports You intend to introduce as exhibits at the trial, a hearing, or in a deposition concerning this case.

RESPONSE: Expert reports will be produced as applicable, as expert witnesses are disclosed and identified.

5. Produce all documents You intend to introduce as exhibits or affidavits at the trial, a hearing, or in a deposition concerning this case.

RESPONSE: Trial exhibits or affidavits have yet to be specifically determined but will be identified and/or produced as discovery progresses and/or pursuant to the discovery schedule.

6. Produce all documents and/or communication which You prepared, sent, and/or received concerning or referencing Pierre and/or his death.

RESPONSE: N/A

7. Admit that You were aware that Pierre had a sickle cell disease prior to 9:45p.m on December 9, 2018.

ANSWER: Deny.

8. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically Your basis for each such denial(s) or qualification(s).

ANSWER: I am not medical health care provider. As such, I would not have access to an inmate's medical history nor would such access or knowledge be appropriate. I had no personal knowledge that Pierre Howell had sickle cell disease prior to 9:45 p.m. on December 9, 2018.

9. In the event Your response to Request for Admission No. 7 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

10. Admit that You conducted a cell front observation of Pierre while he was in the restraint chair at 6:06p.m. on December 9, 2018.

ANSWER: Admit I performed an examination /observation of Pierre Howell while he was in the restraint chair at approximately 6:06 p.m. on December 9, 2018.

11. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state

specifically Your basis for each such denial(s) or qualification(s).

ANSWER: N/A

12. In the event Your response to Request for Admission No. 10 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

13. Admit that from 6:07p.m. to 6:10p.m. on December 9, 2018, You were in Pod A of the North 21 Building at the Jail with a member of the Naphcare staff and another Hamilton County Sheriff Deputy and conducted an observation of Pierre while he was in the restraint chair.

ANSWER: Admit.

14. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically Your basis for each such denial(s) or qualification(s).

ANSWER: N/A

15. In the event Your response to Request for Admission No. 13 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

16. Identify the Hamilton County Sheriff Deputy who accompanied You into Pod A of the North 21

Building at the Jail from 6:07p.m. to 6:10p.m. on December 9, 2018.

ANSWER: Matthew Collini.

17. Admit that You conducted a cell front observation of Pierre while he was in the restraint at 6:23p.m. on December 9, 2018.

ANSWER: Admit I performed an examination /observation of Pierre Howell while he was in the restraint chair at approximately 6:23 p.m. on December 9, 2018.

18. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically Your basis for each such denial(s) or qualification(s).

ANSWER: N/A

19. In the event Your response to Request for Admission No. 17 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

20. Admit that You conducted a cell front observation of Pierre while he was in the restraint chair at 6:41p.m. on December 9, 2018.

ANSWER: Admit I performed an examination/observation of Pierre Howell while he was in the restraint chair at approximately 6:41 p.m. on December 9, 2018.

21. In the event Your response to the preceding Request for Admission is anything other than an

unconditional and unqualified admission, state specifically Your basis for each such denial(s) or qualification(s).

ANSWER: N/A

22. In the event Your response to Request for Admission No. 20 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

23. Admit that You conducted a cell front observation of Pierre while he was in the restraint chair at 7:07p.m. on December 9, 2018.

ANSWER: Admit I performed an examination /observation of Pierre Howell while he was in the restraint chair at approximately 7:07 p.m. on December 9, 2018.

24. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically Your basis for each such denial(s) or qualification(s).

ANSWER: N/A

25. In the event Your response to Request for Admission No. 23 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

26. Admit that You conducted a cell front observation of Pierre while he was in the restraint chair at 8:03p.m. on December 9, 2018.

ANSWER: Admit I performed an examination/observation of Pierre Howell while he was in the restraint chair at approximately 8:03 p.m. on December 9, 2018.

27. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically Your basis for each such denial(s) or qualification(s).

ANSWER: N/A

28. In the event Your response to Request for Admission No. 26 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

29. Admit that other than as set forth in Request for Admission Nos. 10, 13, 17, 20, 23, and 26, You conducted no other observations of Pierre while he was in the restraint chair on December 9, 2018 prior to 9:45p.m.

ANSWER: Admit.

30. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically Your basis for each such denial(s) or qualification(s).

ANSWER: N/A

31. In the event Your response to Request for Admission No. 29 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

32. Admit that You did not offer Pierre the opportunity to use the restroom at any point on December 9, 2018 while he was confined to the restraint chair.

ANSWER: Deny.

33. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically:

a. Your basis for each such denial(s) or qualification(s).

b. The time(s) You offered Pierre the opportunity to use the restroom.

ANSWER: All inmates, including Pierre Howell, were offered the opportunity to use the restroom facilities per policy as well as habit and routine. Per that policy and habit and routine, Pierre Howell would have been offered such opportunity. I do not recall any specific times, but he was not denied the opportunity to use the restroom.

34. In the event Your response to Request for Admission No. 32 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: See restraint chair policy.

35. Admit that You did not offer Pierre drinking water at any point on December 9, 2018 while he was confined to the restraint chair.

ANSWER: Admit that I do not recall whether I offered Pierre drinking water.

36. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically:

a. Your basis for each such denial(s) or qualification(s).

b, The time(s) You offered Pierre drinking water.

ANSWER: All inmates, including Pierre Howell, have access to fresh drinking water per policy as well as habit and routine. Per policy and habit and routine, Pierre Howell would have had access to fresh drinking water. I do not recall whether I offered, but he was not denied access to fresh drinking water.

37. In the event Your response to Request for Admission No. 35 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: See restraint chair policy.

38. Admit that You did not offer Pierre the opportunity to exercise any of his limbs while he was confined to the restraint chair on December 9, 2018.

ANSWER: Deny as written.

39. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically:

a. Your basis for each such denial(s) or qualification(s).

b. The time(s) You offered Pierre the opportunity to exercise any of his limbs.

c. What actions You took when offering him the opportunity to exercise any of his limbs.

d. The Jail supervisor You contacted when offering Pierre the opportunity to exercise any of his limbs.

ANSWER: All inmates, including Pierre Howell, would be offered and/or considered for the opportunity to exercise limbs per the policy and recommendations. However, the circumstances and/or behavior of the inmate is the determining factor whether such exercise is performed. Per policy and habit and routine, Pierre Howell would have been considered for limb exercise and/or such opportunities would have been available. I do not recall any specific times or discussions in this regard.

40. In the event Your response to Request for Admission No. 38 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: See restraint chair policy and restraint chair form.

41. Admit that prior to 9:45p.m. on December 9, 2018, You did not consider Pierre for removal from the restraint chair.

ANSWER: Deny.

42. In the event Your response to the preceding Request for Admission is anything other than an

unconditional and unqualified admission, state specifically:

a. Your basis for each such denial(s) or qualification(s).

b. The time(s) when You considered Pierre for removal from the restraint chair.

c. All actions taken by You when considering Pierre for removal from the restraint chair.

e. The Jail supervisor You contacted after considering Pierre for removal from the restraint chair.

ANSWER: Per policy as well as habit and routine, inmates in the restraint chair are considered for removal at least hourly but there is no minimum time an inmate can be restrained in the restraint chair. Per that policy and habit and routine, such removal would have been considered for Pierre Howell.

43. In the event Your response to Request for Admission No. 41 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: See restraint chair policy.

44. State whether you have been disciplined by the Hamilton County Sheriff's Office for any actions You took related to Pierre.

ANSWER: No.

45. Produce any and all documents or correspondence which support Your response to the preceding interrogatory.

ANSWER: None.

/s/ John B. Welch (0055337)
Counsel for Defendants Jim Neil, Matthew Collini, Daniel Erwin, Justin Hunt, and Brad Buchanan
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Counsel for Plaintiff

AMENDED RESPONSES OF DEFENDANT MATTHEW COLLINI TO PLAINTIFF'S FIRST SET OF INTERROGATORIES, REQUEST FOR PRODUCTION OF DOCUMENTS AND REQUESTS FOR ADMISSION (MARCH 12, 2021)

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

KARLA HOWELL, AS ADMINISTRATRIX OF THE ESTATE OF CORNELIUS PIERRE HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

Case No. 1:19-CV-00373

Before: Douglas R. COLE, United States District Judge, Stephanie K. BOWMAN, Magistrate Judge.

---

1. Identify all persons who participated in responding to these Interrogatories, Document Requests, and Requests for Admission.

ANSWER: In addition to counsel, Deputy Matthew Collini.

2. Identify all persons whom You intend to call as lay witnesses in this case.

ANSWER. Lay witnesses to be called at trial have yet to be determined. Such will be identified and disclosed as discovery progresses.

3. Identify all persons whom You intend to identify as expert witnesses in this case along with the subject matter of their opinions.

ANSWER: Expert witnesses to be called at trial have yet to be determined. Such will be identified and disclosed as discovery progresses and/or pursuant to the discovery schedule.

4. Produce any and all expert reports You intend to introduce as exhibits at the trial, a hearing, or in a deposition concerning this case.

RESPONSE: Expert reports will be produced as applicable, as expert witnesses are disclosed and identified.

5. Produce all documents You intend to introduce as exhibits or affidavits at the trial, a hearing, or in a deposition concerning this case.

RESPONSE: Trial exhibits or affidavits have yet to be specifically determined but will be identified and/or produced as discovery progresses and/or pursuant to the discovery schedule.

6. Produce all documents and/or communication which You prepared, sent, and/or received concerning or referencing Pierre and/or his death.

RESPONSE: N/A

7. Admit that You were aware that Pierre had a sickle cell disease prior to 9:45p.m. on December 9, 2018.

ANSWER: Deny.

8. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically Your basis for each such denial(s) or qualification(s).

ANSWER: I am not medical health care provider. As such, I would not have access to an inmate's medical history nor would such access or knowledge be appropriate. I had no personal knowledge that Pierre Howell had sickle cell disease prior to 9:45 p.m. on December 9, 2018.

9. In the event Your response to Request for Admission No. 7 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

10. Admit that from 6:07p.m. to 6:10p.m. on December 9, 2018, You were in Pod A of the North 21 Building at the Jail with a member of the Naphcare staff and another Hamilton County Sheriff Deputy and conducted an observation of Pierre while he was in the restraint chair.

ANSWER: Admit.

11. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state spe-

cifically Your basis for each such denial(s) or qualification(s).

ANSWER: N/A

12. In the event Your response to Request for Admission No. 10 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

13. Admit that You conducted a cell front observation of Pierre while he was in the restraint chair at 7:24p.m. on December 9, 2018.

ANSWER: Admit that I performed an examination/observation of Pierre Howell while he was in the restraint chair at approximately 7:24 p.m. on December 9, 2018.

14. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically Your basis for each such denial(s) or qualification(s).

ANSWER: N/A

15. In the event Your response to Request for Admission No. 13 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

16. Admit that You conducted a cell front observation of Pierre while he was in the restraint chair at 7:40p.m. on December 9, 2018.

ANSWER: Admit that I performed an examination/observation of Pierre Howell while he was in the restraint chair at approximately 7:40 p.m. on December 9, 2018.

17. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically Your basis for each such denial(s) or qualification(s).

ANSWER: N/A

18. In the event Your response to Request for Admission No. 16 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

19. Admit that You conducted a cell front observation of Pierre while he was in the restraint chair at 9:14p.m. on December 9, 2018.

ANSWER: Admit that I performed an examination/observation of Pierre Howell while he was in the restraint chair at approximately 9:14 p.m. on December 9, 2018.

20. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically Your basis for each such denial(s) or qualification(s).

ANSWER: N/A

21. In the event Your response to Request for Admission No. 19 is anything other than an uncondi-

tional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

22. Admit that other than as set forth in Request for Admission Nos. 10, 13, 16, and 19, You conducted no other observations of Pierre while he was in the restraint chair on December 9, 2018 prior to 9:45p.m.

ANSWER: Admit. *See also* deposition testimony.

23. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically Your basis for each such denial(s) or qualification(s).

ANSWER: N/A

24. In the event Your response to Request for Admission No. 22 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: N/A

25. Admit that You did not offer Pierre the opportunity to use the restroom at any point on December 9, 2018 while he was confined to the restraint chair.

ANSWER: Deny.

26. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically:

a. Your basis for each such denial(s) or qualification(s).

b. The time(s) You offered Pierre the opportunity to use the restroom.

ANSWER: All inmates, including Pierre Howell, are offered the opportunity to use the restroom facilities per policy as well as habit and routine. Per policy and habit and routine, Pierre Howell would have been offered such opportunity. I do not recall any specific times, but he was not denied the opportunity to use the restroom.

27. In the event Your response to Request for Admission No. 25 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: See restraint chair policy.

28. Admit that You did not offer Pierre drinking water at any point on December 9, 2018 while he was confined to the restraint chair.

ANSWER: Admit. Further answering, admit I did not ask him, as he was sleeping. If he would have asked, I would have given it to him.

29. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically:

a. Your basis for each such denial(s) or qualification(s).

b. The time(s) You offered Pierre drinking water.

ANSWER: All inmates, including Pierre Howell, have access to fresh drinking water per policy as well as habit and routine. Per policy and habit and routine, Pierre Howell would have had access to fresh drinking water. I did not offer, but I did not deny him access to fresh drinking water.

30. In the event Your response to Request for Admission No. 28 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: See restraint chair policy.

31. Admit that You did not offer Pierre the opportunity to exercise any of his limbs while he was confined to the restraint chair on December 9, 2018.

ANSWER: Deny as written.

32. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically:

a. Your basis for each such denial(s) or qualification(s)

b. The time(s) You offered Pierre the opportunity to exercise any of his limbs.

c. What actions You took when offering him the opportunity to exercise any of his limbs.

d. The Jail supervisor You contacted when offering Pierre the opportunity to exercise any of his limbs.

ANSWER: All inmates, including Pierre Howell, would be offered and/or considered for the opportunity

to exercise limbs per policy recommendations. However, the circumstances and/or behavior of the inmate is the determining factor whether such exercise is performed. Per policy and habit and routine, Pierre Howell would have been considered for limb exercise.

33. In the event Your response to Request for Admission No. 31 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: See restraint chair policy and restraint chair form.

34. Admit that prior to 9:45p.m. on December 9, 2018, You did not consider Pierre for removal from the restraint chair.

ANSWER. Deny.

35. In the event Your response to the preceding Request for Admission is anything other than an unconditional and unqualified admission, state specifically:

a. Your basis for each such denial(s) or qualification(s).

b. The time(s) when You considered Pierre for removal from the restraint chair.

c. All actions taken by You when considering Pierre for removal from the restraint chair.

d. The Jail supervisor You contacted after considering Pierre for removal from the restraint chair.

ANSWER: Per policy as well as habit and routine, inmates in the restraint chair are considered for

removal at least hourly but there is no minimum time an inmate can be restrained in the restraint chair. Per policy and habit, and routine, such removal would have been considered for Pierre Howell. I have no specific recollection as to specific times.

36. In the event Your response to Request for Admission No. 34 is anything other than an unconditional and unqualified admission, produce all documents which support such denial(s) or qualification(s).

RESPONSE: See restraint chair policy.

37. State whether you have been disciplined by the Hamilton County Sheriff's Office for any actions You took related to Pierre.

ANSWER: No.

38. Produce any and all documents or correspondence which support Your response to the preceding interrogatory.

ANSWER: None.

/s/ John B. Welch (0055337)
Counsel for Defendants Jim Neil, Matthew Collini, Daniel Erwin, Justin Hunt, and Brad Buchanan
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DEFENDANTS' STATEMENT OF PROPOSED UNDISPUTED FACTS BY DEFENDANTS (MARCH 15, 2021)

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

_____

KARLA HOWELL, AS ADMINISTRATRIX OF THE ESTATE OF CORNELIUS PIERRE HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

_____

Case No. 1:19-CV-00373

Before: Douglas R. COLE, United States District Judge, Stephanie K. BOWMAN, Magistrate Judge.

Pursuant to Ohio Civil Rule 56(C), Defendants Jim Neil, Matthew Collini, Daniel Erwin, and Justin Hunt respectfully move this Court for summary judgment. The reasons for this Motion are set forth more fully in the following Memorandum.

/s/ John B. Welch (0055337)
Counsel for Defendants Jim Neil, Matthew Collini, Daniel Erwin and Justin Hunt

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[. . .]

II. Statement of Proposed Undisputed Facts

On 12/2/2018, Howell was incarcerated at HCJ after being arrested and booked for criminal damaging and aggravated menacing. (Doc #72, PAGEID #868) On 12/9/2018 at approximately 5:00 p.m., Hunt was contacted by officers assigned to the north building G42 advising him of a fight/altercation involving Howell. (Doc #69-13, PAGEID #720; Doc #69-8, PAGEID #547) It was determined Howell stabbed his cellmate with a pencil. (Doc #69-8, PAGEID #547) Hunt responded to medical where Howell's cellmate Grant was being seen in the treatment room for a stab wound. (Doc #69-13, PAGEID #720) Howell was brought to a secure entry area of medical in a wheelchair waiting to be seen, yelling, and stating he was in pain. (Doc #69-13, PAGEID #720) He was handcuffed but slid out of the chair to the floor. Staff placed him back into the wheelchair and took him to the sallyport area of medical. (Doc #69-13, PAGEID #720)

Jordan evaluated the patient. (Doc #69-9, PAGEID #583) Upon arrival, the patient was found in the chair, blood on bottom lip, and hands cuffed behind back. Cuffs were moved to the front per her request. The patient was yelling and complaining of back pain

and that he has sickle cell. (Doc #69-9, PAGEID #583) Howell was sweating. (Doc #69-9, PAGEID #583) Jordan obtained vital signs, BP 110/56, respirations 22, and pulse 99. (Doc #69-9, PAGEID #583) A blood sugar was obtained and noted to be 78. (Doc #69-9, PAGEID #583) A glucose tablet was administered but Howell refused and spit it out. Howell then went to the floor and began rolling around yelling. (Doc #69-9, PAGEID #583) As medical is assessing Howell, he was complaining of back pain, yelling, and asked to lay on the ground. (Doc #69-8, PAGEID #547) Howell was able to go from the wheelchair to the ground on his own power. (Doc #69-8, PAGEID #547) Hunt confirmed that while on the ground, Howell was yelling and complaining about back pain and rolling from side to side. (Doc #69-8, PAGEID #547) Jordan assessed Howell but he kept rolling on the floor and yelling – she asked him for a urine sample for assessment, but the patient refused. Howell kept refusing medical treatment. (Doc #69-9, PAGEID #583) Hunt stated he was involved in a fight and hurt his back. (Doc #69-13, PAGEID #720) Hunt noticed that Howell was using his legs to push with. (Doc #69-13, PAGEID #720) Jordan determined Howell should be taken to psych (mental health) for evaluation and to be placed into the restraint chair for his safety. (Doc #69 8, PAGEID #547; Doc #69-9, PAGEID #583) Jordan made the decision to place Howell into a restraint chair for his safety, thinking he was having a mental issue. Hunt advised officers to obtain the restraint chair from the psych unit for his safety. (Doc #69-13, PAGEID #720; Doc #69-8, PAGEID #521) Howell was placed into the restraint chair at approximately 5:40 p.m. (Doc #69-8, PAGEID #547) Howell was placed into the

restraint chair per medical for his safety. (Doc #69-8, PAGEID #547; Doc #69-13, PAGEID #714; Doc #69-8, PAGEID #521) Howell was placed into the restraint chair without incident; he was cooperative, and no force was used. (Doc #69-8, PAGEID #523; Doc #69-12, PAGEID #652; Doc #69-2, PAGEID #267)

Jordan determined that in her medical judgment, Howell was not having a serious medical issue or condition. (Doc #69-9, PAGEID #567-569) Jordan and Arthur, who was also present during the evaluation, knew of Howell's history of sickle cell disease. (*Id.*) Jordan considered that history and determined that Howell was not having a sickle crisis or any other serious medical issue. (*Id.*) Jordan determined that in her medical judgment, Howell did not need to be sent out to the hospital for evaluation. (*Id.*) In fact, whether to send Howell out to the hospital for evaluation was *discussed and considered* by Jordan and Arthur. (*Id.*) Hunt and Erwin heard the medical providers discussing and considering whether to send this patient out. (Doc #69-8, PAGEID #520-521; Doc #69-5, PAGEID #409-410) However, the medical care providers determined that Howell did not have a serious medical condition and that sending out to the hospital was not necessary. (*Id.*) Neither Hunt, Erwin, or any other deputy sheriff or corrections officer is a medical provider. Hunt may have heard the term sickle cell being considered by Jordan, but he had no knowledge of what sickle cell is or what it meant – not being a medical provider. (Doc #69-8, PAGEID #523) After the death of Howell, Erwin told investigators that he recalled hearing discussion about whether medical would send the patient to the hospital but that it was medical's (Jordan) decision. (Doc #69-

5, PAGEID #410) Erwin's statement that he felt bad because Howell should have gone to the hospital was made after the death and in retrospect. (*Id.*; *see also* Doc #72, PAGEID #909) Howell was brought to medical for evaluation, assessment, and further disposition, that is medical's role. (Doc #69-8, PAGEID #520) At no time did Hunt, Erwin, or any corrections officer believe at the time of medical's evaluation that Howell should have gone to the hospital. (*Id.*) Jordan determined Howell was not having a serious medical condition and did not need to go to the hospital – in essence ruling out that Howell had a serious medical condition at that time. (Doc #69-9, PAGEID #569)

Once Jordan made the determination Howell was not going to the hospital, Jordan ordered the restraint chair for calm and Howell's safety. Hunt agreed with the restraint chair for Howell's safety, since he was rolling on the floor and engaging in activity which contradicted his pain complaints and using his legs, which also contradicted his statement that he could not use his legs. (Doc #69-8, PAGEID #521; Doc #69-2, PAGEID #264) Howell had just been in an altercation, needed to calm down, and the safest and least restrictive approach under the circumstances was to be placed in the restraint chair as ordered by Jordan. (Doc #69-8, PAGEID #520-521; Doc #69-5, PAGEID #401) Hunt and Erwin have a right to rely on the medical judgments of the medical staff, particularly when that medical staff determines in their presence that an inmate need not be transported to the hospital at that time.

Howell was taken to G21 in restraint chair and placed in cell 6 in pod A. (Doc #69-13, PAGEID #718-723) Between 6:00 p.m. and 6:10 p.m., Howell was

noted to be in the chair but yelling. (Doc #69-13, PAGEID #714; Doc #69-1, PAGEID #242) Arthur noted, however, that Howell was alert and had no signs or symptoms of distress. In Erwin's presence, Arthur determined Howell did not have a serious medical condition which required further treatment at that time. (Doc #69-1, PAGEID #232) Erwin, a corrections officer, had a right to rely on the assessment of Arthur. Thus, Erwin performed observational checks on Howell in the restraint chair that evening under circumstances in which medical had ruled out a serious medical condition. Erwin performed subsequent observational checks per video evidence at approximately 6:23 p.m., 6:41 p.m., 7:07 p.m., and 8:03 p.m. (Doc #71-2, PAGEID #859-862) During these checks, Howell appeared to be sleeping and in no distress, *i.e.* he was not complaining of pain or requesting assistance. (Doc #69-5, PAGEID #407) Collini, also on duty that night, performed subsequent observational checks per video evidence at approximately 7:24 p.m., 7:40 p.m., and 9:14 p.m. that evening. (Doc #71-1, PAGEID #851-853) During these subsequent checks, Howell appeared calm, sleeping, and in no distress whatsoever. (Doc #69-4, PAGEID #360) These observational checks were performed by Collini and Erwin by looking through the window of the locked cell door. While Howell appeared to be sleeping, he may not have been sleeping but instead may have already passed away form an acute medical condition of which they were unaware. (Doc #69-4, PAGEID #364) Per policy, corrections officers are supposed to conduct observational checks for inmates in restraint chairs approximately every ten minutes. (Doc #69-13, PAGEID #707-710) These ten-minute checks are a guideline, and, at times, checks cannot

be performed at exactly every ten minutes. (Doc #69-5, PAGEID #405) In this case, checks were not performed every ten minutes. Collini and Erwin documented observational checks every ten minutes per the restraint chair form. Admittedly, this is a policy violation, as Erwin and Collini documented checks they did not perform. However, there is no evidence that Collini, Erwin, or any other corrections officers routinely documented checks not performed or that these officers, or any other officers, had routinely or created a pattern of not checking on inmates in restraint chairs at HCJ. (Doc #69-5, PAGEID #355; Doc #69-5, PAGEID #410; Doc #69-8, PAGEID #508, 528; Doc #69-3, PAGEID #302, 303, 310) At the 7:24 p.m. check, Collini said Howell appeared to be looking out the window but he could not see his eyes. From his point of observation, he could not tell if Howell was alive or not. (Doc #69-1, PAGEID #364)

The deceased person's report notes that Collini last saw Howell alive at 1930; that time simply refers to the observational check at that particular time, as Collini testified he did not know whether Howell was, in fact, alive or not at 7:30 p.m. (*Id.*; Doc #69-4, PAGEID #392)

At 9:45 p.m., Hunt came to check on Howell and remove him from the restraint chair. (Doc #69-8, PAGEID #547) Howell was unresponsive. Deputy Dominic Pierani ("Pierani") did a sternal rub and Hunt shook his shoulder, but Howell was stiff, after which a G100 (emergency) was called. (Doc #69-8, PAGEID #547; Doc #69-13, PAGEID #718-723) EMS arrived and noted Howell to be unresponsive. A NaphCare nurse arrived and began performing CPR. Paramedics from the Cincinnati Fire Department

arrived a short time later but did not perform life-saving measures. The paramedics felt Howell's arm and it was cold. (Doc #72, PAGEID #869)

On 12/10/2018, Hamilton County Deputy Coroner Dr. Gretel Stephens ("Stephens") performed a post-mortem examination. Stephens determined the cause of Howell's death was *sickle crisis following physical altercation due to hemoglobin SC.* (Doc #73, PAGEID #43) Stephens noted the approximate interval between onset and death to be minutes, *i.e.* a short time after the altercation and ensuing 'sickle crisis.' The significance of this finding and the overwhelming medical expert testimony is that even had Jordan made the medical determination to send Howell to the local emergency department for assessment and evaluation, Howell would not have survived. Stephens determined Howell's manner of death was homicide – Stephens stating, "that although the injuries from the altercation occurred prior to his sickle crisis were not major, his increased physical exertion was thought to have led to a sickle crisis, making his manner of death medically a homicide, even though the investigative information suggests that Howell was the initial aggressor in the altercation and the other participant's actions were primarily in self-defense." (Doc #73, PAGEID #939-943)

PROPOSED STATEMENT OF UNDISPUTED FACTS BY DEFENDANTS NAPHCARE, INC., CHRSTINA JORDAN, RN AND PIERETTE ARTHUR, LPN (MARCH 15, 2021)

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION AT CINCINNATI

KARLA HOWELL, AS ADMINISTRATRIX OF THE ESTATE OF CORNELIUS HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

Case No. 1:19-CV-00373-DRC-SKB

Before: Douglas R. COLE,
United States District Judge.

Pursuant to this Court's standing orders, in connection with NaphCare Defendants' Motion for Summary Judgment, NaphCare Defendants proposed the following undisputed material facts:

1. When an inmate is booked into the HCJC, an initial medical screening is performed by NaphCare

medical personnel. (Jordan Dep., Doc. 76, at PID 975-977.)

2. Prior to Howell's incarceration on December 2, 2018, Howell had been incarcerated at the HCJC and see by NaphCare personnel in 2010, 2015, 2016 and August of 2018. (*Id.* at PID 983.)

3. There is no evidence of any prior issues or complaints with Howell's medical care at the HCJC.

4. When Howell was booked into HCJC on December 2, 2018, he refused to receive a medical screening and signed a Release of Responsibility. (See Declaration of Maria Perdikakis and attached NaphCare Medical Records, Doc. 79-1 at PID 1276.)

5. Howell was thereafter placed in general population in the HCJC. (*Id.* at PID 1279.)

6. Howell received a medical screening the following day, December 3, 2018, which was performed by Lindsay Webster, a NaphCare LPN. (*Id.* at PID 1279-1284, 1289-1293.) Nurse Webster noted vitals within normal limits and charted that Howell had "sickle cell disease." (*Id*. at PID 1280, 1290) She also noted his ADHD diagnosis in 2016. (*Id*. at PID 1282.) A Mental Health Screening was also performed on this date by Nurse Webster. (*Id*. at PID 1280-1284.) During his mental health screening, Howell stated he felt depressed and rated his depression as a 7-10/10. (*Id*. at PID 1281) He further stated he felt "a little messed up" about his current situation. (*Id*.) His medical screening did not raise any concerns and Howell continued to be housed in general population. (*Id*. at PID 1280-1284.) He was placed on NaphCare's chronic care list due to his underlying sickle cell disease. (*Id.* at PID 1279-1284, 1289-1293.)

7. Later, on December 6, 2018, Howell was seen by NaphCare nurse, Jerell Wilburn, LPN. (*Id.* at PID 1263-1265.) He was seen for skin irritation/contact dermatitis. (*Id.*) No other issues were noted on this date. (*Id.*) He was also started on Ibuprofen, because he reported he took this daily for pain related to his underlying sickle cell disease. (*Id.* at PID 1255-56, 1262.)

8. The next day, on December 7, 2018, Howell was seen for a chronic care visit by Michael Pegram, a nurse practitioner employed by NaphCare (*Id.* at PID 1266-1273.) Nurse Pegram noted that Howell reported taking Oxycodone for his sickle cell pain and he reported that his pain had worsened since his incarceration. (*Id.* at PID 1267.) Nurse Pegram noted that Howell's level of disease control was "good" overall. (*Id.* at PID 1270.) Nurse Pegram noted a discussion with Howell educating him on the disease process, medical compliance, signs and symptoms of worsening illness/complications, diet/exercise, treatment goals, infection control and he was encouraged to drink more fluids. (*Id.* at PID 1271-1272.) Other than this, Howell's order for Ibuprofen was continued and he was told he should follow up on his condition in six months. (*Id.* at PID 1271.)

9. On December 9, 2018 at approximately 5:00 p.m., Howell got into a physical altercation with his cellmate, Demarcus Grant. (Jordan Deposition, Doc. 76 at PID 986.) It was determined that Howell had started the altercation with his cellmate by stabbing him with a sharp object and that his cellmate had struck Howell in self-defense. (*Id.*) Guards responded and separated them.

10. The cellmate, Grant, was first brought to NaphCare's medical office for evaluation. Nurse Jordan was the acting charge nurse. She talked to Grant and treated his puncture wound. (*Id.* at PID 987-988, 1022, 1030-1031.) Grant told her that Howell's attack on him was unprovoked and that Howell was not acting right. (*Id.*) At the time, Howell was in a holding area outside the medical unit.

11. After Grant was taken back to his cell, Howell was brought into the medical area for evaluation. (*Id.*) While in the medical unit, he was assessed by Nurse Christina Jordan and other LPN nurses who were on duty. (*Id.* at PID 988.)

12. After trying to take a history from Howell but before physically assessing him, Nurse Jordan reviewed Howell's electronic medical chart noting a history of sickle cell disease and hoarding narcotics among other things (*Id.* at PID 989.)

13. At the time that Nurse Jordan saw Howell, he was yelling, sweating, and bleeding from the lip. (*Id.*; see Jordan Dep. Exhibit 33, PID 1058.)

14. Howell complained of back pain, leg pain and reported that he had sickle cell disease, which Nurse Jordan had separately gleaned from his chart. (*Id.* at PID 989.)

15. There is no evidence that Howell indicated that he was having any type of sickle cell crisis event on December 9, 2018 despite having a lifetime of episodic experience with that condition.

16. In the past, when Howell would have a sickle cell pain event outside of the jail setting, he would typically not seek medical attention or go to the hos-

pital. Rather, according to his sister and administrator of his estate, Kara Howell, he would self-manage his pain symptoms with rest, a heating pad, water and OTC pain medications. (Kara Howell Dep., Doc. 77, at PID 1084-1087.) On average, Howell would have a sickle cell pain event every 1-3 months, which were generally self-managed. (*Id.*)

17. When a glucose tab was given to Howell, he spit it out. (*Id.* at PID 988.) He then put himself on the floor and began rolling around and yelling. (*Id.* at PID 989.) As Nurse Jordan attempted to assess him, he continued to roll on the floor, yelling. (*Id.*)

18. Nurse Jordan was unable to obtain his temperature due to his behavior, but she obtained his pulse, respiratory rate and blood pressure. (*Id.* at PID 988-989.) His vitals were generally stable and within normal limits and did not cause Nurse Jordan to have any concerns. (Id. at PID 1011.)

18. Nurse Jordan had noted in Howell's medical chart that he had a history of hoarding/abusing narcotics. (Jordan Dep., Doc. 76, at PID 995.) As such, Howell was asked to give a urine sample but refused and continued to refuse medical treatment. (*Id.* at PID 1036.) Howell repeatedly stated that he "was sorry." (*Id.* at PID 988, 1012.)

20. Ultimately, Nurse Jordan felt that Howell was likely experiencing an acute psychological issue. (*Id.* at PID 990.) She suggested to the corrections officers that they take him to the psych area of the jail to be assessed by mental health personnel, including a drug screening to see what was going on with him that would explain his erratic behavior. (*Id.* at PID 1038.)

21. In her nursing judgment, Nurse Jordan did not subjectively believe that Howell was having a serious medical condition, which warranted emergency transport to University Hospital or any other medical intervention or treatment. (*Id.* at PID 1039.)

22. Because of Howell's behavior, it was decided that he needed to calm down and that he should be placed into a restraint chair for his own safety before being transported to the mental health unit, located on a different floor within HCJC. (*Id.*) Although there is a factual dispute as to who initially suggested/ ordered the restraint chair, the factual evidence and testimony is uncontroverted that Howell's behavior warranted placement into the restraint chair.

23. After Howell was put into the restraint chair at approximately 5:43 PM by correctional staff, Nurse Jordan again assessed Howell, checked the restraints and again took his vitals a second time. (*Id.* at PID 1014.) His vital signs again did not cause Nurse Jordan any concerns for his physical well-being. (*Id.* at PID 1023.) Howell was then transported to the mental health unit.

24. There is no evidence that, following his physical altercation, Howell requested any specific medical services, asked for anything to drink, asked to go the hospital, asked to see a doctor, or otherwise indicated that he was having any type of sickle cell crisis event, which Howell had experienced many times over his life living with sickle cell disease. (Jordan Dep., Doc. 76 at PID 988-996, 1030-1039; See also generally Kara Howell Dep., Doc. 77, PID 1085-1087.)

25. Howell was never denied medical care, but instead refused all care that was offered, including hydration. (Jordan Dep., Doc. 76, at PID at 1007.)

26. As of December 2018, the general, agreed-upon policy at HCJC regarding inmates in restraint chairs included the requirement that corrections staff would visually observe/monitor inmates every 10 minutes and medical/nursing staff would assess the inmate at least every 2 hours. (Jordan Dep., Doc. 76, at PID 1018.)

27. Shortly after coming to the mental health unit, and well before Howell was scheduled for his two-hour medical check, he was observed by Defendant Pierette Arthur, LPN at approximately 6:20 PM. (Arthur Dep., Doc. 78, at PID 1195.) Arthur had no prior contact with Howell. (*Id.* at PID 1200.) This occurred as Nurse Arthur was doing her final med pass in the mental health unit shortly after 6 PM while accompanied by a guard. (*Id.*)

28. After the guard opened the locked door of the cell where Howell was being held, Arthur observed that Howell was still belligerent, yelling obscenities and threatening staff. (*Id.* at PID 1196-1197.) He did not complain of pain and was in no apparent physical distress. (*Id.*) There is no evidence that Howell asked for water or for any medical/nursing services during this encounter.

29. Rather than continue to cause Howell to escalate, Nurse Arthur, a very experienced mental health nurse, determined that she would walk away to allow him to hopefully calm down. (*Id.* at PID 1196.) There was nothing about Howell's appearance or behavior which made Nurse Arthur believe that he

was experiencing any type of serious, life-threating medical condition. (*Id.* at PID 1228.)

30. Nurse Arthur has worked as an LPN at HCJC for more than 15 years. (*Id.* at PID 1163-1164.) She has worked in the mental health unit for more than 10 years. (*Id.* at PID 1164.) She has observed and assessed countless inmates in restraint chairs, on almost every one of her shifts. (*Id.* at PID 1173.) In that time, she never experienced an occurrence where an inmate was injured or otherwise suffered an adverse medical event while being in a restraint chair. (*Id.* at PID 1182-1183.)

31. After Nurse Arthur finished her shift on this particular day (12/09/2018), she clocked out and went home sometime between 7:30-8:00 PM.

32. Before leaving HCJC, Nurse Arthur went to the medical unit. She told Nurse Jordan that she had recently seen Howell and that he was still yelling and carrying on but that he was in no physical distress. (*Id.* at PID 1200.)

33. Nurse Jordan, busy with a variety of other nursing duties, planned to see Howell a few hours later per policy or earlier if notified by corrections. (Jordan Dep., Doc. 76, at PID 997.)

34. At no time was Nurse Jordan or anyone in the medical unit contacted by corrections staff regarding Howell until approximately 9:47 p.m., when a medical emergency was called after Howell was found unresponsive by correctional staff. (*Id.* at PID 985.) NaphCare medical staff immediately responded and 9-1-1 was also called. Upon arrival by Nurse Jordan and other medical staff at approximately 9:50 p.m.,

Howell was noted to still be sitting in the restraint chair. He was then taken out of the restraint chair and placed on the floor supine. CPR was initiated by medical staff while medical supplies were gathered, including supplemental Oxygen and an AED. (*Id.*) EMTs then arrived and took over care. (*Id.*) Howell was pronounced dead at 9:57 p.m.

35. Dr. Gretel Stephens with the Hamilton County Coroner's Office performed Howell's autopsy and concluded that his death was as a result of "sickle cell crisis following physical altercation due to hemoglobin SC" and that his contributing cause of death was "increased pulmonary fibrosis due to tobacco smoke exposure." (Stephens Declaration, Doc. 73, PID 941, 949.) Dr. Stephens opined that the interval between Howell's sickle cell crisis and death was "minutes." (*Id.*)

36. Defense medical experts, Nathanial Evans, MD and Joseph Kiss, MD opine that Howell suffered a sudden, unforeseeable cardiac death and that a contributing factor was a prior chest stab wound that Howell suffered approximately one year earlier resulting in open heart surgery. (Evans Declaration, Doc. 79-2, PID 1295-1306; Kiss Declaration, Doc. 79-3, PID 1309-1315.)

37. Plaintiff's own medical expert, Dr. Steinberg, has conceded that Howell suffered an unforeseeable sudden death following his physical altercation and that Howell's placement into a restraint chair had no causal relationship to his sudden death. (Steinberg Dep., Doc. 69-15, at PID 779-787.)

38. Plaintiff has no evidence that NaphCare Defendants could have reasonably predicted or prevented Howell's death.

39. Plaintiff has no evidence that any act or omission of NaphCare caused injury or death to Howell.

40. Howell's death was sudden and unexpected.

41. Howell's death was not reasonably foreseeable.

42. Plaintiff has no evidence that any NaphCare policy, procedure or custom deprived Howell of his constitutional rights or were the moving force behind any such deprivation.

43. There is no evidence of any prior similar incident involving serious injury or death of an inmate at HCJC while in a restraint chair under the same or similar circumstances.

Respectfully submitted,

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PLAINTIFF'S RESPONSE TO DEFENDANTS' PROPOSED STATEMENT OF UNDISPUTED FACTS (APRIL 5, 2021)

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

KARLA HOWELL, AS ADMINISTRATRIX OF THE ESTATE OF CORNELIUS PIERRE HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

Case No. 1:19-CV-00373

Before: Douglas R. COLE, United States District Judge, BOWMAN, Magistrate Judge.

Now comes Plaintiff, by and through counsel, and for her Response to Defendants' NaphCare, Inc., Christina Jordan, and Pierette Arthur's (collectively, the "Nursing Defendants")[1] Proposed Statement of Undisputed Facts states as follows:

[1] Defendants Jim Neil, Justin Hunt, Matthew Collini, and Daniel Erwin failed to provide a Proposed Statement of Undisputed Facts in accordance with the Court's Standing Orders.

1. It should first be noted that throughout their Proposed Statement of Undisputed Facts, the Nursing Defendants plainly violate the Court's Standing Orders. Specifically, they fail to offer any citation to affidavits or declarations from witnesses who are competent to testify to the facts at trial, a deposition, or other evidence, including documentary evidence, that would be admissible at trial in Paragraphs 3, 15, 31, 38, 39, 40, 41, 42, and 43. *See Standing Order on Civil Procedures* at ¶ F(2)(a). In many of these Paragraphs, the Nursing Defendants likewise cite to disputed legal issues. *Id.* at ¶ F(2)(c). They likewise fail to offer citations at several other points which will be discussed, *infra.*

2. These failures are indicative of the reality that there are significant factual disputes in this case which render summary judgment inappropriate.

Notwithstanding the foregoing,

RESPONSE TO THE NURSING DEFENDANTS' PROPOSED UNDISPUTED FACTS

1. Admit.

2. Admit.

3. See introductory Paragraph No. 1 above.

4. Admit.

5. Admit.

6. Admit that the medical records speak for themselves. Deny that medical screening did not raise any concerns as there is no evidence in the record concerning the same.

7. Admit that the medical records speak for themselves.

8. Admit that the medical records speak for themselves.

9. Admit that Cornelius Pierre Howell ("Pierre") got into an altercation with his cellmate and that guards separated them. Deny that Pierre used a "sharp object" and that he was struck a single time by his cellmate. (Doc. 72 at PID 876).

10. Admit.

11. Admit that Howell was brought into medical area and assessed after Grant by Jordan and other nurses. Deny any knowledge about where Grant was taken after leaving the medical area as there is no evidence in the record to support said statement.

12. Deny. (Doc. 76 at PID 988-989).

13. Admit Pierre was exhibiting symptoms described, but deny that they were extent of things Jordan saw. (Doc. 76 at PID 983, 988-989, 993, 1008, 1012, 1022).

14. Admit.

15. See introductory Paragraph No. 1 above. *See also* Doc. 87-1 at PID 1638-1639 Doc. 87-3 at PID 1692).

16. Admit that Pierre would attempt to manage sickle cell symptoms with rest, a heating pad, water, and pain medication and that he had sickle cell pain event every other month or every one to three months, but deny that he would "typically not seek medical attention." (Doc. 77 at PID 1107).

17. Admit Pierre spit out glucose table and rolled on the floor in pain. Deny remainder. (Doc. 69-7 at

PID 479, T.P. 66; Doc, 69-13 at PID 689, T.P. 61; Doc. 69-2 at PID 264, T.P. 66).

18. Admit Jordan was able to obtain Pierre's pulse, respiratory rate and blood pressure, but not temperature. Deny remainder. (Doc. 69-6 at PID 448, T.P. 61; Doc. 87-6, at PID 1706).

19. Admit that Jordan testified to seeing history concerning narcotics in his chart, that she asked him to give urine sample in sallyport, and that he said he was apologetic. Deny remainder. (Doc. 69-2 at PID 265, T.P. 72; Doc. 76 at PID 995, 1003, 1005).

20. Admit that Jordan believed Pierre was having psychological issue, but deny remainder. (Doc. 72 at PID 873; Doc. 69-7 at PID 481, T.P. 73-73; Doc. 69-2 at PID 266, T.P. 73; Doc. 69-13 at PID 690, T.P. 65; Doc. 76 at PID 995, 1003, 1005).

21. Deny. (Doc. 76 at PID 995, 1003, 1005).

22. Admit that issue of material fact exists concerning who made decision to place Pierre in the restraint chair. Deny remainder. (Doc. 86-1 at PID 1621-1622).

23. Admit that after Pierre was placed in the restraint chair, his vitals were checked again and that he was then sent to the mental health unit. Deny remainder. (Doc. 69-6 at PID 448, T.P. 61; Doc. 69-1 at PID 242-243, Exhibit 28).

24. Deny as Defendants failed to check on or personally interact with Howell after 6:06 p.m. (Doc. 86-1 at PID 1627; Doc. 69-1 at PID 224, T.P. 42-43, at PID 225, T.P. 47; Doc. 76 at 998, 1003-1004; Doc. 69-13 at Exhibit 6, PID 714 with Doc. 69-2 at PID

288, Exhibit 12[2] at 6:06 p.m., 6:10 p.m., 6:23p.m., 6:41 p.m.; Doc. 69-4 at PID 390, Exhibit 23[3] at 7:07 p.m.; Doc. 92 at PID 1787, CD #2 at 8:03 p.m.; Doc. 88-1 at PID 1767; Doc. 69-5 at PID 403, T.P. 36, at PID 404-405, T.P. 40-42, at PID 411, T.P. 65-67; Doc. 71-2; Doc. 69-4 at PID 390, Exhibit 23[4] at 7:24 p.m., 7:40 p.m. and PID 391, Exhibit 24[5] at 9:14 p.m., at PID 348-349, T.P. 99-101, at PID 354, T.P. 121-124).

25. Deny. (Doc. 86-1 at PID 1627; Doc. 69-1 at PID 224, T.P. 42-43, at PID 225, T.P. 47; Doc. 76 at 998, 1003-1004; Doc. 69-13 at Exhibit 6, PID 714 with Doc. 69-2 at PID 288, Exhibit 12[6] at 6:06 p.m., 6:10 p.m., 6:23p.m., 6:41 p.m.; Doc. 69-4 at PID 390, Exhibit 23[7] at 7:07 p.m.; Doc. 92 at PID 1787, CD #2 at 8:03 p.m.; Doc. 88-1 at PID 1767; Doc. 69-5 at PID 403, T.P. 36, at PID 404-405, T.P. 40-42, at PID 411, T.P. 65-67; Doc. 71-2; Doc. 69-4 at PID 390, Exhibit 23[8] at 7:24 p.m., 7:40 p.m. and PID 391, Exhibit 24[9] at 9:14 p.m., at PID 348-349, T.P. 99-101, at PID 354, T.P. 121-124).

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[2] *See also* Doc. 91 at PID 1780, CD #4.

[3] *See also* Doc. 91 at PID 1780, CD #7.

[4] *See also* Doc. 91 at PID 1780, CD #7.

[5] *See also* Doc. 91 at PID 1780, CD #8.

[6] *See also* Doc. 91 at PID 1780, CD #4.

[7] *See also* Doc. 91 at PID 1780, CD #7.

[8] *See also* Doc. 91 at PID 1780, CD #7.

[9] *See also* Doc. 91 at PID 1780, CD #8.

26. Deny. (Doc. 69-10 at PID 598, T.P. 53, Exhibit 34; Doc. 86-1 at PID 1613-1614, 1627).

27. Admit that Arthur saw Pierre during a medication pass at 6:06 p.m. while accompanied by guards and that she had no prior contact with him. Deny remainder. (Doc. 86-1 at PID 1627; Doc. 69-1 at PID 225, T.P. 47; Doc. 69-4 at PID 344, T.P. 83).

28. Admit all but uncited last sentence.

29. Admit that Arthur walked away, but deny remainder. (Doc. 69-1 at PID 225, T.P. 47; Doc. 69-4 at PID 344, T.P. 83).

30. Admit.

31. See introductory Paragraph No. 1 above. Notwithstanding the foregoing, admit.

32. Admit that Arthur spoke to Jordan before leaving work the day of Pierre's death. Deny remainder. (Doc. 69-4 PID 225, T.P. 47).

33. Deny as Jordan never saw Pierre again alive. (Doc. 76 at PID 998).

34. Admit.

35. Admit that Dr. Stephens opined about cause of death, but deny that it is accurate. (Doc. 87-3; Doc. 69-15 at PID 777, T.P. 60-61; Doc. 87-1 at PID 1638; Doc. 72 at PID 875, Doc. 69-2 at PID 288, Exhibit 12[10] at 6:10 p.m, 6:23 p.m., 6:41 p.m.; Doc. 69-4 at PID 346, T.P. 90-91, PID 351, T.P. 109-110, at PID 361, T.P. 150, at Exhibit 25, PID 392).

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10 *See also* Doc. 91 at PID 1780, CD #4.

36. Admit that Dr. Evans and Dr. Kiss opined about cause of death, but deny that they are accurate. (Doc. 87-3; Doc. 69-15 at PID 777, T.P. 60-61; Doc. 87-1 at PID 1638; Doc. 72 at PID 875, Doc. 69-2 at PID 288, Exhibit 12[11] at 6:10 p.m, 6:23 p.m., 6:41 p.m.; Doc. 69-4 at PID 346, T.P. 90-91, PID 351, T.P. 109-110, at PID 361, T.P. 150, at Exhibit 25, PID 392).

37. Deny. (Doc. 69-15 at PID 777, T.P. 60-61 at PID 786, T.P. 96, lines 9-14; Doc. 87-1 at PID 1638).

38. See introductory Paragraph No. 1. Answering further, deny. See Plaintiff's Memorandum in Opposition to Summary Judgment.

39. See introductory Paragraph No. 1. Answering further, deny. See Plaintiff's Memorandum in Opposition to Summary Judgment.

40. See introductory Paragraph No. 1. Answering further, deny. See Plaintiff's Memorandum in Opposition to Summary Judgment. (*See also* Doc. 69-15 at PID 777, T.P. 60-61 at PID 786, T.P. 96, lines 9-14; Doc. 87-1 at PID 1638).

41. See introductory Paragraph No. 1. Answering further, deny. See Plaintiff's Memorandum in Opposition to Summary Judgment. (*See also* Doc. 69-15 at PID 777, T.P. 60-61 at PID 786, T.P. 96, lines 9-14; Doc. 87-1 at PID 1638).

42. See introductory Paragraph No. 1. Answering further, deny. See Plaintiff's Memorandum in Opposition to Summary Judgment.

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[11] *See also* Doc. 91 at PID 1780, CD #4.

43. See introductory Paragraph No. 1. Answering further, deny. See Plaintiff's Memorandum in Opposition to Summary Judgment.

STATEMENT OF PROPOSED DISPUTED ISSUES OF MATERIAL FACT AS TO ALL DEFENDANTS

1. Cornelius Pierre Howell ("Pierre") was in need of emergent medical attention in the medical sallyport. (Doc. 69-13 at PID 715, Exhibit 9 (*see also* Doc. 91 at PID 1780, CD #3), Doc. 69-16, at PID 825-826, T.P. 42-45, 47; Doc. 69-2 at PID 264, T.P. 65; Doc. 69-12, at PID 652, T.P. 45, Doc. 69-7, at PID 479, T.P. 66, Doc. 69-5, at PID 401, T.P. 26, Doc. 69-8 at PID 519, T.P. 71-72, at PID 520, T.P. 73, at PID 520-521, T.P. 76-77, at PID 523, T.P. 88; Doc. 72 at PID 873, 875; Doc. 93 at PID 1794, CD at 10:30-10:38, Doc. 79-1 at PID 1262; Doc. 69-6 at PID 448, T.P. 61; Doc. 76 at PID 988-989, 993, 1008, 1012).

2. By custom and practices, nurses at the Hamilton County Jail had authority to order inmates into restraint chairs. (Doc. 69-8 at PID 511, T.P. 38-39; Doc. 69-16 at PID 821, T.P. 26-27; Doc. 69-12 at PID 646, T.P. 23; Doc. 69-7 at PID 473, T.P. 41; Doc. 69-3 at PID 300, T.P. 34-35).

3. Pierre was ordered into the restraint chair by Christina Jordan. (Doc. 72 at PID 873; Doc. 69-7 at PID 481, T.P. 73-73; Doc. 69-2 at PID 266, T.P. 73; Doc. 69-13 at PID 690, T.P. 65).

4. Pierre's behavior and medical issues in the sallyport did not meet the criteria for him to be medically ordered into a restraint chair. (Doc. 86-1 at PID 1621-1622; Doc. 78 at Exhibit 28, PID 1240).

5. Pierre was ordered into the restraint char by Justin Hunt. (Doc. 76 at PID 990).

6. Pierre's behavior and medical issues in the sallyport did not meet the criteria for him to be ordered into a restraint chair by jail staff. (Doc. 87-9 at PID 1741-1743).

7. Pierre's behavior and medical issues once in the restraint chair did not meet either medical or custodial criteria to remain in the restraint chair. (Doc. 69-1 at PID 242, Exhibit 28; Doc. 69-16 at PID 829-830, T.P. 60-61; Doc. 69-2 at PID 268, T.P. 82; Doc. 86-1 at PID 1621-1622; Doc. 78 at Exhibit 28, PID 1240).

8. Pierre's behavior and medical issues while being wheeled to the psych department did not meet either medical or custodial criteria to remain in the restraint chair. (Doc. 69-2 at PID 268, T.P. 82; Doc. 69-12 at PID 653, T.P. 51).

9. Pierre's behavior and medical issues once placed inside of a cell in the psych department did not meet either medical or custodial criteria to remain in the restraint chair. (Doc. 72 at PID 875; Doc. 69-4 at PID 337, T.P. 53-54, at PID 341, T.P. 69; Doc. 69-2 at PID 258, T.P. 42-43, at PID 288, Exhibit 12,[12] at PID 361, T.P. 150; Doc. 69-7 at PID 476, T.P. 55; Doc. 69-8 at PID 515, T.P. 53; Doc. 69-16 at PID 823, T.P. 36).

10. Pierette Arthur failed to conduct 15-minute checks of Pierre while he was in the restraint chair as required by Naphcare Policy when inmates are ordered into the restraint chair by medical staff.

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[12] *See also* Doc. 91 at PID 1780, CD #4.

(Doc. 86-1 at PID 1627; Doc. 69-1 at PID 224, T.P. 42-43, at PID 225, T.P. 47).

11. Christina Jordan failed to conduct 15-minute checks of Howell while he was in the restraint char as required by Naphcare Policy when inmates are ordered into the restraint chair by medical staff. (Doc. 86-1 at PID 1627; Doc. 76 at 998, 1003-1004).

12. Pierrette Arthur failed to conduct a proper check of Pierre within two hours of him being placed into the restraint chair by Jail staff. (Doc. 69-4 at PID 344, T.P. 83).

13. Christina Jordan failed to conduct a proper check of Pierre within two hours of him being placed into the restraint chair by Jail staff. (Doc. 76 at PID 998).

14. Matthew Collini and Daniel Erwin failed to conduct 10-minute checks of Howell while he was in the restraint chair as required by Jail Policy when inmates are confined to a restraint chair. (*Compare* Doc. 69-13 at Exhibit 6, PID 714 with Doc. 69-2 at PID 288, Exhibit 12[13] at 6:06 p.m., 6:10 p.m., 6:23p.m., 6:41 p.m.; Doc. 69-4 at PID 390, Exhibit 23[14] at 7:07 p.m.; Doc. 92 at PID 1787, CD #2 at 8:03 p.m.; Doc. 88-1 at PID 1767; Doc. 69-5 at PID 403, T.P. 36, at PID 404-405, T.P. 40-42, at PID 411, T.P. 65-67; Doc. 71-2; Doc. 69-4 at PID 390, Exhibit 23[15] at 7:24 p.m.,

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[13] *See also* Doc. 91 at PID 1780, CD #4.

[14] *See also* Doc. 91 at PID 1780, CD #7.

[15] *See also* Doc. 91 at PID 1780, CD #7.

7:40 p.m. and PID 391, Exhibit 24[16] at 9:14 p.m., at PID 348-349, T.P. 99-101, at PID 354, T.P. 121-124).

15. Matthew Collini and Daniel Erwin falsified Jail records indicating that they conducted 10-minute checks of Howell while he was in the restraint chair. (*Compare* Doc. 69-13 at Exhibit 6, PID 714 with Doc. 69-2 at PID 288, Exhibit 12[17] at 6:06 p.m., 6:10 p.m., 6:23p.m., 6:41 p.m.; Doc. 69-4 at PID 390, Exhibit 23[18] at 7:07 p.m.; Doc. 92 at PID 1787, CD #2 at 8:03 p.m.; Doc. 88-1 at PID 1767; Doc. 69-5 at PID 403, T.P. 36, at PID 404-405, T.P. 40-42, at PID 411, T.P. 65-67; Doc. 71-2; Doc. 69-4 at PID 390, Exhibit 23[19] at 7:24 p.m., 7:40 p.m. and PID 391, Exhibit 24[20] at 9:14 p.m., at PID 348-349, T.P. 99-101, and PID 354, T.P. 121-124).

16. Howell was alive at 6:10pm. (Doc. 72 at PID 875, Doc. 69-2 at PID 288, Exhibit 12[21] at 6:10 p.m.).

17. Howell was alive at 6:23pm. (Doc. 72 at PID 875, Doc. 69-2 at PID 288, Exhibit 12[22] at 6:23 p.m.).

18. Howell was alive at 6:41pm. (Doc. 72 at PID 875, Doc. 69-2 at PID 288, Exhibit 12[23] at 6:41 p.m.).

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16 *See also* Doc. 91 at PID 1780, CD #8.

17 *See also* Doc. 91 at PID 1780, CD #4.

18 *See also* Doc. 91 at PID 1780, CD #7.

19 *See also* Doc. 91 at PID 1780, CD #7.

20 *See also* Doc. 91 at PID 1780, CD #8.

21 *See also* Doc. 91 at PID 1780, CD #4.

22 *See also* Doc. 91 at PID 1780, CD #4.

19. Howell was alive at 7:30pm. (Doc. 69-4 at PID 346, T.P. 90-91, PID 351, T.P. 109-110, at PID 361, T.P. 150, at Exhibit 25, PID 392).

20. Matthew Collini called Justin Hunt at the two-hour mark to consider Pierre for removal from the restraint chair, but Justin Hunt did not respond. (Doc. 69-4 at PID 339, T.P. 61-62).

21. At the time of Pierre's death, it was the policy of the Hamilton County Sheriff's Department to keep inmates who fall asleep confined in the restraint chair. (Doc. 69-13 at PID 685, T.P. 46-47, Doc 69-8 at PID 515, T.P. 53, at PID 340, T.P. 66; Doc.69-3 at PID 304, T.P. 52).

22. At the time of Pierre's death, it was the policy of the Hamilton County Sheriff's Department that inmates in a restraint chair would remain confined for a minimum of two hours. (Doc. 69-4 at PID 332, T.P. 36, at PID 337, T.P. 56; Doc. 69-3 at PID 304, T.P. 49; Doc. 69-14 at PID 740, T.P. 62).

23. At the time of Pierre's death, it was the policy of the Hamilton County Sheriff's Department, rather than physically interacting with inmates in the restraint chair during the required ten-minute observations, staff would only look at them through the small window on the closed cell door. (Doc. 69-4 at PID 335, T.P. 46-47; Doc. 69-8 at PID 515, T.P. 55-56; Doc. 69-12 at PID 648, T.P. 29-30; Doc. 69-2 at PID 257, T.P. 38-39; Doc. 69-3 at PID 305, T.P 53-54).

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23 *See also* Doc. 91 at PID 1780, CD #4.

24. At the time of Pierre's death, it was the policy of the Hamilton County Sheriff's Department that rather than actually detail an inmate's activities and significant developments while in the restraint chair, they would simply write "Chair" following a check. (Doc. 69-2 at PID 258, T.P. 44; Doc. 69-14 at PID 738, T.P. 54; Doc. 69-7 at PID 474, T.P. 48).

25. Neil failed to conduct a proper investigation of Howell's death despite knowledge within hours after Howell's death that the 10-minute checks had not been conducted. (Doc. 69-14 at PID 727, T.P. 10-11, PID 746, T.P. 88; Doc. 83 at PID 1499).

Respectfully Submitted:

/s/ Ryan J. McGraw
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DEPOSITION OF ASHLEY ROETTKER
(JANUARY 23, 2020)

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

_____

KARLA HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

_____

Case Number: 1:19-cv-00373

Before: Kelly GREEN, RPR, Notary Public.

ASHLEY ROETTKER,

a witness herein, having been duly sworn, was examined and testified as follows:

CROSS-EXAMINATION BY MR. MCGRAW:

Q. Good morning, ma'am.

A. Good morning.

Q. My name is Ryan McGraw. We just met. Along with Konrad Kircher, we represent the estate of Cornelius Pierre Howell.

Can you state your name and spell your last name for the record.

A. Ashley Roettker, R-O-E-T-T-K-E-R.

Q. "RET-ker"? Am I saying that right?

A. "RET-ker," yeah.

Q. Ms. Roettker, have you ever given a deposition before?

A. No.

Q. So let me give you just a couple of ground rules so we make sure that today goes as smoothly as possible. I'm not going to try to keep you here any longer than I need you to be.

As you can see, there's a court reporter who's taking down everything that we say. For that reason, if you will, allow me to finish my question so that only one of us is talking, and I will allow you to finish your answer to my question.

If I ever cut you off, it will be inadvertent. Please bring that to my attention, and I will allow you to finish. Is that fair?

A. Mm-hmm.

Q. You just did a great job there, so I need you to have audible answers.

A. Yes.

Q. That way, she's not trying to take head nods or anything like that.

A. Right.

Q. So if you ever do that and I ask you is that a yes or no, I'm not trying to be rude. I'm simply just trying to make sure we have a record. Okay?

A. Okay.

Q. If at any point I ask you a question, and I probably will today, that is unclear or you don't understand, please bring that to my attention. I'll attempt to rephrase that. Okay?

A. Okay.

Q. But if you answer a question, I will assume you understood it. Is that fair?

A. That's fair.

Q. If I ask you a yes-or-no question, will you cooperate in providing a truthful answer to it?

A. Yes.

Q. Is there any reason today that you can't give truthful testimony: Bad night's sleep? You're on medication? Anything like that?

A. No.

Q. Other than speak with your attorney, what have you done to prepare for today's deposition?

A. That's it.

Q. Okay. Have you reviewed any documents?

A. I reviewed this document and this one (indicating).

Q. Okay. And the two documents you're referring to, it looks to be a handwritten statement?

A. Yes.

Q. And—

A. The Non Routine Restraint Use Report.

Q. Why did you look at those documents?

A. Those were the two documents that I had from the incident.

Q. Okay. Did you speak with anyone other than your attorney about today? Family members? Anyone?

A. No.

Q. Did you speak with anyone in the sheriff's department about your deposition today?

A. No.

Q. Okay. Have you ever been a party to a lawsuit before?

A. No.

Q. Okay. Are you married?

A. No.

Q. Okay. Do you have any children?

A. No.

Q. Okay. Tell me a little bit about your education. Where did you go to high school?

A. I went to Seaton High School.

Q. What year did you graduate?

A. 2011.

Q. And from Seaton, where did you go next? Did you attend college?

A. Yes.

Q. Okay. Where at?

A. University of Cincinnati.

Q. And did you graduate?

A. Yes.

Q. What years were you at UC?

A. 2011 to 2015.

Q. And what is your degree in?

A. Criminal justice.

Q. Associate's or bachelor's?

A. Bachelor's.

Q. And what drew you to criminal justice?

A. Sorry?

Q. What drew you to criminal justice?

A. It's just something I've always wanted to do.

Q. Okay. Was the plan always to go-

A. Since I was little.

Q. Since you were little?

A. Yes. Since high school at least.

Q. After you graduated, did you immediately start working?

A. Not in criminal justice, but yes.

Q. Where was your first job after college?

A. It was at, I think, Dick's Sporting Goods.

Q. Okay. When did you work—from when to when did you work at Dick's?

A. I worked there from August of '15 to December, maybe.

Q. Okay. And what role were you in at Dick's Sporting Goods?

A. Just a sales associate.

Q. Okay. Were you at the Kenwood location?

A. No, West Side one.

Q. Okay. Where on the West Side is that?

A. Glenway Avenue.

Q. And where did you go after Dick's Sporting Goods?

A. I was a student aide for Delhi Middle School.

Q. From when to when?

A. That was only for about a month, month and a half. January.

Q. Okay. Where did you go after that?

A. I worked at a law firm and was an affidavits processor.

Q. What was the name of that law firm?

A. Something Van Ess and Barragate, Phillips and Barragate. I only worked there for like four or five months, and then I started at the sheriff's office.

Q. So that would have been about February—

A. Till May or June. May, June.

Q. And you said you were an affidavit what?

A. Processor.

Q. Okay. Describe to me what you did as an affidavit processor.

A. It was mostly on the computer. We—I just filled out documents and sent it to my supervisor.

Q. Okay. What type of cases were you working on?

A. Foreclosures, I believe.

Q. All right. And then you said you started at the sheriff's office?

A. Yes.

Q. When was that?

A. Started in June 2016.

Q. And prior to starting at the sheriff's office, did you have to go through any particular schooling or training?

A. No.

Q. Have you done any peace officer training—

A. Yes.

Q. —or schooling?

A. Yeah. For—like, I started the—I started in June at the sheriff's office; and then in August, that's when I had the corrections academy.

Q. Okay. And when did you graduate from the corrections academy?

A. I want to say October of '16.

Q. Other than that graduation certificate, do you hold any other licenses or certificates?

A. The OPOTA certification, yes.

Q. And did you get that in October of '16?

A. No. I started in February 2018 on that and then graduated in December '18.

Q. And what role are you currently in at the sheriff's office?

A. Corrections officer.

Q. Have you been employed as a corrections officer for the entirety of your time with the sheriff's office?

A. Yes.

Q. And are there different roles that you play as a corrections officer within the jail? Do you do one specific thing?

A. No, not necessarily.

Q. Okay. Describe for me, if you can, sort of the roles that you take on at the sheriff's department.

A. It kind of differentiates each day. Like, whatever post I'm working that day has a different role.

Q. What are the different types of posts that you work on?

A. You can work on the housing units.

Q. Okay.

A. You can be a base operator, work in intake and process inmates into the jail.

Q. And describe for me the role of a housing officer. What do you do in that role?

A. You do security rounds, walk around the unit, do counts or chow, uniform exchange.

Q. Okay. What about a base officer?

A. Base is you control—or you have cameras to the whole building. So you control the doors and pretty much just viewing cameras all day.

Q. Okay. So if someone's in a hallway, they need to get somewhere, you'll see them on a camera and open that door?

A. Yeah. You don't have cameras—the cameras can change. It's not like there's every single camera on the screen. You can change it to different ones.

Q. Okay. And what about an intake or processing officer? Describe for me those roles.

A. Intake, you could be a female search officer. When inmates or prisoners come into the jail, you search them and their property, or you can be back in IDENT, which is pictures and prints. You could be—do releases of prisoners. That's it. That's what I've done in intake.

Q. Okay. Are there any other roles that you haven't played but that are available at the jail? And when I say—let me just say that when I say jail, I mean the Hamilton County Justice Center. Okay?

A. Okay.

Q. Are there any other roles that officers play at the jail other than the three that you've just described?

A. Yeah. The vocal control officer.

Q. Okay.

A. The ones that control the booth. They control the doors of that unit, the computer, answer the phone, that type of thing.

Q. And are they in each particular housing unit?

A. Yes.

Q. Okay. In which of these roles would someone be responsible for looking over an inmate who was in a restraint chair?

A. Usually the suicide watch officer.

Q. Okay. So is that another specific role?

A. Only on—yeah, on the female unit, and then the psyche unit for guys.

Q. So there is a specific officer who is assigned on the female side to the suicide—

A. Watching restraint chair people, yes.

Q. And on the male side, it's in the psyche department?

A. Yes.

Q. Have you ever performed duties as a suicide watch officer?

A. Yes.

Q. I think I know the answer to this, but have you ever performed suicide watch duties in the psyche department?

A. No.

Q. Okay. Only male officers would work in the psyche department?

A. Yes.

Q. Does the sheriff's department have a policies and procedures manual?

A. Yes.

Q. Why is that in place?

A. To give us guidelines on what we should do and should not do.

Q. Who orders them?

A. Our compliance department, I assume.

Q. They're all signed off on by the—ultimately by the—

A. By the sheriff.

Q. —sheriff, correct?

A. Correct.

Q. Are you knowledgeable about the policies and procedures of the sheriff's department?

A. Yes. I've looked at them.

Q. Are you expected to follow them?

A. Yes.

Q. How did you learn about them?

A. Through the corrections academy, you have some policy and procedures that we go over, and you have to sign off on them.

Q. And that corrections academy, is that run by the Hamilton County Sheriff's Department?

A. Yes.

Q. So they're teaching you jail-specific policies and procedures?

A. Yes.

Q. Other than the corrections academy, are you provided any refresher courses on the policies and procedures?

A. They'll—they'll send out some emails about—like, if anything changes in it—in the policy that we have to sign off—we have to read and sign off on.

Q. But only changes. So there's not, like, yearly, you don't have a test—

A. No.

Q. —on "Tell me what this policy is"?

A. No.

Q. Are you ever permitted to disregard a policy and procedure of the jail?

MR. WELCH: Objection. You can answer if you can.

A. I'm not sure.

Q. Okay. Why are you not sure? Was the question confusing?

A. Yeah. Can you ask it again?

Q. Yeah. So if the jail has a policy and procedure which says X, are you ever not permitted to follow that policy and procedure?

MR. WELCH: Same objection. You can answer. If you understand the question, go ahead.

A. I guess some of them you can use your own discretion on—on some policies.

Q. Can you give me an example of a policy that permits you to use your discretion?

A. I can't think of one.

Q. Okay. Can you be disciplined for failing to follow a policy and procedure of the jail?

A. Yes.

Q. Should you be disciplined for failing to follow the policies and procedures of the jail?

MR. WELCH: Objection. Go ahead.

A. It depends—it's—I guess it depends case by case.

Q. Can you give me an example of a time when you failed to follow a policy and weren't disciplined?

A. No.

Q. Have you ever had any disciplinary write-ups since you've been with the sheriff's office?

MR. WELCH: Objection. You can answer.

THE WITNESS: I can?

MR. WELCH: You can answer, yes.

A. I've had, I think, one write-up before.

Q. Do you remember—

A. Or it was just a written . . . I don't even know what they called it.

Q. Do you remember what it was about?

A. It was about an inmate that walked out of the medical tank. Somebody had left it propped open, and he walked out. He was—I had thought he was the porter. The porters go around and collect trash and stuff. So I thought that was him, but he walked out that front tank and walked

down the hallway. So it was my fault because the door wasn't secured.

Q. Okay. Is there a policy and procedure at the jail about securing the doors so that that doesn't happen?

A. I'm not sure.

Q. Okay. Are there any rules and regulations at the jail which are not contained in the policies and procedures manual?

A. Say that again.

Q. Yeah. Are there any rules that you're expected to follow at the jail that aren't in a policies and procedures manual?

A. Not that I know of.

Q. Would you agree that the policies and procedures of the jail are designed for the safe and orderly operation of it?

A. Yes.

Q. To protect you as employees of the sheriff's office?

A. Yes.

Q. To protect contractors within—working within the jail?

A. Yes.

Q. Inmates?

A. Yes.

Q. And anyone else who might be in the jail?

A. Yes.

(Plaintiff's Exhibit 1 marked.)

Q. I am going to hand you what I've marked as Plaintiff's Exhibit 1. And when I hand you things, please feel free to take as much time as you need to look at it.

Does this appear to be the policies and procedures concerning contract employees at the jail?

A. Yes.

Q. Are you knowledgeable about this policy and procedure?

A. Not really.

Q. Why is that?

A. I'm sure I looked over it before, but I don't know it, like, verbatim.

Q. And that's fair. But you'd be expected to follow it, correct?

A. Correct.

Q. Was this policy in place, to the best of your knowledge, in December of 2018?

A. I assume so.

Q. At the top, you see a date revised—

A. Yes.

Q. —of January 20th of 2016. Are you aware or do you recall any policy which revokes or amends that?

A. Not that I know of.

Q. So you don't ever remember getting an email saying the policy with respect to contract employees has changed?

A. No.

Q. Okay. So if you look there in the second paragraph down where it says, Policy, do you see that?

A. (Witness nodded.)

Q. The second sentence in says that all contract employees shall remain under the authority and work at the discretion of the sheriff. What does that mean?

A. I guess that all contract employees should follow our policies and procedures.

Q. Okay. Does this policy give you the ability to overrule something that a contractor is doing?

MR. WELCH: Objection. Go ahead. You can answer if you can.

A. Probably not myself but maybe my supervisor.

Q. Okay. Who would your supervisor be?

A. My sergeant.

Q. And if you see down there under Definition, it says, Contract Employee. You would agree that that includes medical professionals at the jail, correct?

A. Correct.

MR. WELCH: Objection. Go ahead.

A. Yes.

(Plaintiff's Exhibit 2 marked.)

Q. I'm going to hand you what I've marked as Exhibit 2. Have you had a chance to look at Exhibit 2?

A. Yes.

Q. Okay. And would you agree that it's a policy and procedure of the Hamilton County Sheriff's Office concerning the use of restraints?

A. Yes.

Q. Are you knowledgeable about this policy and procedure?

A. Yes.

Q. How and when were you taught this policy?

A. I was probably taught in the corrections academy. This is one that we went over.

Q. In order to get your OPOTA certification, did you review or get any refresher courses on the use of restraints?

A. Not for the corrections officer—or not for Hamilton County Sheriff's Office. That's separate.

Q. So the only time you would have learned about this particular policy was while you were in the corrections academy between August and October of 2016?

A. Correct.

Q. Okay. Since you graduated from the corrections academy, have you had any refresher courses on this policy?

A. I mean, they sent this out to review—or to—for revision, but not that I—I don't remember.

Q. No specific class?

A. Not that I remember.

Q. Okay. And when they send out these amendments or revisions to the policy, what is the protocol that you take saying that, yes, I've seen this and I know it? How does that work?

A. It's a link on our email with a copy of the policy, and then you just click off—there's a—I don't know—a box to click that you've read and understand the policy.

Q. Other than clicking that box to say, yes, I've read the policy, are there any other methods that the sheriff's office takes to verify that you have, in fact, read the policy?

A. No, I don't think so.

Q. You don't ever take a test on, hey, sit down and tell me what the policy is on use of restraints?

A. No.

Q. To the best of your knowledge, was this policy in place in December of 2018?

A. Yeah.

Q. Are you aware of any policy since December of 2018 which revokes this policy?

A. Not that I know of.

Q. What about amends the policy?

A. I don't think so.

Q. So if you go there to that second paragraph, it talks about policies. It indicates that it's the policy of the Hamilton County Sheriff's Office,

Jail Service, to use restraining devices as a precaution against escape or to protect an inmate from injuring themselves or others as well as to prevent property damage within the Hamilton County Corrections System.

Did I read that correctly?

A. Correct.

Q. Are you aware of any other basis upon which you could utilize restraints at the jail?

A. Any type of restraint?

Q. Yeah.

A. Like handcuffs?

Q. Yes.

A. If somebody is suicidal, usually handcuff them in the front and take them on suicide watch. If there's a fight, you handcuff them and take them to medical.

Q. So let's touch on suicide watch. Is suicide watch not contained within precaution against escape or to protect an inmate from injuring themselves or others or to prevent property damage?

A. Like I said, it's to protect them from injuring themselves.

Q. Okay. And then you also talked about if there's a fight. Is that also encompassed within the policy?

A. Yeah, from protecting them from injuring others.

Q. Okay. So any other reason other than what we've just talked about that you would be permitted to utilize restraints?

A. I don't think so.

Q. Okay. And if you look down under Procedural Guidelines at Roman numeral I, the second-to-last sentence says that restraining devices shall only be used when one of these criterion have been met and applied only when absolutely necessary.

What is your understanding of absolutely necessary?

A. When they're—if the inmate is harming themselves or others. I don't really know. (Reading) Restraining devices . . . Oh, it's like—that's like the last means of restraint—or . . . It's only necessary . . . I don't know.

Q. It's okay. I'm not trying to trick you. I promise. But is it fair to say that restraining devices are sort of a last resort?

A. Yes.

Q. So before you choose to restrain an inmate, you are expected to try other means to calm them down or deescalate the situation; is that fair to say?

A. Yes.

Q. So if you go down to Roman numeral II, letter A, it talks about routine transportation and the utilizing of restraints for routine transportation. Is that something like someone's going to court?

A. Yes.

Q. Things where if you're moving an inmate, they've got to be restrained?

A. Yes.

Q. Okay. So as I understand it—and let me read the policy—that when restraints are used for other than routine transportation or routine security, such as after an inmate fight or disturbance, the shift supervisor must approve their use.

Explain situations when a shift supervisor is required to approve the use of a restraint device.

A. I would say going in the restraint chair, we always notify our supervisor about what's going on.

Q. And as I understand it, before an inmate can go into the restraint chair, your supervisor would have to approve of that; is that fair to say?

A. Yes. He's usually the one that makes the overall decision of that.

Q. Okay. So you as a corrections officer, do you have the authority to order an inmate into a restraint chair?

A. If they're being extremely aggressive or disruptive, I believe I can make the decision to put them in there, but I have to notify my supervisor.

Q. And does your supervisor then ultimately have to sign off and say, yes, I agree with your decision to do this?

A. Yes.

Q. In practice, how does that play out? So let's say that you decide, you know, an inmate needs to go into a restraint chair. What happens next?

A. I'll notify my supervisor and have him come to where I'm at and assess the situation.

Q. Okay. And how quickly after the inmate is put into the restraint chair is that supervisor supposed to come and assess the situation?

A. He's usually already there. Like, if I call him before we put somebody in the chair, he's there.

Q. Okay. What about if they're not there when the inmate's put in the restraint chair?

A. It's usually within minutes that they come onto the post.

Q. And what happens after they come onto the post?

A. (No response.)

Q. The inmate's in the restraint chair. They either say, yes, they can stay, or no, they can't?

A. What do you mean?

Q. So you've put an inmate in a restraint chair. You've notified your supervisor. Your supervisor has come to where the inmate is restrained. What happens next?

A. Medical checks the restraints, and we just start our log of them being in the restraint chair.

Q. We'll talk about some of that here in a second. So if you can flip the page to Roman numeral III, letter A. It says, Types of Security Restraints. Do you see that?

A. Yes.

Q. It lists numerically, number 1, Handcuffs; 2, Belly belt; 3, Leg irons; 4, Restraint chair; and 5, Stun-Cuffs.

Is it fair to say that's sort of an escalation of restraints starting with handcuffs being the least restrictive going to Stun-Cuffs as the most restrictive?

A. Yeah.

Q. So before, let's say, you put someone in a belly belt, would you have to make the determination that handcuffs would not be sufficient to restrain the inmate?

A. Yes.

Q. Same thing with leg irons; if you're putting someone in leg irons, do you have to feel confident that handcuffs and belly belts would not be sufficient to restrain the inmate?

A. You don't always have to have the belly belt to put leg irons on somebody.

Q. So those two are sort of synonymous with one another; you could do one or the other?

A. Yeah.

Q. What about the restraint chair? Before you put someone in a restraint chair, do you need to feel confident that they could not be restrained by any of the first three?

A. Yeah, but they may already be in handcuffs when they go in the restraint chair.

Q. Okay. So if you can turn to page 3. You see Roman numeral VI there talks about the restraint chair. And in letter A, the last sentence of that first paragraph says that the use of the restraint chair must be authorized by the mental health, slash, medical staff or security supervisor for one of the following reasons.

As I read that, it seems like there is a custodial reason for putting someone in a restraint chair and a medical basis for putting someone in a restraint chair. Is that fair to say?

A. Yes.

Q. What's the difference between the two?

A. I guess medical, if they're not—like, to prevent themselves from harming themselves for—I'm not really sure why medical would put somebody . . . Like, being uncooperative and being disorderly, but that goes into, you said, the custodial aspect of it, corrections side of it.

Q. Okay. So there may be a medical reason—you can't think of a medical reason to put someone in a restraint chair; is that fair to say?

MR. WELCH: Objection. She's not a medical person, but go ahead. You can answer.

A. I'm not sure. I don't . . . I'm not—I don't know. I don't know medical's policy of why they put someone—would restrain somebody into the restraint chair.

Q. Under this policy, not all use of the restraint chair is custodial; is that fair to say?

A. That's what it says, yes.

Q. Okay. And who can order a custodial use of a restraint chair?

A. Security supervisor.

Q. And you talked a little bit earlier about, you know, your sergeant needed to sign off on that. Is there a certain level at which you are a security supervisor at the jail?

A. It could be a sergeant, lieutenant.

Q. Okay. But as you understand the policy, only those individuals can order a restraint chair?

A. It says on here that . . . (Examining document.) If there's an urgent need for a person uncontrollably violent, a deputy may decide when to apply restraints.

Q. Okay. But as we talked about earlier, it—I think you gave the example that if you were to order someone because there was that urgent need, you would still need to go to your supervisor to get approval for the inmate to remain in there, correct?

A. Correct.

Q. Do you know who can order—who on the medical staff can order an inmate in a restraint chair?

A. I don't know who. I assume any nurse or anybody in medical staff. It doesn't specifically say.

Q. NaphCare is the—do you know who the medical provider is for the jail?

A. NaphCare.

Q. Have you ever seen their policies and procedures?

A. No.

Q. Under letter A on this policy, it talks about the use of restraint chairs for the following reasons, and I'm going to read those. To prevent self-injury, injury to others, or property damage; display of extremely aggressive or disruptive behavior; and 3, when other approved techniques for control have proven unsuccessful.

Are you aware of any other justification for placing an inmate in a restraint chair?

A. No, not that I know of, not that I can think of.

Q. Would you agree that the use of the restraint chair is one of the most restrictive forms of restraints?

A. Yes.

Q. Is the goal when you put an inmate in a restraint chair to get them out as soon as their conduct warrants?

A. Yes.

Q. So on letter B, it says that upon placement in the restraint chair, a member of the health trained staff must examine the inmate every 10 minutes.

Do you know what health trained staff means?

A. I would assume NaphCare.

Q. There aren't any—or are there any individuals working within the jail system that have a health training designation, to your knowledge?

A. Mental health—I think mental health and medical. Are they both under NaphCare?

Q. And I'm—

MR. WELCH: You just tell them what you know. If you don't know, you can say you don't know.

Q. And from your answer, I don't think that my question was clear. So I'm asking specifically about sheriff employees. So any other corrections officer have a designation as being health trained?

A. No.

Q. When it says, B, that they examine the inmate every 10 minutes, is that your understanding of the responsibilities, though, of the jail staff, to look at the inmate every 10 minutes?

A. Yes.

Q. What are you supposed to do during those 10-minute observations?

A. You're supposed to document on the paper—or observe what that individual's doing in the restraint chair, just the overall what—if they're doing anything specific—yelling or anything like that.

Q. Are you expected to go into the cell where they are restrained?

A. It's different for the guys—the guy unit and the female unit. Female unit, when they're in the restraint chair, they're just sitting out in the pod with us. So for the guy unit, I'm not sure what their—what they did because they had a cell for the restraint chair. The females did not.

Q. And during these observations, are you attempting to determine if they still meet the criteria for being in the chair?

A. Yes.

Q. If they're no longer exhibiting any of the behaviors that are described in this policy, should they be considered for removal from the chair?

MR. WELCH: Objection. Go ahead.

A. Yes.

Q. How does that process work? If you're observing an inmate and they're no longer engaging in the behaviors described in this policy, what do you do?

A. Notify my supervisor.

Q. Okay. Can you make the determination alone to remove them from the restraint chair?

A. No.

Q. It has to be the supervisor—

A. I can recommend it to my supervisor, but he'll make the call whether to take them out or not.

Q. To your knowledge, is there a minimum amount of time someone has to stay in the restraint chair?

A. No.

Q. Is there a maximum amount of time they're allowed to stay in the restraint chair?

A. No.

Q. But ultimately, the amount of time that they spend in the restraint chair is dictated by their behavior?

A. Correct.

Q. If someone is sleeping in a restraint chair, can they meet the criteria described in this policy?

MR. WELCH: Objection.

Q. You can answer.

MR. WELCH: Do you understand the question?

A. Ask it again.

Q. Okay. Let me go through each of these specifically. One of the reasons set forth in the policy and procedure for keeping an inmate or putting an inmate in the restraint chair is to prevent self-injury, injury to others, or property damage; is that correct?

A. Correct.

Q. If they're sleeping, can they be a danger for self-injury, injury to others, or property damage?

MR. WELCH: Objection. Go ahead.

A. If they wake up and they can—they can continue that behavior right when they wake up.

Q. But at that moment, they're not engaging in any of that behavior if they're sleeping, right?

A. Yeah. Right.

Q. Is it necessary to keep a sleeping inmate in a restraint chair?

MR. WELCH: Objection. Go ahead. You can answer.

A. It all depends on the situation. Each situation's different.

Q. What would be a situation where it would be appropriate to keep an inmate who's sleeping in a restraint chair?

A. I mean, if they were harming themselves or others beforehand and they fall asleep right away, say they're just drunk and they just fall asleep, they might still—they can wake up and still be combative.

Q. Okay.

A. Or if they're harming themselves, then you might keep them in the chair to prevent themselves from, like, cutting themselves or doing any harm.

Q. So talk me through, then, how you make those determinations during that 10-minute observation cycle while an inmate's sleeping.

A. I'm confused.

Q. You talked about if someone could be combative when you wake them up. So how if they're sleeping do you assess whether they need to stay in the chair or not?

A. You—I guess you don't determine it when they're sleeping. It's really when they are awake. You can determine if they are ready to come out or still have to be in the chair. But if they are sleeping, I would just say they're sleeping.

Q. Do you notify a supervisor when they're sleeping?

A. Not necessarily.

Q. Why not?

A. I was never told that you have to notify them if they're sleeping in the chair.

Q. In your experience, would you keep an inmate who's sleeping in a restraint chair?

A. Yes. Yes and no. I mean, there's been times when inmates are sleeping in the restraint chair, they'll sleep for a little bit and I keep them in there. It's not like I take them out right away just because they fall asleep.

Q. So you wait for them to wake up to assess their behavior; is that fair?

A. Not all the time. Sometimes they'll be sleeping for a while, and if they—everything seems okay, I'll notify my supervisor and say, She's been quiet for a while. Might be time to take her out. And he'll come talk to her, or I'll wake her up and try to talk to her, Are you ready to come out of the chair, and then we'll proceed.

Q. Is there a certain time limit on sleeping before you make that—

A. Not necessarily.

Q. So it could be 10 minutes? It could be three hours?

A. I don't think I've ever let somebody sleep in the chair for three hours, but I don't . . .

Q. Okay.

A. But there's no time—no. No time.

Q. So going back to this policy, the second basis for someone to be in a restraint chair is if they dis-

play extremely aggressive or disruptive behavior. So my question is, when sleeping, can they display aggressive or disruptive behavior?

A. No.

Q. Okay. And the third is when other approve—I assume it means approved—techniques for control have proven unsuccessful.

When someone is sleeping, are you trying any other form of restraint?

A. No.

Q. So it talks about—you talked a little bit earlier about logging their activities.

A. Mm-hmm.

Q. What specifically are you taught to put when logging those activities?

A. I've never really been taught what to write. You just—whatever you observe, you kind of jot down. There's only a small space for you to write anything.

Q. Would you agree that you would want to be as descriptive as possible about what the inmate is doing?

MR. WELCH: Objection. Go ahead.

A. Yeah. Like, if they're—if they're yelling or making threats, I'll jot that down.

Q. What if they're just sitting there?

A. Then I can jot that down as well.

Q. How would you describe if someone was just sitting there?

A. Sitting in the chair.

Q. To your knowledge of this policy, is writing "chair" sufficient?

A. (No response.)

Q. Is that a sufficient description of what the inmate's doing?

MR. WELCH: Objection. You can go ahead.

A. I mean, according to policy, it says they shall detail the inmate's activities while in the restraint chair. So I would say "chair" is not sufficient enough . . .

Q. Okay.

A. . . . to say their activities.

Q. Okay.

A. But they are sitting in the chair.

Q. So if you look down at D, it talks about exercising each limb at least 10 minutes every two hours. Who conducts the exercise of the limbs?

A. The officer that's observing the inmate in the chair.

Q. And can that policy or practice be ignored?

A. Yes.

MR. WELCH: Objection. Go ahead.

Q. How so?

A. It depends on the inmate's behavior.

Q. So if the inmate is still displaying the behaviors we talked about, they don't necessarily need to be exercised?

A. Correct.

Q. Okay. But at least every two hours, you should be considered for the exercise, correct?

A. Correct.

Q. If someone is sleeping, would you still offer them exercise at the two-hour mark?

A. Sometimes you don't want to wake them up because you don't want—so I don't know. It would—I would consider it, but you don't—I really don't want to disturb them. They're sleeping. You just leave them alone.

Q. Is that sort of the policy of the jail with respect to inmates who are sleeping in a restraint chair: You just sort of let them sleep?

MR. WELCH: Objection. Go ahead.

A. Yes, kind of, yeah.

Q. So if you look down at letter E, it talks about inmates must be afforded the opportunity to use the restroom facilities and have access to fresh drinking water. How often is that supposed to happen?

A. I don't know if there's a time that that has to happen. You just—once—to use the restroom, I mean, they have to be compliant enough to go and use the restroom. We just offer them the restroom and water. It's not like I have to give it to them.

Q. Okay.

A. It depends on their behavior. I don't want to give somebody water if they're going to spit it out at me.

Q. So again, it's largely behaviorally driven?

A. Yes.

Q. Let's go to the exercise piece. At the two-hour mark, does a supervisor need to be notified to say, yes, I've offered this person exercise or—

A. Yeah, I would notify him.

Q. Okay. Would there be any type of written record of that notification?

A. I don't think so.

Q. All right. So down at letter F, it says that the restrained inmate must be considered for removal from the restraint chair at least hourly.

What does that hourly consideration entail?

A. What do you mean?

Q. What happens at the one-hour mark if an inmate is in a restraint chair?

A. I mean, if they're still being uncooperative, then you would continue the—to keep them in the chair. If they seem to be cooled down and everything is okay, then I'll consider taking them out of the restraint chair or call my supervisor to talk to them.

Q. So that's what I want to ask next.

Is this consideration one that is only made by the officer who is observing the inmate?

A. I would say so.

Q. So at the one-hour mark, you wouldn't necessarily need to call a supervisor to come down and say, What should we do with this inmate?

A. No.

Q. It's ultimately the officer who's observing them that is making that determination—

A. Yes.

Q. —that they should be considered or not?

A. Yes.

Q. So if you turn to the last page. Letter G talks about—it says that the medical staff will check all inmates in the restraint chairs every two hours.

To your knowledge, is that the only time medical is supposed to look at these inmates in a restraint chair?

A. I don't know.

Q. In practice, does that happen at the two-hour mark?

A. Yes, I would say so.

Q. Every time?

A. I don't know every time. I don't know.

Q. Whose responsibility at the two-hour mark is it to ensure that medical comes to look at the inmate?

A. Can you say that again?

Q. Yeah. So if you're watching an inmate and it gets to the two-hour mark, is it your responsibility to make sure that medical then comes and looks at that inmate?

A. No.

MR. WELCH: Objection. Go ahead.

A. No.

Q. So medical is just supposed to come?

A. Yes.

Q. Okay. Does medical get notified when someone gets placed in a restraint chair?

A. Yes.

Q. To your knowledge, do they keep any type of log about what's happening?

A. I don't know.

Q. Okay. So down to letter H. It talks about the use of physical restraints shall be reviewed and signed off by a non-involved supervisor or higher ranking personnel and reviewed for less restrictive alternatives. Talk to me about what that means.

A. So if somebody, I guess, writes an incident report about somebody going in the restraint chair, a non-involved supervisor—so not the one that, I guess, initiated him or her to go in the chair—would review it. I'm not sure what reviewed for less restrictive alternatives means.

Q. Okay. But you talked about earlier, you know, you put someone in a restraint chair, usually the supervisor is right there or is there in a matter of minutes. Do you recall that discussion?

A. Yes.

Q. So under this policy, that supervisor would not be the person who ultimately signs off on the use of—

A. I thought they were. But per this policy, it says not involved.

Q. Okay. In practice, does a non-involved supervisor get involved in the use of restraint chairs?

A. Can you say that again?

Q. Yeah. In your experience, do non-involved supervisors ultimately sign off on the use of restraint chairs?

A. Not that I know of. I don't really—once I type the report, it goes off to them. I don't know what happens, who signs off on it.

Q. How frequently is the restraint chair utilized at the jail?

A. It's hard—I can't really say how many times it's used, but—

Q. And that's fair. Is it used weekly?

A. Probably.

Q. Daily?

A. I'm not sure.

Q. Okay.

A. I don't work every single day, so I don't know. But it's used often.

Q. Okay. And as I'm sure you're aware, Mr. Howell was found deceased in a restraint chair. Are you aware of that?

A. Yes.

Q. Other than Mr. Howell, are you aware of any other inmate at the jail who was found deceased in a restraint chair?

MR. WELCH: Objection. You can answer if you know.

A. I don't know. To my experience, no, I don't think anybody has been found dead.

Q. Other than—

A. Other than.

Q. —Mr. Howell?

A. Yes.

(Plaintiff's Exhibit 3 marked.)

Q. I'll hand you what's been marked as Plaintiff's Exhibit 3. And can you describe for me what this is?

A. This is the briefing information from Major Ketteman.

Q. So when we talked about earlier, you know, if there's revisions to the policy they'll come out via email, is this an example of something that would have come out in an email about a policy revision?

A. Yeah. It says, Restraint Chair Policy Updates.

Q. Were you aware of this?

A. I'm sure. It's been so long, though, I don't specifically remember this email.

Q. Is this how policy updates would be communicated to the staff?

A. I don't think every time, no. Sometimes we get a separate email with just a link to click on. It's not in our briefing notes all the time.

Q. So the briefing notes, is that something you are physically given?

A. No.

Q. Okay. How do you get the briefing notes?

A. You may attend briefing—it used to be Monday, Wednesday, Friday. You would have to attend one of those days.

Q. Okay. What's the—

A. And the—

Q. —policy? I'm sorry. Go ahead.

A. The supervisor just goes over the briefing notes, and you sign that you were there.

Q. You were in attendance?

A. Yes.

Q. Okay. You said it used to be Monday, Wednesday, Friday. What is the policy—how frequently does it happen now?

A. I assume it's still the same. We switched to 12-hour shifts, so I assume it's still Monday, Wednesday, Friday. I attend.

Q. Okay. So during those briefing sessions, you would have been told about this restraint chair policy update?

A. Yes.

Q. Okay. To your knowledge, why was this update necessary?

MR. WELCH: I'll object. You can answer that question, but let me just put on the record in terms of Plaintiff's Exhibit 3, I do want to object to any and all questions regarding Exhibit 3 just based on the date of the update, January 11, 2019.

But with that objection, you can answer if you know. You might have to repeat the question.

A. What was your question?

Q. Why was this update to the restraint chair policy necessary?

MR. WELCH: Objection. Answer if you know.

A. I really don't know. I assume because of the incident with Mr. Howell.

Q. What do you understand to be the changes to the policy that are contained in this Exhibit 3?

A. It says, Male inmates in a restraint chair will be placed in B Pod on George 21.

Q. Okay. What—

A. They used to be in A Pod.

Q. What's the difference between A and B Pod?

A. It's just two different—two different pods separated by a wall.

Q. Is there any—

A. I don't know what—for the guys' side, I really don't know what . . .

Q. Okay.

A. Suicide watch is in B Pod for them.

Q. Okay. So going down to that third, I'll call it a bullet point, it indicates that when an inmate is in the restraint chair due to his—and is due his/her two-hour limb rotation, the building supervisor will be notified. The supervisor shall respond to the location to verify the limb rotation occurs and documented.

Why do you believe there was a change with respect to that policy?

MR. WELCH: Objection. I think she already said she didn't know. But if you know, you can answer.

A. I'm not sure.

Q. Was it explained to you during one—during your briefing sessions why this was the policy?

A. No, not that I remember.

Q. Prior to this—and you may have already answered this. But prior to this, at the two-hour mark was anyone from the supervisory staff coming to interact with the inmate in a restraint chair?

A. Yeah. I don't know if they were every single time, but I would say most the time you would have a supervisor come back and check on them. They knew that they were in the restraint chair.

Q. At the two-hour mark, somebody would come and assess them?

A. Around there, yeah.

Q. And it also says that medical will be checking on the inmate in the restraint chair every 15 minutes. Was that not happening prior to this briefing update?

MR. WELCH: Objection. Go ahead.

A. No.

Q. Okay.

A. They were not coming there every 15 minutes.

Q. How frequently were they coming?

A. I don't know.

Q. Were they coming at all?

A. I mean, if we called them up there, they would come up and look at them.

Q. But other than that, your experience with the medical staff is that they would not be observing an inmate when they were in the restraint chair?

MR. WELCH: Objection. Go ahead.

A. They would observe when they were put in the chair, and then sometimes they would come back up and check on them, but I don't know time frame or anything.

Q. It wasn't every time that they would be coming—

A. I don't know.

Q. —to check on them? It certainly wouldn't be every 10 minutes—

A. No.

Q. —is that fair?

A. That's fair.

MR. MCGRAW: Now would be a good time to take a break.

(A brief break was taken. Plaintiff's Exhibit 4 marked.)

Q. (By Mr. McGraw) Ms. Roettker, I'm going to hand you what I've marked as Exhibit 4. Is this one of the documents that you reviewed prior to your deposition here today?

A. Yes.

Q. Okay. Setting this aside for a second, what do you remember about Mr. Howell?

A. In regards to what?

Q. In regards to your interactions with him.

A. He came down to medical after an inmate fight. And I didn't really have much interaction with him because I wasn't out in the sallyport with him. I was controlling the booth at the time.

Q. Okay. So that was one of my questions. So you were not actually physically in—I think it's like a white and red floor—checkered floor. You were not actually out on the floor?

A. Correct.

Q. You were back inside of a control room?

A. Correct.

Q. Okay. Could you see what was going on?

A. Yeah, I could see. There's windows right there.

Q. Can you hear what's going on?

A. No.

Q. Okay.

A. I didn't.

Q. So going to your statement, you indicated that he repeatedly was falling out of the wheelchair. Describe for me what that looked like.

A. He was just—he was slipping out of the chair. He wasn't sitting up on his own.

Q. Okay. So did it appear to you that he was doing it intentionally?

A. I don't know.

Q. Did it look like he could physically hold himself up?

A. It appeared that way, yeah.

Q. Indicated that he eventually slipped out of the wheelchair onto the sallyport floor. Describe the circumstances of that.

A. Like, what? What do you mean?

Q. What proceeded him falling?

A. I have no idea. I wasn't out on the sallyport. I couldn't hear what was going on.

Q. But could you see what was happening?

A. (No response.)

Q. What do you recall seeing before he slipped out?

A. I don't remember.

Q. Okay. You indicated that he is whining in pain. Could you hear?

A. No. It just appeared—no, I couldn't hear him.

Q. Okay. How did you make the determination he was whining in pain, then?

A. It appeared to me that he was being uncooperative with medical staff. He wasn't doing what they were telling him to do when they were evaluating him, and he just visibly looked upset.

Q. But he looked like he was in pain; is that fair to say?

A. No, not really. I don't know if he was or wasn't.

Q. So let me ask you, then, why did you write "Whining in pain"?

MR. WELCH: Objection. I think she just said that. But go ahead.

A. He was whining in the aspect of just complaining. And that's normal after a fight. I don't know if he was in pain or not because I wasn't out there. I didn't hear him saying anything that he was in pain. By just dropping out of the wheelchair, I guess I made that assumption, but no.

Q. You indicate here that the decision was made by medical staff to have him placed in the restraint chair. Who on the medical staff made the decision, to your knowledge?

MR. HOJNOSKI: Objection.

A. I believe it was Christina. I wrote in the restraint chair report it was Christina.

Q. Okay. Slipping out of the restraint chair—or out of the wheelchair, is that abnormal in the medical area?

A. No.

Q. Okay. During the entirety of the time he was—before he was placed in the restraint chair, for the entirety of that time he was handcuffed, correct?

A. I don't remember.

Q. Okay. Was there any custodial justification for putting Mr. Howell in the restraint chair?

MR. WELCH: Objection. Go ahead. You can answer.

A. Like, supervisor present?

Q. Any custodial reason he was in the restraint chair?

A. What do you mean by custodial?

Q. Any from the custody staff?

A. Okay. Ask the question again.

Q. Was there any custodial justification for placing Mr. Howell in the restraint chair?

A. I don't remember. I wasn't—I couldn't hear anything out in the sallyport, so I don't know who—what they were talking about, who completely made the decision. I know Christina did from people telling me that.

Q. Okay.

A. She was the one that came and assessed, I believe.

Q. So when you write here that the decision was made by medical staff to have Howell placed in restraint chair, that's not information you heard firsthand; someone told you that's what happened, correct?

A. That medical staff, yeah.

Q. Prior to placing Mr. Howell in the restraint chair, are you aware of any less restrictive means which were considered?

A. I don't know.

Q. Did you ever hear him say that he had sickle cell disease?

A. No.

Q. Did anyone ever tell you that he had sickle cell disease?

A. No.

Q. Did you ever hear him say that he couldn't feel his back or legs?

A. No.

Q. Did anyone ever tell you that he said that?

A. No.

Q. To your knowledge, did anyone consider sending him to the hospital?

A. I'm not sure.

Q. The decision to place him in the restraint chair, did you agree with it?

MR. WELCH: Objection.

A. It wasn't my decision. It was medical. Medical observed him and thought it was necessary to place him into the chair, so . . .

Q. Okay. When medical makes that decision, does that change any of the officers' duties with respect to observation of Mr. Howell?

A. No.

Q. By that, I mean are they—if medical puts him in the chair, are you, as an officer, still required to look at him every 10 minutes?

A. Correct.

Q. Nothing changes from the policy on observation?

A. Correct.

Q. Okay. Was Mr. Howell at all resistant to efforts to place him in the restraint chair?

A. No, not to place him in the chair, no.

Q. Describe his conduct and behavior after he was placed in the restraint chair.

A. I don't know that.

Q. You couldn't see it?

A. He was taken down to psyche after that. Once he was placed in the chair, they directly take him down to psyche, and they observe him down there.

Q. How long between placing him in the chair and taking him out of the sallyport do you estimate that it was?

A. I don't know. I can't remember.

Q. Less than 5 minutes?

A. Less than 5 minutes.

(Plaintiff's Exhibit 5 marked.)

Q. Okay. I'm going to hand you Plaintiff's Exhibit 5. This appears to be a Non Routine Restraint Use Jail Incident Report; is that accurate?

A. Correct.

Q. Is this, too, one of the documents that you looked at before you came here today?

A. Correct.

Q. In the second-to-last sentence, it says, Per RN Christina Jordan, Howell was placed into the restraint chair for being uncooperative with medical staff. Is that your understanding of the basis with which he was placed into the restraint chair?

A. Yes.

Q. That he was uncooperative with medical staff?

MR. WELCH: Well, objection. Go ahead.

A. Yes, that's what I was told.

Q. Okay. Do you remember who told you that?

A. No.

Q. Earlier, we looked at the restraint chair policy. My question is where under the policy does uncooperative with medical staff fall for the basis of a restraint chair use?

MR. WELCH: I'll object, but you can answer if you can.

A. I'm not sure. If it was medical's decision to put him in the chair, they felt it was necessary to place him into that chair, so . . .

Q. So medical—to your knowledge, medical doesn't have to utilize these—the three bases for a restraint chair to place someone in it?

MR. WELCH: Objection.

A. I'm not sure.

Q. Okay. At the time he was placed in the restraint chair, did you believe it was necessary to prevent self-injury, injury to others, or property damage?

MR. WELCH: Objection.

A. I wasn't out in the sallyport, so I don't know what all was going on, what they were talking about.

Q. What you observed, did you believe it was to prevent self-injury?

A. I'm not sure.

Q. Injury to others?

A. He did just get in a fight, but I'm not sure.

Q. Who was the supervisor on duty on that night?

A. I believe Sergeant Hunt.

Q. Okay. And you—down here on Exhibit 5, it says, Sergeant Hunt on post. Was he in the sallyport the entire time that this was happening?

A. I believe so.

Q. Okay.

A. I can't remember exactly.

Q. On that night, to the best of your recollection, was Sergeant Hunt the person who should have checked on Mr. Howell at the two-hour mark?

A. I assume so. I mean, if he—he was the supervisor, so yes.

Q. Okay. Did he ultimately sign off on the use of the restraint chairs, to your knowledge?

MR. WELCH: Objection.

A. I'm not sure.

Q. Once this report, Exhibit 5, is generated, what is supposed to happen?

A. A supervisor signs off on it.

Q. Okay. At the bottom there, there's a place for an officer signature, supervisor's signature, inmate's signature. Is there a reason, to your knowledge, that these are unsigned by you or Sergeant Hunt?

A. I don't know why.

Q. Okay. But the policy—the practice would have been that Sergeant Hunt would have signed off on this, correct?

A. I don't know if they have to sign off on this paper. They sign off on the computer.

Q. Okay.

A. To my knowledge.

Q. Are you aware of anyone from the jail that considered Mr. Howell for alternative placement other than the restraint chair?

A. What do you mean?

Q. Do you know anyone who said, Maybe we should take this guy to the hospital?

A. I don't know because I didn't hear anything that was going on between them—him and medical staff and the other officers out there.

Q. What about after—did you have any interaction with Mr. Howell after he was placed in the restraint chair and taken out of the medical—

A. No.

(Plaintiff's Exhibit 6 marked.)

Q. I'm handing you Exhibit 6.

MR. WELCH: This is the log that they did when he was in the chair.

Q. Okay. Does this appear to be a standard Restraint Chair Form as utilized by the jail?

A. Yes.

Q. So we talked earlier that once an inmate is placed in a restraint chair, you guys start—you, as corrections officers, start this log, correct?

A. Correct.

Q. Okay. And the reason in the chair is something that you then would put on this piece of paper; is that correct?

A. Correct.

Q. Okay. And the reason here is again consistent with what Exhibit 5 was, is that he was uncooperative with medical, correct?

A. Correct.

MR. WELCH: Well, objection. You can answer.

A. Say the question again.

Q. Yeah. The stated reason on this form is that he was uncooperative with medical.

A. Oh. Yes.

Q. Would you agree? Yeah.

MR. WELCH: Well, the form does say for his safety, right? Doesn't it?

A. Yeah, Per medical uncooperative for his safety.

Q. Okay.

MR. WELCH: I mean, again, you can ask all the questions you want. I just wanted the record to be clear because you said the form says the reason for the chair is he was uncooperative. It does say a little bit more than that, but . . .

Q. And you see a one-hour log, a two-hour log, a three-hour log, and a four-hour log. And you agree that a lot of these—or would you agree that the vast majority of these just say chair?

A. Yes.

Q. Okay. And we talked earlier that in your mind, that's not sufficient documentation, correct?

MR. WELCH: Objection. You can go ahead and answer.

A. Like, I've written chair before. People—we've—there's a lot of people that do write chair. Like, I see—if they're physical—or actively doing something, that is when you can write—or you'll write observed behavior, what they're actively doing.

Q. Okay. So are you—

A. Like—go ahead.

Q. Are you changing your answer that chair wouldn't be a sufficient response?

A. No. I'm clarifying that. I think it—I think you took it wrong the way I said it earlier.

Q. Okay.

A. Because I know plenty of people that write chair. He's in the chair, she's in the chair, and just write chair.

Q. Okay. So in your mind, this is sufficient documentation of about what's going on?

A. Yeah.

Q. Okay. But again in the female side, you're physically interacting with that inmate, correct, whereas on the male side, they're in a cell?

A. Correct.

Q. And you've indicated that this is sufficient documentation of observations. Do you have—do you receive any specific training on filling out this form?

A. No.

Q. Had you ever received any training on filling out this form?

A. I mean, they've showed us the form before, how you write the time and stuff, but they don't really tell us what we need to write in it.

Q. When you say "they," who are you referring to?

A. I guess supervisors.

Q. Do you recall on December 9th, 2018, what role Brad Buchanan was playing?

A. No.

Q. Do you know if he was working—

A. I don't remember.

Q. —that evening? Okay. Do you utilize social media?

A. Yes.

Q. Have you ever on any social media site posted about the death of Mr. Howell?

A. No.

Q. Okay. Any of the events giving rise to his death?

A. No.

Q. Ever spoken with anyone and said, Boy, you won't believe what happened at work today?

A. Hmm-mm.

Q. Is that a no?

A. No.

MR. MCGRAW: I'm going to show—can we go off the record for a second?

(Off-the-record discussion, and
Plaintiff's Exhibit 7 marked.)

Q. (By Mr. McGraw) This will be Exhibit Number 7. So Ms. Roettker, I'm about to show you Exhibit Number 7. It is a DVD that I was provided by the sheriff's office which is titled North 42 Hallway. It's dated 12/9/18. It says, it looks like, EN2-085, 5:03:28 to 5:08:55 p.m.

I'm going to fast-forward this to roughly 5:06 p.m., and I'm going to let this play.

(Video playing.)

Q. So Ms. Roettker, can you describe for me where in the jail we're looking at right now?

A. It's on the fourth floor, the right side of the hallway if this is George 42.

Q. Okay. So where they just turned the corner, is that coming from a pod?

A. Sallyport.

Q. Sallyport. Outside of the—

A. Pod.

Q. —pod? Okay. What particular pod, if you know, would they have been coming out of there?

A. I don't know.

Q. Can you identify for me who these two officers are?

A. Deputy Adams is the one walking around. I don't know—I can't tell who the other one is.

Q. Is that Shane Adams?

A. Yes.

Q. Okay. He is the officer who is not interacting—was not interacting with the inmate?

A. Yes.

Q. Okay. I'm just going to let this continue to play. Are you able to tell there who that inmate was—or that—

A. Sanderson.

Q. Sanderson?

A. Deputy Sanderson, it looks like.

Q. Do you know Deputy Sanderson's first name?

A. Not for sure.

Q. Okay. I've seen a reference to a Deputy Itskin. Do you know who that is?

A. I know of him. I mean—I know of him.

Q. But that's not him on the video?

A. It doesn't look like it.

Q. Do you know who that deputy who just came out of the elevator is?

A. I can't tell.

Q. Okay. All right. So we're going to—the video is going to end here at the 17:08:54 mark.

(Video stopped.)

(Plaintiff's Exhibit 8 marked.)

Q. So the next Exhibit is Exhibit 8. It's labeled as Elevator, EN1-0065, 5:08:35 p.m. to 5:09:23 p.m., dated 12/9/18.

I'm going to play this video again, and I'm going to ask if you can identify the deputies in this video for me.

(Playing video.)

A. That's Shane Adams.

Q. To the right next to the elevator—

A. Control.

Q. —buttons?

A. Yes. And then Deputy Waters is . . .

Q. Waters?

A. (Nodded.)

Q. Do you know Deputy Waters' first name?

A. Ryan.

(Video stopped.)

(Plaintiff's Exhibit 9 marked.)

Q. So this will be Exhibit 9. It's labeled as G21 Medical, JC-267, 5:04:37 p.m. to 5:34:53 p.m., dated 12/9/18, and it indicates that it's a copy.

Deputy Sanderson, you said? Can you remind me of his first name?

A. (No response.)

Q. You don't know it?

A. For sure, no.

(Playing video.)

Q. So I started this video. Is what we're seeing depicted here, is that the medical sallyport?

A. Yes.

Q. Okay. To your knowledge, are there any cameras in the sallyport of medical other than the one from which we're looking right now?

A. There might be another one on the—like, that's one corner of the sallyport. And then the other corner, there might be one on that side.

Q. When you say other corner, do you see this blue chair and what looks like a blue sort of cork board?

A. Yeah.

Q. Would that be where the other camera was?

A. It would be not on—not against that wall. It's up, like, towards the ceiling.

Q. Okay. But you believe there may be another camera up there?

A. On that side, yeah.

Q. I'm going to fast-forward this to just before 5:14 p.m.

Where in relationship to the camera that we have right now are you located in the control room?

A. Inside—do you want me to point to it?

Q. Yeah, or if you could, describe where you are.

A. In . . .

Q. If you want to just—

A. I don't really know.

Q. Yeah.

A. It's like (indicating)—

Q. I'll try to describe it.

A. Like, inside that (indicating).

Q. So there's a desk with what looks like a blue chair to the side of it after you turn the corner, and you would be sort of behind that desk behind a glass wall? Is that—glass window?

A. Correct.

Q. Okay. All right. Can you identify who this bald individual is?

A. I can't tell. I can't see.

Q. Okay. Can you identify who any of those—

A. That might have been my supervisor.

Q. The bald individual?

A. Yeah.

Q. Sergeant Hunt?

A. Yes. I don't know. I can't tell for sure, but he did have stripes on his shirt.

Q. So I'm going to stop it here. Can you identify this individual in the white coat?

A. No, I can't tell.

(Playing video.)

Q. Can you identify this individual in the red pants?

A. No, I cannot tell.

Q. I'm going to fast-forward here to just before 5:18 p.m. and play. Can you recognize this individual in black pants and a blue top who just walked through?

A. No, I can't tell.

Q. Would that look like Christina Jordan?

A. I couldn't tell.

Q. Okay. I'm going to let it play for just a second to see if you can . . .

Do any of the cameras within this area of the jail have audio capabilities?

A. I don't know.

Q. And this individual, again, with the bald head, you believe that may be Sergeant Hunt?

A. Yeah.

Q. I'm just going to let this play out a little further. If you can see the African-American woman right there in the blue top with black pants . . .

A. It's so small, I can't really tell.

Q. Okay. Does it help at all now that . . .

A. I don't—I can't say 100 percent.

(Video stopped.)

Q. Okay. All right. So I only have a few follow-up questions for you. In the wake of Mr. Howell's death, you were interviewed by a jail investigator, correct?

A. I don't remember.

Q. Did you ever talk with a Detective Mike Stock?

A. I can't remember.

(Plaintiff's Exhibit 10 marked.)

Q. Okay. I'm handing you what's been marked as Exhibit 10. It appears to be a case summary written By Detective Mike Stock.

MR. WELCH: Is this 7?

MR. MCGRAW: 10.

Q. (By Mr. McGraw) So I'm going to ask you to turn to page 5. In the fourth-to-last paragraph, do you see where your name is referenced?

A. Yes.

Q. Okay. And I'll let you read that if you need to, but if Detective Stock is representing comments that you made or statements that you made, does this refresh your memory at all about talking with him?

A. Hold on. (Examining document.) Yeah, I vaguely remember talking to him.

Q. Okay. And it indicates here, written and taped statements. Is it customary to audio record these statements?

A. I don't know.

Q. Do you recall being audio recorded?

A. I think so. I can't say for sure.

MR. MCGRAW: I'm going go ahead and make a Rule 34 request for all of the audio tapes in conjunction with this investigation of Mr. Howell's death.

Ms. Roettker, if you'd just give me one second, that might be all the questions I have for you.

(A brief break was taken.)

MR. MCGRAW: Deputy Roettker, I don't have any more questions for you. Thank you for your time today. Mr. Hojnoski may have some questions. MR. HOJNOSKI: I do not.

MR. WELCH: We will reserve signature.

(Whereupon, signature was requested, and the deposition concluded at 11:58 a.m.)

_____

ASHLEY ROETTKER

HAMILTON COUNTY SHERIFFS OFFICE
POLICY AND PROCEDURE JAIL SERVICES
(USE OF RESTRAINTS)

Procedure No: C.8.

Subject: Use of Restraints

Effective Date: 10/01/1985

Date Revised: 02/05/2015, 03/15/2016, 02/12/2018

M.S.J.O. Section 5120: 1-8-03(B)(9)

PURPOSE:To provide specific information regarding the use of restraining devices in the Hamilton County Corrections System.

POLICY: It is the policy of the Hamilton County Sheriff's Office-Jail Service-to use restraining devices as a precaution against escape, or to protect an inmate from injuring themselves or others as well as to prevent property damage within the Hamilton County Corrections System.

PROCEDURAL GUIDELINES:

I. Restraining devices shall be used as a precaution against escape during transfer, to prevent an escape within the Hamilton County Corrections System, to protect an inmate from injury themselves or others, or to prevent an inmate from damaging property within the Hamilton Country Corrections System. Restraining devices shall only be used when one of these criterion have been met, and applied only when absolutely necessary. Restraining devices shall never be used as punishment or in a way to cause undue physical pain, or restrict the blood circulation or breathing, to an inmate.

II. Use of Restraints for Security Purposes

A. When restraints are used for other than routine transportation or routine security, such as after an inmate fight or disturbance, the shift supervisor must approve their use. The only exception would be if there is an immediate and urgent need to restrain a person uncontrollably violent to their self, others, or property. In this case, any deputy may decide when to apply restraints. All non-routine restraint incidents which do not require a use of force to restrain the inmate will require an incident report but not a use of force report. All non-routine restraint incidents that do require the staff to use force to restrain the inmate will require an incident report and use of force report. All of the above mentioned reports will be completed no later than the end of shift. The deputy(s) must notify the shift supervisor immediately of any non-routine incident that requires the use of restraints.

B. Those inmates who post an imminent threat of physical harm due to apparent mental problems shall be transported to the Mental Health unit for appropriate services as soon as possible. Female inmates will be seen on their post by the Mental Health Staff. Female inmates will not be taken to the Mental Health Office without supervisor permission. If circumstances prevent the immediate application of the Restraint Chair to transport the inmate to the Mental Health Unit, metal restraints may be used for the length of time necessary to control the inmate until the Restraint Chair can be utilized.

III. Types of Security Restraints

A. The following types of restraints are allowed to be used to train staff in the Hamilton County Corrections System:

1. Handcuffs
2. Belly Belt
3. Leg Irons
4. Restraint Chair
5. Stun-Cuffs (See Policy G.6.A.-Stun-Cuff)

IV. Use of Handcuffs

A. When placing handcuffs on a lone inmate, the handcuffs should be snug against the inmate's wrists, but not so tight as to stop the blood circulation or injure the either wrist. All handcuffs must be double-locked to prevent tightening of the restraints which might result in the restriction of blood flow. Lone inmates will be handcuffed with their wrists cuffed behind their body. One exception to this is if a female inmate has been confirmed to be pregnant by the medical staff. Another exception is if the inmate has a medical condition which does not allow the inmate to be handcuffed behind his/her back. If one of these exceptions is met, the inmate in question will be handcuffed in the front. The belly belt shall be used to help secure the inmate when handcuffed in the front for safety purposes.

V. Use of Leg Irons

A. Leg irons will be placed on a lone inmate, in addition to handcuffs, when appropriate. If handcuffs cannot be utilized, leg irons will be applied. All leg irons must be double locked to prevent tightening of the restraint which might restrict blood circulation.

When a female inmate has been confirmed by the medical staff to be pregnant, leg irons will not be used. The hands will be handcuffed in the front of the body as mentioned previously. If an injury prevents the use of leg irons, the hands will be handcuffed in the front of the body, if the use of handcuffs is possible.

NOTE-Inmate on Administrative Segregation shall be handcuffed and the use of leg irons will be administered in accordance with policy G.6.

VI. Restraint Chair

A. An inmate may be placed in the restraint chair when his/her behavior is so violent to themselves, or others, when unrestrained as to constitute a serious risk to the institution's security and good order. Use of the restraint chair must be authorized by the Mental Health/Medical Staff or Security Supervisor for one of the following reasons:

1. To prevent self-injury, injury to others, or property damage.

2. Display of extremely aggressive or disruptive behavior.

3. When other approve techniques for control have proven unsuccessful.

B. The restraint chair shall only be utilized in the appropriate mental health unit based on the gender of the inmate. Upon placement in the restraint chair, a member of the health trained staff must examine the inmate every ten (10) minutes. All such observations shall be logged on the suicide watch and restraint form.

C. All log entries shall be complete, noting the condition of the inmate and his/her activities at the time or any significant developments. Times and notes will be legible and accurate, and they shall detail the inmate(s) activities while in the restraint chair. Time in and out of the restraint chair must be noted on the suicide watch and restraint form and in the unit's daily log.

D. When inmates are restrained in the restraint chair, exercising each limb at least ten (10) minutes every two (2) hours is recommended to prevent blood clots. The behavior and cooperation of the inmate will be the determining factor when it becomes time to release one (1) limb at a time for the recommended exercise. This shall be documented on the Suicide Watch/Restraint Chair form.

E. The restrained inmate must be offered the opportunity to use the restroom facilities, and the restrained inmate shall have access to fresh drinking water. The behavior and cooperation of the inmate will be the determining factor when it becomes time to allow access to the restroom and drinking water.

F. The restrained inmate must be considered for removal from the restraint chair at least hourly but there is no minimum time an inmate can be restrained in the restraint chair. Mental Health/ Medical staff and the shift supervisor shall confer on when it would be appropriate for the inmate to be released from the restraint chair.

G. The medical staff will check all inmates in the restraint chair(s) every two (2) hours. When an inmate has been in the restraint chair for four (4)

hours the psychiatrist will be contacted further guidance.

H. Incident reports of the use of physical restraints shall be reviewed and signed off by a non-involved supervisor or higher ranking personnel and reviewed for less restrictive alternatives.

I. This use of physical restraints shall be reviewed for policy compliance by the Division Major or designee.

J. Prior to any inmate removed from the restraint chair, medical shall be notified by Jail Service Staff.

K. All non-routine restraint reports shall be signed by the deputy completing the report and a non-involved supervisor. The incident report will then be sent to the Administrative Captain or designee.

NOTE-The amount of time an inmate spends in the restraint chair will be dictated by the inmate's behavior. If an inmate continues to exhibit behavior that is self-injurious in anyway, it is the responsibility of all staff to keep the inmate safe. Keeping an inmate in the restraint chair for an extended period of time is a decision made by the Corrections Medical/Mental Health Staff to maintain safety for this inmate, not as a form of punishment.

VII. Woodburn and Reading Road

A. Inmates housed at Woodburn and Reading Road facilities will only be put in handcuffs and leg irons for transport. Once in handcuffs and leg irons Intake will be notified and the inmate will be transferred immediately. If more restrictive restraint is needed the inmate will be transported to the Hamilton

County Justice Center. See section VI of this policy for compliance.

Sherrif's Approval: /s/ Jim Neil

Date: 02/12/18

RESTRAINT CHAIR FORM

Inmate Name: Howell, Cornelius

1676106

Reason in Chair:

Per Medical uncooperative for his safety

Time placed in chair: 1740

On Watch: N

Time out of chair:

1 Hour 2 Hour

1740	In chair medical sallyport to N21	1900	Chair DM
50	Yelling in chair	10	Chair DM
1800	Yelling in chair	20	Chair MC
10	Chair DM	30	Chair MC
20	Chair DM	40	Chair MC
30	Chair DM	50	Chair MC
40	Chair DM		

Completion of 2 hours in chair

Was 10 minute limb rotation started: N

If unable to exercise limbs explain why:

Sleeping doesn't want.

3 Hour 4 Hour

2000	Chair DM	10	Chair MC
10	Chair DM	20	Chair MC

20	Chair DM	30	Chair MC
30	Chair DM	40	Chair MC
40	Chair MC	50	Chair MC
50	Chair MC		
2100	Chair MC		

Completion of 2 hours in chair

Was 10 minute limb rotation started:

If unable to exercise limbs explain why:

HAMILTON COUNTY SHERIFF
INVESTIGATION REPORT

Offense No. 1286018

Complainant: Cornelius Howell

Address: 1000 Sycamore Street (HCJC)

Type of Offense or Investigation:

Death Investigation

Date of Offense or Incident 12/09/18

-Details of Investigation-

On 12/09/18, at 2206 hours, Detectives Stock, Wissel, and Powers, along with Evidence Technician Sanderson, were directed by Lt. Stapleton to respond to the Hamilton County Justice Center for the report of an inmate death. Detectives arrived on scene at 2258 hours and were met by Sgt. Henn.

Investigators proceeded to the North Building, Psych Unit (G21). Present upon detective's arrival were Sgt. Timon, Sgt. Henn, Sgt. Hunt, and Capt. Kerr. The deceased was lying face up on floor in A pod. He was identified as Cornelius Howell, male, DOB of SSN ■■■■■ and extremely thin. He was incarcerated pending a criminal damaging and aggravated menacing charges. He was wearing and inmate uniform, plaid boxer shorts, and white socks.

Evidence Technician Sanderson photographed the scene. Detectives Stock, Wissel, and Powers began conducting interviews. Sgt. Hunt provided Detective Stock with a handwritten log. He identified the

nurses, who were on post, as Christina Jordan, Melissa Tucker, Ben Carl, Rose Kerrence, and Jen Carpenter. Sgt. Hunt identified the officers working the post as Erwin, Pierani, and Collini.

The times listed were as follows:

> 2145 — On post N21
> 2147 — G100
> 2148 — G100 on post
> 2150 — 911
> 2151 — Spence, Henn, Franklin
> 2154 — Lt. Buchanan no contact
> 2154 — Capt. Kerr contacted
> 2154 — Engine 3 Medic 3
> 2156 — CFD on post
> 2156 — Sgt. Timon calling D1
> 2157 — Assessment stopped on him
> 2205 — Medic 3 off post no transport
> 2211 — Engine 3 off post
> 2244 — Capt. Kerr on post

On December 10, 2018, at 0023 hours, Detectives Powers and Wissel conducted an interview of Corrections Officer Dominic Pierani at the Hamilton County Justice Center on floor 1-M of the North Building.

Deputy Pierani advised he has worked for the Hamilton County Sheriff's Office for 16 years all of which have been in the Corrections Division. He started his shift on 12/9/18 at 1500 hours working on North 21 (N-21), which is the mental health unit. His first post was acting as the suicide watch officer. He was to perform those duties until 1740 hours when he and the other two officers rotate posts. Deputy Pierani advised he did not switch at 1740 hours

because there was an inmate in medical being placed into the restraint chair. He responded to the medical unit (N-22) to assist in placing the inmate into the restraint chair. When he first arrived at the medical unit, he observed inmate Howell lying on his stomach on the floor in the sally port. Inmate Howell was complaining his back hurt and was moaning a lot. He did not complain of any other pain. Deputy Pierani assisted in placing inmate Howell into the restraint chair, while he was still handcuffed in the front. Deputy Pierani then removed the handcuff from inmate Howell who said "ow". Inmate Howell didn't complain of anything while being put in the restraint chair. Deputy Pierani advised inmate Howell complied with all verbal commands and no force was used to get him in the chair.

Deputy Pierani advised inmate Howell was then wheeled in the restraint chair down the main hallway to N-21 from N-22. Inmate Howell let out a few more moans, while being transported. Deputy Pierani advised after he chained the restraint chair to the wall in cell 6 he had no further contact with him until Sgt. Hunt came on post to remove him from the chair.

Sgt. Hunt came on post with Deputy Collini to remove inmate Howell from the restraint chair so he could be placed in cell 1. Inmate Howell was asked if he was ready to come out of the chair and he did not respond. Deputy Pierani then shook inmate Howell before giving him a sternum rub. There was no response by inmate Howell. Deputy Pierani then called a George 100 on the radio for medical to respond. Medical staff responded and felt inmate Howell's arm. They then requested he be removed

from the restraint chair. Sgt. Hunt and Deputies Pierani and Collini removed inmate Howell from the restraint chair. One of the nurses then began performing CPR. Deputy Pierani advised he did not know the nurse's name. He stood by in the pod and awaited further direction. Deputy Pierani advised additional officers arrived. Paramedics and firefighters arrived in the pod but did not perform life saving measures. One of the paramedics felt inmate Howell's arm and said it was cold before telling the medical staff to stop what they were doing.

Deputy Pierani advised he stayed around A-pod until he was dismissed and told to write a statement. He went into the mental health offices and wrote out a statement and had no further contact with inmate Howell.

Detective Wissel then showed Deputy Pierani a copy of the restraint chair form. He advised he did not fill any of it out. Deputy Pierani was then shown a copy of the daily report log for N-21. He verified at 1801 hours he made an entry of medical staff on housing unit. Deputy Pierani advised the medical staff was on post for med pass and it lasted about 15 to 20 minutes. The med pass was done by Nurse Pierette Arthur. Deputy Pierani confirmed his last entry into the log occurred at 2032 hours, and shortly after, he became the housing officer. Deputy Pierani verified all the log entries, which ended with "DP", were entered by him. He also advised nothing out of the ordinary except inmate Howell being placed in the restraint chair occurred on 12/9/18.

On 12/10/18, Detective Stock interviewed Deputy Brian Barth at the Hamilton County Justice Center, in reference to the death of inmate Cornelius Howell.

Barth was assigned to 2nd shift, 1500 hours to 2300 hours, and was working as the Medical Rover (G45).

At approximately 1700 hours, he transported inmate Demarcus Grant from North 42 to medical, after he had been involved in a fight. Inmate Cornelius Howell was also taken to medical. While Grant was being tended to by the medical staff, Barth could hear Howell yelling. Barth observed Howell sliding out of the wheelchair and complaining about back pain. Howell was not cooperating with medical staff. He wanted to lie on the floor. Medical requested a urine sample from Howell but was unable to obtain the sample from him, due to lack of cooperation.

Deputy Barth was advised to retrieve the restraint chair from North 21 (Psych). He placed the chair next to Howell in the sally port. Barth assisted in placing Howell in the chair. Howell was not combative. Deputy Barth stated that Howell was passive resistant. The nurse checked the restraints, so they weren't too tight, and Deputy Barth wheeled him down the hall, placing him in cell three, in A pod, on North 21. Barth advised he had no further contact with Howell.

On 12/10/18, at 0002 hours, Detective Stock interviewed Sgt. Justin Hunt at the Hamilton County Justice Center in reference to the death investigation of inmate Cornelius Howell. Sgt. Hunt is assigned to the North Building on second shift as G90. He has been employed by the Hamilton County Sheriff's Office for seventeen years.

Sgt. Hunt stated on 12/09/18, at approximately 1700 hours, he was contacted by the officers assigned to North Building G42 advising him about a fight

between two inmates. He advised to take the involved inmates to the medical unit (G22) to be evaluated. Sgt. Hunt responded to medical where Inmate Demarcus Grant was being seen in the treatment room for a superficial stab wound. Deputy Barth and Deputy Spence were also present. Deputy Spence is a jail investigator and photographed the injury. Inmate Grant advised he was involved in a fight with his cellmate Cornelius Howell. Howell attempted to stab Grant with a pencil leaving a minor injury.

Cornelius Howell was in the secured entry area of medical in a wheelchair waiting to be seen. He was yelling and stating he was in pain. He was handcuffed because of being involved in a fight. Inmate Howell was stating he could not feel his legs. Inmate Howell then slid out of the chair to the floor. Staff placed him back into the wheelchair and took him to the sally port area of medical.

After Inmate Grant was seen by medical, he was placed in the secured exit area of medical to await transport to South 22, pending a disciplinary hearing for the fight. Inmate Howell continued yelling that his legs wouldn't work. He continued to slide out of the wheelchair. Sgt. Hunt stated inmate Howell was using his legs to push with. Staff moved inmate Howell's handcuffs to the front so he could be evaluated. Inmate Howell complained about back pain and wanted to lie down on the floor as he continued to slide out of the chair. He would not cooperate with the medical staff and eventually laid flat on the floor. He stated he was involved in a fight and his back hurt. The medical staff attempted several tests on him and to give him medication. He spit the medication out.

The nurse, Christina Jordan, told him he was not going to the hospital and she wanted him to urinate in a cup. He refused to urinate in a cup and Nurse Jordan made the decision inmate Howell was having a mental health issue. Sgt. Hunt asked Nurse Jordan if she wanted him to get the restraint chair. She said she wanted inmate Howell in the chair for his safety. Sgt. Hunt had someone get the chair from the psych unit (G21). Sgt. Hunt went into the Local Control Unit to speak with Lt. Buchanan. They discussed administrative segregation due to the stabbing. Inmate Howell was then transported to G21.

Sgt. Hunt went to G21 several minutes later to have another inmate removed from the restraint chair. While in G21, Sgt. Hunt started a log for inmate Howell's time in the restraint chair. Approximately four hours later, at approximately 2145 hours, while on rounds, Sgt. Hunt responded to G21 to physically check the suicide watches. Sgt. Hunt also responded to remove inmate Howell from the restraint chair and put him in cell one in A Pod. He approached cell six, opened the door, and yelled for inmate Howell, who looked like he was sleeping. Deputy Pierani attempted a sternum rub on inmate Howell with no response. Sgt. Hunt went to inmate Howell's right side and shook his shoulder. Inmate Howell was stiff. Sgt. Hunt told Deputy Pierani to call G100 of a medical emergency. Sgt. Hunt walked out into the pod area. He then walked back into the pod and checked vitals. Sgt. Hunt then obtained a blank piece of paper and started a log. He then provided that log to Detective Stock.

Once Deputy Spence arrived, Sgt. Hunt called for Sgt. Timon to also respond. Once Sgt. Timon arrived,

he and Deputy Spence began investigator duties. Sgt. Hunt then described how the chair is used. There are no handcuffs on this chair. Soft restraints are used to secure the inmate to the chair, which is secured to the wall. He then explained the chair is used for out of control inmates or inmates who are a threat to themselves or others. Sgt. Hunt confirmed that medical requested inmate Howell be put in the chair.

On December 10, 2018, at 0054 hours, Detectives Powers and Wissel conducted an interview of Corrections Officer Daniel Erwin at the Hamilton County Justice Center on floor 1-M of the North Building.

Deputy Erwin advised he has been employed with the Hamilton County Sheriff's Office for the last 5 years and 8 months, all in the Corrections Division. He started his shift on 12/9/18 at 1500 hours working on North 21 (N-21) as the housing officer. He advised at 1740 hours he would normally switch to the suicide watch officer but went to medical instead to assist with placing an inmate in the restraint chair.

Deputy Erwin advised Deputy Barth transported the restraint chair from N-21 to medical. Deputy Erwin went through the psych offices and through the medical offices to get to the medical sally port. When he arrived at medical, he observed inmate Howell lying on the floor of the sally port on his right side handcuffed in the front. Deputy Erwin advised his understanding was inmate Howell was going to be placed in the restraint chair and sent out to the hospital. He heard inmate Howell making noises and was told he had refused medical treatment. Deputy Erwin advised he saw a half broken pill on the floor about a foot from inmate Howell's toes. He observed

the pill when he bent down to put inmate Howell in the restraint chair. He advised inmate Howell was not combative but reluctant to get in the chair. Deputy Erwin had to bring inmate Howell up to get him in the chair properly. Inmate Howell was apologetic after he was placed in the chair, which is the norm. Deputy Erwin advised inmate Howell had no complaints after he was placed in the chair but was "grunting a little bit."

Deputy Erwin advised he heard a nurse say inmate Howell was going to the hospital, which led him to believe inmate Howell was going to the hospital, due to refusing treatment, because something was wrong with him, and he needed to be looked at further to be assessed. Deputy Erwin advised a nurse then checked the straps of the restraint chair and inmate Howell was wheeled to psych cell 6. Deputy Erwin stated he had no further contact with inmate Howell.

Detective Wissel showed Deputy Erwin the restraint chair form. Deputy Erwin advised the form was started by Sgt. Hunt and his first entry was at 1800 hours. He stated all the entries with "DBE" at the end were made by him. Deputy Erwin stated all his checks on inmate Howell were conducted by looking through the cell door window. He was asked to clarify what he saw when he wrote "chair" on the form. Deputy Erwin provided the additional description of inmate Howell's behavior.

> 1810 — looked at him
> 1820 — was looking out the exterior window
> 1830 — was looking down feeling defeated, saw him blinking
> 1840 — appeared to be sleeping

> 1900 — appeared to be sleeping
> 1910 — appeared to be sleeping
> 2000 — appeared to be sleeping
> 2010 — appeared to be sleeping
> 2020 — appeared to be sleeping
> 2030 — appeared to be sleeping

Detective Wissel then showed Deputy Erwin the daily log report. Deputy Erwin advised all the entries from 2106 to 2154 hours were made by him. The entries mostly ended with "DBE #349".

Deputy Erwin stated he switched to the LC officer at approximately 2030 hours. He stayed in the LC after inmate Howell was found unresponsive. He advised there was nothing out of the ordinary except for what occurred with inmate Howell.

Deputy Erwin advised he heard a nurse say inmate Howell was going to the hospital prior to being placed in the restraint chair. He was talking to Sgt. Franklin and heard several people talking about inmate Howell going to the hospital but was unsure if it was other corrections officers or nurses. Deputy Erwin advised he was not told by any of the nursing staff or any supervisor that inmate Howell was going to the hospital. Deputy Erwin advised he was upset about the situation because he thought inmate Howell should have gone to the hospital.

Deputy Ashley Roettker and Deputy Brian Barth both witnessed the behavior of inmate Howell while in medical. Inmate Howell continued to fall out of the wheelchair and be uncooperative with staff until medical staff advised he be placed in the restraint chair. Barth assisted in placing him in the restraint chair with other officers. Deputy Roettker witnessed

Howell being placed into the chair from the medical unit control room. There was no force necessary to place Howell in the chair. A copy of Barth's and Roettker's written and taped statements are contained in the case file.

Coroner Investigator John Hatfield arrived at 0045 hours. He photographed the body and prepared it for transport. Deputy McClendon, Badge #577, arrived on scene with inmate William Herms (1671353) and inmate Raymond Morris (1674471). The transport unit and Investigator Hatfield left the scene at 0117 hours.

On 12/10/2018, at 0141 hours, Detective Stock and Detective Powers interviewed inmate Demarcus Grant at the Hamilton County Justice Center, located at 1000 Sycamore Street, Cincinnati, Ohio

45202. Demarcus Grant is further described as male, DOB ■■■■■, black hair, brown eyes, 5'08", 150 lbs., SSN ■■■■■ and last known address before his incarceration was 2058 Auburn Avenue #25, Cincinnati, Ohio 45232.

The interview started by Detective Stock reading and showing Demarcus Grant his Miranda warnings. Demarcus acknowledged he understood his rights and agreed to speak to detectives. Demarcus signed the Hamilton County Sheriff's Office Advice of Rights form. This waiver of rights form is available with this case file. The interview was also audibly recorded and is on file.

Detectives asked Demarcus Grant why he was incarcerated. Grant advised he was locked up for charges his girlfriend had on him. Grant stated "she said I broke into her house". Grant advised he was

from the Avondale neighborhood. Grant advised he has been locked up about two weeks.

Grant stated he had an altercation with Cornelius Howell after Howell claimed he stole a pencil from under his bed. Grant stated Howell told him to come into the cell, and he then closed the cell door behind him, as he entered the cell. Grant advised he knew the altercation was going to happen when Howell closed the door behind him. Grant further stated the altercation began with Howell stabbing him with a pencil in the side. Grant said he struck Howell in the face about five times busting his lip. Grant advised at that point he felt he was winning the fight and began to hold Howell until the officer broke up the fight. Grant stated after they were separated he was told to sit in the pod area by the officer. Grant asked another inmate "did he stab me". The inmate stated he did and handed him the pencil tip. Grant stated during the fight Howell never hit the floor or hit his head on anything in the cell.

Detectives asked Grant if he noticed anything odd about Howell. Grant stated "he acted a little weird". Grant stated Howell, at times, appeared to talk to himself. Grant was asked if he ever heard Howell complain about pain in the past with cellmates. The only time Grant heard him complain was in medical after the fight. Grant continued with "I heard him complaining about his legs hurting from the other room in medical".

Detectives told Grant about Cornelius Howell's death after the fight. Grant appeared to be very upset stating he did not do anything to cause Howell's death. Grant advised the incident was just a fight between two people. Grant could not believe Howell

had passed. Grant advised he did not slam Howell or do anything that would cause Howell's death. Grant was very upset and emotional stating it was just a fight.

On 12/10/19, HCJC Investigators Keeton and Jones conducted interviews of all of the inmates housed on North 42 in reference to the fight that occurred between Cornelius Howell and Demarcus Grant. Some of the inmates knew that the two had a fight and some didn't hear or see anything. The ones that knew of the fight didn't see the fight. They heard the fight and saw both inmates as they exited the cell breathing heavy. A report was generated and a copy is contained in the case file. There is also a separate investigation into the incident by HCJC Investigator Randy Spence. A copy of that report is also contained in the case file.

On 12/10/18, Detective Stock contacted John Hatfield and inquired about a preliminary cause of death. He advised there was no obvious cause of death determined from the autopsy. There were no signs of trauma or substantial bodily injury. The autopsy would rely on lab and toxicology results.

On 03/14/19, Detective Stock received the final Coroner's Report from the Hamilton County Coroner's Office. The death was ruled a homicide. According to Dr. Stevens, the fight between Howell and Grant, even though instigated by Howell, caused Howell to have Sickle Cell Crisis, which led to his death. It is also believed that Grant acted in self-defense and there were no physical injuries from the fight that led to his death.

RA

DEPOSITION OF JUSTIN HUNT
(JUNE 17, 2020)

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

_____

KARLA HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

_____

Case Number: 1:19-cv-00373

Before: Kelly GREEN, RPR, Notary Public.

MR. KIRCHER: We are on video at 1:41 on June 17th, 2020, in Case Number 1:19-cv-373 in the United States District Court for the Southern District of Ohio in the case captioned Karla Howell versus NaphCare, Inc., et al. The written transcript will be the official record of the proceedings. Would you swear the witness, please.

4 4 3 JUSTIN HUNT,
a witness herein, having been duly sworn,
was examined and testified as follows:

CROSS-EXAMINATION BY MR. MCGRAW:

Q. Good afternoon, sir.

A. Good afternoon.

Q. Can you please state your name and spell it for the record.

A. Justin Hunt, J-U-S-T-I-N, last name Hunt, H-U-N-T.

Q. And Mr. Hunt, what is your rank at the sheriff's office?

A. I am a sergeant assigned to jail divisions.

Q. And Sergeant Hunt, my name is Ryan McGraw, and along with Konrad Kircher, we represent Karla Howell in the estate of Pierre Howell.

Have you ever given a deposition before?

A. No.

Q. Okay. So let me just give you a couple ground rules—I know before we started, your attorney was kind of giving you the quick rundown—just to make sure that everything goes smoothly today. Okay?

A. (Nodded.)

Q. As you see, we've got a court reporter here who's taking down everything that I say, and she'll take down everything that you say. So for that reason, I'd ask please allow only one of us to speak at a time. Okay?

A. Yes.

Q. If we try to speak over one another, she can't get everything down. So for that reason, please allow

me to ask my question before you give an audible answer to it.

You may be expecting what the end of my question is going to be and want to jump in. It's bound to happen. But if that does happen, I'll ask you please allow me to finish, and I'll allow you to answer.

If I ever interrupt you when you're giving an answer, it will have been inadvertent. So please bring that to my attention. I'll gladly allow you to finish your answer. Okay?

A. Yes.

Q. Because we've got a written transcript here, I'm going to ask you for audible answers. If you say uh-huh or uh-uh, nod or shake your head, I may ask you is that a yes or a no. I'm not trying to be rude; I'm just making sure that the record is clear. Okay?

A. Yes.

Q. If at any point during my questioning there is something that is unclear to you or you're thinking about something, an answer you gave previously, please bring that to my attention. Okay?

A. Yes.

Q. But if you answer my question, I will assume you understood it. Is that fair?

A. Yes.

Q. Will you agree today to provide responsive answers to my questions?

A. Yes.

Q. If I ask a yes-or-no answer—or a yes-or-no question, will you cooperate in providing a truthful answer to it?

A. Yes.

Q. Is there any reason that you can't give truthful testimony today?

A. No.

Q. Other than speak with your attorney, what have you done, if anything, to prepare for today's deposition?

A. I have reviewed some of our policies that were active at the time of this incident.

Q. Other than any policies that you are talking about, did you review any other document?

A. As in . . .

Q. Anything.

A. As in anything? A copy of my statement I gave to our detective unit.

Q. Your handwritten statement?

A. Yes.

Q. Okay.

A. Let's see. What else did I review?

MR. WELCH: If you remember, you can tell him.

A. I was asked—

MR. WELCH: Could it be this one (indicating)?

THE WITNESS: Critical incident?

MR. WELCH: The critical incident report.

A. Yes, I reviewed the critical incident report that I typed up. I reviewed the critical incident report that I had typed up previous that day for the incident that occurred also involving him.

I was asked a couple questions by my attorney—

MR. WELCH: Let me interrupt. You don't need to discuss anything that you and I discussed or anything that you told me or that I asked you. So just listen to his question. And answer it as best you can. He'll go through it with you. Okay?

THE WITNESS: (Nodded.)

Q. All right. So other than—and which policy, specifically, did you review?

A. I reviewed our use of force—or restraint chair policy. I reviewed—there was two other ones. Death—in-custody death policy and notification of command policy.

Q. What was significant about those policies that made you review them for today?

A. I reviewed those policies immediately following the incident. As a supervisor, after the incident was said and done—I don't carry a checklist around with me in my pocket—so going back and making sure that I completed everything that I needed to complete during the critical incident, making sure that I had the correct notifications, making sure that I followed what needed to be done during that critical incident that I did do.

Q. And do you believe that you've complied—do you believe that you did comply with those policies with respect to the death of Mr. Howell?

A. For the critical incident—handling the critical incident, yes.

Q. What about the restraint chair?

A. The restraint chair? I believe I was in policy with that as a supervisor.

Q. Have you talked with anyone in the sheriff's department about your deposition today?

A. No.

Q. Did you speak with Deputy Barth at all about today's deposition?

A. No.

Q. Did you speak with Deputy Barth at all about his deposition?

A. No. I did read his deposition.

Q. What about Deputy Roettker; did you speak with her about her deposition?

A. No.

Q. Did you speak with her about your deposition?

A. No.

Q. Did you read her deposition?

A. No.

Q. Deputy Terry; did you read her deposition?

A. No.

Q. Did you speak with her about your deposition?

A. No.

Q. Speak with her about her deposition?

A. No.

Q. Deputy Pierani or "puh-RONNIE"—I may have mispronounced his name—did you speak with him about his deposition?

A. No.

Q. Did you read his deposition?

A. No.

Q. Did you speak with him at all about your deposition?

A. No.

Q. What about Sergeant Franklin; did you discuss your deposition with him?

A. No.

Q. Did you read his deposition?

A. No.

Q. Did you discuss your deposition with him?

A. No.

Q. Officer Collini; did you discuss your deposition with him?

A. No.

Q. Did you discuss his deposition earlier this morning?

A. No.

Q. What about Deputy Erwin; have you talked with him at all about your deposition?

A. No.

Q. Officer—or Lieutenant Buchanan?

A. No.

Q. Did you talk with him at all?

A. No.

Q. And Jessica Jones?

A. No.

Q. Why did you read Deputy Barth's deposition?

A. I've never done a deposition before. I informed my attorney that I've not, and he provided me a copy of that to read over to get an understanding of the questions that may be asked, how the operation of it goes. That way, I can read that and just kind of be familiar coming in instead of—

Q. Sure.

A. —coming out of left field.

Q. Sure. Is there anything of note that you saw during—when you read Officer Barth's deposition? Anything surprise you, I guess, is a better question.

A. No.

Q. Did you review any video or audio?

A. Brief—very brief video.

Q. What specific video did you review?

A. The time. What—about—just a couple moments of the time, and that was to answer a question.

THE WITNESS: Can I say that?

MR. WELCH: Yeah, you can tell him what—yeah.

A. Answer a question from my attorney about access in and out of A Pod on North 21, and I believe he had asked a question about something else.

And I reviewed just a very short period on one of the videos where I saw one of the officers completing a round, and I just looked to see about what the time frame was to complete a round.

Q. Okay. So—

A. And that was it.

Q. So the video you're describing would have been of G-21 of the North building? It would have—that's what would have been depicted on the clips that you reviewed?

A. Yes.

Q. So it's got the A Pod, B Pod, C Pod, D Pod around . . .

A. Yes.

Q. You didn't review any video from the medical pod or the medical sallyport?

A. No.

Q. Have you ever been involved in a lawsuit before?

A. No.

Q. Have you ever been charged or convicted with a crime?

MR. WELCH: I'll object. You can answer.

A. Charged with a traffic—traffic violations.

Q. Were you ever—did you ever plead guilty in—or did you plead guilty in November of 2013 to a reckless driving charge?

MR. WELCH: Objection. You can answer.

A. Yes.

Q. And as I understand it, the sentence was a three-day driver intervention program and probation?

A. Yes.

MR. WELCH: Objection.

Q. Which you successfully completed the probation?

MR. WELCH: Objection. Go ahead.

A. Yes.

Q. Are you married?

A. No.

Q. Do you have any children?

A. No.

Q. Did you graduate from high school?

A. Yes.

Q. What year?

A. 2002.

Q. And where did you graduate high school from?

A. Northwest, here in Hamilton County.

Q. And did you grow up in that area of town, Northwest? I guess I'm trying to figure out what the cities—what city is—

MR. KIRCHER: Colerain.

Q. Colerain?

A. Colerain, no.

Q. Where did you grow up?

A. Pleasant Run Farms.

Q. And after you graduated from high school, did you go on to any further education?

A. No.

Q. Did you go right into the workforce at that point?

A. Yes.

Q. Where were you employed?

A. Right out of high school, I was working at Frisch's Big Boy and filed my application here with the Hamilton County Sheriff's Office and began employment here at the age of 18 with the Hamilton County Sheriff's Office August 1st, 2002.

Q. And as part of the hiring process, did you attend the corrections academy?

A. Yes.

Q. From roughly when to when?

A. It was an eight-week academy that began August 1st, 2002.

Q. And you successfully completed it?

A. Yes.

Q. Did you attend any other academies as part of—in the time period that you've been employed with the sheriff's office?

A. Yes, I have.

Q. What are those?

A. I attended the Ohio Peace Academy—Peace Officer Academy through Butler Tech.

Q. From when to when, roughly?

A. 2018, and finished the academy in the beginning of 2019.

Q. Any other—

A. Wait a second. When did I get certified? 2020, certified all through there. It was 2019, 2018. I wouldn't have been back on second shift. I got my dates mixed up right now.

MR. WELCH: That's all right. Just do the best you can.

A. Yeah, I've been OPOTA certified for—since February of 2019. So I believe the academy—no, the academy had ended in November of 2018, and I transferred back to second shift. Okay. Okay. There we go. There we go.

Q. Is there any significance about why you chose to attend OPOTA when you did?

A. Work-wise and personal life at the time. It was accommodatable[sic] with work and personal.

Q. I guess what I was—and this is an example of me asking a bad question. Was there any significance about your role at the sheriff's office that required you to go get OPOTA certified when you started in roughly the middle of 2019—or 2018, I guess?

A. No.

Q. So you were hired in August of 2002. Was that—were you hired as a corrections officer?

A. Yes.

Q. And obviously I know now you're a sergeant. Trace for me your path through the sheriff's office.

A. I went through the academy in 2002; completed my FTO program for five-week training, switch, different shifts; was then assigned to Queensgate Correctional Facility from 2003 through 2008.

Q. And let me stop you there and ask during—from 2002 to 2008, were you employed as a corrections officer?

A. Yes.

Q. So 2008, take me from there.

A. 2008, Queensgate facility shut down; transferred to the Justice Center; worked second shift there till—what was it? 2012. 2012, transferred to first shift. 2014, promoted to the rank of sergeant.

As the rank of sergeant, with everywhere that I have worked in the jail, I've worked first shift; I've worked second shift; I've worked third shift. I've worked and supervised in all buildings in all areas.

Q. Is there a spot where you are most often assigned as a sergeant?

A. Where have I served the most?

Q. Yeah. And I guess the better question is presently, do you serve as a sergeant of one specific unit?

A. One specific area, yes.

Q. Okay. Where is that?

A. It is intake. I'm currently assigned to first shift intake.

Q. And when did that assignment start?

A. In the second year, I believe, working intake on first shift.

Q. So that would have been, you think, 2014? I guess year-wise, when?

A. Okay. The first shift—back to first shift again in 2019. I transferred back to first shift and then transferred to intake. So I'm roughly a year and a half back in intake right now.

Q. Prior to that—and, I guess, let's focus specifically on December 2018. Were you assigned to any specific role or specific area, I think you said, at the jail in December of 2018?

A. Yes. I was assigned to second shift North building.

Q. Tell me about the duties and responsibilities of a sergeant in—on second shift in the North building.

A. Second shift in the North building—the North building has a variety of housing assignments and areas from the visiting entrance to the main entrance where officers and visitors and attorneys, clergy members, support staff, all enter and exit through one area on the first floor there.

The opposite end of the first floor is the jail's kitchen. That falls under my supervision. We go

up to the 1-M floor, which is where the briefing area is, training room area is, maintenance is, commissary is. Storage room's there as well.

We go up to the second floor. As you come off the elevator, we're going to call—2 side is our medical unit. Our 1 side is the mental health unit.

We go up to the third floor, and that is where the females are housed on both ends. Also, there's a break room in the back there, other areas of offices for support staffs around that back corner—around the back area there.

Fourth floor houses detail workers, inmate program, minimum security, and also general population on the 1 side, and the detail workers on the 2 side up to our fifth floor, has our general populations on our fifth floor on the 1 and 2 sides.

Q. How many sergeants on any one shift are assigned to the North building?

A. At one time, we'll have up to two of us working.

Q. So all of these different areas that you just described, there would be two sergeants in charge of that, correct?

A. For the shift time frame, yes, that's being that—if our off-day schedules have both of us working on that day. If not, if my partner is on his two off days, then I'm there by myself for two days. And then we work together for two days; and then he's off for two days, and I'm by myself for two days, et cetera.

Q. Got it. So there could be as little as one sergeant on duty; there could be as many as two?

A. Yes.

Q. And is there any—is there anyone in the command above you who is also responsible for that North building?

A. Yes. There would be a lieutenant that is assigned to the North building. That lieutenant is also in charge of our Reading Road and Talbert House facilities as well as the North building; however, when the South building lieutenant is not there, or if we even had a South building lieutenant at the time, our lieutenant is in charge of the whole entire second shift Justice Center.

Q. Okay. So since 2014, you've been in a supervisory position, correct?

A. Yes.

Q. As part of your role, are you expected to make or create written records or logs?

A. Yes. We do carry a daily shift log, yes.

Q. Other than the daily—what's included on the daily shift log?

A. Our briefing from the previous shift; our staff that gets assigned that they've all signed in, they're on post; put on there time—that payroll or time and attendance has been completed.

Any other miscellaneous things that may pop up will be logged on there. Rounds that I complete as a supervisor throughout the facility or throughout my area I will put on there, and any other things that are—happen will get documented.

Q. Would you agree that you have a duty to be accurate in those logs?

A. Yes.

Q. Why is that? Why is accuracy important?

A. To me, it shows accountability.

Q. You would agree that you can't put anything on those logs that didn't actually occur, correct?

MR. WELCH: Objection. Go ahead.

A. If it didn't occur, then why would it be—what is there to put on a log?

Q. What happens if you put things on the log that didn't occur?

A. I don't understand.

Q. If you wrote something—let's say you wrote you did a round at X time period, but you didn't actually do that round. Would that be a problem?

MR. WELCH: Objection. Go ahead.

A. It's definitely not right.

Q. Do your subordinates have to keep records or logs in their duties?

A. Yes.

Q. What types of logs would—or records would they be required to keep?

A. They keep a daily log, a unit log, functions pretty much almost the exact same as what I just described.

Q. And as it relates to medical, or I guess let's call it the suicide watches or the restraint chairs,

one of the other logs that people would create are the observation logs, right?

A. Yes.

Q. That's a 10-minute observation log, right?

A. Yes.

Q. And you would expect your subordinates to maintain accurate logs, right?

A. Yes.

Q. They can't put things on those logs that didn't occur, correct?

A. To my knowledge, they don't.

Q. If you ever had a subordinate who put things on that log that didn't actually happen, what would your response be?

MR. WELCH: Object. You can go ahead and answer.

A. My response would be, one, me actually having knowledge of the fact that something's on there that isn't supposed to be on there; and if that is the case, that officer, or whoever that would be at the time, would have to explain why and what's going on. And barring where that goes, it all depends. It all depends.

Q. Could they be subject to discipline?

MR. WELCH: Objection. Go ahead.

A. It all depends on the circumstances. If something's not right with that, it could be.

Q. Does the jail have a policies and procedures manual?

A. Yes.

Q. Why is that in place?

A. Those are in place as written guidelines to be followed to assure that duties and tasks are completed.

Q. Who orders those?

A. Those are written by our administration.

Q. Are you subject to them?

A. Yes.

Q. Are you knowledgeable about them?

A. Most.

Q. Are you expected to follow them?

A. As I was—policies? They are written, they are guidance, but every—there's different situations where a policy might not actually cover on how something is to be done or what is to happen.

So if it's not—that policy, or whatever it is, is not exactly done the way it is written because of circumstances of the incident don't apply, (shrugged shoulders) . . .

Q. Excluding sort of extenuating circumstances, for the most part, you're supposed to follow the policies, right?

MR. WELCH: Object. Go ahead.

A. As far as every incident that you're occurring is in line with the perfect order as the policy depicts.

Q. So is that a yes—

MR. WELCH: Well, objection.

Q. —you're expected to follow them?

A. Yes and no. I mean, it's not no as to not follow the policy, but yes as long as it's—what is going on directly in front of you is in line with how the policy is written.

If the policy is not written to cover the incidents directly in front of you, how can you follow something that isn't there, or if the incident takes you that direction that the policy doesn't have?

Q. Got it. Okay. Are you required to enforce the policies and procedures of the jail in your role as a sergeant?

A. Yes.

Q. Are there any rules or regulations not contained within the policies and procedures manual which you are expected to follow?

A. I don't understand.

Q. Are there any unwritten rules at the jail?

A. No.

Q. Any unwritten rules that you expect your subordinates to follow?

A. No.

Q. Would you agree that the policies and procedures are designed for the safe and orderly operation of the jail?

A. Yes.

Q. To protect your employees?

A. Protect the inmates as well and protect all staff.

Q. Anybody who might be in the jail?

A. Absolutely.

Q. All right. I'm going to hand you what has previously been marked as Plaintiff's Exhibit 2. Take whatever time you need to familiarize yourself, and let me know when you're ready to discuss it.

A. (Examining document.) Okay.

Q. Do you agree that this is the Hamilton County Sheriff's Office policy and procedure for the use of the restraints?

A. Yes.

Q. And was this policy in place in December of 2018?

A. Yes.

Q. Are you aware of any policy and procedure revision or amendment prior to December of 2018?

A. According to the date revised of 3/15/2016, as for what that policy stated before this one current—this policy for 2018 went into effect, I do not recall what the policy previous states.

Q. And I'm sorry. My question was—and I may have asked it incorrectly. After December 12th of 2018, but before December of 2018, are you aware of any policy—amendments or revisions to this?

A. No.

Q. Are you knowledgeable about what is contained within this policy?

A. I do not know it verbatim, but yes.

Q. How and when—let me ask this. When did you learn about the jail's policy on the use of restraints?

A. The use of restraints are used daily in the correctional setting. Policy is there and it's put out for us. We read it. We do review it.

Q. And my question was when did you first become aware of the jail's policy on the use of restraints? Was it during your corrections officer academy? Was it later that you were taught this policy?

A. Use of restraints would have been reviewed, to the best of my knowledge, when I first started in the corrections academy.

Q. Other than the corrections academy, do you recall any refresher training courses on the use of restraints?

A. Courses? No. When policies come up for review or for revised—revisions, they are sent out. And I'm not sure if December of 2018, or before that, we were going and doing it electronically or if it was handwritten signatures.

But administration will send out a—It's time for a review, or if there's a revision to the policy, Please read and update yourself on it. And myself, as well as everyone assigned under me, would sign for the review or the revision.

Q. So you get the policy; you have to acknowledge in some way that you've reviewed it. Is that fair to say?

A. Yes.

Q. But there's not any specific in-person training on, Hey, guys, here's the new policy; here's what it means? It's you read it on your own?

A. I, myself—as a supervisor, I will say, Hey, here's the policy. This is just a review. There were no revisions that were sent out on this. Please review it, and if you do have any questions, please come see me. We can go over it. We can talk about it, however that is.

Or if there was a revision, administration will also send out what has been revised. Those areas—what I would do is I would highlight those, and I would make note of those as I'm just speaking with the officers as I'm telling them to review. Hey, review it, sign you're reviewing it, whatnot, and pay close attention to these revisions.

Q. And are you part of any team that decides how these policies get reviewed, or revised, I should say?

A. No.

Q. And do the revisions come out to you as a supervisor before they go out to the staff as a whole?

A. Since we've gone to the electronic signing, no. It gets sent out to all for electronic sign-off and review.

Q. So when you're talking about the discussions that you have with your direct reports, are those like informal discussions—

A. Yes.

Q. —or—yes. Okay.

So you don't hold any, like, all staff meeting one morning to say, Hey, here's the new policies, here's what's been revised, anything like that?

A. No.

Q. I'm going to have you turn to page 3 of that Exhibit 2, specifically Roman numeral 6-A. Do you see that?

A. Yes.

Q. All right. And the last sentence says that the use of the restraint chair must be authorized by the mental health, slash, medical staff or security supervisor for one of the following reasons. Do you see that?

A. Yes.

Q. Are you aware of any other basis, other than the three listed here, which would permit the use of a restraint chair?

A. No.

Q. And as I've come to understand it, and as I read in this policy, a supervisor is required to approve the use of it—a jail supervisor; is that correct?

A. Not just a jail supervisor. In this policy here, it states mental health/medical staff or the security supervisor.

Q. Okay. That's a good clarification. But a corrections officer cannot order the use of the restraint chair; is that correct?

A. If there is an incident occurring and a decision needs to be made immediately for the well-being and the safety of the inmate or the staff at that

exact moment in time and they make that decision, I'll follow their decision.

Q. But ultimately, you, as a supervisor, would need to sign off on that, right?

A. Yes.

Q. So if it's the jail employees who are ordering the restraint chair, it's got to be approved by a supervisor, right?

A. It can be approved by—would be approved by the supervisor speaking of different incidents that may occur. And there's so many—there's different hypothetical situations where the use of the restraint chair, or any restraint at that moment in time, needs—is needed immediately.

Q. And I'm not talking about the immediate need of it. I'm just saying if somebody's in that restraint chair or is put in that restraint chair, ultimately, it has to be approved by a supervisor for them to remain in it, right?

A. No. Not to remain in it, no.

Q. Who else can order them to remain in it from the jail other than a supervisor?

A. To remain in the chair, that's a medical—medical area, or it's also based upon the inmate's behavior.

Q. But can a corrections officer remove an inmate from the restraint chair without the approval of a supervisor or medical?

A. No.

Q. Were you in a position in December of 2018 where you could order an inmate into a restraint chair?

A. I have the ability to do that, yes.

Q. And were you in a position in December of 2018 where you can approve a corrections officer placing an inmate into a restraint chair?

A. Circumstantial.

Q. Circumstantial meaning what?

A. In 2018, circumstantial. If the inmate's behavior is needed for an immediate placement of into—a placement into a restraint chair, then the officer can act.

Q. And what I'm saying is—okay—that situation, the officer acts, places them in a restraint chair, right?

A. I am notified.

Q. You are notified. And are you in a position, then, when you can—you would be the person who says, yes, he or she stays, or no, he or she goes?

A. What do you mean by go or stay?

Q. Out, removed from the chair. Let's take a step back. An officer places an inmate in a restraint chair. The officer believes the immediacy of the situation requires the inmate to go in the restraint chair. Are you with me?

A. Yes.

Q. All right. So that officer makes that decision. You are then notified, right?

A. Yes.

Q. Ultimately, it's your decision whether the inmate remains in the restraint chair, right?

A. For that specific incident that you're speaking, hypothetical you're speaking, and they give me the details of that incident, and I believe that their reasoning and their actions are justified and are correct, then the inmate will stay in that chair.

Q. And were you in a—are you, as a supervisor, in a position to order the removal of an inmate from a restraint chair?

A. Yes.

Q. During the interim time period where the—between when an inmate is placed in the chair and when they're removed, it's the corrections officers who are responsible for monitoring them, correct?

A. Yes.

Q. Is there any special training that those corrections officers get in how to monitor inmates in a restraint chair?

A. No special training, no.

Q. And we talked about it could also be authorized by mental health or medical staff. Who, to your knowledge, from the medical side can order the use of a restraint chair?

A. If I recall, in 2018, anyone involved with medical staff.

Q. So that would include, to your knowledge, nurses?

A. And I believe counselors—mental health counselors. I very well could be mistaken.

Q. But you would feel—in December 2018, would you feel comfortable taking direction from a nurse saying, Put this inmate in a restraint chair?

A. Yes.

Q. You wouldn't require any higher level provider, like a doctor?

A. No.

Q. In your experience in December 2018 and prior to that, was it typical for nurses to order inmates into the restraint chair?

A. If the reason presented itself.

Q. And by—I guess, let me just clarify that a little.

A. Or the incident determined that for the safety of the inmate or prisoner.

Q. I guess, let me clarify one piece of that. Did you get direct—did you receive direction from nurses in December 2018 and prior to place inmates in restraint chairs?

A. If the situation resulted in that, and medical was notified of the incident occurring and what type of action needed to take place, and medical staff would say, Place them into the restraint chair, okay.

Q. And all I'm trying to understand, and all I'm trying to make sure is clear, is who you were

taking those directions from on the medical staff.

Were you taking—would you take direction from a nurse who told you in that— who presented to you in that situation that you just described?

MR. WELCH: Objection. Go ahead.

A. Yes.

Q. On Roman numeral 6-B, it indicates that a member of the health-trained staff must examine the inmate every 10 minutes. Do you see that?

A. Yes.

Q. And would you agree that health-trained staff refers to corrections officers?

A. Yes.

Q. So you would agree, then, with the statement that jail policy requires a corrections officer to observe an inmate in a restraint chair every 10 minutes?

A. Yes.

Q. Why is that required?

A. I don't have an answer for the reason why it's required. It is in our policy.

Q. Well, are there risks associated with placing an inmate in the restraint chair?

A. There's always risks.

Q. Like what, for example?

A. It depends—it's all—it's all incident-based.

Q. Okay. But generally, what are the risks associated with the restraint chair that you're aware of?

A. Risks as in what can happen to an officer while putting an inmate into the restraint chair?

Q. No. What risks are there to the inmate who's in the chair, or are there any risks, in your mind, associated with being restrained for any significant period of time?

A. I don't have an answer for that. I don't know how to answer that question. I don't know if that's a medical question that you're asking me on what my . . . It's for medical reasons? I don't know. I'm not medical.

Q. There's a chance an inmate could develop blood clots, right, if they're restrained?

A. Okay.

Q. I'm asking you. Do you agree with that?

MR. WELCH: Okay. Object to form, but you can go ahead and answer.

A. I mean, from what I've heard. I'm not a medical-trained person. I mean, I've heard that there's blood clots that could occur.

Q. In fact, the policy notes specifically that blood clots are a possibility when inmates are restrained, right?

A. (Examining document.)

Q. Looking specifically at 6-D.

A. (Examining document.) Okay.

Q. Well, that's a risk associated with the restraint chair, right?

A. I would say.

Q. Anything else that you can think of that might be a risk to inmates in a restraint chair?

A. I mean, not that I can think of. I don't see where an inmate could harm themselves if they're restrained in the restraint chair properly in the restraints that are checked by medical staff.

Where else—how they could harm themselves, I don't see that as a risk. And the reason why they're in the chair is to prevent self-harm or to protect themselves.

Q. Do you know of the health conditions of every inmate who's placed in a restraint chair?

A. No.

Q. Do you know anything about the health of inmates placed in a restraint chair?

A. No.

Q. For that reason, is it important to keep an eye on them?

MR. WELCH: Object to form, but you can answer.

A. You're keeping an eye on the inmates—I mean, it's—it's doing—doing what you're supposed to do. You make your checks.

Q. Would failing to conduct—would you agree that failing to conduct a check puts an inmate at risk?

MR. WELCH: Object. Go ahead. You can answer.

A. The checks are supposed to be done. I mean, I believe, as a supervisor, that the checks are done.

Q. Why, as a supervisor, do you want the checks done?

A. For the safety of the inmate; for the policy for the officers; for the well-being.

Q. The well-being of that inmate?

A. Well-being of the inmate; well-being of the facility.

Q. Do you have any knowledge as to what's—why 10 minutes is the magic number, if you will?

A. That, I do not know.

Q. Does the jail policy ever permit an officer to skip a 10-minute check?

MR. WELCH: Objection. Go ahead.

A. No.

Q. So you would agree, then, it is a violation of jail policy for an officer responsible for an inmate in the restraint chair to not observe them every 10 minutes?

A. No.

Q. It is not a violation of policy for them not to do it?

A. They're—the policy, as I have said before, it's guidelines set. You have circumstances that arise or something else that may occur where that officer is not able to check on them every 10 minutes.

Is that a missed round? Is that a—is that a—what you would say a black-and-white to the policy? Yes.

But what if there was another critical incident going on down the hall of an officer needing emergency assistance and fighting for his life down the hall, and that officer responds, but he responds back to his unit 12 minutes later. Did he miss that 10-minute check? Yes, he did. Did he have a justified reason for missing that 10-minute check? Yes, he did.

Q. Okay. Taking aside other events within the jail. Let's assume nothing out of the ordinary is occurring at the jail. Is it a violation of policy, then, for an officer to miss that 10-minute check?

MR. WELCH: Objection. Go ahead.

A. Again, are the checks being done? To my knowledge, the officers are doing their checks.

Q. That's not what I asked you. That's not what I asked you.

A. If an officer at the 9-minute and 30-second mark has to use the restroom and he comes back at the 12 minutes and 2-second mark, completes the round, was the round completed? Yes. Was it at the exact 10 minutes? No. Can you, or can I, or whoever, be there at exactly 10 minutes every single time?

Q. Can you?

A. That—I don't believe so, no.

Q. What would prevent you from doing that?

MR. WELCH: Objection. Go ahead.

A. I believe I could not go to that door at 3:00 exactly and put my hand on that door at 3:00 exactly, because right before I reached, you said, Hey, question, and I stopped. It's 3:00 and 2 seconds I touch the door. I guess—I guess that would get to human error, per se. I don't know.

Q. But in your mind, as close to 10 minutes as possible, those checks should be getting done, right?

MR. WELCH: Objection. You can answer.

A. As long as they're—that is— yes.

Q. And ultimately, the removal of an inmate from the restraint chair is dictated by their behavior, right?

A. Yes.

Q. And if you look at paragraph 6-F, it talks about that the restrained inmates must be considered for removal at least hourly.

So at least on an hourly basis, they've got to be considered for removal, right?

A. That's what it says.

Q. And who is making that consideration? Who should be doing this at the one-hour mark?

A. The officers that are working the units can assess. I, myself, as a supervisor, can assess.

Q. So what should officers be looking for—

A. Medical could also assess. Sorry to cut you off.

Q. That's okay. I interrupted you. That was inadvertent. Please continue.

A. That covers . . .

Q. So what should officers be doing during these 10-minute checks in considering them—considering an inmate for removal? What are they looking for?

A. That is going to be on the officer's perception of what is going on. I can't speak for how every officer or what officer is going to interpret the behavior.

There are a lot of other cues out there that are identifiable for behaviors. I don't know that without me having personal interaction with the individual.

Q. And my question is more what are the cues that officers should be looking for during their observations?

A. Their behavior.

Q. What, specifically, about their behavior?

A. I can't answer that because everything is situationally based.

Q. Okay. Do you train your officers to look for anything specific?

A. I don't train them to look for anything specific.

Q. What would warrant an inmate being removed from the chair in your mind? What do you need to see?

A. In my mind, as a supervisor, I'm going to ask the inmate how they're feeling; what's their inten-

tions; are they going to cooperate with our instructions; is there going to be any further issues.

And their response is their tone, the way they look, and how they're holding themselves while sitting there will help me assess the situation. Not determine, will help me assess it. That's me, personally.

Q. What about your officers who are doing these 10-minute checks; should they be doing the same things that you're doing?

A. They should be—they're always assessing. The officer's always assessing.

Q. Should they be looking at what the inmate is doing in the chair?

A. You're seeing what he's doing.

Q. How the inmate's holding himself?

A. You're seeing that. You should be seeing that.

Q. So when an officer believes—and I guess, let me back up. An officer could make that observation at the 30-minute mark, right, that this person's a candidate for removal, correct?

A. Yes.

Q. It could be the one-and-a-half-hour mark, though, too, right?

A. Yes.

Q. So what is supposed to happen when an officer believes that an inmate is a candidate for removal? How does that process work?

A. I do not recall correctly if . . . I believe the policy had changed after this incident. And prior to that, I am not exactly for sure how the policy worked or what it said unless I referenced . . .

(Reading) Medical staff will be notified . . . Supervisor will be notified—would be notified or could be notified by the officers, and an assessment will take place of the prisoner or inmate in the restraint chair; and if determined that we are going to remove that person from the restraint chair, we then would. And then medical staff would be notified that they are out of the chair at that time.

Q. So does an observing officer—is he—I guess I can say "he" because only men observe men in the restraint chair in December of 2018, right?

A. (No response.)

Q. Only male officers were doing those observations, correct?

A. Not specifically, no.

Q. Okay. So if the officer—is the officer required to notify their supervisor at the one-hour mark?

A. No.

Q. And if you don't get notified at the one-hour mark, do you assume that the inmate is still engaging in behavior which warrants the chair?

A. Yes.

Q. Do you, yourself, once you place an inmate or you become aware that an inmate is placed in the restraint chair—do you set any type of alert

at the one-hour mark to inquire about what's going on with that inmate?

A. I, myself, personally, no.

Q. So you're reliant, then, upon the observing officers to notify you before the two-hour mark?

A. I, myself, yes. And I, myself—I try to keep a mental note of the approximate time that the person went into the restraint chair, and throughout the duties of my day, and at what course of the duties I get taken to . . . at whether or not getting down—getting there to assess the inmate myself or not.

Q. If an inmate is sleeping, can they be displaying behaviors which warrant the use of the restraint chair?

A. If they are sleeping at the exact moment in time of them sleeping, your answer would be no.

Q. And is it the practice of the sheriff's department to allow inmates who fall asleep in the chair to remain sleeping?

MR. WELCH: Objection. Go ahead.

A. If they are sleeping and . . . circumstantial as to what time they fell asleep, how long they've been asleep, let them rest for a little bit because—let them rest for a little bit.

Q. And earlier today, Officer Collini testified that in his experience, if an inmate fell asleep prior to the two-hour mark, the practice was to allow them to just sleep until that two-hour mark. Does that sound correct?

MR. WELCH: Objection as to that testimony, but you can answer the question if that's the practice.

A. As that being the practice? I cannot—I don't—I don't know. When it's time for a limb rotation, and the officer's followed the policy for a limb rotation and it's not done based on the behavior of the inmate or the circumstances at the time and it's logged, okay.

Q. What other—aside from behavior of the inmate, what other instances—what other circumstances would warrant not conducting that limb rotation at two hours?

A. The inmate behavior.

Q. I said excluding inmate behavior, does that two-hour limb rotation need to occur?

MR. WELCH: Well, I object to form, but go ahead and answer.

A. It is recommended at the two hours for it to be done. If—and it's circumstantial with that too. Is the intake—is the inmate an intake prisoner? And at 2 hours and 15 minutes, I know that they're going to be ready to go right back down to intake booking to complete the process.

At the two-hour mark, he's being completely—probably being completely removed from the chair in a matter of getting him down there at that time.

Or at the two-hour mark, I'm on a route. Hey, intake, are you ready for this guy? It's at the two-hour mark. Yeah, we're going to send somebody up to get him.

Their officer doesn't show up for 15 minutes. Did we exceed that two-hour mark? Yes, we did. Is that individual 15 minutes later completely removed from the chair? Yes, they are.

Q. We'll come back to the 2 hours in a second, but I want to talk about the observation of inmates in the restraint chair. As I understand it, in December of 2018, men placed in the restraint chair were in Pod A of the G-21 building, right?

A. Yes.

Q. And they were either in cell 4 or cell 6, right?

A. Yes, unless those were filled with people already in the restraint chair.

Q. How many restraint chairs does the jail have?

A. By last count, I think it was six operational.

Q. And when an inmate was placed in the chair and placed in a cell, the door to that cell is closed then, correct?

A. Yes.

Q. And they are attached—the chair itself is attached to the wall, correct?

A. Yes.

Q. And from—there's only—the only way to look in, as an officer, is through a small window on the cell door, right?

A. Yes.

Q. And when you're looking in, you get a side profile of the inmate, correct?

A. Yes.

Q. In order to see that inmate, you need to be standing directly in front of that cell window, right?

A. From the width of the window . . .

Q. Give or take a few inches, you could see inside?

A. You're pretty—yes, you're pretty much looking through the window, and you can see.

Q. You couldn't see inside of cell 6 specifically from B Pod, right?

A. No.

Q. And in December of 2018 and prior, officers were never trained to have any physical interaction with the inmate in a restraint chair, correct?

MR. WELCH: Objection. Go ahead and answer.

A. What do you mean by physical?

Q. On their 10-minute checks, they weren't opening the door and going into the cell, right?

MR. WELCH: Object. Go ahead.

A. No, unless they deemed it necessary.

Q. But their general practice is you look through the window and see what the inmate's doing, right?

MR. WELCH: Objection as to form. Go ahead.

A. That is the officers working that unit and how they conduct their rounds and how they conduct their checks.

Q. How do you teach officers in that unit to conduct their checks?

A. I, specifically, do not teach them.

Q. Are you aware of anybody on the sheriff's staff who does teach inmates[sic] how to do those checks?

A. No.

Q. Is it a skill and a practice that they learn on the job?

A. Yes.

Q. It's generally the policy in 2018, December of 2018 specifically, to not open the door on every 10-minute check, correct?

MR. WELCH: Objection as to the form. Go ahead.

A. If the door needed to be opened, the door would be opened. If the officer wanted the door opened to check, the officer can open the door to check.

Q. And during these 10-minute checks, officers are required to log the activity that they see, right?

A. Yes.

Q. What type of training are they provided about how to log activities?

A. I cannot answer that question.

Q. You don't provide any of your officers with any training, right?

A. No.

Q. Are those logs required to be done in real time?

A. If accurately possible.

Q. So as much as possible, you do a round; you log it on the sheet, right?

A. Yes.

Q. Is "chair" a sufficient notation?

A. I believe so.

Q. Based on what?

A. Based on the circumstances facing the officer at the time. If that's how they perceive what is going on, that is what they write.

Q. So if you look at the policy 6-C, it says that all log entries shall be complete noting the condition of the inmate and his or her activities at the time or any significant developments.

Do you believe that "chair"—writing "chair" is consistent with this policy?

A. I do.

Q. From the window outside of the cell where an inmate's in a restraint chair, can an officer tell if the inmate is sleeping or dead?

A. I don't know how you could tell a real true difference on that. I don't know.

Q. All right. So we talked a little bit about limb rotation. In December of 2018, was a monitoring officer permitted to do a limb rotation by him or herself?

A. A supervisor is supposed to be present for that.

Q. So the answer to my question is no, the monitoring officer cannot do it by him or herself, right?

A. Unless otherwise directed by the supervisor.

Q. Okay. So tell me about that. Would you, as a supervisor—you, as a supervisor, would direct an officer, Hey, go ahead and do the limb rotation?

A. The assessment of the officer—now, we're talk situational-based things that occur. If I am the supervisor that day and I'm working by myself, but I just had three—two critical incidents and another inmate fight that just occurred, and it is at the 24-hour mark and the unit called and says, Hey, it's limb rotation time; Hey, what's your assessment on this guy? You going to have a problem with it?

No, I don't think we're going to have a problem with doing the one limb rotation right here. Okay. Well, I am very busy with three other things, filling sick calls, handling three other critical incidents that occur quite often at the same time. Make sure you have another officer with you or call another officer down and complete those, document it.

Those are instructions that I would give, but those are also situational-based and not as frequent but still occur.

Other than that, yes, as soon as I'm able to get down there, if I'm not tied up with a civilian complaint over the telephone, and I'm not able to get down there until the 2-hour and 22-minute mark, I get down there at the 2-hour and 22-minute mark for a limb rotation with them.

Q. Why is limb rotation important, in your mind?

A. Well, according to the policy, it prevents possible blood clots.

Q. So you're aware that there are risks with not doing the limb rotation, right?

A. I'm not a medical—I'm not medically trained as to the reasons why of all this right here besides what I've been told and what I've read.

Q. What have you been told? What have you read?

A. Been told through policy that it's possible—prevent blood clots—can occur.

Q. Now, is it the job of the observing deputy to alert you, as a supervisor, at the two-hour mark?

A. They should, yes. They are, yes.

Q. Do you, as the supervisor, keep an alarm or any kind of log that says, okay, it's two hours; I better try to get down there to check the inmate out?

A. As a supervisor, I try to keep a mental note.

Q. How will the observing officers notify you, typically, or how did they in December of 2018 and before that? How would they typically notify you?

A. How they would typically notify me? They would call me on the radio to call them, and I will call that post. They would inform me of what's going on, and we will go from there.

Q. So because they would be calling you on the radio, there would be no written log of anything like that—of them notifying you, right?

A. If they log that, they log that. If they didn't log that . . .

Q. They weren't required—they're not required to log it and say, Hey, I called the sergeant at X time, right?

A. No.

Q. Officer choice as to whether they log it?

A. Officer choice.

Q. But you, as a supervisor, should always get notified around the two-hour mark, right?

MR. WELCH: Objection. Go ahead and answer.

A. As long as it's applicable. I don't see why I wouldn't be notified that, Hey, boss, it's two hours.

Q. Can an observing or monitoring officer make the determination that an inmate does not want limb exercise at the two-hour mark?

A. I don't understand your question.

Q. For example, can—you know, two hours comes; the inmate's sleeping. Can the officer say, Oh, he doesn't want his limb rotation?

A. That is possible.

Q. Do you believe that's appropriate?

A. We had already talked about this. If they're sleeping, they're sleeping. When did they start sleeping? How long have they been sleeping? It's an assessment of the officer working.

Q. So, still at the two-hour mark if the inmate is sleeping, you should still get a phone call, and then you guys should have that dialogue: Okay. When was he sleeping, for example?

A. If they notify me of that and I'm aware—if I'm aware. If I'm unaware and the two hours have gone by, or two-plus hours have gone by, Hey, what's going on with this guy? I may call down and find out, Hey, he's been sleeping, this and that. Okay. Is it logged? Understand.

Q. So the policy letter E-6-E talks about restroom and fresh drinking water. Are officers trained to ask an inmate, Do you need to use the restroom?

A. Not to my knowledge.

Q. Are they trained to ask, Would you like any water?

A. Not to my knowledge.

Q. So if an inmate needed to use the restroom, you would—the officer would be reliant upon the inmate to bring that to his or her attention. Is that fair to say?

A. I would say that's fair.

Q. Same thing with drinking water?

A. I would say that's fair.

Q. If an inmate needs to use the restroom, does a supervisor need to be present to take him or her out of the chair?

A. Yes.

Q. What about water; does an inmate need to be present to—I'm sorry. Does a supervisor need to be present to give the inmate water?

A. No.

Q. So that's one of the instances where an officer could go into the cell if an inmate asks for water and say, Hey, here's a drink; let me pour it for you?

A. To my knowledge, on past practice with that, medical staff would be the one to give them water.

Q. On the jail observation log, should restroom and water be noted if they're provided?

A. If they are provided and—if they are provided to them, yes. I would write that. If I was the officer working there, I would write that.

Q. And then if you look on the fourth page of that exhibit, specifically letter G, it says that the medical staff will check all inmates in the restraint chair every two hours. Do you see that?

A. Yes.

Q. Prior to Mr. Howell's death, was medical checking on inmates in the restraint chair every two hours?

A. To my knowledge. I can't speak for whether they did or whether they did not.

Q. In your experience, did you ever see medical, prior to Mr. Howell's death, checking on inmates in a restraint chair every 15 minutes?

A. Everything was circumstantial when it comes to certain things.

Q. Okay. And I'm speaking generally. Was it a practice—did you see in practice that the medical staff was going to check on restraint chair inmates every 15 minutes?

A. As a common practice, I do not recall.

Q. But you think probably every two hours, they were checking on them. Is that what you said earlier?

A. Yes.

MR. MCGRAW: Now might be a good time to take a couple minutes to stretch.

MR. WELCH: All right.

MR. KIRCHER: Going off video at 2:58.

(A brief break was taken.)

MR. KIRCHER: We're back on video at 3:14.

Q. (By Mr. McGraw) Back on the record. Sergeant Hunt, you testified earlier that you believed that the officers were accurately completing their observation logs. Do you recall that?

A. Yes.

Q. What did you do, if anything, to assure that that was the case—or ensure that that was the case?

A. Ensure that they're correct—that they're documented on the logs?

Q. Yes.

A. I take a look at their log when I'm on rounds, and I look for completeness. And at that time, I sign off on the form for the time that I'm down there, and that's it.

Q. You ever do any spot checks on the surveillance camera to confirm that what's on that piece of paper is what was accurately performed?

A. No. I don't believe that's necessary.

Q. Why not?

A. I believe the officers are always doing what they're supposed to be doing down there. The officers that work those units, they're down there for a reason, because they do a good job.

Q. So I want to go specifically to December 9, 2018. Where did you first encounter Mr. Howell?

A. To my recollection, my first encounter with him is in the medical sallyport George-22.

Q. And I'm not asking you what's on your—

A. No.

Q. —written report.

A. No.

Q. I'm asking—I'm exhausting your memory as to what you recall.

A. My memory of my first interaction with him is the medical sallyport on George-22.

Q. Around what time did you—did you get to the medical sallyport?

A. Oh, I don't know.

Q. Let me ask it—let me try to put it in context. Was Mr. Howell in the restraint chair when you arrived?

A. No.

Q. Was he in a wheelchair when you arrived?

A. Yes.

Q. When you got there, tell me what you recall seeing Mr. Howell doing.

MR. WELCH: Apart from the record?

Q. Yeah. No recollections about the written stuff yet.

A. My recollection of all the incidents that happened there in the medical sallyport is very vague on that. I remember him being wheeled in. He was in one of the holding tanks.

Our practice is to not have two individuals who were in an altercation to be in the same area at the same time after that.

They were—medical staff was treating and assessing the other guy, where it was brought to my attention that he had been stabbed with a pencil, and they pulled a pencil out of him.

Once medical had cleared him and we had moved him from the sallyport of medical, we had brought Howell in next. And he was brought in in the restraint chair—or not a restraint chair, a wheelchair. And I do remember him—his handcuffs being moved from behind his back to the front of his body.

Q. Do you know why they were moved from behind his back to in front of his body?

A. Without going through—without going to what's written—or my statement, I don't recall. Usually, by that time—usually, for that reason right there and they're coming into medical sallyport, handcuffs are moved from the back usually to the front for medical staff to assess them a little bit easier.

Q. Did Mr. Howell appear—was he complaining about anything when he was in the medical sallyport?

A. I remember hearing a lot of moaning and groaning and him yelling stuff to just—it was hard to understand what he was saying, if I recall correctly.

Q. Do you recall him ever saying that he was in pain?

A. I can't recall exactly what words were coming out of his mouth.

Q. Do you recall him ever saying that he couldn't feel his legs?

A. I do recall hearing something about—or hearing something about legs, maybe about back. I don't know. It's—it was a long time ago.

Q. What do you recall of—was he able to—you know, how was he acting in the wheelchair? Was he able to hold himself up?

A. I remember him sliding out of the chair and not being able to remain in it. And I know that he was picked back up and put back into the chair and reseated into the wheelchair.

Q. Did it look like he was able to—I mean, is that natural or is that normal, people sliding out of the chair?

MR. WELCH: Objection. Go ahead.

A. I mean, that's—it happens, yes. It happens. Why? I don't know.

Q. And at a certain point, do you recall that he started laying on the ground?

A. Yes.

Q. Describe for me how he got to the ground.

A. I can't describe how he got to the ground. I just know that he was—he ended up on the ground. And to my knowledge, he ended up on the ground on his own—on his own accord.

Q. What was he doing when he was on the ground?

A. I do recall him rolling around, rolling from one side to the other side onto his stomach, onto his back, extending it. I do believe he was still handcuffed in the front. I remember his arms at one point being stretched above him on his own and him rolling side to side.

Q. Was he still groaning and moaning when he was doing that?

A. I believe so, yes.

Q. Did he sound like he was in pain?

A. I can't determine, personally, what pain is for someone.

Q. Was his demeanor at all concerning to you?

A. His action—his being and what he was displaying at that time, it was unknown to me what was going on.

Q. Did you ever hear any discussion about sending him to the hospital?

A. I know the nurses discussed some things about what to do, and I do recall that, yes. I do recall hearing that. I do.

Q. What were the nurses discussing?

A. That, I don't know.

Q. So talk to me about what you remember about any discussions about the hospital.

A. I remember somebody saying, Do you want to send him out? And I don't know what other discussion was in the middle of that. And then I heard, No. And then I heard it brought up again. And then I heard, No, from there.

Q. So to the best of your recollection, was it the medical staff who said no on both of those occasions to sending him to the hospital?

A. Yes, because medical staff is the one who would determine whether or not they're going to go to the hospital.

Q. And as I understand it, the jail—the officers at the jail can only order a hospitalization if somebody's, like, bleeding out of their head or something very significant; is that correct?

MR. WELCH: Objection as to form, but you can answer.

A. If you . . . That is . . . If I see someone having what I believe to be a true medical emergency and I think that I should—I should call the ambulance for them. And knowing that it's outside . . . I'm trying to answer this—how to answer this.

We have medical staff there. Now, if I come around a corner and I see this guy's gushing and—gushing blood from somewhere, yes, I'm going to go ahead and notify that because, in my under-

standing, yes, they're going to say the same exact thing.

Q. So you talked about if you thought it was a true medical emergency. You mentioned true medical emergency. And as I understand it, that you would call for a hospitalization or call for an ambulance, right?

A. Yes.

Q. And on December 9, 2018, you did not make a call to an ambulance while Mr. Howell was in the medical sallyport, correct?

A. He was surrounded by medical staff. If we did not have a medical staff arriving, or near or close by or whatever, and there was a situation that we knew resulted in needing the person to go to the hospital, then, yes, we would make that call. Other than that, we—medical makes the decision.

Q. And my question is simply while Mr. Howell was in the medical sallyport, you personally did not call any ambulance, correct?

A. No.

Q. Did you ever hear anyone mention any concerns for Mr. Howell's mental health?

A. I remember someone saying something about mental health. What the exact words were, I cannot recall.

Q. Do you recall who the conversation—who was having the conversation about whether to send him to the hospital?

A. No.

Q. Do you recall who was having the conversation about mental health issues?

A. No.

Q. Did you ever see anyone call a psychiatrist while you were in the medical sallyport with Mr. Howell?

A. No.

Q. Did you ever hear of anyone call a psychologist while you were in the medical sallyport with Mr. Howell?

A. I did not.

Q. Ultimately, Mr. Howell was placed in a restraint chair, correct?

A. Yes.

Q. Who made the decision to place him in that chair?

A. The charge nurse at the time.

Q. Christina Jordan?

A. I believe that's so.

Q. So tell me about how that decision was—tell me about the lead-up to that decision.

MR. WELCH: Objection. Go ahead.

A. I recall being there in the sallyport; Mr. Howell rolling around on the ground. The decision—whether or not he was going to be sent out to the hospital or not was—decided that he was not going to be sent out by medical.

And with him laying there in the floor of the sallyport—we can't just have someone laying in

the middle of the floor in the sallyport rolling around from side to side.

So the question that I do recall asking was, Where is he going? Where do you want him? What is going on? I can't just leave him laying here in the middle of the floor rolling around.

He's rolling into a—into chairs. He's rolling from side to side. He's bumping into chairs, a file cabinet. I can't have him doing that here. In my eyes, him rolling around side to side is—got a danger of harming himself some way, somehow.

I said, Where do you want him to go? What do you want to do? I remember that's about—I think that might be when I heard something about mental health.

So I asked, Do you want him housed down here? Do you want him in sight? Do you want him in the restraint chair? What are we doing? What's the next step?

If is this a medical emergency, if this is, what's your next step? I have other steps that I have to follow upon their decision. So I was asking those questions.

When it was decided that he's not going to the hospital and that, for his safety and for observation, he's going to be put into the restraint chair, the restraint chair was called for and brought down to the medical sallyport.

Q. All right. And you said you're having those conversations with the charge nurse?

A. There were several nurses standing around. Was my actual discussion directed specifically to one person in medical? I cannot recall.

If they were all there, it was as a group, who's making this decision, or who is making this decision if somebody is. Let's make a decision.

Q. And was it Christina Jordan that was the ultimate decision maker, then?

A. I believe so.

MR. WELCH: Objection. Go ahead.

THE WITNESS: I'm sorry.

MR. WELCH: No, you're fine.

Q. And it was—it was decided that the chair was going to be utilized for his safety and then observation of him?

A. Yes.

Q. And that was what Christina Jordan or the charge nurse—one of the nurses said was the basis for putting him in the chair?

A. For his safety.

Q. And observation?

A. When they're going into the restraint chair, they're going into the restraint chair and they're going to be observed. So for observation, it serves the same purpose of being placed into the restraint chair.

Q. What, if any, less restrictive restraints were considered?

A. Less restrictive constraints considered? Well, he was handcuffed behind his back following the altercation he was in. Restraints were then removed from his back to the front of his body. That, itself, puts less restraint to it.

Outside of the handcuffs being completely removed and then him . . . Considered? If he was—I believe for his safety if he was to be placed into a cell and put on regular 30-minute checks at the—how he was displaying his behavior and—in medical, that he possibly could have still continued to cause harm to himself inside of a cell.

Q. So did you agree with the decision to place him in a restraint chair?

A. I did.

Q. Do you believe that that decision was justified under the jail's policies and procedures?

A. I do.

Q. All right. And at some point, did you have a conversation with Lieutenant Buchanan about Mr. Howell?

A. I believe I informed him kind of what all had gone on and what all went down. Oh, he left early that night. He was already gone when that happened. I believe I did. I informed him of the incident that occurred, I believe, on George-42 and just kind of let him know what was taking place at the time.

Q. Tell me about—tell me specifically what you remember about that discussion. I guess, let me

take a step back. Was that a discussion that you had in person with Lieutenant Buchanan?

A. I would say, per se, yes. I do recall him being in the LC on medical and me out in the sallyport and talking on the phone while directly looking at each other. I'd say that's still personal.

Q. And earlier, you said that the chair was called for. Who called for the chair?

A. Once it's decided—once it was decided by medical that he was going to be placed into the restraint chair and other officers hear that, or whatever it is, or they say, Yes, he's going into the restraint chair, I look around for someone and say, Hey, can you go get the chair? That is calling for the chair.

Q. So you would have directed someone to go and retrieve the chair and to bring it back to the sallyport, correct?

A. If it wasn't me saying, Yes, get the chair, or another officer standing there saying, Yes, go into the chair, and them going and getting the chair and bringing it to medical sallyport.

Q. Why did you speak with Lieutenant Buchanan about this incident?

A. He is my supervisor. He is my boss, and I will inform him of what is going on. He is part of my chain of command.

Q. And did he ultimately need to sign off on the use of the restraint chair?

A. If he did not—if he was not the one that signed off on it, then it would have been another super-

visor that was there. But at the same time, if I recall the policy and the way that it was being done at that time, I was not the one that ordered the inmate into the chair, and I was not participating in placing him into the chair; I was there as strictly a supervisory role, then I could sign off on that report as well.

Q. And I just want to understand how the policy interacts with what sounds like you testified is a medical decision to place him in the chair.

So if medical says he's going into the chair, does the jail supervisor—does a jail supervisor still need to say, Yes, that's okay, or do you just follow what medical says?

A. We follow what medical says.

Q. So if you look at Exhibit 2, which is right there, that fourth page, letter H says that incident reports of the use of physical restraints shall be reviewed and signed off on—signed off by a non-involved supervisor or higher ranking personnel and reviewed for a less restrictive alternative.

Am I understanding your last answer to be this would only apply if it was a jail decision to place someone in a restraint chair?

A. Stand by. (Examining document.)

MR. HOJNOSKI: Ryan, give me 30 seconds.

(Attorney Hojnoski left the room.)

THE WITNESS: Can you repeat the question?

MR. KIRCHER: We've got to wait.

(A brief break was taken, and then

the question was read back.)

A. That's actually a good question. (Examining document.) For me as a non-involved supervisor, although I was present, I was there, I was not a—I don't believe I was—I was not a determining factor of it. I did not assist in securing him into the restraint chair.

Therefore, I believe I could sign off on that with medical. And if it's me who would, for any such incident, direct the prisoner to be placed into a restraint chair, then it would fall under another supervisor to review the report at that time.

Q. All right. So you were present while Mr. Howell was in the medical sallyport, right?

A. Yes.

Q. All right. So your presence alone doesn't make you an involved supervisor?

A. Explain.

Q. Well, my question is aren't you involved in the situation? You're there when that decision is being made, right?

A. I'm there, but I'm not the one making that decision.

Q. You're the one who's saying to medical, What are we doing here, right?

A. I'm asking that question.

Q. That doesn't—you're still uninvolved at that point, or non-involved, when you're asking that question?

A. My understanding of that, yes, I'm still not involved. I'm not making that decision. I'm not the one placing him into the chair. With me being a supervisor with that, I'm there to supervise.

I'm not involved in the decisions and the actions. I'm there to make sure that it's going to be done and that he's placed into the restraint chair appropriately.

Q. To your recollection, do you recall any other jail supervisor who was present in the medical sallyport at the time the decision was made to place him in a restraint chair?

A. Off the top of my head and trying to look back that far, I cannot recall who all was in the sallyport.

Q. Was Mr. Howell resistant in any way to being placed in the restraint chair?

A. I honestly do not know.

Q. Have you ever looked at the video of him being placed in the restraint chair?

A. No, I've not.

Q. Do you recall if force was necessary to place him in the restraint chair?

A. I do not believe.

MR. WELCH: Objection.

Q. At any point when you were in the medical sallyport, did you ever hear Mr. Howell say that he had sickle cell disease?

A. I remember hearing something about sickle cell. Where it came from, I don't know.

Q. Describe what you recall hearing about sickle cell.

A. I just remember hearing sickle cell.

Q. Do you know anything about sickle cell?

A. I do not.

Q. After Mr. Howell was placed in a chair—in the restraint chair, describe his demeanor.

A. I cannot recall.

Q. Was he thrashing around in the chair?

MR. WELCH: Objection. Go ahead.

A. I do not recall.

Q. Did you ever hear him complain of any pain?

A. I do not recall. I believe I was—I know I was present in the sallyport until he was rolled out of the sallyport, but I honestly do not recall at all.

Q. All right. Were you part of the transportation process from the sallyport to Pod A of G-21?

A. No.

Q. Ultimately, he was placed in Pod A, correct?

A. Yes.

Q. And did you participate in the process of securing him in that cell?

A. No.

Q. Do you know who was responsible for securing him in that cell?

A. No.

Q. And in terms of Pod A's layout, there's a door that you walk into from just outside the control room, correct?

A. Yes.

Q. It's got clear windows, right?

A. Yes.

Q. And then there's a fire door between Pod A and Pod B, correct?

A. Yes.

Q. There are no other points of ingress or egress into Pod A, correct?

A. No. A Pod door and fire door are the only two access doors into and out of that pod.

Q. So what's the next thing you— what was your next interaction with Mr. Howell?

A. My next interaction with Mr. Howell would be when I came down on my final round to mental health to check on the suicide watches, check on Mr. Howell, and evaluate him to get out of the restraint chair.

Q. Okay. So I want to—I'm going to hand you what has been previously marked as Plaintiff's Exhibit 6. Let me know when you've had a chance to review that.

A. (Examining document.) Okay.

Q. All right. Is your handwriting anywhere on this form?

A. Yes.

Q. Where on this form specifically? I guess, let me do it a different way. Inmate name, did you write Cornelius Howell?

A. Yes.

Q. You can't see that, but I assume that is the jail number, inmate number?

A. Yes.

Q. That's your handwriting?

A. Yes.

Q. All right. And under inmate name, what does that—there's something circled. Did you circle that?

A. Yes.

Q. And what does that say? I can't read it, so I'm hoping you can help.

A. POP, population.

Q. What's D—is that DET or POP?

A. Yes.

Q. So what does DET mean?

A. Detention prisoner.

Q. And what does that signify?

A. That signifies someone who just came into jail. The detention prisoner is someone who came into jail who is pending their arraignment. They're still in their street clothes. They've not

been classified as an inmate yet. They're still considered prisoner—detention prisoner and not classified as an inmate yet.

Q. And POP you said is population?

A. Yes?

Q. Which means that that inmate has been at the jail; they're in the jail population at this point?

A. Yes. They've been classified and they're in jail population.

Q. All right. And then reason in the chair, did you write that?

A. Yes.

Q. And it says, Per medical, uncooperative for his safety?

A. Yes.

Q. Time placed in chair, 17:14. Did you write 17:14?

A. That says 17:40.

Q. I apologize.

A. Yes.

Q. And next to that, I think it says, On watch?

A. Yes.

Q. And is that specifying on suicide watch?

A. Yes.

Q. All right. And he was not on suicide watch. Was that you circling "no"?

A. Yes.

Q. And underneath 17:40, there's the hour and the number 1. Did you write that?

A. Number 1, number 2, number 3, and number 4, I cannot specify that is my handwriting.

Q. All right. What about the time there; it says 17:40?

A. Yes.

Q. And in chair, medical sallyport to N-21?

A. Yes, that is mine.

Q. What does that signify?

A. That signifies him being placed, and the time that he was placed into the chair, and the time that he was being transported to North 21.

Q. All right. And where were you, physically, when you filled that row in?

A. That row? When I filled this in, I was sitting in B Pod on North 21.

Q. From your vantage point, could you see—in B Pod, could you see who was securing him into the cell at all?

A. No.

Q. And then it looks like 17:50, Yelling in chair. Is that your handwriting as well?

A. Yes, it is.

Q. So did you—you physically conducted the observation of him at 17:50?

A. I did not.

Q. All right. How did you write that, then?

A. I wrote that at 17:50. What I had done is I had walked down—and at 17:40 when he went in the chair, I know that—I walked down, I started the log, grabbed the paper while the officers were securing him into that cell, and I started the paperwork for him, got the top part filled in, got the first entry right there for them filled in on that time.

Backdating for the times that this happened, these are the times that I know. At 17:50, officers are present in that cell, and I'm hearing yelling while he's secured in that chair. And I feel very comfortable documenting "yelling in chair" because I know there are officers present.

Q. Do you know, roughly, at what point after this notation that officers had left the cell?

A. No.

Q. So you don't recall how long it took to secure him into the cell?

A. No.

Q. All right. And other than these two entries where you're in B Pod, prior to discovering Mr. Howell deceased, did you have any other interaction with him?

A. No.

Q. Were you ever contacted by any deputy indicating that they believed Mr. Howell was a candidate for removal from the restraint chair?

A. I do not recall.

Q. Now, Officer Collini earlier testified that he contacted you at the two-hour mark, and you told

him, I'll be down when I can. Do you recall that conversation?

MR. WELCH: I'll object, but you can answer.

A. I do not recall that.

Q. And you didn't respond at the two-hour mark, right?

A. I do not believe I did, no.

Q. So Mr. Howell got no limb rotation, right?

A. To my knowledge of reading this form in front of me.

Q. Why didn't you come down around the two-hour mark?

A. I cannot answer that question. I do not recall exactly what was transpiring that evening during my shift, what I was in the middle of—what other responsibilities I was in the middle of handling or doing.

Q. Was there anything more important that you would have been doing at the jail that evening?

MR. WELCH: I'll object, but you can answer if you can.

A. As a supervisor, I'm responsible for not just one unit, one inmate. I'm responsible for all staff. I'm responsible for the whole facility and all the units that are housed there.

At any moment in time, there might be another incident on another unit. That is my current responsibility right there.

I can't say whether or not one thing is—you can prioritize some things, but the officers working on George 21 are there because they work, and they do what they're supposed to do. They do their jobs. And that's why I rely on them. I rely on the officers to do their jobs.

Q. Is there any reason you don't prioritize restraint chair inmates?

MR. WELCH: Objection as to form and assumptions, but go ahead.

A. Ask the question one more time.

Q. Is there any reason you don't prioritize in your responsibility inmates who are in a restraint chair?

MR. WELCH: Objection. Go ahead.

A. I personally—I personally make mental note of the time when they go into the chair. I make mental note of what's going on and make attempts to, but everything is subject to change at any moment in time.

Q. Other than Mr. Howell's death, there was nothing of any significance that occurred on December 9th, 2018, was there?

MR. WELCH: Object. Go ahead. You can answer if you can.

A. I would have to reference my supervisor's daily log.

Q. All right. So I'm going to hand you what was previously marked as Plaintiff's Exhibit 10. It is details of an investigation which were prepared

by Detective Mike Stock. I'll give you a chance to look at that.

A. (Examining document.)

Q. Have you had a chance to review that?

A. Yeah.

Q. All right. I'm going to turn your attention to page 2, third-to-last paragraph on the page. The last sentence reads, Deputy Pierani verified all the log entries—second-to-last sentence—which ended with "DP" were entered by him. He also advised nothing out of the ordinary, except inmate Howell being placed in the restraint chair, occurred on 12/9/18.

Do you have any reason to question what Deputy Pierani reported to Detective Stock?

MR. WELCH: Objection. Go ahead.

A. No.

Q. All right.

A. If I'm—I'm not sure if I'm fully understanding what you're asking, what log you're talking about; but I don't have a reason to think anything out of the ordinary or think of anything not right at all, no.

Q. And my question was nothing out of the ordinary occurred on December 9th, 2018, except for Mr. Howell's death—

MR. WELCH: Objection.

Q. —correct?

MR. WELCH: Objection. You can go ahead and answer it again. It's been asked and answered.

A. I . . . I don't understand. What I'm not understanding is I'm not understanding the question versus somebody else's statement.

Q. You said you couldn't remember when I asked it originally. You couldn't remember if anything—what else was going on that day. Do you recall that you couldn't—

A. I recall that, yes.

Q. All right. Do you remember anything else out of the ordinary which occurred on December 9th, 2018, aside from Mr. Howell's death?

MR. WELCH: Objection. Go ahead. Tell him again.

A. Work-wise or out in the world in general?

Q. Work-wise with respect to the jail.

A. With respect to the jail? I recall a fight that had taken place and someone being stabbed with a pencil prior to involving Mr. Howell.

Q. You indicated a couple times that you keep mental notes when inmates are in the restraint chair?

A. Mm-hmm.

Q. Is that a yes?

A. Yes.

Q. Is there any reason your mental notes didn't go off on this day prior to when you came down at four hours?

MR. WELCH: Objection.

A. I would have to—I'd have to look at my supervisor's—my supervisor daily log to see what I had there.

MR. MCGRAW: We'll make a Rule 34 request for those supervisor logs.

Q. (By Mr. McGraw) And looking at Exhibit 6—so I'm done with Exhibit 10 now. Looking at Exhibit 6, there's the completion of the two-hour in chair portion of that. Do you see that?

A. I do.

Q. And it says, If unable to exercise limbs, explain why. And Officer Collini testified that that's his handwriting that says, Sleeping, doesn't want.

So my question to you is are those notes about exercise appropriate?

MR. WELCH: Objection. I think it's been asked and answered, but you can answer if you can.

A. It is the officer's perception of how they see things and how that officer will document things.

Q. Can an officer make the determination that an inmate does not want his limbs exercised?

MR. WELCH: You can answer.

A. If the inmate's behavior presents that and the circumstances at foot, yes.

Q. What about when he's sleeping?

MR. WELCH: You can answer.

A. Yes. He can decide—the officer has that decision—has that decision if the inmate is sleeping.

When was the inmate sleeping? How long has he been sleeping? What's the behavior prior to that? All these—they're all factored into the decision of the officer.

Q. So without talking to the inmate or without talking to a supervisor, the observing officer can make a decision that the inmate in a restraint chair doesn't want limb exercises?

A. Based upon the behavior and the policy also stating recommended based upon the behavior.

Q. Prior to you coming down at the four-hour—roughly the four-hour mark, did you receive any communications from Deputy Erwin about how Mr. Howell was doing?

A. Not to my knowledge.

Q. And you've already testified that you didn't hear anything from Officer Collini either, correct?

A. Correct. I do not recall.

Q. Do you recall ever reaching out to either Deputy Erwin or Deputy Collini to ask, How is Mr. Howell doing?

A. I do not recall that either.

Q. If you had, would you have logged it on your supervisor's log?

A. I cannot say whether or not I would have at that moment in time. I would say, myself, I would have logged, yes.

Q. Is it your custom and practice to log inquiries about inmates who are in a restraint chair?

A. At what point?

Q. At any point.

A. At any point? Yes.

Q. And earlier, you talked about reviewing some video prior to today's deposition. Do you recall that?

A. Yes.

Q. When, prior to today's deposition, did you review that video?

A. I cannot recall exactly when—when it was sent through my administration to review these at the request of my attorney.

Q. Sometime before today?

A. Yes.

Q. And if Officer Collini says that he called you at the two-hour mark, do you have any reason to dispute his recollection?

MR. WELCH: Well, objection. He said he didn't recall, but go ahead and answer.

A. I have no reason to dispute that. I clearly don't recall whether it happened or it didn't happen.

Q. I'm going to play you a few portions of an audio-recorded interview by jail investigators with Detective Collini—I'm sorry, Officer Collini. I'm going to play three separate clips. So I'll let them play, and then I'm going to ask you questions after that. Okay?

We are going to start at the 7:30 mark, and is this what's previously been identified as Plaintiff's Exhibit 21.

(Audio playing.)

I'm going to stop it there at the 8:37 mark. I'm going to fast-forward to the 9:30.

(Audio playing.)

I'm going to stop it there at 9:58. I'm going to fast-forward to 11:25, starting it at 11:23.

(Audio playing.)

I'm going to stop it there at the 12-minute mark.

If that is what Officer Collini observed of Mr. Howell, how in the world was he still in the chair at 21:45?

MR. WELCH: I'm going to object to the form and foundation, but you can answer if you understand the question.

A. I don't fully understand the question.

Q. Every observation that Officer Collini makes says he's sleeping. Shouldn't somebody get him out of the chair if he's sleeping?

A. The officers are assessing the situation and—while they're making their rounds. I have other responsibilities as a supervisor. And if they call and inform me that, Hey, we'd like to get this guy out of the chair, okay, I'll be down there as soon as I'm able to.

Q. So if what you just heard Officer Collini say is what he observed, should he have contacted you to consider Mr. Howell for removal?

MR. WELCH: Objection. At what time? Are you talking about time or just in general?

Q. Any time.

MR. WELCH: I object. You can answer if you can.

A. I can't answer for the officer. I can't answer for him and what he's saying and what he's doing.

Q. And you talked about earlier that your officers do their checks, right?

A. To the very best of my knowledge, they do.

Q. All right. So if you see on Exhibit 6, there are three different checkmarks on the right side of the page that are dated 6/17/2020. Do you see that?

A. Yes.

Q. And earlier today, Officer Collini testified that those were the only three checks that he did of Mr. Howell. Did you—were you aware of that?

A. No.

Q. Is that concerning to you?

MR. WELCH: Objection. Go ahead.

A. Yes.

Q. Why?

MR. WELCH: Same objection. You can answer.

A. Because I really believe that the officers do their jobs and do what they're supposed to be doing. I really truly believe that they do what they are supposed to do. They make their rounds, they make their logs, and they do what they're supposed to do.

Q. And it's clear, based on Officer Collini's notations, that the only times that he reviewed him

were these three times. Is this just a one-time screwup by him?

MR. WELCH: Objection. Go ahead.

A. As far as I'm concerned, I would have to say yes, but I don't know exactly what his full testimony was. I don't—to my knowledge, yes. I've never known him to falsify rounds. It has not been ever brought to my attention. I've not had any reason to question the officers.

Q. Officer Collini also—we went through the surveillance video with him. As you can see here, he notes that—he represented that he did 12 checks on Mr. Howell during the two-plus hours that he was observing him. And we now know that to be inaccurate. He only did the three. But he observed him in the two-plus hours only 43 seconds. Is that concerning to you?

MR. WELCH: Objection. You can answer if you can.

A. 43 seconds for what you're saying is three checks?

Q. No. What I'm saying is he was in charge of Mr. Howell for two-plus hours where he was supposed to do 12 checks of him, and he observed Mr. Howell for only 43 seconds. Does that concern you?

MR. WELCH: Objection as to form and foundation. You can answer if you understand the question.

A. I mean, outside of me now—me knowing that he completed just only three rounds—as for seconds of checking on an individual, it only takes seconds to check on an individual to my understanding

and—to working. It takes seconds to check on an individual.

Q. But not doing the checks at all, that's got to be concerning to you at least?

MR. WELCH: Objection. That's been asked and answered, but you can answer.

A. With it brought to light now, yes.

Q. Failing to conduct these checks puts inmates at risk, doesn't it, who are in the restraint chair?

MR. WELCH: Objection. You can answer if you can.

A. The inmate is in a restraint chair. They are restrained. Them causing physical harm to themselves is minimized tremendously.

Q. How does the officer know what's going on if he doesn't check?

A. I can't answer that question on the officer. I can't answer that question. I'm not the officer there. I can't answer that.

Q. So let me ask it a different way. Can an officer know what's going on with that inmate if he doesn't check on him?

A. At the exact time frame of a specific time? I would have to say no. It's the same thing as whether or not the inmate's looking to the right out the window and—but as soon as you step away from that window, he looks straight ahead. You don't know exactly what transpires at each second and whether or not that's also changing.

Q. Do you believe that Deputy Erwin conducted all of the checks that were noted for him here?

A. To the best of my knowledge, yes.

Q. Can you commit, after today's deposition, to review the surveillance footage of that night?

MR. WELCH: Objection.

A. I will not.

Q. Why not?

MR. WELCH: Objection.

A. I will not because as far as I'm understanding, this is still an open investigation—or open through—the department still has an open investigation, and I'm not the one responsible for investigating.

Q. Okay. Now that you know Officer Collini represented on this form that he conducted observations that he did not conduct, what will you do to check his other shifts—

MR. WELCH: Objection.

Q. —if anything?

MR. WELCH: Objection. You don't have to answer that question.

MR. MCGRAW: I'm sorry. On what grounds is he not answering the question?

MR. WELCH: It's not relevant to this case.

MR. MCGRAW: It may not be relevant. That's no basis for him not to answer the question.

MR. WELCH: I'm instructing him not to answer that question.

MR. MCGRAW: Mark that.

MR. KIRCHER: Maybe the prosecutor's office will look into it.

Q. (By Mr. McGraw) Is it acceptable for officers to represent on this form that they observed inmates when they have not actually done so?

MR. WELCH: Objection. You can answer.

A. If a check was not done, a check shouldn't be logged.

Q. Is it acceptable to tail—to tell jail investigators investigating a death at the jail that you conducted these checks when you didn't actually conduct the checks?

MR. WELCH: Objection. You can answer.

A. I cannot answer for someone else's—someone else's testimony.

Q. I'm not asking about his testimony. I'm just asking you in general. Is it acceptable for an officer to say on a form that he's conducted a check and to tell the investigator, I conducted that check, when he didn't actually conduct the check?

MR. WELCH: Same objection. You can answer.

A. If you didn't conduct the check, you didn't conduct the check. Saying that you conducted the check, that's on you.

Q. You shouldn't tell an investigator that you conducted it, right?

A. Myself, personally, I would not. I can speak for myself. I would not.

Q. If you found out one of your subordinates told investigators that they did something that they didn't actually do, what would you think, or in this case, what do you think?

A. It's definitely not right. It's not right at all. It is definitely not right. But at the same time, this is still an open investigation. It's still an open case.

Q. What, to your knowledge, is open about this case?

A. As far as I know, it's still under investigation. I know there's been—I know there's been an autopsy report, but I just don't—I haven't heard or been told or anything, and I'm not sure even if I am told that, Hey, this investigation's closed. Okay.

And I don't know if I'm supposed to hear that, but to my knowledge—to me in my knowledge, me being a supervisor and being a part of this whole incident as a whole, if it's not closed, then—so as far as I know, it's still an open investigation.

Q. Have you ever disciplined Officer Collini concerning Mr. Howell's death?

A. No.

Q. Now that you know what you know, will you?

A. I cannot speak on that.

Q. Now that you know what you know about his completion of this form, will you report it to your supervisors?

A. Through investigation—

MR. WELCH: Objection. Go ahead.

A. Sorry.

MR. WELCH: Go ahead.

A. Through investigation and through, I guess, this discovery or this—however— whatever process this is, it's going to be forwarded on, and it will be known by our internal affairs division who will then do their investigation off of the findings, which is why I still believe—which is why I believe this is considered an open case still.

Q. Okay. If the investigation is closed and you now know what you know about Officer Collini's completion of this observation log, do you believe it should be reopened?

MR. WELCH: Well, objection. Go ahead.

A. I believe that it should be looked into. It should definitely be looked into. Something should be relooked into with this regarding checks being logged that weren't made.

MR. MCGRAW: Now would be—I think I've only got a couple minutes, but I want to check my notes.

MR. KIRCHER: Let's go off video at 4:19.

(A brief break was taken.)

MR. KIRCHER: Going back on video at 4:29.

Q. (By Mr. McGraw) We're back on the record. Sergeant Hunt, just a couple follow-up questions.

On that restraint chair form Exhibit 6 where it says, Reason in chair, Per medical, uncooperative

for his safety, was that all written at the same time?

A. I'm trying to recall, and I—I cannot recall. I believe so.

Q. And was that done when you started this form, to the best of your knowledge?

A. To the best of my knowledge, yes. I believe the reason being is continuing for his safety. There was just not any more room with the next line there, so I went directly under.

Q. Okay. And you wrote that all, to the best of your recollection, at the same time?

A. I believe so, yes.

Q. All right. You were interviewed by jail investigators, correct, as part of Mr. Howell's—the investigation of Mr. Howell's death?

A. Our criminal investigative section from our road patrol did that investigation, interviewed me, yes.

Q. Was your interview, to your recollection, audio recorded?

A. I do believe so.

Q. On December 9, 2018, were you in charge of any inmates who required more frequent observation than suicide watches and restraint chair inmates?

A. My direct supervision? My eyes?

Q. Correct.

A. Those inmates are supervised by the officers, not my direct eyes.

Q. But the officers that you oversee, are there any officers who are required to observe inmates more frequently than the 10 minutes for restraint chairs and suicide watches?

A. Would be the same thing regarding with the female housing unit if they had suicide watches or a female in a restraint chair up on that unit. They fall under the same with that. So the—the period of checks for those fall under the North 21 and George 31 housing units.

Q. But my question is for the men and women suicide and restraint chairs, there's nobody else—no other inmate is required to be observed any more frequently than them, correct?

A. According to the policy, I would say yes.

(Plaintiff's Exhibit 27 marked.)

Q. All right. I'm finally going to hand you what has been marked Plaintiff's Exhibit 27.

MR. HOJNOSKI: Ryan, that just reminded me. We've now marked up Exhibit 6 or at least cleaned it. Are you going to make that a different exhibit? Because, like, you know, currently my Exhibit 6 doesn't have the mark-ups.

MR. MCGRAW: Kelly is, yes. We'll talk about that.

MR. HOJNOSKI: So that's going to be a substitute Exhibit 6 or a different number?

MR. MCGRAW: We can do it—

MR. HOJNOSKI: However you want, so my notes—I know where to go back to it.

Q. (By Mr. McGraw) Have you had a chance to review that?

A. Yes.

Q. My only question is is this your handwritten report about what happened on December 9th, 2018?

A. Yes.

Q. Sergeant Hunt, do you utilize social media at all?

A. Yes.

Q. What site do you use?

A. Facebook.

Q. At any point, have you ever posted on Facebook anything concerning Mr. Howell's death?

A. No.

Q. Anything concerning Mr. Howell at all?

A. No.

Q. Have you ever had a conversation with anyone outside of the sheriff's office concerning Mr. Howell's death?

A. Besides speaking with my parents regarding a—regarding the incident? No.

Q. What did you tell your parents?

MR. WELCH: Objection. Go ahead.

A. While at work, had an inmate pass away during my shift and had a critical incident to handle.

Q. That's it?

A. Yes, pretty much.

MR. MCGRAW: I've no other questions.

MR. WELCH: We'll read it.

MR. KIRCHER: Going off video at 4:34.

(Whereupon, signature was requested, and the deposition concluded at 4:34 p.m.)

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JUSTIN HUNT

DEPOSITION OF MATTHEW COLLINI
(JUNE 17, 2020)

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

KARLA HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

Case Number: 1:19-cv-00373

Before: Kelly GREEN, RPR, Notary Public.

MR. KIRCHER: We are on video at 9:08 a.m. on June 17th, 2020, Case Number 1:19-cv-373 in the United States District Court for the Southern District of Ohio captioned Karla Howell versus NaphCare, Inc.

The official record will be the written transcript. Would you please swear the witness.

MATTHEW COLLINI,
a witness herein, having been duly sworn,
was examined and testified as follows:

CROSS-EXAMINATION BY MR. MCGRAW:

Q. Good morning, sir. How are you?

A. Good morning. How are you?

Q. Good. My name is Ryan McGraw, and along with Konrad Kircher, I represent Karla Howell and the estate of Cornelius Pierre Howell. Can you please state your name and spell it for the record.

A. Matthew Collini, M-A-T-T-H-E-W, C-O-L-L-I-N-I.

Q. And is it okay if I call you Officer Collini?

A. It doesn't matter. You can call me whatever.

Q. Officer Collini, have you ever given a deposition before?

A. No, have not.

Q. Okay. So let me give you a couple just ground rules so that we make this process go smooth.

A. Okay. That's fine.

Q. As you can see, there's a court reporter who's taking down everything we say. For that reason, only one of us should speak at a time. It allows her to take down accurately the record. So please don't try to speak over me. I will do the same to you and not try to speak over you.

Please allow me to ask my full question. You may anticipate what I'm asking and be ready to answer, but just for the record's sake, please allow me to finish my question. Okay?

A. Okay.

Q. And if I interrupt you at any point, please know it will have been inadvertent; I thought you were finished. If you need to complete your answer, please just let me know, and I'll be happy to let you continue. Okay?

A. Okay.

Q. Because we're making a written record, we're going to need audible answers today. So uh-huh or uh-uh or a nod or shaking of your head, I may ask you is that a yes or a no. I'm not trying to be rude; I'm simply trying to make sure that the record is clear. Okay?

A. Yes.

Q. If at any point my questions to you are unclear, please bring that to my attention, or you didn't understand it, you were thinking about something else, bring that to my attention. I'll happily rephrase it. Okay?

A. Okay.

Q. But if you answer my question, I will assume you understood it. Is that fair?

A. Yes.

Q. Will you agree today to provide responsive answers to my questions?

A. Yes.

Q. If I ask you a yes-or-no question, will you cooperate in providing a truthful answer to it?

A. Yes.

Q. Is there any reason that you can't give truthful testimony today: a bad night's sleep?

A. No.

Q. Okay. Other than speaking with your attorneys, what have you done to prepare for today's deposition?

A. Not much. Not much of anything, really. Just talking to them, going over the material that they gave me. Other than that, nothing.

Q. Did you go over some documents?

A. Yes, different documents. What was it? The deposition paperwork or whatever and the policies that we have, our chair policy and everything like that.

Q. So you reviewed the restraint chair policy?

A. Yes.

Q. Any other policies that you reviewed?

A. No.

Q. Anything else that you reviewed?

A. Video.

Q. Okay.

A. Some video. Not much of it. Only a little bit of the video that—on the cell of where it was. Only maybe a half an hour of it.

Q. Do you remember what half hour of it?

A. From 19:30 to 20:30, I think it was.

Q. And that doesn't-that 19:30 to 20:30, that doesn't cover the entirety of the time that you are responsible for observing Mr. Howell in the restraint chair, does it?

A. No.

Q. Is there any reason you didn't review any additional video?

A. No, not really. Just didn't—just didn't do it.

Q. Did you review any audio?

A. Audio? A little bit the other day, the audio of me talking to the detectives.

Q. Okay. Did you speak at all with Deputy Barth?

A. No.

Q. Deputy Roettker?

A. No.

Q. Deputy Terry?

A. No.

Q. Deputy Pierani?

A. No.

Q. Sergeant Franklin?

A. No.

Q. Deputy Erwin?

A. No.

Q. Sheriff Neil?

A. No.

Q. Sergeant Hunt?

A. No.

Q. Lieutenant Buchanan?

A. No.

Q. Jessica Jones?

A. No.

Q. Have you ever been involved in a civil lawsuit before?

A. No, not that I know of.

Q. Have you ever been sued before?

A. No.

Q. Have you ever been charged or convicted of a crime?

MR. WELCH: Objection. Go ahead.

A. I had a DUI a couple years ago—two three years ago over in Kentucky, and I also had a disorderly conduct I think a year before that just for a ticket. It was a ticket, but misdemeanor 1, I think it was, or something.

Q. Okay. And that was in July of 2014?

A. Yes.

Q. And you paid out a $140 fine on that?

A. Yes.

MR. WELCH: Ryan, can I have a continuing objection to these questions rather than interrupt every question that you ask?

Q. And in November of 2014, were you charged and convicted of obstructing a traffic officer?

MR. WELCH: Objection.

A. Objection. No. I'm sorry. No. They think—they thought I was.

(Reporter clarification.)

A. They tried because I was—I had my badge on me, and they thought I was—looked like impersonating a cop, but I wasn't.

Q. And did you pay a $340 fine for that?

MR. WELCH: Same objection. Go ahead.

A. No, I don't think so.

Q. Officer Collini, are you married?

A. No.

Q. Do you have any children?

A. No.

Q. Talk to me about your education. Where did you go to high school?

A. Oak Hills over on the West Side. I graduated high school. I had a little bit of college in and out, but I didn't really make it. So I went to the Army, did like five years in the Army, then got out and became a correction officer.

Q. And what year did you graduate from Oak Hills?

A. 2002.

Q. You said you had a little bit of college. Where did you go?

A. Went to, like, Antonelli down here for the—like, taking pictures and stuff. It didn't really work out that well. I couldn't really make criticism, I guess. Then I went to Sinclair up in Dayton for a chef for a year, and I just didn't really like it, so I quit doing that. And I jumped from job to job, so I went on to the Army.

Q. And what year did you join the Army?

A. 2006.

Q. And did you start at Antonelli College immediately following graduation?

A. Pretty much. Yes, pretty much within the next year.

Q. And you say you—how long would you say, roughly, that you were at Antonelli?

A. Probably about six months.

Q. And then that was to do, like, photography?

A. Photography. Mainly photography. A lot of different, like—had three or four different classes of photography and then one class of psychological—psychology or whatever.

Q. And then when that didn't work out, did you immediately go to Sinclair?

A. No. I took off, like, another couple months or whatever and then went to Sinclair, because my sister was living up there. She was up in Dayton. So I moved up there with her. And she's like, Hey, you need to go to Sinclair. And I looked around. I liked the cooking because it was one of the better schools, so I did that, and that only lasted about a year too.

Q. All right. And you said you did about five years in the Army?

A. Yes.

Q. Where were you stationed?

A. Ft. Riley, Kansas.

Q. Were you ever deployed?

A. Yes, one time in 2008.

Q. Were you discharged from the Army?

A. Yes.

Q. When?

A. It would have been 2011, January of 2011. That's why I say it's like the fifth year.

MR. WELCH: Try to slow down and speak up—

THE WITNESS: Okay.

MR. WELCH: —so that the court reporter can hear you. And just answer the question that's asked. Ryan does a good job of follow-up. You're doing fine.

Q. And when you left the Army, talk to me—trace for me your employment history.

A. Once I left there, I really didn't do much at the time. I was trying to get jobs. I was trying to go around, like, CSX, the train thing, whatever, a couple different warehouse kind of jobs and everything like that. It didn't really—not anything really set in stone.

I know my uncle—he works for the courts. He helped me out in getting in with the sheriff's department. I forget what he does over there. His last name is Collini too. He helped me out getting into the sheriff's department. And that was probably 2012, so about two years later after I got out of the Army, maybe a year.

Q. Between leaving the Army and joining the sheriff's office, were you ever terminated from a job?

A. No.

Q. All of the employment that you had, you left voluntarily?

A. Yes.

Q. And in 2012, you said you started with the sheriff's office. In what role were you hired?

A. Correction officer.

Q. Do you maintain that same rank—

A. Yes.

Q. —today?

A. Yes.

Q. Have you ever been promoted at any point?

A. No.

Q. Talk to me about your duties and responsibilities as a corrections officer.

A. Rounds. We have to do rounds on all the cells in the area, whatever floor we're on, feeding dinner or lunch or any meals, med passes with the nurses.

Just pretty much mainly that stuff, or, like, where I work right now, we have to do suicide watches, or that would be where—helping in the chair. That would be where that would be at. We have to deal with that. Cleaning. Nothing really else. Mainly rounds and keeping everything secure, I guess.

Q. And you said that—you talked a little bit about the restraint chair.

A. Yes.

Q. So is that—is the observation of restraint chairs and suicide watches, is that a special role as a deputy?

A. It's just on that floor. On that floor, like I said, we have usually three officers on the floor. And the first—you know, we'll do—we break it up for the 8 hours. It will be 2 hours and 40 minutes each time. 2 hours and 40 minutes that you're sitting in this room, then 2 hours and 40 minutes that you're running around doing all the rounds, and then 2 hours and 40 minutes of you doing the suicide watches.

Q. And this is a perfect example of me asking a bad question. I appreciate your answer for that. I was going to ask it later.

But my question is more is could you be assigned as working on that floor one day and working an entirely different building on another?

A. Yes, you could.

Q. Is it typical that you move around within your job duties, or are you sort of focused on one specific floor or role in your schedule?

A. When I first started, it was the way you're saying it. But now I've been on the same floor that's like—it's like the mental health floor for the last, like, five years or four years.

Q. And just so the record is clear, when you first started, you were moving around—

A. Yes.

Q. —a lot in jobs?

A. Yes.

Q. It's okay.

A. My bad.

Q. And now for about the past five years, you've been specific to one floor and one sort of job duty?

A. Yes.

Q. And as I understand it, on that mental health floor, there are three different roles. There is the officer who's in charge of suicide watches; there's a housing officer for B Pod, C Pod, and D Pod; and then there is an officer who's in the control room?

A. Yes.

Q. Is that accurate?

A. Yes.

Q. So on your shift, as you described it, you do 2-hour-and-40-minute increments of each role?

A. Yes.

Q. Does the jail have a policies and procedures manual?

A. Yes.

Q. Why is that in place?

A. To go by—you have to go—90 percent of the time, you have to go by the policies, I guess. Policies on everything. Policies on the chair, like the restraint chair; policies how to do rounds; policies how to do anything and everything

within the jail. You know, the supervisors have their own policies too and everything.

Q. And you said 90 percent of the time you've got to go by those policies?

A. Oh, yeah, if not even a hundred percent, really.

Q. Can you describe for me any scenario when you can ignore a policy?

A. Well, even like on the restraint chair, there's different times—like, the whole thing—I think it says something to do with, like, giving water or a restroom break or anything like that. You would-if the-if an inmate comes in the restraint chair and he's agitated, he's, you know, banging his head-if I pulled the person out of the restraint chair and then two seconds later he's banging his head against the wall, then we have to throw him right back in. I mean, that's the reason it'd be outside of the policy, I guess.

Q. Who orders the policies and procedures at the jail?

A. I'd say someone way higher than me. The sheriff, maybe?

Q. And you would agree that you're subject to the policies and procedures of the jail, right?

A. Yes.

Q. Are you knowledgeable about them?

A. Yes.

Q. How did you learn them?

A. In the academy, we had to go through them. That was like eight years ago. I mean, I haven't

really looked at them since, a lot of them. If I have to, I'll pull one out. We have them at our homes and stuff.

But it's eight years ago when I first started we had to go through training, and I think it was two days—I think it was a week, actually, we went through all the policies.

Q. So on a yearly basis, you guys don't do any refresher training on policies?

A. No, not on policies. I mean, just on-the-job training.

Q. How does the on-the-job training work?

A. Like, it's in the—like, the main thing we're talking about, the restraint chair, it's just on-the-job training. I mean, I might show you how to do something or somebody else shows you, Hey, this is a new trick or, you know, to help out so they can get the—you know, a safer thing, I guess, out of it.

Q. Is that sort of on-the-job training reflective of what's in the policy itself?

A. Yes, it could be. I mean, the actual—we don't actually do like training like, you know, desk work training or anything like that.

We have to do like, you know, on—like, on the job, like anything and everything, like—as in doing the rounds, you walk around with somebody. You'll have somebody—like, when you first start there, you'll have somebody walking around with you and just show you to see you're actually doing everything right.

Q. When you're doing that, do you have the policy and procedure for that specific job with you?

A. No.

Q. Are you expected to follow the policies and procedures of the jail?

A. Yes.

Q. Are you permitted to disregard them?

MR. WELCH: Objection. Go ahead.

A. No. I don't know.

Q. So your answer is no, you are not permitted to disregard them?

A. No, no. I can't—yeah. Yeah, I would say no. Yeah, no.

Q. Can you be disciplined for disregarding a policy of the jail?

A. Yes, we can.

Q. Should you be disciplined for failing to follow a policy of the jail?

MR. WELCH: Objection. You can answer.

A. I guess you could, but high—you know, it's higher than my pay grade. So I'm not the one getting discipline. I mean, I would be, but I'm not the one doing disciplinary.

Q. Are there any rules or regulations not contained within the policies and procedures manual which you are expected to follow at the jail?

A. Like, dress code. There's me—me—when I got my DUI, I mean, there's still disciplinary there.

There's other things, but it's not—it's mainly in the policies.

Q. Does the jail have any unwritten rules which you're expected to follow?

A. No.

Q. Any unwritten rules with respect to observation of restraint chair inmates?

A. No.

Q. Would you agree that the policies and procedures of the jail are designed for the safe and orderly operation of it?

A. Yes.

Q. To protect the employees who work at the jail?

A. Yes.

Q. To protect any contractors who might be working at the jail?

A. Yes.

Q. To protect inmates?

A. Yes.

Q. And to protect anybody else who might be in the jail at any point?

A. Yes.

Q. In your role as a corrections officer, are you expected to make or keep written records?

A. Of . . .

Q. Of anything.

A. Of anything? Well, like, the daily logs for—on a computer, we do a daily log in the booth while we're sitting in the booth on anything, any rounds happening, count—we have to do count like three or four times. Any medical staff come on post, any lawyers come on post, we have to put them on it. Any food, et cetera, et cetera.

Now, on the, like, suicide watch, we have to do those forms. Right when the person comes up, whenever they show up, we have to do that. And then we do a strip search form if they're doing, you know, suicide watch because they-you know, you have to undress them. If you don't have that, they can sue you for that because it'd would be, like, wrongful, I guess.

Other than that, there's like a smock and blanket count book. It's like the thing you would wear if you're going on suicide watch. We fill it out. And other than that, there's really nothing for my job.

Q. Do you have a duty to be accurate in those records?

A. Yes.

Q. Why?

A. To make sure everything is, you know, correctly right, written down, and it falls with everybody else. I mean, there's other times that people haven't done it, and yeah, I mean, you know, it reflects on them and . . . Like, one guy got fired because he, you know, beat the crap out of somebody. And now he's gone now because he

wrote a whole different report. So you have to be truthful, yeah.

Q. And you would agree you can't—to your point there, you would agree that you can't put things in the records that didn't occur, right?

A. Yes.

Q. And there are—as you just talked about, there are consequences if you don't put accurate things—

A. Yes.

Q. —in those records, correct?

A. Yes, in the past, yes.

Q. Do you believe the consequences such as termination are appropriate if you inaccurately complete—

A. Yes. It depends on the—

MR. WELCH: Object, leading. Wait until he finishes his question before you answer. So can you ask the question again?

MR. MCGRAW: Yeah, can you read that back?

(The question was read back.)

MR. WELCH: I'm sorry, I was talking to him as she was reading the question back, so I missed it and so did the witness. I apologize.

Q. (By Mr. McGraw) Do you believe consequences like termination are appropriate for officers who inaccurately complete reports?

MR. WELCH: Objection. You can answer.

A. Yes. Depending on the person. Like I said, like the person that slammed that person against the wall, he wrote in his report or something, oh—I mean, Oh, I never did that. But on camera, it shows him, you know, throwing the guy on the wall, broke his jaw and broke his—you know, and back and everything. Yeah, he got fired. I think he's serving time right now, actually.

I mean, I've seen people trip people up against the wall like it's a bad thing (inaudible) some things—if I wrote a round like 10, 15 minutes later than what it was, they're not going to terminate you. I mean, it's not like I waited six hours or anything like that.

Q. Do you think it's appropriate to write a round late?

A. No, it's not inappropriate. Sometimes it happens. Sometimes—because, like, even you write the round, is it a—like a regular round? Somebody might not have done it at that time. Because if I write the round, then that's—I forget what the word's called.

I guess you're putting in a round what's never got done, I guess. That's what—but it got done maybe 5, 10 minutes later by that person. Because if somebody's doing a round—so after they do the round, then you type in the round. And if it's not 30 minutes or 40 minutes, it might be 45 minutes, whatever, then. I mean, it did—it was done. It just wasn't done on time.

Q. Officer Collini, I am handing you what has previously been marked as Plaintiff's Exhibit 2.

Take whatever time you need to familiarize yourself with this; and when you're ready for me to ask you questions about it, let me know.

A. (Examining document.) Should be good.

Q. And you would agree with me that this is the Hamilton County Sheriff's Office policy and procedure for the use of restraints?

A. Yes.

Q. And are you knowledgeable about this policy?

A. Yes.

Q. Were you taught this as part of the corrections academy in 2012?

A. Yes.

Q. Since 2012—and let me qualify it by prior to December of 2018. So between 2012 and December of 2018, did you ever have any refresher course on the restraint chair policy?

A. Not the restraint chair policy, but on-job training, we have.

Q. And is that on-the-job training—is that recorded in any way?

A. No, not recorded. It just—we have like a little, like, kind of like a class. Not a class, but a couple people around. They'll show you how to put somebody in the restraint chair, because there's a lot of people—younger people that just started there that has no clue how to put anybody in a restraint chair who were messing it up.

You can't do this. You can't tighten this arm down. You can't—circulation and stuff. So we

just do it with trainings, like (inaudible) training. We just—I mean, I guess they don't have the budget to do it, I guess, or something that they can't do every day of training on something.

Q. How many times between when you started at the corrections academy and December 2018 do you think that you had any of those little trainings?

A. About six to eight times.

Q. So about once a year?

A. Yeah, pretty much, yeah.

Q. And to your knowledge, there's no records of, hey, this training occurred on this day? These are sort of informal?

A. Yes, informal. It could just pop up. Like, I could go in today and be like, Hey, we're going (inaudible) . . .

THE REPORTER: You would go where?

A. To work. I have to go to work today. And I could show up to work today and, hey, we're doing the restraint chair thing, or we're doing some kind of thing.

Q. Who conducts those informal trainings?

A. Usually a supervisor.

Q. And between 2012 and December of 2018, who would have been the supervisor over the restraint chair duties?

A. It could have been any one of our supervisors. He—like, the one I have in here, Sergeant Hunt,

he could have. Lieutenant Buchanan could have. Sergeant Trayer (phonetic), Sergeant Kilday. Any supervisor, really.

Q. So it's not specific—

A. Not specific.

Q. —to one supervisor?

A. No.

Q. Okay. And you would agree that this Exhibit 2 was in place in December of 2018?

A. Yes.

Q. Are you aware of any policy which revokes or amends Exhibit 2 prior to December of 2018?

A. No.

Q. I'm going to have you go to page 3. All right. And if you see there, there's a Roman numeral 6-A. Do you see where I'm looking?

A. Yes. 6-A, Inmate will be placed?

Q. Yes. So it says that the use of the restraint chair must be authorized by mental health, slash, medical staff for one of the following reasons. Do you see that?

A. Yes.

Q. And are you aware of any other basis other than those three reasons right there why an inmate could be placed in a restraint chair?

A. No.

Q. And as I understand it, a jail supervisor is required to approve the use of a restraint chair; is that correct?

A. Yes. Or—

Q. So—go ahead.

A. Or mental health or medical staff can.

Q. But in terms of the jail's personnel, you, as a corrections officer, could not order an inmate in a restraint chair, correct?

A. No. I could call on the radio and tell my sergeant—supervisor that, like, this guy's banging his head on the wall. We need to maybe put him in it. But at the end, it's his option.

Q. And a supervisor is required to remove an inmate from the restraint chair as well, correct?

A. Yes.

Q. So you, as a sheriff's—or a corrections officer cannot make the decision on your own to remove an inmate?

A. Yes, that's true.

Q. But once the inmate is in the chair, there are deputies in charge of monitoring him or her, correct?

A. Yes.

Q. And you have performed that role?

A. Yes, I have.

Q. And you performed that role, it sounds like, for the last five years, correct?

A. Yes.

Q. And other than sort of the informal trainings that you've talked about, there's no specialized

training that you go through in order to work on the mental health floor, correct?

A. Oh, no.

Q. And as I understand it, in sort of the observation of an inmate in a restraint chair, you're permitted to alert a supervisor that you think the inmate is ready to come out of the chair; is that correct?

A. Yes, we would.

Q. So how does that process work?

A. If the person's calm. It's usually if the person's calm. If they're still, you know, wild or anything like that, we—you know, but if they're calm, if they're—you know, I mean, or anything like that, we would give them a call on the radio.

He would actually have the final say if this person needs to come in or out. We would just call them on the radio or call them on the phone and, like, Hey, I mean, if you want to come down here, check on this guy to see if you feel like he can come out.

Q. Is there any record of that call to a supervisor?

A. I would say so. I think it was, yeah, around 9:00 or something that we said—

Q. And I'm not speaking about Mr. Howell specifically. I'm just talking in general.

A. Oh, yeah. Oh, yeah. It's, yeah, every time, usually. And nowadays, more and more, I mean, two-hour limb rotations (inaudible)—we're always calling them now, especially because a lot more people are coming that are usually on, like—

like, drinking, and then they sober up; and like two hours later, they're calm. It's not necessarily we're trying to keep somebody in the chair.

Q. Okay. So let me ask it a different way. So prior to December of 2018, if you were observing an inmate in the restraint chair and you thought that he was a candidate to come out, what I'm asking—do you note, Called sergeant so and so at X hours?

A. No.

Q. So the answer to my question of whether or not there would be any record, there would be no record of those?

A. No. Just if—when the supervisor comes down, you record that the supervisor's here to assist, I guess.

Q. And how often would you make those calls to supervisors?

A. Around that time frame, we have to do a two-hour limb rotation. We would do it. We would call and say, Hey, we need to do a limb rotation, if you can come down here. Or one—like, medical would talk to us sometimes, and we would say, Hey, we feel like he can come out. So medical (inaudible)—would call them then, or if it hit the four-it was the four-hour mark, that's, you know, kind of excessive to be in a chair, we'd call then.

Q. But in your experience, between zero and two hours, you're not making a call—

A. Not to—not till two hours.

MR. WELCH: Wait until he finishes his question, and then—

A. Horrible.

MR. WELCH: You're doing all right.

I just want to make sure we've got a clear record. Okay?

Q. All right. So if you see on the restraint chair policy letter 6-B. Actually, I'm sorry. Let me go back just a second. You talked about medical staff. Who, to your knowledge, on the medical side of things can order an inmate in a restraint chair?

MR. HOJNOSKI: Objection.

A. I would not say medical necessarily. It would be more on the lines of mental, because I've never really had to deal with the medical side. It'd be the mental health.

It could be like a doc that if they needed forced meds by a court order or whatnot, they would actually have to force—force meds. So we have to put them in the restraint chair for that or—like something like that. But actually, medical stuff, I've really never dealt with it, because it's down the hall from me.

Q. So you would have no knowledge, then, if a nurse, for example, could order an inmate into a restraint chair?

A. No. No.

Q. So now, if you go to letter B, it talks about that a member of the health trained staff must

examine the inmate every 10 minutes. Do you see that?

A. Yes.

Q. And you would agree that health trained staff refers to corrections officers?

A. Yes, yes, just recently.

Q. So then you would agree with the statement that jail policy requires a corrections officer to observe an inmate in a restraint chair every 10 minutes, correct?

A. Yes.

Q. Why is that required?

A. To make sure of the safety of the inmate, mainly.

Q. Are there risks associated with placing an inmate in the chair?

A. Yes. There can be. Just—I mean, shaking, I guess. It depends if the restraints are on too damn long, they-something could happen. Bang their head back. Yelling, I guess. I mean, there's-there is, but there's not much.

Q. So you're aware of the risks that are associated with the restraint chair, correct?

A. Yes, yes. Some of them, yes.

Q. And you're talking about the straps being too tight?

A. Yes.

Q. Because that could cut off circulation, right?

A. Yes, yes.

Q. And you're talking about an inmate hitting their head on the back—

A. Yes.

Q. —of the—

A. Chair.

Q. —the chair which would cause head injuries?

A. Yeah.

Q. Do you discuss the risks of placing an inmate in the chair during those informal training sessions?

A. No, not really. Just kind of show how to do it so other people know how to do it when it has to happen.

Q. Were the risks of the restraint chair discussed with you during your officer training?

A. No, not really. Just mainly—it was just mainly going over the policy and then putting someone in the restraint chair. It was only like a 10-minute class. (Inaudible.)

(Reporter clarification.)

A. Only like a 10-minute class. They do other classes.

Q. How did you become aware of the risks that were associated with the use of a restraint chair for an inmate?

A. Just on-the-job training, mainly.

Q. Other than Mr. Howell, do you know of any other inmate who has died while in the restraint chair?

MR. WELCH: Objection. You can answer if you know.

A. No.

Q. Do you know an inmate's medical conditions when they're placed in a chair?

A. No.

Q. Is that one of the other reasons that it's good to keep an eye on them?

A. I guess so, yes. But, yes, we have no recollection of knowing anything about inmates being . . .

Q. So it's important to observe them for their safety, as you talked about, correct?

A. Yes. Mainly the safety, yes.

Q. What's significant about 10 minutes?

A. No idea, sir. Just the time frame, I guess, they put, 10 minutes. I think at one point in time it was even 15 minutes, but they shortened it down to 10 minutes to just keep an eye on, 10 minutes. I don't exactly know why.

Q. What can happen if a 10-minute observation is missed or skipped?

MR. WELCH: Object. Go ahead. You can answer if can you.

A. Not much. I mean, it depends what the person's doing. I mean, if the one person-like, he's banging non-stop, I mean, it could get worse, maybe.

If it's 10 minutes and somehow—I've seen guys actually literally get out of the whole restraint

chair and actually just standing at the door and looking at you like, Hey, I'm out. I mean, if you're not doing for, you know, 15, 20 minutes, oh, well, sure, he's out. Well, now we've got to put him back in because he got out. No, not really.

Q. If they're left unattended, could they be at risk for injury?

A. It all depends on the person. It all depends on the situation. I mean, some people—like, a lot of people usually go up there and they just take a nap. I mean, they'll be drunk, whatever, boom, they'll just take a nap.

There's not many people that, like, just run, you know, their heads into the wall, and then the next thing you know, they're bashing their head or they're trying to hurt themselves non-stop.

There's not many of those. It's usually if someone's coming in to intake and they're usually drunk, and that's usually what happens, but . . .

Q. Is it the practice of the sheriff's office if somebody falls asleep in the restraint chair to just let them sleep?

MR. WELCH: Objection. Go ahead.

A. No, not necessarily. I mean, it comes up, like I said, at a four-hour time frame, we try to wake them up to get them out or even like the two-hour time frame if we had to, but, I mean . . .

It's not that we're just going to leave the guy in there sleeping the whole time. I mean, we're going

to have to, you know, take care of him, et cetera, et cetera, but . . .

Q. Is there a certain—other than the two-hour mark and the four-hour mark, are there any other time periods when you've-when an inmate is sleeping for, let's say, 30 minutes that you would say, okay, you know, I think that we can—we should call a supervisor, or do you wait for the two-hour and four-hour mark?

A. Usually, the two-hour, four-hour marks. Like I said, there's one guy that he—within the last, like, six months, he pulled out both his eyes, broke them out of his eyes. He's actually in Summit Behavioral right now.

And he was in the restraint chair for like three days straight. But they did the two-hour, four-hour rotations to try to get him out, because every time they went to try to get him out, he tried to rip his eyes out or the stitches out.

There's been people in restraint chairs for very long times, but they try to at least get something done after four hours.

Q. Does the jail policy and procedure ever permit you to skip a 10-minute observation?

A. The policy and—no. But there's also when I have eight suicide watches and after I get through them—so I have to do the eight suicide watches, then somehow make it back to him, then, yeah, it could happen. I mean, it could—we might miss it by, you know, 15 minutes maybe or 20 minutes.

Q. Is that a violation of—

A. Yes. It would be a violation.

Q. the policy?

A. Yes, it'd be a violation of the policy, but we're not neglecting the guy. We're not, you know. We'll get back to him. I mean, we're trying to—we're trying to be there for security and safety.

Q. So let's talk about the actual observation of individuals in the restraint chair, and I want to go December 2018 and prior to that. So I don't want to talk about anything that's happened—I know the policy has changed now, so let's go back to 2018.

As I understand it, inmates in a restraint chair were in Pod A of the G-21 building—

A. Yes.

Q. —is that correct? Is that a yes?

A. Yes, yes. Sorry.

Q. And they were placed in a cell, correct?

A. Yes.

Q. Cell 6?

A. Or 4.

Q. And the chair was attached to the wall; is that correct?

A. Yes, with a chain, yes.

Q. And as you're looking into the cell, the inmate would not be looking directly back out at you, correct?

A. No, no.

Q. They were to the side?

A. Yes, to the side.

Q. So you would have seen their right profile; is that correct?

A. Their left side.

Q. Left side?

A. Yes, yes.

Q. Okay.

A. They would be facing this way. I would be looking in this way. Or vice versa if it's the other side. It would be the right side, yeah. So you're right.

Q. But either way, in cell 4 or cell 6, you've only got a profile view of them?

A. Yes.

Q. A side profile?

A. Yes.

Q. And the inmates were only observed through a small window outside of the door, correct?

A. Yes.

Q. In order to see the inmate, you would then need to stand directly in front of that window, correct?

A. Yes.

Q. You couldn't see inside of cell 6 specifically when sitting in B Pod, correct?

A. No.

Q. And you were never trained to have any physical interaction with inmates while they were in the restraint chair, correct?

MR. WELCH: Objection. Go ahead.

A. No. We wouldn't—we wouldn't have any actual training unless it's when we're taking them out or like limb rotations or if someone needed water or a drink or something like that or those kind of things. But a supervisor would be there with us.

Q. So you stay outside—as the observing officer, you stay outside the cell at all times?

A. Yes.

Q. And absent the presence of a supervisor, you could not—you would not open the cell door and physically interact?

A. Unless like a medical staff was there or someone like that. Someone had to be there, pretty much. We wouldn't just walk in there.

MR. MCGRAW: I'm going to set this up real fast.

MR. HOJNOSKI: I'm fine now, but I have an 11:00 phone call with a federal magistrate on a case. I'm going to need a break at some point.

MR. KIRCHER: We're going off video at 9:50.

(A brief break was taken.)

MR. KIRCHER: We are back on video at 10:00.

Q. (By Mr. McGraw) All right. We're back on the record. Officer Collini, one of the things you indicated that you had reviewed prior to today is the audio recording of an interview that was conducted of you at the jail, correct?

A. Yes.

(Plaintiff's Exhibit 21 marked.)

Q. I have marked a Zip drive here as Plaintiff's Exhibit 21. It contains an MP3 file that we were provided by your attorney titled_Extraction _1_1_CO_Matthew_Collini_1_CO_Matthew_Coll ini_contains_personal_info.

So I'm going to play a portion of that for you, and my first question is just for you to confirm that this is, in fact, you who is being interviewed. So we're going to let this play for the first 28 seconds. Okay?

(Playing audio.)

A. That's me, yes.

Q. All right. I'm going to take you to the 8:41 mark of the video—of the audio, and I'm going to let it play for about 30 seconds, and I'm going to stop and ask you a question. Okay?

A. Okay.

(Audio playing.)

Q. Did you hear and understand that?

A. Yes.

Q. Is that an accurate description of how you generally conduct rounds?

A. Yes.

Q. And did you learn how to conduct those rounds in the corrections academy or through on-the-job training?

A. On-the-job training.

Q. From the window outside of cell 6 or cell 4, could you tell if someone was sleeping or dead?

A. Yes, you could tell if he's sleeping, yes, or they're having a seizure or anything, yes.

Q. So you're required to log the activity during those 10-minute checks, correct?

A. Yes.

Q. What type of training, if any, on those requirements were you provided?

A. Just on the job. Mainly on the job. Just from people past who have showed me how to do it (inaudible).

Q. Are those logs-are they done in real time?

A. No, not necessarily. I mean, logs on real time? What do you mean?

Q. You do the observation?

A. Yes.

Q. You write it down?

A. Usually, yes.

Q. Is there ever any instance where you do an observation, you fail to log it, you do another observation, and then you log that one plus the one previous?

A. Yeah, yes.

Q. Do you write down the exact—I shouldn't say that. Are you supposed to write down the exact time that you conduct your rounds?

A. In policy, I don't think it actually says the exact time. I think it says you're supposed to do it

every 10 minutes. It might be, you know—you know, say 0011 or the next one would be 0021 or like 20 or something like that or shorter, because we've been doing, like, shorter times.

Q. Based on your training, is writing the word "chair" sufficient documentation?

A. Yes. He's in the restraint chair. Like I said, like even, like, on suicide watches, if they're sleeping on their left, we won't really write sleeping on the left with legs down or anything. We just usually put left. Like, shorthand it, I guess you would say.

Q. So let me ask you on Exhibit 2, Page 52 letter C—

A. 2 . . . Wait a minute. This one?

Q. Yeah.

A. Okay.

Q. It says that all log entries shall be complete noting the condition of the inmate and his or her activities at the time or any significant developments.

So I guess my question to you is why not include sleeping, feet on the ground—

A. I just—I started sleeping.

MR. WELCH: I'm sorry. Were you done with your question?

Q. Mm-hmm.

A. Sleeping, I wouldn't necessarily put sleeping. Usually, if they're sleeping, I just put they're in the chair. Usually, if—even if they were having

a seizure, I would say something. If they were banging their head, I would say something. I mean, more—something more harmful towards them, I would have to put something.

Q. Do you believe writing "chair" is consistent with what the jail's policy requires?

A. I wouldn't necessarily say what the policy is. But, like, as what I've been doing for the last, you know, five years, I mean, it's just that way. But, I mean, safe—he looks safe. Every time we walk in there, he looks safe, looks like he's sleeping.

Q. And ultimately, the time an inmate is in a chair is largely behavioral dictated, correct?

A. Could be, yes.

Q. What do you look for as an observing officer in determining whether or not an inmate should remain or get removed from a chair?

A. Remove-wise, but I would say more calm, if they're calm, or if like they're sleeping. If they're wild out, if they're banging or yelling, you know, or cursing, et cetera, et cetera, I would say no.

Q. So if they're calm or sleeping, that's an indication to you that their behavior no longer requires the use of the chair?

A. Yes. Because you could just-you know, you could just put them in a cell.

Q. If they're sleeping, can they be exhibiting behaviors which warrant the use of the restraint chair?

A. I don't know. I have no clue of exactly why they're going in, but no, not necessarily.

Q. In your experience, if someone falls asleep at, say, the 30-minute mark, are you going to allow them to sleep until that two-hour mark when a supervisor—

A. I would say yes because we—I mean, we have no clue really why—I mean, I've seen people in the past, you know, bang their head against the wall and then literally, like I said, fall asleep 30 minutes later. And then the next thing I know, we let them out, and they go right back in the room and bang their head again.

So we just try to wait two hours until they're calm enough to actually do this. Or even like last night, I had—or not last night. Sunday night, I had some guy yelling, blah, blah, blah. He was drunk. Woke up, and he just came right back at me again like, I hate you, everybody, all cops die, dadadadada. It's like, Oh, okay. You're back.

Q. On Exhibit 2, letter F—do you see where we are there?

A. Yes.

Q. It says that the restrained inmate must be considered for removal from the restraint chair at least hourly. Why is the hourly consideration important?

A. The behavior. I mean, to actually say the behavior. And like you said, if he's, like, calm and good, I mean, we can get him out of there so we don't have to have him there anymore, so we can just move him along, because a lot of people go in the restraint chair. We don't want, you know, five or

six people up there at a time in a restraint chair. There's safety, but it's non-stop rounds. It's non-stop everything like that.

And if he's calm—like, we've had guys recently calm as hell, nice as hell, and go, Hey, are you good? Or even one Covid 19 now. He just had Covid 19. Came in with Covid 19. He was out of the chair within an hour.

Q. So the goal ultimately is to get the inmate out of the chair, right?

A. Yes, yes. Yeah, you don't want to keep them in, no.

Q. At the one-hour mark, are you supposed to call your supervisor and give him or her a report on the condition of an inmate?

A. No. It's usually like that two-hour. That two-hour thing's the main time. One hour, like, I would talk to our—the guy that's in the LC office, and he would, like, log it. He can log it if he wanted to. Like, hey, dude is calm. I mean, he seems calm, but maybe get him out, but they're usually not going to let them out at least until the two hours just to make sure—just to make sure (inaudible).

Q. So in your experience, most inmates who go into the chair prior to December 2018 are-were going to remain in there for at least two hours?

A. Yes.

MR. WELCH: Objection. Go ahead.

A. Yes, yes. Under their behavior. If their behavior was good, I mean, you might come out early. If

their behavior was worsened, then you might stay longer.

Q. But even for calm or sleeping inmates, that two-hour mark was sort of—

A. Yes.

Q. —when they would usually come out?

A. Yes, they can.

Q. Is it your understanding that the supervisors are keeping track of the time an inmate is in the restraint chair as well?

A. Yes. I mean, they're usually the ones when they're there to put them in. So say, boom, 3:00 they started, so they know kind of the time frame. I mean, they're not on the logs, but they know the same time frame.

Q. So prior to December of 2018, if you were observing an inmate, would you get a call at the one-hour mark from a supervisor asking, Hey, how's inmate so and so doing?

A. Some. Like, we have—we've had—in the past we have, but not that much.

Q. You talked about logging it with the LC officer. Is that the officer who's in the control room?

A. Yes, yes.

Q. And what would you say to that officer?

A. Like, Hey, it seems like the guy's calm. It seems like he's, you know, calm or sleeping or whatnot. If you wanted to log it, because we—I mean, usually, like I said, the supervisor will only come

down for the two-hour till they do a limb rotation, at least talk to them.

That's when they evaluate them, every, like, two-hour increment kind of deal. And just to see—I mean, if it is and the—they will want to call the boss, I mean, we'll call the boss and try and get him down there. But if not, then we just wait for the two hours.

Q. Are you aware of anyone logging Mr. Howell's activities in the chair?

A. Not that I know of, no. I wasn't in there.

Q. I know you weren't in the LC office.

A. I have no clue.

Q. Did you ever go to the LC office and say, Hey, why don't you log this?

A. No, not at the time, no.

Q. All right. So letter D on Exhibit 2, 6-D, it talks about the exercise of the limbs. Do you see that?

A. Yes.

Q. And as I think you've stated, in order to exercise an inmate's limbs, a supervisor needed to participate?

A. Yes.

Q. Why is that exercise at the two-hour mark significant?

A. To, like, say they don't have blood clots-don't get blood clots. They don't—you know, they can stretch out their arms. They can, I mean, get blood flow moving. Sometimes you can—you know,

in that little area, tight, you know, compact area, you could lose blood flow, et cetera, et cetera, and yeah, so that's mainly what the . . .

Q. So there are risks to inmates when they are restrained for long periods of time, right?

A. Yes. They can.

Q. And you're aware—

A. Yes.

Q. —of those risks?

A. Yes, yes.

Q. And you can't offer exercise to an inmate by yourself?

A. No.

Q. And at the two-hour mark, are you responsible for calling the supervisor to say, Hey, we've hit the two-hour mark; come on down?

A. Yes, or he will just come down because he kind of knows about the—about what time frame.

Q. Is there any written record of the notification either to or from—

A. It's just on the—on the radio. We do it on the radio, so it probably wouldn't be on there. Sorry.

Q. If the supervisor is not available at the two-hour mark, what happens?

A. We wouldn't do the limb rotation because—I know in our instance, my partner was actually gone too. So it would have just been me trying to do a limb rotation myself, and-yeah, I wouldn't have done that. That's why I put on the log

saying sleeping, which he was sleeping and—yeah.

Q. And we'll get to the log here in a second.

A. Okay.

Q. So you've got a main supervisor, I presume?

A. Yes.

Q. Any supervisor in the jail could do the limb rotation, correct?

A. Yes.

Q. With respect to Mr. Howell, did you notify your supervisor that you had reached the two-hour mark?

A. Yes, on the radio. Just we reached the two-hour radio—we reached the two-hour mark and if you wanted to come down and help assist with this.

Q. And that supervisor was Justin Hunt?

A. It should have been, yes, that night.

Q. And what do you recall Sergeant Hunt saying to you at the two-hour mark?

A. I'll be down when I can.

Q. And he never came down prior to the four-hour mark, correct?

A. Yes, yeah.

Q. All right. So if you look at letter E, it talks about the use of the restroom.

A. Drinking, yeah.

Q. And I'm going to ask you first about the restroom. So that-the inmate must be offered the opportunity to use the restroom. Do you see that?

A. Yes.

Q. And as I understand it in 2018, in order for the inmate to use the restroom, a supervisor would have needed to be present, correct?

A. Yes.

Q. You cannot get the inmate out if he says, Hey, I've got to use the restroom—

A. No.

Q. You can't get him out by yourself?

A. No.

Q. Sorry. Just let me get my question out. You're doing okay.

Are you trained to ask the inmate periodically, Do you need to use the restroom?

A. Yes.

Q. Or does the inmate need to say to you, Hey, I need to go to the bathroom?

A. That also, too. I would actually go off that more to the point where—I mean, if he asked me, he said, I need to go to the bathroom, I would-yes, I would ask the supervisor, Hey, Mr. Howell needs to go to the bathroom.

Q. So in practice, you're sort of waiting for the inmate to say something—

A. Yes.

Q. —to you?

A. I'm not going to go every 10 minutes like, Hey, do you need to go to the bathroom? Do you need to go to the bathroom? Do you need to go to the bathroom? He keeps on telling me no, no, no, no, but . . .

Q. Did you ever ask Mr. Howell if he needed to use the restroom?

A. No.

Q. If an inmate asks to use the restroom and a supervisor is not available, the inmate just doesn't get to go to the restroom?

A. We would use-no, we'd call over—call the supervisor, and the supervisor would come down and help out to assist him getting out of the chair to use the restroom.

Q. So the restroom is sort of a mandatory response from a supervisor; is that fair to say?

A. Yes, I guess so.

Q. But the limb rotation is when I can get there?

A. Yes. Well, it's the same. It's the same thing. I mean, it's—because if you're doing a limb rotation, it's about the same as getting a person out of the chair or the—getting the person out of the chair or going to the bathroom or anything like that.

The drinking water, you can still stay in the restraint chair and administer them getting water. But, you know, them actually getting out of the chair is the same as getting a supervisor. The supervisor usually has to be there.

Q. And in terms of giving an inmate water, did that require a supervisor to be present?

A. No.

Q. So that was an instance where you could have gone into the cell—

A. Yes.

Q. —by yourself—

A. Yes.

Q. —and said, Hey, here's some water?

A. Yes.

Q. Are you trained to ask the inmate periodically, Do you need water, or do you wait for them to say, Hey, can I have a drink of water?

A. It's usually wait for them to ask if they want water. I mean, we're trained to do it. We're trained—we can go in and do it. We can train to go in there. Like, if someone's having a seizure, we can go in the cell.

Q. But in practice, putting the seizure aside, in practice, you're not—you're going to wait for the inmate to say—

A. Usually.

MR. WELCH: Objection. First of all, wait until he finishes the question, then answer. Okay?

Q. In practice, you're going to wait for the inmate to say, Can I have some water, before actually offering it to them?

MR. WELCH: Objection. Go ahead and answer.

A. Yes. Yes, usually, because, like I said, it depends on circumstances, et cetera, et cetera. I mean, if he's sleeping, I'm just going to let the guy go to sleep, let him sleep, keep him calm till we can get him out of there quicker. If he's sleeping, yes.

I mean, if he—I'm not going to wake him up every 10 minutes like, Hey, do you want a water, when in realty, I could just let him sleep. He's calm, and then we can get him out quicker.

Q. Did you ever ask Mr. Howell if he would like a drink of water?

A. No.

Q. All right. And if you go to page 4 of that document, letter G talks about the medical staff will check all inmates in the restraint chair every two hours. Do you see that?

A. Yes.

Q. Prior to Mr. Howell's death in December of 2018, was it the custom and practice of medical to check every two hours?

A. Yes. It should have been, yes. They usually do it every two to four hours, yes.

Q. So it's not every time that they were doing it at the two-hour mark?

MR. WELCH: Object. Go ahead—

A. Yeah.

MR. WELCH: —if you can.

A. No, no recollection of it. I mean, not necessarily. There's some times, yes, they have, and I may

not have seen them. It's usually around the four-hour time, they usually come in and say, Oh (inaudible)—

(Reporter clarification.)

A. The four-hour time frame, trying to get him out of the restraint chair, or if—we ask him, like, Hey, you know, this guy's calm; can we get him out of the restraint chair? They have a say in it too.

Q. In your experience in December of 2018 and prior, did you ever see the medical staff checking on inmates in a restraint chair every 15 minutes?

A. 15? No.

Q. And I think we're done with Exhibit 2, if you want to go ahead and push that aside. In December—I'm going to take you to December 9th now of 2018 when Mr. Howell came to the mental—to your area.

A. Yes. Okay.

Q. You were working in the control room; is that correct?

A. Yes.

Q. And tell me about what you observed when he came onto the post.

A. He came in to my right side in the restraint chair, came in front of me, went to my left. They opened the door, and he just went right into a cell.

Q. What was his demeanor like?

A. Seemed like he was calm. I mean, it kind of seemed like he was calm and everything. But at that point in time, I'm logging in that, you know, plus one person in the restraint chair. But I seen him for like maybe 2 seconds, 3 seconds. It looked like he was sitting there calm walking around—or in the—sitting down.

Q. And I think in your interview with the officers, you described him as silent and not thrashing—

A. Yes.

Q. —is that correct?

A. Yes, yes.

Q. And I'm going to hand you what's been previously marked as Plaintiff's Exhibit 15. Go ahead and take a second to review that.

A. (Examining document.)

Q. Have you had a chance to review it?

A. Yeah. Yes. That's above . . .

MR. WELCH: Let me just take a look. Which one is it?

Q. So this is the daily log for your area of the jail; is that correct—

A. Yes.

Q. —for December 9th of 2018?

A. Yes.

Q. All right. And you see there towards the bottom, there's a movement notation or a movement code, and it says, Plus 1 in restraint chair, count at 36, dot, dot, dot, MC. Do you see that?

A. Yes.

Q. And that was when Mr. Howell was brought into that pod, correct?

A. Yes.

Q. And why didn't you put him on the count originally?

A. I didn't have his name yet, so I had no clue exactly who he was yet. Once I do that, then we usually do.

Q. But you didn't think he was staying there, did you?

A. No, not totally. I mean, there's sometimes we have intakes that come in, and 90 percent of the time they'll go up. They'll do the—what they have to do when they do it in the restraint chair, and then they go right back down to intake and do the Page 71 process and not come back to us.

Q. Why didn't you think he was staying?

A. I didn't necessarily think anything like that at all. I just didn't have his name at the time, so I didn't put it on the count. I mean, I would have probably put it on our little roster saying that he was going to stay.

And once he got away from us, I would erase it off. But an actual hard count like that, I wouldn't probably never put him on the count just thinking that I don't think he would necessarily stay with us.

Because usually when people are in a restraint chair that, like, are batting their heads, they

usually put them on suicide watch afterwards, and those are the ones who usually stay with us.

Q. And you saw him wheeled in, and because he wasn't banging his head, you thought he would be out of there pretty quickly?

A. Yes.

MR. WELCH: Objection.

A. Yes, yes, or depending on his papers. Like, I mean, I wasn't there when anything happened, but it depends what happened. I mean, he could have—you know, wake up, and the next thing I know, he could be thrashing around. But at the time, yeah, he could have been out of there pretty quick.

Q. So where did you get the information that he wasn't—you didn't think he was going to be staying with you guys?

A. Just my own observations. I mean, he came from medical area. He—I mean, he didn't come from intake. Usually intake, they'll have, like, regular clothes on. He had a inform on. And no one told me that he was going on suicide watch. That's usually the only two times they really keep anybody or have somebody leave.

Q. You later learned, right, that he was going to stay with you?

A. I don't actually remember—actually remember knowing that he was actually going to stay with us.

Q. Okay. Let me . . .

A. I can't remember. Maybe he was, I guess.

Q. I'm going to play you a portion of what we've previously identified as Exhibit 21 beginning at the 4:20 mark. So I'm just going to have—I'm going to let this play, and then I'm going to ask you some questions.

A. Okay.

Q. Okay?

A. That's fine.

(Audio playing.)

Q. So there you're talking about later you learned that he was—

A. Yes.

Q. —going to stay with you?

A. Yes.

Q. So who told you that?

A. Probably one of the bosses, bigger boss. You know, maybe Sergeant Hunt or someone higher than us.

Q. Do you recall what they said to you?

A. Not really. I just remember—I remember saying—I remember hearing something about he's probably going to stay in A Pod instead of 1 for observation for now. But not those words. It could have been something totally different, but it was something like that.

Q. And again, you didn't put him on the count originally because you thought he was going to be kind of in and out?

A. In and out kind of, yes.

Q. What did you understand about—or what did you learn—what did you learn about why he was in the chair?

A. We didn't really find out until later, later, later on for what I—like, we did or something like that. The other person in that—that part actually came back to our unit, and he stayed in our C Pod. And I was like, Who's this guy? He's like, He's the guy that had to deal with the argument I guess they had up on North 41.

Q. Tell me everything that you heard about why Mr. Howell was placed in the chair originally.

A. That he—him and another roommate, I guess, upstairs were having a fight or something like that—I don't know what—exactly what it was—and that Howell stabbed that other inmate.

Q. And who did you hear that from?

A. The higher boss.

Q. Would that be Sergeant Hunt?

A. I don't think it was Hunt. I think it was someone else, but . . . It might have been another sergeant.

Q. And did you learn about that after Mr. Howell was discovered deceased?

A. No. It was probably about 8—about 8:00, somewhere around there, because that's when the inmate-the other inmate came back from the hospital.

I don't know exactly if it was 8:00, but whenever the inmate came back, I think the actual intake supervisor—it might have been Sergeant Franklin

at the time?—was the one that came up and said, Here's this inmate. He's the one that got stabbed. Oh, okay. And we kind of figured out, oh, okay, I guess that's why he—yeah.

Q. Did any of the higher bosses ever indicate that Mr. Howell was going to go to the hospital to you?

A. Not that I know of, no.

Q. Did anyone ever tell you about any medical conditions that he had?

A. No.

Q. Do you have access, in your duties on the mental health floor, to jail incident reports?

A. The actual incident, yes, on the computer.

Q. And does that access go back years?

A. I would say so. I'm not exactly how many years, but I guess it does, yes.

Q. And with respect to Mr. Howell, you never accessed any incident reports concerning him, correct?

A. No, no.

Q. Never looked at any of his old intake paperwork?

A. No.

Q. Have you ever, for any inmate who's placed in a restraint chair, looked at any of their intake—

A. No.

Q. —information?

A. No.

Q. Are you aware that that intake information would note health conditions that that inmate has?

A. Yes. Because usually when they come in—an inmate come in, they would talk to a nurse, medical staff, you know. I have blood problems, blood sugar problems, et cetera, et cetera. They'll tell them that. We wouldn't know anything about it, though.

Q. Wouldn't it be helpful to know that information about an inmate if they're in a restraint chair?

MR. WELCH: Objection. Go ahead.

A. I guess so, yeah, it would be, but I mean, it doesn't necessarily mean that I need to know it, I mean. But, I mean, if he has a medical issue, maybe he shouldn't be in the chair, but I don't know.

Q. But you've never been trained or have you ever been trained to look at that information?

A. No.

Q. All right. So Mr. Howell is wheeled in, and he's placed in Pod A, correct?

A. Mm-hmm.

Q. Did you participate at all in securing him into cell—which I understand to be cell 6, correct?

A. No, I did not.

Q. Do you remember who did secure him?

A. It would be Erwin and Pierani and a supervisor, which I think was Sergeant Hunt.

Q. Could you see, from your vantage point in the LC unit, them place him into cell 6?

A. I saw them walk him into cell 6, and at that point in time, I turned back to the computer to type in other things.

Q. Can you hear what's going on in Pod A from the LC?

A. No, not really, unless someone's really banging hard or anything.

Q. Did anyone ever talk about anything significant that happened placing him into cell 6?

A. No, not that I know of, no.

Q. And as I understand A Pod, its layout, there's sort of a front door that they would have walked Mr. Howell into, correct?

A. Yes.

Q. And that's got kind of clear windows?

A. Yes.

Q. And then there is an additional fire door that goes between Pod A and Pod B, correct?

A. Yes.

Q. There are no other points of ingress or egress to Pod A—

A. Hmm-mm.

Q. —correct? That's a no?

A. No.

Q. And when the cell door is closed, you cannot see into cell 6 except when standing directly in front of it?

A. Yes.

Q. So then your next interaction with Mr. Howell would have been on med pass, correct?

A. Yes.

Q. Describe for me his behavior or what you observed during that med pass.

A. When we got to A Pod, he was yelling. You can hear him through the door. We looked into it. Even the nurse looked inside. He was yelling and screaming like, Get me out of this chair. Get me out of the chair. And I think the nurse said something along the lines like, Hey, you need to stay calm so we can get you out of there.

Q. Well, he actually wasn't yelling, was he?

A. Yes, he was.

Q. I'm going to go to the 6-minute mark of Exhibit 21, and I'm going to let this play, and then I'm going to ask you some questions about it. Okay?

A. Okay.

Q. So this is actually—I'm going to start at the 5:56 mark.

A. Okay.

(Audio playing.)

Q. I'm sorry. That's the wrong time here. So let me go back to 5:30.

(Audio playing.)

Q. So we stopped at the 5:51 mark. So you told the officers that he wasn't actually—

A. Yeah, yeah.

Q. —yelling, right?

A. Yeah, sorry, yeah. He was talking in a loud voice, I guess you could say, because you couldn't hear it through the doors. I mean, you could hear it through the door. He wasn't screaming. He wasn't yelling that loud, but you could hear it and stuff, and the door was shut.

Q. And he was asking to be let out?

A. Yes.

Q. And did you or the nurse ever go into the cell and interact with him?

A. I want to say, yes, we did one time with the nurse and we talked, and that's the one she said, You need, you know, to calm down so we can get you out of there quicker. You know, just stay calm, et cetera, et cetera, and we walked out.

Q. Did you say anything to him during that time period?

A. I did. I think I said something along the lines of like, Hey, you know, I don't know why you got in the chair, but, I mean, you—just stay calm, you know, so we can get you out of there.

I mean, I said something along the lines of—might not have sounded as good. I think I said something like, Hey, I don't know what you did, man. You might have messed up, dadadadada, but, I mean, the main thing is we're trying to get

you out of here. We're not, I mean, trying to hurt you. We're not trying to do anything.

Q. What was Mr. Howell's response to that?

A. He just kept on yelling—or not yelling, but talking like, Hey, get me out of the chair. Get me out of the chair.

Q. Did he say anything about that he was in pain or discomfort?

A. No.

Q. Did the officer—or, excuse me. Did the nurse administer any medications to him?

A. Not that I know of, no.

Q. Did she conduct any-and it was a woman, correct?

A. Yes.

Q. Do you know her to be Pierette Arthur?

A. Yes.

Q. Is Ms. Arthur still employed at the jail?

A. Yes.

Q. Did you see Ms. Arthur conduct any tests on Mr. Howell?

A. No, nothing else.

Q. Didn't take his blood pressure?

A. No. Because they would have done that when he first got in the chair. They should have. They should have, yeah, medical.

Q. So basically, you guys walked in—

A. Stay calm. Because on top of, like, the meds—like, his meds would have been on North 41 cart, so they—he wouldn't—if he had meds, he wouldn't have gotten them till later on.

Q. Was Deputy Erwin in the cell with you—

A. No.

Q. —at that time?

A. No.

Q. He was standing outside?

A. He was in the other pod.

Q. He was in the other pod?

A. Yes. B Pod.

Q. How long would you say that you were in this cell, in cell 6, with Mr. Howell and the nurse?

A. A couple minutes. Two minutes tops.

Q. How many other inmates were in Pod A at that time?

A. I want to say there was three up top and then two on the bottom, so five. Yeah, because cell 1-we were going to, I guess, put him later on in cell 1.

Q. So we've got—

A. 3, 5, 7, then 2 and 8. So five people.

Q. You have just described that Pod A is two floors?

A. Yes.

Q. So during the 10-minute rounds, are you expected to look at all five of those inmates?

A. Yes. You had to go upstairs, downstairs. Same thing in B Pod. Same thing in C and D.

Q. And you said it was two on top, three on the bottom?

A. No. It was the other way around. Three on top and then two.

Q. And all of the inmates in Pod A require 10-minute observations; is that correct?

A. No, no, not all of them, no. It's like 30 minutes-30 minutes—they're usually 30-minute times. And then A and B—the chairs in the B pods, unless there's other suicide watches that fell over into C Pod, then it would be 10 minutes.

Q. So was there anyone else in Pod A on December 9, 2018, who required a 10-minute observation other than Mr. Howell?

A. When Mr. Howell arrived, there was somebody in there. And right when that happened, Mr. Howell went inside cell 6. They pulled him out of cell 4 at the same time. I think it's actually written there too.

Q. So everybody else in—the other four inmates in Pod A would have been on 30-minute watch schedules?

A. Yes. It's like a mental health observation.

Q. Is there a dedicated member of the medical staff in Pod A at all times?

A. No.

Q. And you eventually transitioned to—from the LC to the housing officer—

A. Yes.

Q. —correct?

A. Yes.

Q. And is the housing officer responsible for Pods B, C, and D?

A. All of them, really. They can be. I mean, D, C—D, C, B, and A, yes.

Q. All right. But there is—your partner—one of your partners, then, though, would be specifically assigned—

A. (Inaudible)—

Q. Hold on. Let me get the question. You're okay. One of your partners, while you were the housing officer, would have been specifically assigned to perform the role of observation of Mr. Howell—

A. Yes.

Q. —and the other inmates in Pod A?

A. Yes.

Q. Okay.

A. And B.

Q. All right. And you—so you do 2 hours and 40 minutes—

A. Yes.

Q. —roughly as the housing officer?

A. Yes.

Q. And then you eventually transition to the officer who's doing the suicide watches, correct?

A. Yes.

Q. And you're responsible, then, for observing inmates in the restraint chair?

A. Yes.

Q. And that included Mr. Howell?

A. Yes.

Q. And those monitoring responsibilities required you to complete 10-minute watches, correct?

A. Rounds, yes. Rounds, yes.

Q. And you were responsible in that role for logging the watches in accordance with jail policy, correct?

A. Yes. Policy, yeah.

Q. And other than Mr. Howell's death, nothing out of the ordinary occurred in those pods on December 9, 2018, correct?

A. Not that I know of, no.

Q. You actually at one point became responsible for observing Mr. Howell while you were the housing officer, correct?

A. Yes, just for a small period of time because my partner went on a break.

Q. And he went to get food, correct?

A. Yes.

Q. Is it customary for officers to take breaks during their shifts?

A. Yes.

Q. Do they need to notify anyone, Hey—

A. Yes.

Q. —I'm going on break?

A. Yes. There's actually a code and everything. You say two-seven for chow or two-seven for 5. There's two of us.

Q. Okay. So there would be a log of Erwin-Deputy Erwin is who we're talking about—

A. Yes.

Q. —correct?

A. Yes.

Q. There would be some sort of—would there be—

A. Radio—mainly radio traffic. There wasn't usually a log, but it was mainly radio traffic to the boss.

Q. So that left you, for that time period, as both the restraint chair observation role and the housing officer role, correct?

A. Yes.

Q. Do you believe that you can safely and effectively perform both of those roles simultaneously?

A. Yes. And—yes. I'd say yes.

Q. And how long are you permitted to take food breaks during your shift?

A. He usually would go get food for, like, everybody in the whole facility. So he would be gone for, you know, 30 to 40 minutes, whatever.

Q. Did he bring you food back?

A. I think so on that day, yes. I think so.

Q. Do you remember what it was?

A. Nope. Chipotle, maybe.

(Reporter clarification.)

Q. Did you eat it—

A. Chipotle. My bad. Maybe. Maybe. He liked Chipotle.

Q. Did you eat it during your shift?

A. Yes.

Q. Is that customary—

A. Yes.

Q. —to eat on post?

A. Yes.

Q. And would an officer, then, who's performing the restraint chair duties be eating lunch or dinner at the same time they're performing those duties?

A. Yes. Yeah. You know, take a bite and then go do his rounds and then take another bite, you know.

Q. During that time where Deputy Erwin was on a break—or went to get food, excuse me, what did you observe of Mr. Howell?

A. Sitting there in the chair calm, usually. He was just—like, I know a couple times he was just, you know, staring out the window or looking. And then a little bit later on, he was falling asleep. He fell asleep.

Q. Do you recall what time you think he fell asleep?

A. Like 17:20, something like that. 17:20, 17:30, something around there.

Q. Okay. If he didn't go in the chair until 17:40—

A. Oh. Then I guess . . . 19—19:20, 19:30. My bad.

MR. WELCH: If you want to look at anything, that's fine. You're doing the best you can. If you have a recollection, you tell him that. If you want to look at something before, that's fine to refresh your recollection. That's fine. We'll get there.

Q. And again, as we've talked about, if the inmate falls asleep, the practice is typically to let him sleep—

A. To keep him calm.

Q. —if it's before the two—hold on. Let him sleep if it's before the two-hour mark. We'll handle it with the supervisor at the two-hour mark, right?

A. Yes.

MR. WELCH: Objection. Go ahead.

A. Yes, yes.

MR. MCGRAW: I've got about 5 minutes, and it will be a good time for a break.

MR. HOJNOSKI: Yeah.

Q. (By Mr. McGraw) All right. Officer Collini, I'm going to hand you what's previously been marked as Plaintiff's Exhibit 6. If you want to go ahead and take a peek at that.

A. Okay.

Q. And let me know when you've had a chance to review it.

A. I got it. I'm good on it, yes. I've seen it a couple times.

Q. All right. And I just want to ask you about the handwriting on here first. At the top there where it says the inmate name, did you write Cornelius Howell?

A. No.

Q. And what—I understand the numbers next to his name to be his inmate number. Is that your handwriting?

A. No.

Q. Reason in the chair, is that your handwriting.

A. No.

Q. Time placed in chair?

A. No.

Q. Any of the notations under that 1 hour column?

A. The first one? No.

Q. And what about under the 2 hour column?

A. Yes.

Q. So those designations of MC, those are you—

A. Yes.

Q. —correct?

A. Yes.

Q. And you would have also then written the times, 20, 30, 40, and 50?

A. Yes.

Q. And then you would have written "chair," correct?

A. Yes.

Q. And then, middle of the page, you see completion of 2 hours in chair. Do you see that?

A. Yes.

Q. Were you the one who circled "no"?

A. Yes.

Q. And is that your handwriting that says, Sleeping, doesn't want?

A. Yes.

Q. All right. Then if we go down to the 3 hour column, same question. So on 40, 50, and 21:00, are those—are those rows all your handwriting?

A. The 40, yes. The 40, 50, and 20, yes.

Q. And then the 4 hour column, everything written there is you, correct?

A. Yes.

Q. All right. So the MCs that I see periodically represent times that you personally observed Mr. Howell, correct?

A. Yes.

Q. And did you complete this form truthfully?

A. Yes.

Q. Accurately?

A. Not a hundred percent accurately. It wasn't that we were able to get to his cell because we had to do B Pod rounds and other rounds on other people. So we didn't necessarily make it every—you know, on point 10-minute, 10-minute. I mean, it might have been 11 minutes, but we usually just put the 10 minutes.

Q. So is your answer there to say that you might not have conducted each of these 10-minute observations?

A. Not necessarily in that 10-minute frame. It might have been 12 minutes. It might have been 15.

Q. Okay. But as I calculate it, there are 12 MC notations.

A. Yes.

Q. So you would have personally observed him at least 12 times, correct?

A. Yes. It should have been, yes.

Q. Might not necessarily have been exactly 10 minutes, but there were 12 observations by you of Mr. Howell?

A. But you have to, like—you have to keep it within the two hours. So we'd always put, like, 10, 20, 30, 40, 50. We don't write like 10 (inaudible) you know, for—and then fill—but you have to keep it within that two-hour frame so you know when the two-hour frame ends.

I mean, if I would have put, you know, 10—like, my time 40, and then the next one, say if I did it,

you know, at 55, it's going to get there quicker, I guess you would say, per se. I don't know.

(Inaudible) like, say if I put a 45 here and, you know, I got 58 here, and then the next thing—the hour's going to be quicker. The time frame would be quicker because there'd be, like, say, 21:00, I guess, whatever. 22:00 would be, like, right here. It would be way up here.

Q. But each of these notations of MC is a time that you personally observed Mr. Howell?

A. Yeah, it would be, yes.

Q. And this is what you told to jail investigators too, correct?

A. Yes.

Q. And looking at the top two columns, you would agree that we're missing completely one 10-minute notation, right?

A. I guess so. I don't know.

Q. Let me walk you through it. So the first column, you see 17:40, right?

A. Yes.

Q. 17:50, correct?

A. Yes.

Q. 18:00?

A. 10, 20, 30, 40.

Q. Okay. So then you go up here. I think that says 19:50, but it probably is supposed to mean 18:50?

A. Yes, I would say, yeah.

Q. Okay. And then either . . .

A. 10.

Q. 10 or is that—

A. Yeah, it would be, yeah. We would be missing one here.

Q. So you're either missing 19:00 or missing 19:10, right?

A. Yes.

Q. So either the check didn't occur—right?

A. Yes. Or, yeah.

Q. Or it didn't get logged, correct?

A. Didn't get logged, yes.

Q. And you would agree that both—in both instances, those would be violations of jail policy, right?

A. Yes.

MR. MCGRAW: I think now is a good time to take a break if Bob needs to make a a phone call.

MR. HOJNOSKI: Okay.

MR. KIRCHER: Going off video at 10:50.

(A brief break was taken.)

MR. KIRCHER: Going back on video at 11:24.

MR. WELCH: Ryan, before you ask another question, I believe Deputy Collini just wants to clarify the prior answer.

Is that right?

THE WITNESS: Yes. Yeah, the questions you had earlier about the chair and everything, I did log 12 checks. And I told that to the inspectors or the people I was talking to out there.

But on video, it shows—and I know-I haven't watched all the video, but it shows that I didn't—not do all 12 checks. I did log it, but I didn't actually do the checks.

MR. MCGRAW: Okay.

THE WITNESS: So I didn't know they lied to the, you know, detectives or anything like that. I just—I did log the checks. That's what I meant. I thought you meant—we're just talking about logging the checks, not doing the checks, though.

MR. MCGRAW: No. I asked—the question I asked you was you personally observed Mr. Howell 12 times.

THE WITNESS: No, I didn't.

MR. MCGRAW: Okay.

THE WITNESS: I would not have that because—yes, but I logged it 12 times, but I didn't, yes, no.

MR. MCGRAW: Okay.

MR. WELCH: I think he misunderstood your question. That's why he wanted to clarify.

THE WITNESS: Yeah.

MR. MCGRAW: Okay.

Q. (By Mr. McGraw) How many times do you think you observed him?

A. I don't know, actually. I can't really remember. Maybe five.

Q. And you told investigators-it's your testimony that you told investigators that you didn't actually check on him each of these times?

A. What do you mean?

Q. You told investigators that you-while you logged these—

A. 12 checks.

Q. —checks—

A. Yes.

Q. —you didn't actually do them?

A. No, I did not do them, no.

Q. You did not tell them—

A. I just told him that I logged the checks. That's what I told him. I didn't remember actually saying any other stuff to him. I can't remember. Don't recall.

I do remember actually logging 12 checks because clearly it's on the piece of paper. But actually on video—what you can see on video, it does not look like I did all 12 checks, which was a mistake (inaudible), you know.

(Reporter clarification.)

It was a mistake.

Q. It was a lie, right?

MR. WELCH: Objection. Go ahead.

A. Not—I mean, I guess it would be, but it's-it was a mistake. We did our checks, but-I mean, we didn't do them all, I guess. So I guess it might have been a lie, I guess, but . . .

Q. I mean, you told me earlier you're required to accurately complete this form. Do you recall that?

A. I don't, really.

Q. Okay.

A. I might have. I might have. I mean, I don't know.

Q. Do you have any reason to dispute that you should accurately complete this?

A. You should, yes, because—I mean, you're supposed to do it every 10 minutes, and you're supposed to actually do it. We just—I mean, I guess that day, we just didn't do it.

Q. Any reason you didn't do it that day?

A. No. I—maybe we got behind on the other guys, the other suicide watches maybe or whatnot, but it wasn't like we do this every day at work. We're not trying to—you know, trying to keep the guys safe. We're not trying to. . . . I mean, every time I went by, I went—you know, I mean, he looked like he was sleeping in his cell.

He was safe. In my eyes, he looked like he was safe. I mean, we also might have been—every time we did the 30-minute check over in A Pod, that was probably about the time when we do the checks. So every time we did it in A Pod, the

30-minute check, we would go over there and look at him.

Q. Okay. When you say "we"—

A. Me and Erwin.

Q. So the representations here from Deputy Erwin, are those not accurate—

A. I don't know.

Q. —of his observations?

A. I don't know. I don't know (inaudible).

(Reporter clarification.)

A. I don't know.

Q. At some point, Mr. Howell died, right?

A. Yes, I guess so.

Q. When you were supposed to be watching him, potentially?

A. Yes, I would guess so, yes, but we don't know exactly when he died.

Q. So at the two-hour mark, there's a spot on Exhibit 6 which talks about limb exercise. Do you see that?

A. Yes.

Q. You say, Sleeping, doesn't want.

A. Doesn't want, I guess, probably wasn't the best word, you can say, there. He was sleeping. My partner wasn't there, so he couldn't help me out, and the boss wasn't there. So at that point in time, I just said he was sleeping.

Q. But you wrote he doesn't want it.

A. Yes.

Q. Did you ask him if he wanted it?

A. No.

Q. Did you try to wake him up?

A. No, because he was sleeping. I wasn't going to wake up somebody that's sleeping.

Q. And it's your testimony that you radioed Officer Hunt?

A. Yes.

Q. And he said, I'll be down when I can?

A. When I can, yes.

Q. So really, the fact that what you say here, he doesn't want it, that's not accurate, is it?

A. No, it's not accurate, no. He was just sleeping. I should have just put sleeping.

(Plaintiff's Exhibit 22 marked.)

Q. All right. We're going to use that still, but I'm going to hand you what is now being marked as Plaintiff's Exhibit 22. Take whatever time you need.

A. Are we going to go through it, I guess, or . . .

Q. Yes. Just familiarize yourself with it.

A. Yes, I've seen it. Go through it again real fast, I guess.

Q. Whenever you're ready to have me ask you questions about it, just let me know.

A. Should be all right. Should have been.

Q. And you see there—and I'll represent to you that these are written discovery requests that we provided to you and that you responded to.

A. Yes.

Q. You see there number 1. It asks you to identify who participated. It indicates, in addition to your attorney, you participated in it?

A. Yes.

Q. All right. So I'm going to take you to question 10—

A. 10. Okay.

Q. —on page 2. Are you there?

A. Yes.

Q. Okay. And I ask that you admit that between 6:07 and 6:10, you were in Pod A of the North 21 building at the jail with a member of the NaphCare staff and another Hamilton County Sheriff's deputy and conducted an observation of Pierre while he was in the restraint chair. And you said, yes, that you conducted that observation. Is that right?

A. Yes, it is.

Q. Okay. And when I say Pierre, I mean Mr. Howell.

A. Yes, yes.

Q. The other—the NaphCare staff member, that was Pierette—

A. Pierette.

Q. —Arthur, correct?

A. Yes.

Q. And the deputy was Deputy Erwin?

A. Yes.

Q. Okay. And you talked a little bit ago about what happened during that observation. Do you recall me asking you—

A. Yes.

Q. —questions about that?

A. Yes, yes.

Q. Is there anything that you need to amend or change about your previous answer?

A. No. I mean, it was just . . .

Q. And Ms. Arthur and you specifically went into the cell?

A. Yes.

Q. And why did you tell him that you—at that time that you could not take him out of the chair?

A. I know he just showed up within an hour. It's usually they want to at least wait the two-hour minimum to get him out of the restraint chair, not 30 minutes into it or 40 minutes into it, however long it was at that point in time where he came or med pass was starting. We couldn't-we weren't going to let him necessarily out until he was totally calm, so—and the two-hour limit.

Q. And after this observation with Nurse Arthur, do you ever recall a member of the medical staff observing Pierre on December 9th?

A. I do not recall.

Q. Had they been on the floor after this time period—

A. Yes.

Q. —it would have been logged, correct?

A. Yes.

Q. And previously, we looked at Exhibit 15. I'm going to hand it back to you briefly.

A. Oh, the log? Okay.

Q. And I just want you to confirm that after 18:01 when it notes that medical is on the floor, there are no other designations of medical until the G-100 is called, correct?

A. Yes, it looks like it, yes.

Q. All right. Thank you. All right. So if you go to the third page of Exhibit 22, you see question 13. Do you see that?

A. Yes.

Q. I ask that you admit that you conducted a cell-front observation of Pierre while he was in the restraint chair at 7:24 p.m. on December 9, 2018. Do you see that?

A. Yes.

Q. And you admitted that you did conduct that examination?

A. Yes.

Q. So my first question to you is, is that the 19:20 check or the 19:30 check?

A. That would—on here? It would be probably within the 19:30 check.

Q. All right. So if you could—

A. In between—right in between 19:29 and 30.

Q. All right. If you could, on the right side of Exhibit 6, what I'd like you to do is check and date which check you conducted at 7:24 p.m.

A. Check and a date?

Q. Yes.

A. 6 what?

Q. 6:17.

A. (Writing on document.)

Q. And which line are you checking?

A. The 30.

Q. Okay.

A. It was closer to 30.

Q. All right. Tell me what you did during this check.

A. Went to his window and looked down and seen him. He was just sitting there just looking out the window, it looked like.

Q. So at this time, you specifically recall that he was looking out the window?

A. Yes.

Q. Did you see his eyes open?

A. I couldn't see his face that way. Like, he was just looking that way.

Q. Okay. So he was looking straight ahead?

A. No. He was looking to the right.

Q. Okay. So he was looking out?

A. The window.

Q. The window?

A. Yes.

Q. And you were looking in the window?

A. Yes, into the window, yes. Not the window-not the same window. Out that window. Like, the window out here, and then we have a window that's inside the door too. He wasn't looking at me. He was looking out another window.

Q. Okay.

A. I was looking in the window this way.

Q. Okay. So let me make sure I'm clear. So there's the door—

A. You're looking—

Q. —as you walk into cell 6?

A. Yes.

Q. Mr. Howell would have been at a profile view of you?

A. No. A side profile.

Q. A side profile.

A. So his positioning would be like this. I would be right here at this window.

Q. Okay.

A. There was another window which is the outer window into, you know, the sky or whatever, you know, city or whatever it is. And he was looking out that window.

Q. Okay. So you—

A. So he wasn't looking at me.

Q. Was not looking at you. So you could not see his eyes?

A. No.

Q. Did he look like he was alive?

A. Yes.

Q. Did you tap on the window at all?

A. No. Seemed like he was okay to me.

Q. Why didn't you write, Looking out window?

A. Usually, when I just say anything like—I usually just put "chair" if they're safe and they're calm and look, like, nice and they're doing good.

Usually, a lot of times we only log it if it's something like a seizure, et cetera, or, you know, thrashing in the chair for if one of the bosses come down—Oh, okay, what happened here at 19:40 or, you know, 20—oh, man, he was banging his head, I mean. Oh, well, we'll talk to him. We'll see if he's going to stop banging his head.

Q. How long do you believe the check lasted?

A. About three minutes. Two minutes tops, maybe.

Q. So you believe that you were—and during that check, were you only observing Mr. Howell in A Pod, or did you do a complete—

A. I did—I helped out with—I did the rounds in A Pod. I did him and then, yeah, went around.

Q. So you believe that the entirety of that round in Pod A took about two minutes?

A. Yes.

Q. All right. If you go to just below that question 16—

A. Okay.

Q. —I asked you to admit you conducted the cell-front observation of Pierre while he was in the restraint chair at 7:40 p.m. on December 9, 2018. Do you see that?

A. Yes.

Q. And you admitted that you did conduct that.

A. Yes.

Q. All right. So on Exhibit 6, is that the—which check is that?

A. It would be this one. Do I just do the same thing?

Q. Check and initial—check and date, I'm sorry.

A. (Writing on document.)

Q. And if you could for the record, indicate which time period.

A. The 40.

Q. Okay.

A. 19:40, I guess.

Q. Tell me what you observed during this observation.

A. Around that point in time, I think he fell asleep. He was more—same—facing this way, but not like—his head was facing this way just like this, sleeping.

Q. So you believe he was sleeping?

A. Yes.

Q. But you never interacted with him at all?

A. No. I wasn't going to wake him up or anything.

Q. You have no idea if he was alive at that point, do you?

A. No. I'm going to say no. Alive or asleep, we don't know.

Q. How long do you believe that check lasted?

A. About two minutes. No, not two minutes, about a minute, because we didn't have to do another round in A Pod for another 30 minutes, so it was only like a minute.

Q. So during that time period, you didn't check on any other inmates?

A. No, not at that time.

Q. All right. So if you flip to the fourth page there. I ask on question 19 for you to admit that you conducted a self-run observation of Pierre while he was in the restraint chair at 9:14 p.m. on December 9, 2018. Do you see that?

A. Yes.

Q. And you admitted that did you conduct that check?

A. Yes.

Q. So on Exhibit 6, if you can—

A. Same thing?

Q. —check and initial what check that was.

A. (Writing on document.)

Q. And for the record, if you could—

A. It would be the 21:20 check.

Q. So that's the second row in the 4 hour column?

A. Yes, the—no, the 2—yeah, the 20, yes.

Q. All right. Tell me what you observed during this check.

A. Same thing. Looks like he was sleeping, just maybe his head was maybe a little more down. Like, instead of going like this, it was like this. More straight down, I guess.

Q. It looked like he was sleeping to you?

A. Yes, yes.

Q. You have no idea if he was actually—

A. No.

Q. —asleep?

A. Yes, I have no clue.

Q. How long do you believe that check lasted?

A. Same thing. About a minute, minute and a half. Two minutes tops.

Q. During that time period, did you observe any other inmates?

A. We would have, yes.

Q. So you would have done a full check of—

A. Yeah, just of A. I would have done just A and B, and then my partner would have done the other one too.

Q. But specific to Pod A, you would have been in there about a minute?

A. Yes.

Q. And in each of the three checks that we've talked about—or of the two that you said you'd done a full A Pod check—

A. Yes.

Q. —that would have required you to check the . . .

A. Other cells, 1, 3, 5.

Q. The two inmates on the bottom?

A. Mm-hmm.

Q. The three inmates on the top?

A. (Witness nodded.)

Q. Correct?

A. Yes, yes.

Q. How many stairs are there between—

A. 10.

Q. —the first row and second?

A. About 10.

Q. So during that time period, you would have gone into the cell—

A. Or into the pod.

Q. Let me ask it a better way. So during the two checks at 7:24, or 19:24, and 21:14 when you did the full A Pod check—

A. Yes.

Q. —you would have gone in, observed Mr. Howell, correct?

A. Yes.

Q. Observed the other inmate on the bottom row, correct?

A. Yes.

Q. Walked up the 10 flights or 10 steps, correct?

A. Yes.

Q. Observed each of the three inmates on the top row-

A. Yes.

Q. —correct?

A. Yes.

Q. Walked down the 10 steps, correct?

A. Yes.

Q. And then out of the pod?

A. Yes. But through the fire door.

Q. Through the fire door. Okay. So on Exhibit 22, question 22, I asked that you admit other than the observations in the previous admissions—which would have been the med pass was number 10—

A. Mm-hmm.

Q. —number 13 was the 7:24 check, number 16 was the 7:40 check, and number 19 was the 9:14 check—I asked you to admit that you conducted no other observations of Mr. Howell while he was in the restraint chair. Do you see that?

A. Yes.

Q. And you said that you could not admit it or deny it. Why not?

A. I logged them. Like I said, I logged them and everything like that, but I may have not checked them every 10 minutes, every 20. I mean, it might have been 15 minutes. It might have been 20 minutes. I didn't log it that way. I just logged it as every 10 minutes. Like, even on the one, it says at 8—what is it? 8:24 or whatever time it was, 24. Instead of me putting it on 24, I would have wrote it on the 30. Instead of putting 19:24, put 19:30.

Q. Yeah, and I'm not talking about logging. I'm talking about actual observations—

A. Yes.

Q. —that you—my question was, other than those four observations that you've admitted you conducted—

A. Yes.

Q. —I asked you to admit that you conducted no other ones, and you couldn't admit it or deny it.

A. The video says yes, I did not. Would have not—I would not have checked him more than four.

Q. You would not have checked him—

A. Would have not, yes.

Q. So those are the only four that you did, correct?

A. Yes.

Q. So why didn't you say admit?

MR. WELCH: Objection. Go ahead.

A. It would be admit and—I don't know. I should have said admit, I guess, but I also thought because I was doing other rounds and-I thought mainly it was basically on this, but I didn't know it was mainly on the overall, you know, actual rounds that I did.

Q. And in question 23, I asked if you're not going to admit that, state specifically your basis for such—each such denial or qualification. Do you see that?

A. Yes.

Q. And you indicated there are records indicating additional times of checks or observations. What do you mean by that?

A. The record. This. It was records that they-that it happened. We put it on there. It might not have happened on a timely basis, but . . .

Q. But none of the other ones, as you've just admitted, actually happened, right?

A. No.

Q. You put them on here on Exhibit 6—

A. Yes.

Q. —but they did not occur?

A. No, I guess not.

Q. You guess or you know?

A. No, no, no.

Q. So to go through each of the MCs on Exhibit 6, just so the record is clear, at the 19:20 hour, you did not conduct an observation of Mr. Howell?

A. No, unless I was coming off med pass.

Q. So you're saying—you're admitting you did not conduct them?

A. Yes.

Q. At 19:50, you did not conduct an observation of Mr. Howell, correct?

A. Yes, did not.

Q. At 20:40, you did not conduct an observation of Mr. Howell?

A. I guess not.

Q. At 20:50, you did not conduct an observation of Mr. Howell?

A. I guess not.

Q. At 21:00, you did not conduct an observation of Mr. Howell?

A. No.

Q. At 21:10, you did not conduct an observation of Mr. Howell?

A. No.

Q. At 21:30, you did not conduct an observation of Mr. Howell?

A. No.

Q. At 21:40, you did not conduct an observation of Mr. Howell?

A. At that point, I think we were actually pulling him out of the restraint chair then. I want to say—I forget exactly what time we pulled him out, though.

Q. He was pulled out 21:45.

A. Around that time we would have, yes.

Q. So it's your testimony that at some time between 21—

A. 40.

Q. —after 21:40, you conducted an observation—

A. Yes.

Q. —of Mr. Howell?

A. Yes, because we walked in the cell and were going to let him out.

Q. So at that time, the 21:40 observation would be when you actually removed him from the cell?

A. Yes.

Q. Okay. What did you observe when you removed him from the cell?

A. He looked like he was sleeping. I didn't really do any of the talking or anything. It just looked like he was sleeping. My boss said, Hey, man, wake up. Come on. Time to get up. Time to get up.

And at that point, I guess he might have touched him or something, and then immediately after that, he told me to go to get the nurses. Well, before I could even get to the nurses, the nurses were already headed toward me, I guess, because

he called the George 100. Never had (inaudible) . . .

Q. So if that's what happened at 21:40, why did you include a 21:50 chair?

A. I just—because I went back to my logs afterwards. He was kind of technically still in the chair, I guess, but he was coming out of the chair. I just put one extra one saying chair.

Q. You're representing, though, you conducted an observation of Mr. Howell—

A. Yes.

Q. —at 21:50?

A. Which he was. He was on the ground. I mean, he was on the ground. He wasn't necessarily in the chair. I should not have necessarily put in the chair. He was out of the chair. He was out of the chair. He was just on the ground.

Q. Yeah, and you talked earlier about that you had put notable things that were occurring on this log, right?

A. Yes, you would have, yes.

Q. So at 21:40, during that time period, Mr. Howell was discovered not breathing, right?

A. Yes.

Q. Why not put on this form, Discovered not breathing?

MR. WELCH: Objection. Go ahead.

A. Yeah, I know they do other reports. We don't necessarily have to—we don't put it on this

report. We would actually put it, like, an "on actual" (phonetic) report like a lot—like every—like, there's—lieutenants are doing reports. Sergeants are doing reports. We had to do reports. All these different reports. That's why we didn't necessarily do it because it wasn't a suicide or a restraint chair form type form.

Q. But your representation at both of those, at 21:40 and 21:50, is that Mr. Howell was in the chair, right?

A. Yes. I shouldn't have necessarily put chair. I could have just put, you know, he was on the floor at that point in time.

Q. Because he wasn't actually in the—

A. No.

Q. —chair, right?

A. No.

Q. You talked earlier about reviewing one hour of-roughly one hour of surveillance footage?

A. Yes.

Q. Why not review the entirety of the time that you said you were conducting observations?

A. I had other things to do. I mean, I have to work. I mean, I have other things to do. I have a job routine and stuff.

Q. Do you regret filling this form out like you did?

A. What? This one? Or—

Q. Exhibit C.

A. Oh, yes, yes. I mean, it's not—we don't do this every day. I mean, this is not what we are. I mean, we don't—this just happened this one time. I mean, it doesn't happen every day. It doesn't happen like this all the time. Even on suicide watches, it doesn't happen like this. It just did.

Q. And you already talked earlier that there are significant risks when you place an inmate in a—

A. There can be.

Q. —restraint chair, correct?

A. There can be.

MR. WELCH: Objection.

A. Well, somewhat significant. I mean, bang your head against—not a comfortable—it can give you somewhat of a brain hemorrhaging. It's not the worst. You can have seizures, but you can have seizures not in the chair.

Q. But it's important that you actually conduct these observations, right?

A. Yes.

MR. WELCH: Objection.

Q. For the inmate's safety?

A. Oh, yes.

Q. And you didn't?

A. No. Not all of them.

Q. And you know you're required to conduct those—

A. Per the policy.

Q. —checks?

A. Per the policy.

Q. So let's go back to Exhibit 22.

A. Okay.

Q. And question 25, which starts on the bottom of page 4 and goes onto page 5. Admit you did not offer Pierre the opportunity to use the restroom at any point on December 9, 2018, while he was confined to the restraint chair. Do you see that?

A. Yes.

Q. And you said you deny that?

A. Yes.

Q. And 26 asks you to clarify that denial, and you said that all inmates, including Pierre Howell, are offered the opportunity to use the restroom facilities per policy as well as habit and routine. Per policy and habit and routine, Pierre Howell would have been offered such opportunity. I don't recall any specific times, but he was not denied the opportunity to use the restroom. Did I read that accurately?

A. Yes.

Q. And you testified earlier you never asked him—

A. He was sleeping. I didn't want to wake him up.

Q. Let me ask the question.

A. Sorry.

Q. You never asked him if he wanted to use the restroom, correct?

A. Yes.

MR. WELCH: Objection. Go ahead.

A. Yes.

Q. And so is your answer here that—I'm trying to understand your answer. Is the answer that, Well, he never asked me, so I never denied him? Is that—

A. Yeah, he never—

MR. WELCH: First of all, I'll object, but you can answer if you understand the question. Do you understand the question?

THE WITNESS: I guess, yes, I mean . . .

MR. WELCH: Well, I don't want you to guess at whether you understand the question. You either understand the question, or you don't.

THE WITNESS: I don't. No, sir.

MR. WELCH: Ask it again and you can answer.

Q. So I'm trying to understand. So you never asked him—asked Pierre if he needed to use the restroom.

A. Yes, sir.

Q. But you said he was not denied the opportunity to use the restroom. Do you see that?

A. Yes.

Q. What do you mean by he wasn't denied the opportunity?

A. He wasn't denied at all. No one's denied ever to use the restroom. So if he were to ask me, Hey, can I use the restroom, I would have let him use

the restroom. But he was in there sleeping. I wasn't going to necessarily want to wake up the guy that was sleeping.

So I didn't necessarily go in there and (inaudible) say, Hey, do you want to sleep? Or, do you want to sleep. Do you want to go do that?

I'm not going to go there every 10 minutes or whatnot—every 10 minutes and say, Hey, do you want to—do you want to go to the bathroom? Do you want to go to the bathroom? Do you want to go to the bathroom.

Q. Well, you didn't look at him every 10 minutes anyway.

A. Well, yes, yes, but . . . If he's sleeping, I'm not going to wake up (inaudible) . . .

Q. And again, you don't know if he was sleeping, right?

A. Yes, we don't know.

Q. During all of those time periods where you didn't conduct an observation of Mr. Howell, you had no idea what was going on in that cell, did you?

A. No. It looked like he was sleeping.

Q. I'm sorry?

A. It just looked like he was sleeping.

Q. During those times when you didn't observe him, it looked like he was sleeping?

A. Not necessarily when I didn't observe. I wouldn't have ever known, yes.

Q. So you had no idea during those times where you logged that you observed him but you didn't actually observe him—

MR. WELCH: Objection.

Q. —you had no idea what was going on in that cell?

MR. WELCH: Objection. But go ahead.

A. Yeah. We have no—no—well, it could have been anything. Anything could have been happening in that time frame.

Q. So if you go to question 28, I asked you to admit that you did not offer Pierre drinking water at any point on December 9, 2018, while he was confined to the restraint chair. Do you see that?

A. Yes.

Q. And you said deny.

A. Yes.

Q. But actually, you never offered him the opportunity—

A. No.

Q. —right?

MR. WELCH: Objection. Go ahead.

A. No. I mean, again, he was sleeping. If he would have asked me, I would have gave it to him. I mean, just recently Friday, I had somebody ask me, Hey, can I have some water, and we gave it to him.

Q. But your answer to my question whether you offered Mr. Howell the opportunity to have a drink of water is incorrect on this form, right?

MR. WELCH: Objection.

A. No. I mean, I didn't—no, I never asked—I asked him, no. But if he would have asked me, Can I have some water, I would have gave it to him.

Q. Well, my question was did you ever offer—

A. No.

Q. —Mr. Howell—

A. No.

Q. And you said no, right?

A. No.

Q. So your answer to number 28 is not correct.

MR. WELCH: Objection.

Q. Right?

A. I guess so.

Q. And in 29, I asked you to clarify your answer. And the last sentence says, I do not recall any specific times, but he was not denied access to fresh drinking water.

So my question is for you to explain what you mean by he was not denied access to fresh drinking water.

A. We have fresh drinking water right there on site. I mean, if he asked me, like, Hey, can I have some drinking water, I would have gave it to him.

Q. Other than the two-hour mark when you called Sergeant Hunt, did you ever notify a supervisor that you believed Mr. Howell was ready to come out of the chair?

A. Not until like the 21 or whatever that was, 40 time—around that time, we did.

Q. You—

A. Yes.

Q. You specifically called a supervisor?

A. I didn't, no, not me. Someone else did. The booth person was like, Hey, we're coming off four hours. This guy's been in here four hours. And they called, and then he was going to be getting one of his rounds. So when they did his round, they came down and did it.

Q. Your testimony is that someone called Sergeant Hunt?

A. Yes.

Q. That's not what you told investigators, right?

A. I don't recall on investigators.

Q. I'm going to play you a portion of what was previously marked as Plaintiff's Exhibit 21, and I'm going to take you to the 10-minute mark. And I'm going to let this play out, and I'm going to ask you some questions about it. It's officially starting at 9:58.

A. Okay.

(Audio playing.)

Q. So we stopped it there at the 10:51 mark. So what you told the jail investigators was that Sergeant Hunt called you guys to say, I'm coming down, right?

A. Somebody called the booth, yeah.

Q. So you—

A. That might have been the conversation between the booth guy and the supervisor.

Q. And then earlier, you were talking that the 21:40 check was when Sergeant Hunt was down there?

A. No. It was actually 21:48 or 46, whatever time it was he came down—

Q. No. I'm talking about Exhibit 6.

A. Yes.

Q. Just a few minutes ago, we were talking, and we were talking about that 21:40 and that 21:50 check.

A. Yes.

Q. And you indicated that at 21:40, it was when Sergeant Hunt had come down and you were getting him out, correct?

A. Yes.

MR. WELCH: Objection. Go ahead.

A. Yes, it was.

Q. And what you told investigators there was that that was actually the 21:50 check, right?

A. Yes. Because he came down at like 21:42, 21, whatever time it was. And I logged just an extra

check 21:50 just in case he was going to stay in the chair or whatnot, but he didn't.

(Plaintiff's Exhibit 23 marked.)

Q. So I'm going to show you a portion of the surveillance video. This is going to be marked as Plaintiff's Exhibit 23. It's a CD which on the front of it says, G-21, Number 2, JC-265, 6:45 p.m. to 7:45 p.m.

And Officer Collini, I will represent to you that this is security footage from the time period of 6:45 to 7:45 p.m. on December 9th, 2018. So I am going to go first to the first check that you singularly conducted on Mr. Howell—

A. Okay.

Q. —at just before 7:24 p.m.

A. Okay.

Q. And just so we're clear, earlier you testified about what you would have done during this check—

A. Yes.

Q. —because this was a full Pod A check—

A. Yes.

Q. —correct?

A. Yes. Could have been, yes.

Q. And you estimated that it took roughly two minutes to conduct. All right. We are going to start this video at 7:23 and 45 seconds.

(Playing video.)

So up here—

MR. WELCH: Can you see that?

A. No.

Q. Let me come around on the other side here.

MR. HOJNOSKI: What time is this?

MR. MCGRAW: We started at 7:23.

MR. MCGRAW: Do you want to go off for a second?

MR. KIRCHER: Going off video at 12:05.

(A brief break was taken.)

MR. KIRCHER: We're on video again at 12:06.

Q. (By Mr. McGraw) So where I'm going to be focusing your attention, Officer Collini, is up here in the top portion of the screen.

A. Okay.

Q. And as we're looking at this—I've got my computer turned sideways, but on the left of the screen is Pod A, correct?

A. Yes, up here.

Q. Up on the top left.

A. Yes, yes.

Q. And then there's Pod B just to the right of that.

A. Yes.

Q. Okay. And then there's a fire door between the two.

A. Yes.

Q. Okay. I'm going to play this video.

(Playing video.)

And around 7:24, tell me when you see you go up or go into Pod A.

A. Right about there.

Q. Okay. So we've stopped the video here at 19:24:35. Do you see that at the top—

A. Yes.

Q. —of the screen?

A. Yes.

Q. Okay. And you are just getting ready to enter that pod, right?

A. Yes, yes.

Q. So I want you to tell me to stop it when you leave that pod.

A. Now? Oh, wait. The other pod?

Q. Yeah.

A. Okay.

Q. And you come back into focus.

A. Right about now.

Q. All right. So we stopped the video at 19:24:50; is that right?

A. Yes.

Q. All right. So that's roughly 13 seconds.

A. 13 seconds. Yeah, that might not actually have been the one that we actually did the full pod.

Q. Okay.

A. That was my mistake. I guess it was the other one. (Inaudible.)

(Reporter clarification.)

A. I guess it was my mistake we didn't do the full round then.

Q. Okay. So which of the other two checks that you conducted do you believe that you did a full round?

MR. WELCH: Objection. Go ahead.

A. It might not have been any of them. I'm not a hundred percent sure, but . . . It would have been at some point in time. I mean, we would have done the whole full pod. I'm not exactly sure which one it would have been, though.

Q. All right. So let's check that out. So we are going to again—same Exhibit 23. We are going to go just before 7:40. We're going to go ahead and play this. I started it at 7:39.

A. Okay.

(Playing video.)

Q. So again, I just want you to stop me when you see yourself come on screen.

A. Oh, at the beginning? Okay. At the beginning right here.

(Off-the-record discussion.)

Q. Can you . . . You can see that still?

A. Yep.

Q. All right. I want you to go ahead and stop me when—again, we're starting at—the time now on the camera is 19:40.

(Playing video.)

A. Right there.

Q. So we have stopped it at 19:40 and 50 seconds; is that right?

A. Yes.

Q. And you are just about to enter into Pod A; is that correct?

A. Yes.

Q. All right. So I want you to stop me when you see yourself emerge from Pod A.

A. Now.

Q. All right. So that is at 19:41:01, correct?

A. Yes.

Q. All right. So that was a total of 11 seconds, right?

A. Yes, sir. Just been looking at him. I would have been looking at Howell because I was on watches at that point.

(Plaintiff's Exhibit 24 marked.)

Q. All right. And then I'm going to mark Plaintiff's Exhibit 24, which is another CD, on the front of it is G-21, Number 4, JC 265, 8:45 to 9:45 p.m.

And Officer Collini, I'm going to represent to you that this surveillance video is from 8:45 p.m. to 9:45 p.m. on December the 9th, 2018.

So I am going to fast-forward it to just before 9:14 p.m. when you indicated earlier that you conducted a full inspection of Pod A. I'm going to start the video at 21:13, and I'm going to again

ask you to stop me when you see yourself ready to enter Pod A.

(Video playing.)

A. Right there. Hold on. I got up. Right now.

Q. All right. So you are just about to enter at 21:14, correct?

A. Yes.

Q. All right. Same as we've done previously, tell me when you see yourself emerge from the cell, or excuse me, the pod.

(Playing video.)

A. Right about there.

Q. And that is at 21:14 and 33 seconds, right?

A. Yes.

Q. So that's about 19 seconds total, correct?

A. Yes.

Q. So collectively on your own, you observed Mr. Howell a total of 43 seconds, potentially, right?

A. Yes, potentially.

Q. And you were responsible for him for over two hours, right?

A. Yes.

Q. When did you fill out Exhibit 6?

A. Which one is this? This? Well, I didn't start it, necessarily. It will start right when he gets on the post.

Q. Okay. When did you fill out your MCs?

A. MCs, 19-or whatever that would be, 19:20, 19:30, 40, 50, and then 20, 40, 50, 21:10, 20, 40, 50.

Q. So my question to you, though, is at 19:20—

A. Yes.

Q. —you didn't conduct a check?

A. No. I just—I came on—I just came on post and then wrote it.

Q. So did you write on this form every 10 minutes that you conducted a check?

A. Not necessarily. I just wrote down every 10 minutes that I wrote in chair.

Q. My question to you is did you not write the 10 minutes until after he was discovered deceased?

A. No, no. I did—no, like, while we're-during the shift.

Q. So—

A. We didn't forge the form, I guess you'd say.

Q. You didn't complete it after the fact?

A. No, no.

Q. But at a certain point during your shift, let's say 20:40, you didn't conduct the check, correct?

A. Yes.

Q. But you wrote "chair"—

A. Yes.

Q. —anyway?

A. Because he was in the chair, yes.

Q. You didn't know what he was doing?

A. But he was in the chair, yes.

Q. Did you trust that Officer Erwin was filling out his portions of this accurately?

A. Yes.

Q. Did you ever watch him conduct a check of Mr. Howell?

A. Yes, a couple times.

Q. Which times do you remember watching him conduct the check?

A. A lot in like the early time. Other than that, I mean, back here in the back maybe once. I mean, I don't really recall that much.

Q. So you can vouch for Officer Erwin conducting his checks?

MR. WELCH: Objection.

A. No, not necessarily. Not necessarily because it's—I mean, it's not me. I mean, but I could have been doing rounds. I could have been doing anything else at that time. I mean, if he didn't do it, then I might not have saw it because I might have been in a different pod. I might have been in C Pod or D Pod or somewhere else.

Q. And it's your testimony that you didn't fill any of this form out after Mr. Howell was discovered—

A. No.

Q. —deceased?

A. No.

Q. So the only recollections you have when observing Mr. Howell is that—on your own, excluding the med pass, on your own is that he was just calmly sitting in the chair?

A. Yes.

Q. You thought he was sleeping?

A. Yes.

Q. So let me ask you why in the world is he still in the chair at 21:45?

A. That's not on me. I mean, I could have asked him. I could have called the boss and told him like, hey, can we get this guy out of the chair, which at two-hour, we were trying to do that, and it didn't necessarily happen. The boss didn't come down.

I can't just physically pull the guy out of the chair. I might get in trouble. But, I mean, it'd have to be the boss. The boss is, you know, the upper guy.

Q. Other than Sergeant Hunt, did you notify any other supervisor?

A. Not that I know of because, you know, it was just my own supervisor at the time that day.

Q. And after that two-hour mark, you would agree that you were responsible singularly for Mr. Howell for an hour and 20 minutes or so, correct?

A. Give or take, yes.

Q. And at no point during that hour and 20 minutes did you call a supervisor and say, I think he's ready to come out of the chair?

A. Never did.

Q. Should you have?

MR. WELCH: Objection. You can answer.

A. Per policy I guess we could, because it's supposed to be on hourly we're supposed to per the policy and everything. We just thought, you know, I mean, he was sleeping. So we never actually did it.

Seen it a hundred different times. I see other people just sleeping, and they sit there. Not every time. Not a hundred times, but, I mean, once or twice. Other times I've seen the inmate sleeping, so I wasn't necessarily going to call.

(Plaintiff's Exhibit 25 marked.)

Q. All right. I'm going to hand you what I've got marked as Plaintiff's Exhibit 25. Have you had a chance to review that?

A. No.

Q. Okay.

A. (Examining document.)

Q. Have you had a chance to review this?

A. Yes, yes, yes. Somewhat, yes.

Q. So I'll represent to you that this is a Deceased Person Report that we were provided by the Hamilton County Sheriff's Office. At the middle

of the page, there is a notation of Last Seen Alive. Do you see that?

A. Yes.

Q. And you're listed as the last person to see Mr. Howell alive.

A. Uh-huh.

Q. Are you—do you see where I am?

A. Yes, yes.

Q. And that was at roughly—it was at 19:30, correct?

A. Yes.

Q. How do you know he was alive at 19:30?

A. He—

MR. WELCH: Objection. Go ahead.

A. 19:30 would be about the time that he was just staring out the window before he fell asleep.

Q. And did you report that observation to anyone?

A. Not that I know, no. Not that I know of, no.

Q. Do you have any idea how they would have listed you as the person who was the last to see him alive?

A. I don't know why. I don't know why they would have. Maybe because I was the last person on watches at, like, this time frame—or this time frame maybe, but I don't know why they would put that in my name necessarily.

Q. Could—

A. Because I just said that—

Q. Go ahead.

A. Maybe because just he said there was at that time that he was (inaudible)—

(Reporter clarification.)

A. At that point in time that he was still awake, I guess you would say. Him sleeping, meaning he could still been alive at, you know, 20:30, but he looked like to me he was sleeping.

Q. Okay. But my question is who—did you tell an investigator, Hey, I saw him alive at 19:30?

A. Yes.

Q. And was that as part of your recorded interview?

A. Yes, it was. My bad, sorry.

(Plaintiff's Exhibit 26 marked.)

Q. I'm going to hand you what has been marked as—

A. Do you need these back?

Q. No. Plaintiff's Exhibit 26.

A. (Examining document.)

Q. Have you had a chance to review it?

A. Yes.

Q. Is that your handwritten statement—

A. Yes.

Q. —from December—roughly December 9, 2018?

A. Yes.

Q. And this statement contains inaccurate information, does it not?

MR. WELCH: Objection.

A. Inaccurate information? Not all of it. I mean, there's other times—like, there's other times I was with him, but it didn't show all of it. I guess somebody left it out.

Q. So you indicated here that—

A. I was on 20:20—or 20—whatever that time is. That didn't start really until 20:50. I was going off the basis of what time I usually start on watches.

Q. All right. And you indicated that he—I think it's assumed to be asleep just like any other day on my logs, correct?

A. Well, that, I meant—assumed to be asleep. I was supposed to put like a blank, a period there. Just like any other day on my logs, I put in chair. But I can't see the period.

Q. But as we talked about, you didn't actually review him?

A. No.

Q. You've not been disciplined in any way?

A. Not for this.

Q. So I'm going to hand you what has been previously marked as Plaintiff's Exhibit 20, and take whatever time you need. I'm going to actually ask you a question about something that's on the second page.

A. (Examining document.) Okay.

Q. All right. So—

MR. WELCH: You can read it if you want.

Q. Let me know when you're ready for me to ask you questions about it. Take your time.

A. (Examining document.) Okay.

Q. My question is on the second page. At the end of the first paragraph or the top paragraph there, it says, Inmate Howell was then checked on by deputies every 10 minutes by the housing officer looking through the cell window. Do you see that?

A. Yes.

Q. That is not accurate, is it?

A. No, it's not.

Q. And prior to today, have you ever told any representative from the sheriff's department that your entries on the restraint chair form were inaccurate?

MR. WELCH: Objection. You can answer.

A. No, not necessarily. I guess I would have told my bosses or something or the detectives when I was doing it.

Q. But you already said you didn't tell them that, right?

A. Yes, yes.

Q. At any point between the time you were interviewed and today's deposition—

A. Yes.

Q. —have you ever told any representative of the sheriff's department, excluding your attorneys,

that the information you put on the restraint chair form was not accurate?

A. No.

MR. WELCH: Objection. Go ahead.

A. No. No, I didn't.

Q. Officer Collini, do you use social media at all?

A. A little bit here and there. I don't use it that much.

Q. What sites do you use?

A. Just Facebook.

Q. Have you ever posted on social media about the circumstances surrounding Mr. Howell's—

A. No.

Q. —death?

A. Not at all.

Q. Have you ever talked with anyone other than your attorney about the circumstances surrounding Mr. Howell's death?

A. No, not at all.

MR. MCGRAW: If you can just give us a few minutes.

MR. KIRCHER: We'll go off video at 12:30.

(A brief break was taken.)

MR. KIRCHER: We're back on video at 12:40.

Q. (By Mr. McGraw) Officer Collini, I just have a few follow-up questions for you.

A. Okay.

Q. Why didn't you observe Mr. Howell more frequently?

MR. WELCH: Object. Go ahead.

A. I guess I just got busy with the other rounds on the B Pod guys. Maybe I was talking to somebody else. I mean, it was a mistake. I should have gotten there at least a little-you know, a couple more times at least. But I got behind maybe or might just been looking and talking to maybe some other inmate in cell 16 or 5th or some other cell. They might have had a problem or something. I don't know. But yeah, I should have, but we didn't.

Q. Was there any—did you have any more important responsibility than Mr. Howell in a restraint chair?

A. The suicide watches. I mean, that's like our—that's mainly what the post is is suicide watches and then him. He's the other part of that, though. I mean, it's not the main, main responsibility, but it's—yeah, I mean, we're responsible for him, but we're also responsible for the other guys in B Pod too.

Q. So B Pod is all—

A. Suicide watches.

Q. —suicide watches?

A. Yeah. And then if they have extras, we have to move them to C Pod, but that doesn't happen that much.

Q. How many people do you recall being in B Pod?

A. I want to say that night it was seven, I want to say. It's usually an average of, you know, 6 to 8.

Q. So how often do you watch the folks on suicide watch?

A. About the same time.

Q. Every 10 minutes?

A. Yes, 10 minutes, yeah.

Q. So you saw the surveillance footage, right?

A. Yes.

Q. So is it your testimony that during the time period that you were in charge—

A. Yes.

Q. —of that, that the video will show every 10 minutes you watching the suicide watches?

A. Not necessarily.

MR. WELCH: Objection.

A. Not necessarily. There's some times that you could just—I mean, they could be standing at the doors, and you just look up and you see them. I mean, they're not always, I mean, sleeping on their bed or whatnot.

Q. Nothing of any significance, though, happened on—

A. That night?

Q. —that night?

A. Other than that, no.

Q. Did Deputy Erwin know that you weren't checking on Mr. Howell?

A. No, not necessarily.

Q. Why not?

A. He wouldn't have known. I don't know. He wouldn't have known.

Q. Where would—

A. He would have—he would have been doing rounds or something else probably.

Q. Where would—so you were—you're at a workstation in Pod B, right?

A. B, yes. At a table. A table, yes, a table. Sitting at a table.

Q. When you were there, where would Officer Erwin have been?

A. He could have been anywhere. I mean, he could have been doing the rounds. He could have came back in there once or twice, you know, here and there, or he could have been in the control room hanging out, talking or in C Pod, in D Pod doing his—like I said, doing his rounds. Anywhere. He could have been anywhere.

Q. Do you believe that Officer Erwin was checking on Mr. Howell every 10 minutes?

A. Not necessarily. I wasn't there. I couldn't tell you if he was a hundred percent.

Q. At any point did you say to Officer Erwin, Shoot, man, I missed this check?

A. Not necessarily, no.

Q. Not necessarily or—

A. No.

Q. —no?

A. No. No.

MR. WELCH: Do you recall?

A. No, I don't recall, no.

Q. At any point did Officer Erwin say to you, Hey, man, I missed—

A. No.

Q. —I missed a check?

A. No, do not recall.

MR. MCGRAW: Those are all the questions I have for you, officer. Thank you.

MR. HOJNOSKI: I got just a quick question. I want to clarify my notes on one issue.

CROSS-EXAMINATION BY MR. HOJNOSKI:

Q. Officer, you indicated before and also when looking at the video that you saw and observed Mr. Howell around 7:24, 7:25 p.m. Do you recall that?

A. Yes.

Q. That you looked in and saw him from the side?

A. Yes.

Q. He appeared to be facing towards the window?

A. Yes. The other window.

Q. The other window. You didn't see his eyes, though, did you?

A. No, I did not see his eyes.

Q. You don't know whether he was alive at that point in time—

A. No, I don't.

Q. —for sure, do you?

A. No. He could have been alive or he could have been dead. We don't know.

Q. And the next time you saw him around 7:40, 7:41 p.m., that's when he appeared to be sleeping because his head was—

A. Yes, was down.

MR. WELCH: We'll read it.

MR. KIRCHER: We'll go off video at 12:45.

(Whereupon, signature was requested, and the deposition concluded at 12:45 p.m.)

/s/Matthew Collini

DEPOSITION OF CHRISTINA JORDAN
(JUNE 18, 2020)

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

KARLA HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

Case Number: 1:19-cv-00373

Before: Kelly GREEN, RPR, Notary Public.

MR. MCGRAW: We are now on video.

The time is 12:55 p.m. in Case Number 1:19-cv-373, Karla Howell versus NaphCare, Incorporated, et al., in the United States District Court for the Southern District of Ohio.

Would you please swear the witness in.

CHRISTINA JORDAN,

a witness herein, having been duly sworn, was examined and testified as follows:

CROSS-EXAMINATION BY MR. KIRCHER:

Q. Good afternoon, ma'am.

A. Good afternoon.

Q. Would you please give us—would you please give us your full name.

A. Christina Jordan.

Q. Ms. Jordan, my name is Konrad Kircher, and along with Ryan McGraw, who is sitting next to me, we represent the estate of Cornelius Howell in a lawsuit against your former employer, NaphCare, and others.

Have you ever given a deposition before?

A. No.

Q. Okay. I'm going to ask you to follow a few ground rules that will make it go easier. Everything we say is being taken down by the court reporter, so I must insist on audible answers. If you say uh-huh or uh-uh, I will ask you if that was a yes or no.

A. Okay.

Q. I'm not being rude; I'm simply trying to make sure we have an accurate record. Second, please allow me to finish my question before you begin answering. That way, she doesn't have to take down two people talking at once.

I will do my best to let you finish your answer before I ask the next question. If I ever cut you off, it will have been inadvertent; I thought you were done with the answer. So please bring that to my attention so that you can finish the answer.

A. Absolutely.

Q. If I ask a question which is confusing or unclear or you simply didn't hear it because you were thinking about something else, please let me know. I'll be happy to rephrase it or repeat it. But if you answer a question, I will assume you understood it. Is that fair?

A. Yes.

Q. All right. What have you done to prepare for this deposition?

A. Spoke with my attorneys, really, and that's it.

Q. All right. There was more than—more than Mr. Hojnoski in the conference?

A. It was . . .

MR. HOJNOSKI: My paralegal.

A. Yes.

Q. Oh, okay. All right. I'm not entitled to know what you talked about with your legal counsel. Did you review any documents to prepare for the deposition—

A. I did.

Q. —whether in that meeting or at other times?

A. I did.

Q. What did you review?

A. The . . . what I had written down—well, documented what was going on there and the sheet that we used for the restraints and, like, what the policy was at that time.

Q. Okay. What document did you review to determine what the policy was at the time?

A. It was just a corporate—wide policy about restraint chairs. That's the one that I reviewed.

Q. Okay. Do you remember how many pages long it was?

A. I don't.

Q. Do you remember what date it took effect?

A. Not all the way. I know it was 2014 that it took effect.

Q. Okay. I'm going to hand you Exhibit 29 that we just used. Is that the document you reviewed?

A. Yes.

Q. And you agree that that's the policy that was in effect in the Hamilton County Justice Center in December 2018?

MR. HOJNOSKI: Objection.

A. I'm not sure if that's the one that we used.

Q. Okay. Why are you not sure?

A. Because we have talked about what the restraint policy was, and it was really just, give or take, two hours to check on a patient while in a restraint chair.

Q. Is there anything in writing to support that policy being in effect in December 2008[sic] in the Hamilton County Justice Center for Naph-Care?

A. I'm not sure.

Q. This Exhibit 29 is the only policy that you've seen in writing for that time period, correct?

A. Right.

Q. Where did you graduate from high school?

A. Walnut Hills.

Q. What year?

A. 2001.

Q. And what formal education have you had since that time?

A. I've had—I went to LPN school, got my certificate LPN. Then I got my RN and my bachelor's, and now I'm working on my master's.

Q. From what institution did you get your LPN training?

A. Cincinnati State.

Q. In what year did you become an LPN?

A. 2010.

Q. And where did you go for your RN training?

A. I went to—through Excelsior College.

Q. Excelsior?

A. Yes. E-X-E-X-C-E-L-S-I-O-R.

Q. Is that here in Cincinnati?

A. No. It's—it was an online school based in Albany, New York.

Q. Okay. What year did you become an RN?

A. 2016.

Q. And where did you get your bachelor's?

A. Walden University.

Q. Spell Walden, please?

A. W-A-L-D-E-N.

Q. Is that online also?

A. Yes.

Q. And what year did you get your bachelor's?

A. 2018.

Q. In what subject—major?

A. A bachelor's in nursing.

Q. Nursing. Okay. And you're working on a master's right now?

A. Yes.

Q. In what?

A. Family nurse practitioner.

Q. How far along are you?

A. I have two semesters left.

Q. Through what institution?

A. That's Walden as well.

Q. What year did you first gain employment in the health care field?

A. Like, not even being a nurse?

Q. Well, let's go back to 2010. You became an LPN in 2010. Prior to that time were you already working in health care?

A. Yes.

Q. How long had you been working in health care?

A. Since 2006.

Q. Okay. What was your first position in 2006 in health care?

A. I was a state tested nurse aide at a long-term—long-term care facility.

Q. In this area?

A. Yes.

Q. Where?

A. I believe it was Lincoln Crawford nursing home.

Q. Lincoln Crawford?

A. Mm-hmm.

Q. And for how long did you hold that position?

A. Oh, I don't remember.

Q. More or less than a year?

A. Maybe a little bit less than a year.

Q. What was your next position in health care?

A. Still a state tested nurse aide, and that was at East Galbraith nursing home, and I believe that was just six months or so until I went to work at Drake in 2007.

Q. Okay. What position did you get at Drake?

A. I was a health unit coordinator.

Q. What does that mean?

A. It's like a medical secretary.

Q. Okay. For what type of unit?

A. It was a rehab unit.

Q. And how long did you hold that position?

A. Two years.

Q. And what was your next position in health care?

A. I was a patient care assistant at Christ Hospital.

Q. Was that starting around 2010?

A. 2009.

Q. What did you do in that position?

A. I cared for patients and did EKGs and drew blood from them for labs.

Q. All right. How long did you do that position?

A. About a little bit less than a year.

Q. And what was your next position?

A. That's when I became an LPN, and I worked at Glen . . . Glen Care Center.

Q. As an LPN—is that a long-term care facility?

A. Yes.

Q. So you were an LPN in a long-term care facility?

A. Yes.

Q. For how long?

A. I think I stayed six months until they changed companies, and then I lived in Columbus for a year and worked up there as an LPN.

Q. Where did you work in Columbus?

A. The first place I worked at was Wexner Heritage Village.

Q. Okay. And is that around 2011?

A. Yes.

Q. And how long did you work in that position?

A. I can't remember. Maybe—let me think. Maybe eight months, six months.

Q. So what was your next position?

A. I worked at a home care facility for pediatric clients. I can't remember the name of the agency at this time.

Q. And for how long?

A. That was for a year.

Q. Okay. What year are we in now?

A. We're still in 2011, going into 2012.

Q. Okay. What was your next position?

A. I came back in 2012 and worked at St. Joseph Home in 2012, February 2012.

Q. What position did you hold there?

A. An LPN.

Q. And for how long you were there at St. Joseph?

A. For the whole time, it was like, I think, eight years on and off.

Q. Eight years at St. Joseph Home which would get us up to 2020?

A. Yes, because when I worked at, like, the jail, I would be—just work PRN at St. Joe's. So I would get a job and, like, just kind of keep St. Joseph Home there just in case anything would happen. I could just go back.

Q. Okay. And when did you start at the Justice Center?

A. 2000 and . . . May 2018.

Q. We'll come back to the Justice Center in a minute, but of any of those previous jobs that we talked about from 2006 through 2020 in health care, were you fired from any of those jobs?

A. I was not fired.

Q. Never fired?

A. No.

Q. Okay. So in May 2018, did you become an employee of NaphCare?

A. Yes.

Q. And I just want to make sure. You were employed by NaphCare to work at the Justice Center, right?

A. Yes.

Q. Did you interview with any county officials or sheriff's officials, or was it all hiring through NaphCare?

A. It was all hiring through NaphCare.

Q. Why were you interested in working for NaphCare?

A. I had a friend who worked there, and I had needed a job and was kind of interested in it. And that's when she said she could give me a job, PRN at first.

Q. And who was your friend?

A. Kenya Lewis, the director of nursing.

Q. Director of nursing. Okay. Spell her first name.

A. K-E-N-Y-A.

Q. How did you know Kenya?

A. We had grew up together when we were younger.

Q. And she was a NaphCare employee also as director of nursing, right?

A. Yes.

Q. Okay. Now, you had just gotten your RN in 2016?

A. Yes.

Q. Was this the first job where you actually were applying your RN background?

A. No. Even when I was at St. Joseph Home, I was an RN there. So I started out with my RN skills there.

Q. Okay. So you'd been working for St. Joseph's since 2012, but when you became an RN, did you get promoted?

A. Yes. I became supervisor.

Q. Okay. So in May 2018, when you started working for NaphCare, did you start full-time?

A. No. I started PRN.

Q. PRN. And when did that change, if at all?

A. I became full-time in September.

Q. September of 2018?

A. Yes.

Q. And were you assigned to a particular shift?

A. I was supposed to be day shift.

Q. Day shift?

A. Mm-hmm. Like 7:00 to—7:00 to 7:00.

Q. And did you continue on day shift into 2019?

A. Yes. There were times that I stayed over on day shift to help with staffing, but my—that was my shift.

Q. Okay. Did you ever work any other shift?

A. Yes. I worked night shift just because I stayed over, but not—I didn't come in to work night shift; I just stayed over from day shift.

Q. I see. How often did that happen?

A. I don't really remember how often it happened.

Q. And were you always charge nurse at the Justice Center?

A. Yes.

Q. And you were charge nurse in medical?

A. Yes.

Q. What were your responsibilities with regard to mental health staff?

A. When we had any mental health inmates that were going through anything, we would just refer them to psych. Some of them could go back to general population after we do the referral, and they come and get them, is what—we were told that that's what psych does.

And they'll go get them and evaluate them and do whatever they need to do. And then sometimes they'll come back, or they just—they—I don't know exactly what they do.

Q. While you were the charge nurse in medical for NaphCare, was there, typically on day shift, a staff nurse in mental health?

A. Yes.

Q. And did that staff nurse report to you?

A. Not necessarily. Only if that inmate had something medical going on, then that's when we would, like, collaborate.

Q. And what's your understanding as to who that staff nurse in mental health reported to for mental health reasons?

A. It was whoever the doctor was. I can't remember who it was because we had a couple of them. But they reported to the doctor and the mental health team, like the mental health specialist there. So they would talk to them.

Q. As charge nurse in medical, to whom did you report in the organizational structure?

A. I would report to Kenya, who was the DON. If she wasn't there, then it would be Maria, who was the administrator.

Q. What were your duties as charge nurse in medical for NaphCare?

A. My duty was basically to care for the inmates who were in medical. They were like . . . I was, like, in charge of their health care at the time.

Also, the triage—any inmate that came down from general population to be seen, especially, like, from fights, hurting themselves during recreational activities, or just anything that they're complaining of that—that's really urgent to be

seen, we triaged them. We can do a lot there at the jail to take care of them.

And then I was in charge of, basically, the staff there, delegating, and then just seeing anybody that the guards think that we should see just because they saw something different, like, Hey, this is going on with them. Can you see them? So it was really like a triage.

Q. Did you have authority to order an inmate into a restraint chair?

A. No.

Q. Who did have authority to order an inmate into a restraint chair?

A. Corrections.

Q. Only corrections?

A. Yes.

Q. What about the psychiatrist?

A. I'm not sure.

Q. What about mental health staff?

A. No. Only the corrections officers.

Q. Now, I want to make sure that we're not parsing words here. I know only corrections could place, in other words, physically place and restrain an inmate.

A. Right.

Q. Did you, as charge nurse, have authority to tell corrections that an inmate should go into a restraint chair?

A. No.

Q. Were you ever part of a decision—making process with corrections to determine whether an inmate should be placed in a restraint chair?

A. Not necessarily, no.

Q. Well, do you remember any times when you were involved in that decision—making process?

A. It wasn't really part of my decision. It was just . . . that's—they figured out that's what they want to do, and I'm just—I just go along with it, whatever they thought.

Q. Did you ever, as charge nurse in medical, make a recommendation to corrections that an inmate should be placed in a restraint chair—

A. No.

Q. —a recommendation? No?

A. No.

Q. If corrections places an inmate into a restraint chair, what responsibility did NaphCare employees have in December 2018 to check or observe that inmate?

A. Then we would check the initial assessment while they're in the chair; make sure they have enough movement in their wrists and their legs to make sure that circulation would be good; check their vitals; just kind of see—observe what they're doing at the time; and then they get—they take the restraint chair wherever from medical.

Q. And then what is NaphCare staff's responsibility to follow that inmate in the chair periodically?

A. So we check them every two hours, get vitals, check their circulation as well again, ask just any questions regarding medical, like, Are you having any chest pain, or anything like that, just—like, that's what we do every two hours.

Q. And every two hours, should those vitals be recorded?

A. Yes.

Q. Where would they be recorded?

A. They should be on the restraint chair form.

Q. The log?

A. Mm-hmm.

Q. Is that a yes?

A. Yes.

Q. Any progress note necessary with regard to checking vitals every two hours?

A. No.

Q. Any other responsibility of NaphCare staff to check or observe an inmate in a restraint chair other than what you just described?

A. No.

Q. Are you familiar with sickle cell disease?

A. Yes.

Q. What do you know about it?

A. I know when patients have sickle cell crisis, they really aren't able to do anything, aren't able to move, in a lot of pain to the point where they're just—they kind of get withdrawn and everything

because they can't—they can't do anything. The cells in their blood are sickled, so it doesn't get as much oxygenation as it would a regular red blood cell.

Q. And is pain the primary symptom of sickle cell?

A. Mm . . .

Q. Yes?

A. Yes.

Q. And where, typically, does a patient experience that pain from sickle cell crisis?

A. You mean in their body?

Q. Right.

A. It could be all over. That's what I've heard from what I deal with with patients with sickle cell is an all-over pain.

Q. What stimulates a sickle cell crisis?

A. I'm unsure of that, what (inaudible).

THE REPORTER: I'm sorry?

A. I'm unsure what stimulates it.

Q. You mean you don't understand what I'm asking, or—

A. No. I don't know what stimulates it.

Q. Can overexertion stimulate it?

MR. HOJNOSKI: Objection. She said she doesn't know. But if you know, you can answer.

Q. Do you know?

A. No.

Q. Are you familiar that sickle cell crisis is often manifested by a numbness in the arms or legs?

A. Yes.

Q. How about a hard time speaking?

A. No.

Q. Did you have a desk as charge nurse for Naph-Care?

A. Yes.

Q. Did you have a computer on your desk?

A. Yes.

Q. Did that—through that computer, were you able to access the electronic records of inmates?

A. Yes.

Q. And those records would include medical records from prior incarcerations?

A. Not necessarily medical records but notes about what happened during those times.

Q. What kind of notes?

A. Just anything that prior nurses or the doctor or the NP may have written about him in his prior incarcerations.

Q. Before December 2nd, 2018, which is when Mr. Howell was incarcerated in this particular instance, do you believe you had ever encountered him?

A. No.

Q. Okay. Have you ever been aware that during at least two prior incarcerations at the Hamilton

County Justice Center, Mr. Howell had been sent out to UC Hospital for sickle cell crisis?

A. I was told that, yes.

Q. When were you told that?

A. I think that day by another nurse.

Q. When you say that day—

A. The day that he passed away.

Q. Okay. On December 9th?

A. Yes.

Q. Were you told that by another nurse during the course of interacting with Mr. Howell?

A. After.

Q. After he passed away?

A. Yes.

Q. Okay. And do you recall what nurse told you that?

A. Yes.

Q. Who?

A. His name was Ben Curl.

Q. Ben Curl? And what's your understanding as to how Ben Curl found out?

A. He had had interactions with this inmate prior. Ben had been there, I believe, eight years, so he knew a lot of the inmates there. And that one, he—Mr. Howell, he did know because he was the nurse taking care of him, I guess, on a couple of occasions.

Q. And was Ben Curl a nurse in the medical division rather than mental health?

A. Correct.

Q. What time did his shift start that evening?

A. He came in at 7:00 p.m.

Q. Did he interact with Mr. Howell at all before Mr. Howell passed away?

A. No. He was not present at that time. He came in on shift at 7:00 p.m.

Q. Okay. But Mr. Howell didn't pass away—well, we don't know when he passed away. He was found—

A. Right.

Q. —unresponsive at 9:45.

A. Right.

Q. So during that 2 hours and 45 minutes or so—

A. He did not interact that I'm aware.

Q. Okay. Did you have any interaction with Mr. Howell between December 2nd and approximately 5:00 p.m. or so on December 9th?

A. No.

Q. What is—well, first of all, let me define independent recollection for you. Independent recollection means something that you recall from your mind independent of any documents; in other words, you're not relying on a document to remember something.

A. Okay.

Q. Do you have an independent recollection of Mr. Howell?

A. Yes.

Q. Do you have an independent recollection of interacting with him?

A. Yes.

Q. All right. So that's what I want to focus on right now. We all have documents and we know what the documents say, but now I want to kind of exhaust your memory as to what happened.

A. Okay.

Q. So what do you recall being your first interaction with Mr. Howell?

A. That day, his roommate came in first because Mr. Howell had stabbed him with a pencil. So I was taking care of the roommate first. And usually, it's the policy that when anybody has a fight, we keep the one in there and leave the other one kind of like in the tank. And then when this one is done, we send him out, and then we send the other individual in.

So while I was taking care of his roommate, Mr. Grant, they had brought him into the sallyport, and I could hear him yelling. But the nurse and the paramedic were taking care of him at that time while I was taking care of Mr. Grant.

Q. What nurse and paramedic were taking care of Mr. Howell at the time?

A. The medic was Nicole Halloran, and the nurse was Tammy—I think her last name is Hodges.

Q. Is Tammy Hodges, or was she at that time, a NaphCare employee?

A. Yes.

Q. In the medical side?

A. Yes.

Q. And the paramedic, was that person a NaphCare employee?

A. Yes.

Q. All right. So you heard Mr. Howell yelling. Did you understand what he was yelling at that time?

A. Not at that time I was not because I was still, like, trying to deal with Mr. Grant and trying to get him together to get back where he needed to be.

Once I did that, that's when I came over to figure out what was going on, why was he yelling like that. And at that time, he was yelling—well, he was cuffed, I think, behind him. He was in the wheelchair. And then he was just yelling.

It was just kind of like incoherent yelling at first, and then he said, Oh, my back hurts, and then it was more yelling. Then he said, like, I'm sorry, a few times. And then I was like, What are you sorry about, and he just kept saying it.

And then that's—when I was talking to him, that's when Tammy was able to get his blood sugar and saw that it was 78, which is fine, but she decided in her nurse judgment that he needed some glucose tabs.

So she had tried to put some in there in his mouth. He spit them out. And I'm like, Well, he didn't need them really anyway, so don't worry about that.

I was able to get his vitals, everything except for his temperature, because I kind of was trying to talk to him to see what was going on.

I said, What are you sorry for, and he just kept saying, I'm sorry, and kind of like just yelling. It seemed like his eyes were kind of like popped out a little bit. Like, they were really wide. And he was just—just yelling.

And he slid—slid out the—the wheelchair and was kind of like rolling around on the ground. And I had—I remember going to look at his chart to see what all was going on with him. I saw sickle cell. I saw other issues.

I saw a point in time where he had hoarded narcotics before and that he had tested positive for opioids before. I didn't know about that particular incarceration, but I just saw prior. And so I'm like, oh, maybe that he did this, because it's kind of—they get it in the jail a lot.

I'm like—I'm wondering if this is going on, because I had a prior inmate who went through the same thing who didn't know she took something and started acting different, and we had sent her to psych as well. So that's what I was thinking, that it was a psych issue more than a sickle cell, because sickle cell, you just—you can't move your—you're in too much pain to do anything.

And he was still, you know, just yelling and everything. And I said, Hey, let's take him to psych so we can—they can evaluate him, and I can calm him down, and then we can get, like, a drug screen on him and see what's going on with him.

And then that's when a corrections officer was like, We can do a restraint chair, and then they had, like, a talk amongst themselves about it, and they went and got it.

And I was like, I guess this is what you do. I didn't understand why they just couldn't take him in the wheelchair like how he came. So they're like, No, we need the restraint chair for him; and I was like, Whatever you think. Okay. And that was that.

Q. So of that scene that you just very well described, I want to make sure we name all the players. So was Tammy Hodges present during all this time?

A. Yes.

Q. And the paramedic, whose name I forget?

A. Nicole Halloran.

Q. Nicole Halloran?

A. Mm-hmm.

Q. She was present throughout all this—

A. Yes.

Q. —discussion? Okay. Who else was present?

A. There was another nurse I was talking to. Her name is Kristen. I can't remember her last name.

But she kind of—we were talking for a minute about possible—possibilities and everything like that, just talking things through about what was going on. And then she kind of left. She didn't deal with Mr. Howell at all. She was just kind of talking with me about stuff.

Q. She was brainstorming—

A. Yeah.

Q. —with you? Okay. Was Kristen a staff nurse?

A. Yes.

Q. And Tammy's a staff nurse?

A. Yes.

Q. Any other NaphCare people who were at that scene that you just described?

A. No.

Q. Okay. The other three that you mentioned all reported to you, right?

A. Yes.

Q. Okay. The corrections officers or supervisors, who was present during this scene?

A. I don't remember all their names. I recall Sergeant Hunt being there, but I can't remember—there were a lot of guards there.

Q. Was Sergeant Hunt the senior one?

A. I don't know. I think so.

Q. During this scene you just described, was Mr. Howell complaining that he couldn't feel his legs?

A. For me, no. He just said that his legs and his back hurt, but not feeling his legs. I believe that happened prior to my coming in.

Q. Did it appear to you that he was legitimately in pain?

A. It seemed like he might have been because he was just in a fight, so that's probably why he was in that type of pain.

Q. Okay. What I'm trying to figure out is did you think he was faking, or did you believe that he was in pain?

A. I believed.

Q. Okay. You mentioned you went to the records and you saw multiple things. You definitely saw that he has a history of sickle cell—

A. Mm-hmm.

Q. —right?

A. Yes.

Q. Okay. In your thought process in brainstorming with Kristen, did you consider that he may be having a sickle cell crisis?

A. No, not the way he was acting, no.

Q. What about his behavior was inconsistent with a sickle cell crisis?

A. Like I had stated before, with sickle cell, you're not really able to move. You're in too much pain to do anything. Usually kind of like balled up in a corner. You need fluids because you're really dehydrated. You just don't even have the energy

to be verbally aggressive or anything. You can't do anything. That's how bad the pain is.

Q. Have you treated sickle cell patients in the past?

A. Yes.

Q. Where?

A. At the jail and at my current job before.

Q. St. Joseph Home?

A. Mercy West. I work at Mercy West.

Q. You're at Mercy West now since you left—when did you leave NaphCare?

A. May of '19.

Q. Okay. And why did you leave NaphCare, by the way?

A. I found a job that paid more.

Q. So let's focus on prior to December 2018, where had you encountered sickle cell patients?

A. In the jail, we had a couple that we triaged before.

Q. I didn't really follow this part of your explanation. You mentioned that he had a history of hoarding narcotics. Did you suspect that he was on drugs as he—during this incident?

A. That was a thought that came to me, and that's why I wanted him to calm down so I could get a urine drug screen, and we can do the best that we can for him due to that.

Q. Okay. Did anyone ever get the drug screen?

A. No. He was . . . No.

Q. Was it ordered?

A. I could do it and then just tell the doctors I did this.

Q. Okay. Why didn't you do the drug screen?

A. He was unable to do it. He was refusing medical treatment. There really wasn't anybody to touch him at the time. He didn't want anybody to touch him. So that's why we wanted him to calm down and consult with psych first. And then once he calmed down, we'd be able to get his drug screen.

Q. Okay. What about an hour later, did you follow up to see if he was ready for a drug screen?

A. No. I wasn't trying to follow up like that. With him—with them putting him in the restraint chair, I was going to just check in two hours. Consulted with Pierette about it, said he was still yelling and screaming. So I'm like, oh, we can wait, because after I talked to her, then I'm like, okay, in two hours, I'll go check and see how he is.

Q. When did you talk to Pierette?

A. Around 7:30, 7:45 p.m.

Q. When she was leaving?

A. Mm-hmm.

Q. Is that a yes?

A. Yes.

Q. Okay. And he'd been in the chair for two hours at that time, right?

A. Yes.

Q. So did anyone go check on him at that two-hour point?

A. No, not at that two-hour point from when she talked to me about it, not a nurse or anything like that that I'm aware of.

Q. Why not?

A. It wasn't at the two-hour mark from when she talked to me. And we knew that the guards check on him, so we were just going to check at the two-hour mark from when she left since she had just kind of told me about what was going on. Then we would do what we had to do. And in two hours, it was really whoever was able to get to him. Then we go—whoever gets his vitals and checks on him.

Q. Well, no one from NaphCare saw him from 18:20 until about 21:45, correct?

A. Pierette saw him before she left, so that was around 7:30, 8:45. She didn't chart it, but we had a verbal discussion.

Q. You believe she saw him two times, then?

A. That's what I believed.

Q. You believe that she charted one time on the log?

A. Mm-hmm, and then came and told me because I had asked, How is he doing? She said, He's still yelling, but it seems like he's calming down.

Q. Because she just testified she only saw him one time at 18:20. So if that's true, if she indeed only

saw him one time at 18:20, will you agree with me that no one from NaphCare saw Mr. Howell from 18:20 until 21:45 when he was found unresponsive?

A. I guess nobody did. I know I didn't, but I don't think anybody else from NaphCare did.

Q. So when he was taken in the restraint chair to psych, did you feel like you had no further responsibility over him?

A. Pretty much, yes.

Q. Why is that?

A. Psych is a different department than medical. They have their own staff to evaluate him. My only thing is if an officer calls over to medical and he seems to be having any medical issues or he's concerned about anything, that's when we would go back over to check medically. But if it's psych, they kind of just do their own thing.

Q. So when Mr. Howell was taken to psych around 5:45, or whenever it was, the only mental health staff over there at that time was Pierette Arthur, right?

A. I'm not sure.

Q. Who else do you think may have been there?

A. They have mental health specialists. I'm not sure of their schedule. But I didn't go over there, personally, so I'm not sure if it was just Pierette.

Q. Well, after Pierette left from her shift at around 7:30, do you believe there was anybody in psych to monitor Mr. Howell?

A. No.

MR. HOJNOSKI: You mean from NaphCare?

Q. A person from NaphCare.

A. Right.

Q. You knew there was not anybody over there?

A. Not anybody in psych, but we just had the medical open. So nobody in psych was there after Pierette left.

Q. Okay. You still had some nurses in medical?

A. Yes.

Q. Did you instruct any of those nurses to check on Mr. Howell?

A. Basically, our thing is, Hey, we have somebody in a restraint chair. He needs to be checked on in two hours. Whoever can get to him, please get to him. That's kind of how it was.

Q. But nobody got to him, right?

A. No.

Q. And why is that?

A. Everybody was doing their med pass or whatever. And by the time we all came back, it was kind of at that two-hour mark from what Pierette told me, because I went by when she left. So from her telling me to at that time when we all kind of reconvened at the same time, no, I don't believe any NaphCare saw him.

Q. So in the meantime, you were relying on the corrections officers to do their 10-minute checks, right?

A. Yes.

Q. And you were expecting them to go see Mr. Howell every 10 minutes, correct?

A. Yes.

Q. And to report to you if they saw something unusual?

A. Yes.

Q. And who made the decision to send him to psych?

A. I made the decision to send him to psych to be evaluated.

Q. Who made the decision to place him in the chair?

A. One of the officers did.

Q. So a corrections officer made the decision, We're going to put him in the chair, for what reason?

A. They just felt he needed to go to the chair. It was a conversation like, Well, how are we going to get him over there, because I guess the way he was yelling and everything. And I was like, Well, you used the wheelchair before.

And then one of the other ones—I can't remember his name. I know him by his face. But he said that, Why don't we use the restraint chair. And then they kind of were like, Yeah, we could do that.

And they were looking at me. I'm like, I just need him to go to psych, so whatever you all do, you do—do it. Okay.

Q. So you made the decision—once he was in the chair, you made the decision to send him to psych?

A. To send him to psych.

Q. For what purpose?

A. To be evaluated because of the symptoms that he was experiencing with the—with his eyes being, you know, a little large and him just screaming out and yelling, stabbing his roommate, symptoms of like a psychotic issue.

Q. Okay.

A. So that's why.

Q. So who did you expect to evaluate him?

A. I wasn't sure who was over in psych. I know it was open because there was people over there. So I know Pierette was going to see him, but I didn't know what they were going to do after that.

Q. Who's "they"?

A. Anybody in psych. I don't know their procedures.

Q. Well, what did you do to obtain a psych evaluation of Mr. Howell?

A. All I did was do a housing assignment to say that he should be in psych and not general population at that time. So basically, it was a referral.

Q. Did you order an evaluation?

A. No. I just told Pierette to evaluate him to see what she thinks, because they have a whole dif-

ferent paper system over there that we don't use in medical.

Q. Did you communicate directly with Pierette Arthur about an evaluation for Mr. Howell?

A. I don't recall about an evaluation. I just know I talked to her.

Q. What did you say to her?

A. I told her how he was acting, about how he stabbed his roommate. He seemed a little bit out of it, not himself. Could you just evaluate him and see what you think is going on.

Q. And when did you have that conversation?

A. That was after they wheeled him over to—wheeled him over to psych. And then I came over there with the restraint paper and then kind of just placed it in front of her and was like, you know, just evaluate him and see what you think.

Q. So that was a personal conversation with her at her desk?

A. I think she was at her desk, yeah.

Q. And how many minutes after Mr. Howell had arrived over there in the restraint chair did that conversation take place?

A. I think it coincided, because they take him through the tank, and you can't really see when they take them and bring them sometimes. So I didn't see exactly what time he got there, but it was when they were wheeling him, I got this paper together to give to Pierette and then talked to her.

Q. Who was the psychiatrist in the jail at that time?

A. I don't recall.

Q. It was Dr. Johansen?

A. I'm not sure. They had different doctors. Some were PRN and some—like, we had a new one. I'm not sure who was there or on call at that time.

Q. Did you contact any physician—

A. No.

Q. Let me finish the question. Did you contact any physician to notify them that Mr. Howell had been placed in a restraint chair?

A. No.

Q. Why not?

A. Usually, we don't have to call a physician about them being placed in a restraint chair. It's if they're having any issues related to the restraint chair or something like that.

Q. And your understanding is based on what?

A. We had a paper that says after four hours of being in the restraint chair, somewhere around there—I can't remember exactly, but four hours after being placed in a restraint chair, you should call the doctor just to let him know.

Q. Do you remember seeing any paper that says that you have to notify a physician when a inmate is placed into a restraint chair?

A. Hmm-mm.

Q. No? Is that a no?

A. It's a no.

Q. Okay. Do you remember you and Kristen having a conversation about possibly sending Mr. Howell to the hospital?

A. Mm-hmm, yes.

Q. Tell me about that conversation.

A. It was a brief conversation. It was just like, What do you think we should do? And I'm like, The symptoms that he's experiencing seem more psych than sickle cell just by the way he's acting. So I want to monitor him before we make a decision like that. Even in a sickle cell crisis, we can do a lot of things in the medical department before sending them out to UC.

Q. Was Kristen suggesting that he might go to the hospital?

A. No. She just wanted to know what I thought about it.

Q. So she asked something like, Hey, do you think he should go to the hospital?

A. Yeah.

Q. And how many times did she ask that?

A. Just once.

Q. Because Sergeant Hunt said twice he heard it.

A. It was just once with me and her.

Q. Okay. Low blood sugar is not a sign or symptom of sickle cell crisis, is it?

A. No. And his sugar wasn't low.

Q. Okay. What did you do to treat him for sickle cell crisis?

A. I didn't do anything to treat him for sickle cell crisis because that is not what I believed at the time he was experiencing.

Q. Did you attempt to hydrate him?

A. He refused.

Q. He refused what?

A. He refused hydration, medical care, all of that, which is why we needed him to calm down so we can help him.

Q. Sergeant Hunt testified that you're the one who made the decision to place him into the chair. Is he lying?

A. Yes.

MR. WELCH: Objection.

Q. After Mr. Howell was taken to psych in the restraint chair, did you ever see him alive again?

A. No.

Q. Did you feel that—going back to when you first encountered him and he was all those things you described, did you think he was faking anything?

A. No.

Q. Okay. I think I may have asked you that. If I did, I apologize.

(Plaintiff's Exhibits 30, 31, 32 marked.)

I'm going to hand you three exhibits at once, 30, 31, and 32. Have you ever seen these documents before?

A. I've seen these documents but not from him.

Q. Where do you believe you saw these?

A. The inmate's attorney is in all the time.

Q. The inmate's what?

A. Attorney's papers in all the time, sick call requests.

Q. You mean you've seen forms like this?

A. Forms like this, but none from Mr. Howell.

Q. I see. Okay. Do you believe they were accessible from your computer on December 9, 2018?

A. They could have been. I'm not sure because sometimes it only goes back a certain amount of times.

Q. You don't remember coming across these when you did your search on December 9, 2018?

A. Mm-mm.

Q. Is that a—

A. No.

(Plaintiff's Exhibit 33 marked.)

Q. I'm going to hand you Exhibit 33. Would you agree that these are progress notes from the NaphCare electronic records of Cornelius Howell?

A. Yes.

Q. And they're in reverse chronological order, so let's go to the bottom. There's an entry from

Meghan Reed Corporate, and all the way to the right, it says STATCare. Do you see that?

A. Mm-hmm.

Q. STATCare are the folks in Alabama, right?

A. Right.

Q. So what's your understanding as to why Alabama was focused on Cornelius Howell on December 6, 2018, at 2:53 p.m. Central Time?

A. Probably—usually, when we have things like this, they will look at his chart, see what medications that he was on. And if he was on ibuprofen, then either STATCare will put it in just because they're looking at a chart, or one of the nurses may have realized he doesn't have his ibuprofen; I need to reach STATCare to get his ibuprofen started again.

Q. And the ibuprofen was for sickle cell, right?

A. Yes.

Q. All right. Then right above that is an entry from you.

A. Mm-hmm.

Q. And that's at 6:29:16 p.m. Central Time on December 9. So that would be 7:29 Eastern Time, correct?

A. Yes.

Q. You've got some vital signs in here.

A. Yes.

Q. Is there anything unusual about those vitals?

A. No.

Q. Anything elevated?

A. No.

Q. So you say, Patient was yelling and complained of back pain and that he has sickle cell?

A. Mm-hmm.

Q. That's a yes?

A. Yes.

Q. So you heard him say, I've got sickle cell?

A. Yes.

Q. And what else did he say about that?

A. He just started yelling and just rolling around the floor.

Q. So moaning and groaning, I've got sickle cell, more moaning and groaning?

A. Mm-hmm.

Q. Is that a yes?

A. Yes.

Q. And saying, I'm sorry, over and over?

A. Yes.

Q. Okay. At the end of that entry, you say, Will continue to monitor.

A. Yes.

Q. Who will continue to monitor?

A. Anybody will just continue to keep monitoring him because of all this stuff that was going on.

Q. Anybody will continue to monitor him?

A. Mm-hmm. So if somebody else came in contact with him to evaluate him, such as one of the LPNs, then they would be monitoring him.

Q. And at the top is an entry from Nicole Halloran, the paramedic, correct?

A. Yes.

Q. And it's actually a late entry. But she says, Patient complaining of leg and back pain, 10 out of 10. Do you see that?

A. Yes.

Q. Do you recall someone asking him, How bad is the pain?

A. I wasn't there at that time.

Q. Did you learn that he was complaining of leg and back pain, 10 out of 10?

A. Not 10 out of 10, no.

Q. 10 out of 10 is as high as the pain threshold gets, right?

A. Yes.

Q. Would you look at Exhibit 28, please. Are you doing okay, by the way?

A. Yes.

Q. Do you need a break?

A. Hmm-mm.

Q. All right. Exhibit 28 is the restraint chair log that you had referenced before, correct?

A. Yes.

Q. And these top five or six lines is all in your handwriting; is that right?

A. Yes.

Q. So did you start filling this out when he was placed in the restraint chair?

A. A little bit after.

Q. Okay. So a little bit after you started—

A. After I checked him, checked his arms and legs and got his vitals, then I filled it out a little bit after.

Q. All right. And this is what you took over to Pierette?

A. Yes.

Q. And gave to her and had the conversation about it?

A. Yes.

Q. All right. So look at vitals BP. What does that look like?

A. 90 over 56.

Q. Okay. In that previous progress report, it said 110 over 56. Do you know which one's accurate?

MR. WELCH: Objection.

A. This is the one where he was taken in the chair. The other vitals was taken before while he—before he was rolling around on the ground.

Q. I see. Okay. And under Precipitating Event, you wrote, Yelling, fell on floor, rolling around, non-compliant with medical care; is that right?

A. Yes.

Q. Now, what we're looking at is a NaphCare form, correct?

A. Yes.

Q. Do the corrections officers have anything to do with this form?

A. No.

Q. In the—around the middle of the page, there's a section that says, Observation Codes. Do you see that?

A. Yes.

Q. What's to the right of that?

A. 15-minute intervals.

Q. What does that mean?

A. I'm guessing observation should be at every 15 minutes.

Q. So all these things under these codes should be checked every 15 minutes?

A. Um . . .

MR. HOJNOSKI: Objection, speculation.

A. Hmm . . .

Q. Is that what that means to you?

A. It means that . . . should be observed every 15 minutes for these—for these things.

Q. Okay. Why would that be on there, if you know?

A. Um . . .

MR. HOJNOSKI: Objection. She didn't prepare the form. If you know.

Q. Go ahead.

A. I'm not—I don't know.

Q. You don't know why those are on there?

A. I just . . .

Q. Why it says 15-minute intervals?

A. No. Because we had a different policy we were following at NaphCare.

Q. And that other policy that you were following at NaphCare, you don't know whether that was in writing or not, right?

A. I'm not sure.

Q. I mean, couldn't it be that you had the written policy that we looked at earlier, Exhibit 29—

A. Mm-hmm.

Q. —but, in fact, you all decided to kind of go with some other policy and practice?

A. I'm not sure. It was just what I was taught to do.

Q. It's what you were taught to do?

A. Yes.

Q. By whom?

A. Administrator, DON, and then the nurses who trained me. Basically, this is how this is done here at Hamilton County Justice Center.

Q. Okay. All right. Underneath the observation codes, it's kind of smaller print, but it says, Inmates in

restraints, slash, seclusion must be, and then there's a colon. Do you see that?

A. Yes.

Q. So it says—the first bullet point is that inmates in restraints or seclusion must be observed and monitored at least every 15 minutes. But that's not what you all were doing, right?

A. Not NaphCare, no.

Q. Okay. Because you're saying that wasn't the policy for NaphCare?

A. Correct.

Q. Okay. What about the next bullet point; was that policy for NaphCare in—

A. That was more for—

Q. —December 2018?

A. —corrections.

Q. Okay. So that—

A. These would be something like if it was a medical restraint, then we would do that. Custody restraints, they do their own thing. And that's what we rely on. We rely on their custody restraint policy, and then we go by our policy, which is the every two-hour checks.

Q. The third bullet says, Provide range of motion exercises at least every two hours. Was that policy in December 2018 for NaphCare?

A. It was more for the officers.

Q. But not for NaphCare?

A. No. We're not allowed to take them—do anything with the restraint chair.

Q. The next bullet, Given access to fluids at least every two hours while awake. Was that a policy that was in effect in December 2018 for NaphCare?

A. No. I believe that was for corrections as well.

Q. And the last one, Provided vital sign check every shift and PRN, was that a policy in effect in December 2008[sic] for NaphCare?

A. It was provided vital sign checks every two hours, not every shift, and PRN.

Q. And that wasn't for the corrections officers to do, right?

A. No. That's what we do.

Q. Go to the next page, please. About a quarter of the way down, there's a sentence that says, Inmate informed of criteria for release from restraint/seclusion and demonstrates understanding, and it looks like you've checked the box yes.

A. I checked the box yes, and then it was an error, so that's why I put error and my initials and crossed it out, because that is something that we do at the end of a restraint chair—when they're out—getting out of the restraint chair. That's what we do there.

Q. So you say you did not inform him of the criteria?

A. Not at that time, no.

Q. At any time did you inform him of the criteria?

A. No, because he was too incoherent at that time.

Q. He was too incoherent when he went into the chair?

A. Right.

Q. But no one in the next four hours ever informed him of the criteria; is that what you're saying?

MR. HOJNOSKI: Objection, speculation. If you know.

A. I don't know.

Q. Let me withdraw that question. You never informed him of the criteria—

A. I did not, myself.

Q. Okay. What did you understand were the criteria for him being removed from the chair?

A. That corrections have to make that call, and then we come over there and make our last check to make sure his vital signs are still good, his circulation is still good, that he's okay.

Sometimes they tell us if they're out of the chair. Sometimes they don't, and we have to go find them where they're at to go assess them.

Q. So it was up to corrections as to when he was going to get out of the chair?

A. Yes.

Q. Even though he was in psych?

A. Yes. They have their own psych corrections officers.

Q. Who have authority to make the decision to get an inmate out of the restraint chair?

A. Yes.

MR. KIRCHER: Let's take a break, and we'll come back and finish up.

MR. MCGRAW: We are going off video at 2:06 p.m.

(A brief break was taken.)

MR. MCGRAW: We are back on video at 2:23 p.m.

Q. (By Mr. Kircher) Ms. Jordan, we're back on the record, and you're still under oath. Is there anything from your prior testimony today that you need to correct?

A. Not correct, but I did remember that when I was dealing with Howell's roommate, he did say that that was not normal for him. He's really kind of a chill guy. But he said that this was different for him, the way that he kind of attacked him, and he didn't understand what was going on. So I did want to say that about his roommate.

Q. So Grant told you that it was unusual for Howell to act that way?

A. Yes.

Q. Okay. Thank you for that. Getting back to that time frame.

So look at Exhibit 33, please, which are the progress notes. And you took the vitals here, and I want to make sure I understand what you told me.

So the blood pressure of 110 over 56 was when he was in the medical sallyport?

A. Yes.

Q. And then on Exhibit 28—

A. Yes.

Q. —90 over 56 was when he was placed in the chair?

A. Yes.

Q. So systolic was declining; diastolic was the same on both. Is that right?

A. Yes.

Q. Is there any significance to—well, first of all, is there any significance to the fact that the systolic was dropping?

A. Not really. It was actually the same. 110 over 56, 90 over 56. So it was nothing to be concerned about.

Q. Okay. Is there any significance to a diastolic of 56 in a potential sickle cell patient?

A. No. It would be much lower. Much lower.

Q. And why do you believe that?

A. It's just my experience with sickle cell.

Q. Okay. Your academic training or on-the-job training?

A. Both.

Q. So you believe there's some literature out there that you—was used to train you that says that diastolic in a sickle cell patient would be below 56?

A. It would be.

Q. Okay. And you testified that Mr. Howell refused medical treatment in the sallyport?

A. Right. At that time, he did.

Q. Did he ever refuse medical treatment afterwards?

A. I'm unsure.

Q. You're not aware of him ever refusing medical treatment afterwards?

A. No.

Q. Are there health risks to an inmate from prolonged use of a restraint chair?

MR. HOJNOSKI: Objection. If you know.

A. I'm not sure.

Q. What's your understanding as to why corrections officers are supposed to check on an inmate in a restraint chair every 10 minutes?

A. I'm not sure what their policy is, but just to make sure that they're just—I'm not—I really don't know. I don't want to, like, make up anything about what they do and why they do it, but—

Q. Well, I'm asking—I'm sorry. I didn't mean to cut you off. I'm asking you a medical question. I'm not asking you about their duties.

A. Mm-hmm.

Q. All I'm asking is why—is there a medical reason why they are supposed to check an inmate every so often?

A. Medically, just to see—make sure that they're still okay, but they don't do anything as far as

vitals or anything like that, and then to update medical if anything were to change.

Q. What's the purpose, as you understand it, in the requirement that medical check on an inmate in a restraint chair every two hours?

A. To make sure that his circulation is good, that the arm straps and the leg straps aren't cutting off any type of circulation, and his vitals are still stable, just to try to maybe get to talk to him, see if he'll let us do medical treatment and stuff like that. That's, like, why we do it.

Q. Okay. You don't check circulation and vitals on inmates in suicide watch cells, right?

A. I'm not sure. I don't—I haven't dealt with anybody in suicide watch. That's more psych.

Q. You're not aware of a requirement that any NaphCare employee checks vitals or circulation on suicide watch inmates, right?

A. Right, I'm not aware.

Q. Okay. But you are aware of a requirement that you do that for inmates in restraint chairs?

A. Correct.

Q. So what's the difference between the two?

A. I'm not sure.

Q. Does it have something to do with them being immobilized in a restraint chair?

A. It could be that part where he is not able to move his limbs freely; whereas suicide watch, they're in a cell and walking about—around in the cell, so yeah.

Q. What—I'm sorry. Were you finished?

A. Yes.

Q. And what medical risks can arise from a person not being able to move their limbs freely?

A. I guess their circulation—it could be—could be restricted causing anything to do with blood flow back to the heart. That's really it. They don't really usually sit there long enough to develop any blood clots or anything like that, but that's the biggest thing is circulation issues.

Q. Right at the beginning of the deposition, you mentioned that you had reviewed Exhibit 29 before the deposition—or in preparation for the deposition.

A. Mm-hmm.

Q. When, actually, did you review that?

A. It was before the—before the deposition.

Q. So today?

A. Today, yes.

Q. Okay. I asked you about Sergeant Hunt's testimony. Are you aware that others have also testified that you were the person who made the decision to put Mr. Howell into a chair?

MR. WELCH: Objection.

MR. HOJNOSKI: Objection. He's asking you for your attorney—client communication, I think.

THE WITNESS: Okay.

Q. Okay. I don't mean to get into those communications. Let me represent to you—and I can show

you statements, and we've got some exhibits. Actually, we're going to do that.

I think Roettker—there's a female corrections officer named Roettker, and she's testified that you were the one who placed him into the chair. If she testified that way, is she lying?

MR. WELCH: Objection as to lying.

MR. HOJNOSKI: Objection as to lying.

A. It's . . .

MR. HOJNOSKI: You can testify what you did and what you know and what you remember—

THE WITNESS: Okay.

MR. HOJNOSKI: —as supposed to what someone's intent is otherwise.

A. Yes. My thing was . . . at the time, the policy for the jail was anybody going in restraint, it is the officer's decision to put anybody in a restraint, not nursing, not medical staff at all. That's not our . . .

Q. Well, can you help us understand why these COs got the impression that you were the one who ordered him into the chair?

A. I'm unsure, but I cannot order him into the chair as that is not part of NaphCare's responsibilities to do so.

MR. KIRCHER: Okay. That's all I have. Now, Mr. Welch down there may have some questions.

MR. WELCH: I just have a few.

CROSS-EXAMINATION BY MR. WELCH:

Q. Ms. Jordan, can you hear me okay?

A. Yes.

Q. All right. I'm John Welch. I represent the sheriff's office.

A. Okay.

Q. So I just have a few follow-ups just so I understand here. First of all, you've told us that—several times that you did not order Mr. Howell into the restraint chair, correct?

A. Correct.

Q. Okay. And you were asked some questions about Sergeant Hunt, if they said something else. You're not suggesting—you haven't reviewed any other testimony in the case, correct?

A. No, I haven't.

Q. Okay. So if they say something, you say another, there may be a difference of opinion; it doesn't necessarily mean that one party or the other is actually intentionally lying; is that fair?

A. Yes.

Q. Okay. You—as I understand it, you evaluated Mr. Grant first—

A. Yes.

Q. —before evaluating Mr. Howell, right?

A. Yes.

Q. Okay. Was Mr. Grant sent out to the hospital?

A. I really do not recall.

Q. Okay. But you did your assessment and evaluation; and once you were done, then that's when Mr. Howell came into—

A. Yes.

Q. —the sallyport?

A. He was—he came in while I was still doing the assessment with Mr. Grant, so I could hear him. Usually, they don't have two inmates in there at the same time, so it was kind of a little bit overwhelming for everybody. And then Mr. Grant was finally sent into the tank after I took care of him.

Q. Okay.

A. But I don't believe—I don't think I sent him out. I feel like I sent him back and said that if anything were to change, let me know.

Q. Okay. Have you—during your time at NaphCare, did you, at times, send inmates out or patients out—

A. Yes.

Q. —to the hospital to be evaluated?

A. Mm-hmm.

Q. So it was something that you did if it was—

A. Yes.

Q. If the circumstances warranted it?

A. Yes.

Q. Have you watched any video footage of what occurred in the medical sallyport?

A. I saw pictures.

Q. Okay.

MR. HOJNOSKI: Screenshots of the video.

MR. WELCH: Understand.

Q. (By Mr. Welch) And exhibit—I think it's 29—Exhibit 29 being the restraint and seclusion. Is that—did you review Exhibit 29 prior to your deposition?

A. Yes.

Q. Do you know where Exhibit 29 comes from or . . .

A. Um . . .

Q. The source of that?

A. I believe it's the company-wide policy.

Q. Okay. At the time that you evaluated Mr. Howell—

A. Yes.

Q. —in the medical sallyport, you had—and I think you told us that you had some familiarity with sickle cell disease—

A. Yes.

Q. —or sickle cell crisis, correct?

A. Correct.

Q. And one of the things you mentioned, I thought you did, is that even—not for Mr. Howell, but maybe for other inmates, you had had the opportunity to triage them at the Hamilton County jail while you were working for NaphCare before December 9, 2018; is that correct?

A. Yes. Correct.

Q. Another thing you said is that there are some more treatments that you can do at the jail—

A. Yes.

Q. —for sickle cell crisis before sending them out to the hospital; is that true?

A. Yes.

Q. And had you done that prior to December '18 for some patients?

A. Yes.

Q. You were asked whether you provided any treatment to Mr. Howell for a sickle cell crisis. I think what you said was you did not because you did not believe he was in a sickle cell crisis at the time of your evaluation; is that correct?

A. Correct.

Q. And one of the things you—you had known—I think you noted that he even said that he had had sickle cell, correct?

A. Correct.

Q. But with that knowledge and history and your experience, and based on your clinical evaluation and assessment, your opinion and clinical decision making was that he was like—was not in a sickle cell crisis at the time, correct?

A. Correct.

Q. And based on your knowledge and your training and experience and your clinical decision making at the time, you were of the opinion and did not believe that Mr. Howell, at that time,

needed to be sent out to the hospital for an evaluation, correct?

A. No, not yet. Not at that time.

Q. With respect to the sickle cell crisis, it sounds like that was something that you did, in fact, consider knowing that history?

A. Yes.

Q. But again, given the entirety or totality of the circumstances, your decision making and judgment was that he was not in a sickle cell crisis, correct?

A. Correct.

Q. One of the things you put in your progress note is that Mr. Howell—apparently, he came in in a wheelchair?

A. Yes.

Q. And as I understand, at some point he sort of slid out of the wheelchair and was on the floor?

A. Uh-huh. That's when he was rolling around on the floor.

Q. So he was rolling around on the floor and speaking or yelling to some extent?

A. Yelling, yes.

Q. You noted that this nurse, whoever that was, attempted to assess the patient, but the patient kept rolling on the floor, yelling?

A. Right.

Q. Patient was asked to give a urine sample for assessment, but patient refused?

A. Right.

Q. Patient kept refusing medical treatment. Do you see that?

A. Yes.

Q. Is it fair to say that, you know, Mr. Howell, during this evaluation and assessment, was uncooperative?

A. Yes.

Q. One of the things that we have heard from other—and I won't get into other witnesses' testimony, but that one of the reasons or purposes of putting an inmate in a restraint chair is for the inmate's safety of himself, herself, or others.

Is that something that you have heard or know about in terms of these restraint chairs?

A. That's what I've heard, yes.

Q. When you wanted—and you talked about this—a psych evaluation for Mr. Howell, you wanted him to remain safe?

A. Yes.

Q. And I know that you had mentioned he had come in in the wheelchair. There may have been some discussions with corrections officer about maybe taking him back in a wheelchair?

A. Yes.

Q. But it is true that he was—he slid out of the wheelchair—

A. True.

Q. —was on the floor rolling around?

A. Yes.

Q. When he was put into the restraint chair, is it fair to say that you did not disagree with that in terms of knowing what his assessment was, rolling on the—around on the floor, yelling, and putting him into this chair for his safety?

A. I did not disagree—not disagree or agree. I just said, Whatever your policy is, that's what you do.

Q. Okay. Given the fact that he had slid out of his wheelchair and, at times, was on the floor rolling around, did you think it was reasonable to put Mr. Howell in the restraint chair for his safety given what you were observing in your evaluation?

A. At first, I just wanted to see if we could try to put him back in the wheelchair to get him to psych, because my reasoning was to get him to psych, get him in a cell, and Pierette and whoever was over there could evaluate him. That was my understanding.

Then one of the officers suggested the restraint chair to get him over, and that's when it was all that chatter. And that's when they're like, We'll put him in a restraint chair because that's easier to get him over there with everything going on. And that's when I said, I really—it's whatever you all want, basically.

Q. Okay. All right. So there was—you didn't disagree in the sense that medically—you know, you didn't say anything to the corrections officer, Jeez, medically, you shouldn't do that?

A. No, I didn't.

Q. Let me—a couple of things here. Let's see. If you—Ms. Jordan, if you thought Mr. Howell was having or had a serious medical condition at the time of your evaluation, would you have sent him out to the hospital for further assessment?

A. Yes. If I felt like he was having a serious medical condition that would not be able to be treated at the jail, then, yes.

Q. And given your notes and your testimony today, is it fair to say that based on your knowledge, training, experience, and your clinical decision making, you did not believe he was having a serious or life—threatening—

A. Correct.

Q. —medical condition at the time of your evaluation?

A. Correct.

MR. WELCH: I think that's all I have.

THE WITNESS: Okay.

RECROSS—EXAMINATION BY MR. KIRCHER:

Q. Just a quick follow-up. Ms. Jordan, are you aware of what the coroner found as the cause of death?

A. No.

Q. It's sickle cell crisis after a physical altercation. Is that surprising to you?

MR. WELCH: Objection.

MR. HOJNOSKI: Objection.

A. I don't know.

Q. If that's an accurate cause of death, when do you believe he had the sickle cell crisis?

MR. HOJNOSKI: Objection. It's outside of her scope of licensure.

MR. WELCH: Objection.

Q. Go ahead.

A. I'm not sure.

Q. Well, do you believe it could have been before you ever encountered him that he had a sickle cell crisis that caused his death?

MR. HOJNOSKI: Objection. Outside the scope of her licensure. You can answer if you know.

A. I don't know.

Q. Could it have been while he was in the restraint chair after you saw him?

MR. WELCH: Objection.

MR. HOJNOSKI: Same objection.

A. I'm not sure.

Q. Because, I mean, you said you don't believe it was a sickle cell crisis—

A. I don't believe—

Q. —while you were seeing him, right?

A. While I was seeing him, I do not believe it was.

Q. Okay. So you believe it had to have been some other time?

MR. HOJNOSKI: Objection. She doesn't know one way or the other.

MR. WELCH: Objection.

MR. HOJNOSKI: Mischaracterization of testimony.

Q. Is that right?

A. (No response.)

Q. You believe it must have been some other time?

MR. WELCH: Object.

MR. HOJNOSKI: Same objection.

A. (Inaudible.)

THE REPORTER: I didn't hear your answer.

A. I said I don't know. All I know is that when he was going through—when I was treating him in the medical sallyport, I did not believe that he was having a sickle cell crisis. I do not know when it would have been brought about; but at that time, it did not seem like that.

Q. Okay. So it could have well been in the three—plus hours when he was sitting in the chair without any observation from medical or mental health, right?

MR. HOJNOSKI: Objection.

MR. WELCH: Object.

MR. HOJNOSKI: Calls for speculation.

A. I'm not sure if that were to be.

MR. KIRCHER: No further questions.

MR. HOJNOSKI: We'll read.

MR. MCGRAW: We are going off video at 2:45.

(Whereupon, signature was requested, and the

deposition concluded at 2:45 p.m.)

(Whereupon, signature was requested, and the deposition concluded at 11:05 a.m.)

_____

CHRISTINA JORDAN

PROGRESS NOTES ENTRIES

Progress Notes – HOWELL, CORNELIUS 2165340 (1676106)

Nicole Halloran Paramedic POSTED ON 12/10/2018 8:20:00 AM Central Standard Time

Type: EMT/PARAMEDIC

LATE ENTRY. Pt seen in medical sally port after fight with im on 12/9/18 aprox 1710. Upon arrival pt found in wheelchair, blood on bottom lip. hands cuffed behind back. Cuffs moved to front of pt per medical request. Pt complaining of leg and back pain x10/10. Pt alert and oriented x4. combative. skin clammy. pupils round constricted reactive to light Ica. uto vitals d/t combative behavior. bs obtained=78. glucose tablet administered pt refused to chew, spit it out. Vitals assessed manually per charge m. Pt care transferred to charge at this time.

Christina Jordan Charge RN POSTED ON 12/10/2018 12:39:39 AM Central Standard Time

Type: NURSE

G-100 called at 2147 rt/ unresponsiveness.

Christina Jordan Charge RN POSTED ON 12/9/2018 6:29:16 PM Central Standard Time

Type: NURSE

Patient seen in medical sally port after altercation with inmate. Temp-unable to obtain. P-90, R-22, BP-110/56. Patient was yelling and c/o back pain and that he has sickle cell. Patient was sweating

and lip was bloody. Blood sugar was 78. Attempted to give glucose tabs but patient spit them out. Patient then put himself on the floor and rolled around yelling. This nurse attempted to assess patient but patient kept rolling on the floor yelling. Patient was asked to give a urine sample for assessment but patient refused. Patient kept refusing medical treatment. Patient was put in restraint chair at 1743 and taken to psych for evaluation. Patient still refusing care but had calmed slightly. Will continue to monitor.

Meghan Reed Corporate NP POSTED ON 12/6/2018 2:53:20 PM Central Standard Time

Type: STATCARE

Chart reviewed patient discussed with Marsha Burgess ARNP, verbal order received. Hx of sickle cell, reports Ibuprofen for pain. Will add Ibuprofen 600 mg BID PRN for pain. F/U in CC.

DEPOSITION OF PIERETTE ARTHUR
(JUNE 18, 2020)

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

KARLA HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

Case Number: 1:19-cv-00373

Before: Kelly GREEN, RPR, Notary Public.

MR. MCGRAW: We are now on video at 9:08[sic] a.m. in Case Number 1:19-cv-00373, Karla Howell versus NaphCare, Incorporated, et al., in the United States District Court for the Southern District of Ohio.

Will you swear the witness in?

PIERETTE ARTHUR,
a witness herein, having been duly sworn,
was examined and testified as follows:

CROSS-EXAMINATION BY MR. KIRCHER:

Q. Good morning, ma'am.

A. Good morning.

Q. Would you please give us your full name.

A. Pierette Arthur.

Q. Ms. Arthur, my name is Konrad Kircher. Along with Ryan McGraw, who is sitting next to me, we represent the estate the Cornelius Pierre Howell in a lawsuit against your employer NaphCare and others.

We're here for a deposition. Have you ever given a deposition before?

A. I have once.

Q. When was that?

A. I don't remember. Probably going on 10 years.

Q. Did it relate to your employment?

A. Yes, it did.

Q. What were the circumstances of—

A. It was a young man who had been an inmate of ours, and he passed away after leaving—he had left the jail for several weeks and had been in the hospital and passed away, and the family sought to have some compensation from that. Our company was neglectful in some way.

Q. Were you sued individually?

A. No. I think it was, you know,

NaphCare and the nurses who had attended to this patient . . .

Q. All right.

A. . . . as a . . . as a whole, I believe.

I'm not sure. I don't know how that works.

Q. Do you remember the name of the decedent?

A. No. No.

Q. Well, let me ask you, then—it's been a while since you gave a deposition.

Let me ask you to follow a few ground rules that will make this go easier.

As you see, everything that we say is being taken down by the court reporter, so please keep your answers audible. If you say uh-huh or uh-uh, I will ask you if that was a yes or no. I'm not being rude; I'm simply trying to make sure the record is clear.

A. I understand.

Q. Okay. Second, please allow me to finish my question before you begin answering. That way, she doesn't have to take down two people talking at once.

I will do my best to let you finish your answer before I ask the next question. If I ever cut you off, it will have been inadvertent; I thought you were done with the answer.

In that situation, I want you to bring it to my attention so that you can finish your answer. Will you do that for me?

A. Yes.

Q. If I ask a question which is confusing or unclear, please let me know, and I'll be happy to rephrase it. If you do answer a question, I will assume that you understood it. Is that fair?

A. Yes.

Q. What have you done to prepare for this deposition?

A. I've spoken with my attorney.

Q. And I'm not entitled to know what you spoke about. Did you review any documents?

A. I reviewed the one where I documented—the documentation of the patient in the chair.

Q. All right. The log? The restraint log?

A. The log.

Q. Okay. Anything else that you reviewed?

A. No.

Q. Did you talk with anyone other than your attorney about this deposition?

A. No.

Q. All right. Ma'am, are you a native of France?

A. Yes.

Q. Okay. And then what schooling did you have in France?

A. I graduated from college in France, but my credentials at the time were not accepted in this country. I came here in '69.

Q. In '69. Okay. And when you came here, you got a GED, high school equivalency?

A. Unfortunately, yes.

Q. Why unfortunately?

A. Because this was long before computers and everything, and education from foreign countries was not accepted here. So I came with no education.

Q. Okay. I understand. So you had to do that first before you could then—

A. So I could go back to school.

Q. Okay.

A. Yes.

Q. And what you did next was you went to the University of Cincinnati Raymond Walters College?

A. Mm-hmm.

Q. Is that a yes?

A. Yes.

MR. HOJNOSKI: Everybody does it.

Q. And you were in pre-nursing liberal arts at that time?

A. Yes.

Q. Okay. You didn't graduate from there, though?

A. I did not graduate.

Q. And then you went in a different line of work. You went into cosmetology, correct?

A. Yes.

Q. Okay. You got a diploma in 1987 from the Moore University of Hair Design?

A. Yes.

Q. And then it looks like you got back into nursing around 2003 when you went to the Great Oaks Institute of Technology?

A. Mm-hmm.

Q. Is that right?

A. (Nodded.)

MR. HOJNOSKI: Is that a yes?

A. Yes, I did.

Q. And you were in the practical nurse program there?

A. Yes.

Q. And did you graduate from Great Oaks?

A. I did graduate, yes.

Q. And as far as employment, it looks like you had your own restaurant from 1978 to 1984?

A. Yes.

Q. That was called The Corner Pocket?

A. Yes.

Q. What part of Cincinnati was that?

A. Kenwood.

Q. Okay. And then it looks like you had—either you had your own salon, or you were a sole proprietor in the cosmetology field?

A. I had a salon for 10 years.

Q. Until 2000?

A. I believe so. I'm not sure of the dates.

Q. Your first nursing position, then, for employment was in 2005 at the Montgomery Care Center as a staff nurse; is that right?

A. Yes.

Q. And then were you hired at the

Justice Center in June 2005?

A. Yes. So it was 15—I thought I was there 18 years. It's 15 years, yes. 15 years.

Q. And why did you apply to the Justice Center?

A. I thought it would be interesting work. I had tried the nursing home, and I did think this was something that I would like.

Q. Did you see a posting, or did somebody recruit you or . . .

A. It was a posting in the Enquirer, I believe.

Q. And you were a—you were a staff nurse when you were hired; is that right?

A. Yes.

Q. And are you still a staff nurse?

A. I'm a staff nurse, but I work in mental health and have for the past, I believe, 10 years.

Q. All right. So let's start from the beginning. June 2005, you started as a staff nurse. What were your responsibilities at that time?

A. At the time, we did different things around the jail. We didn't have a particular area where we worked all the time.

You may do a med pass in the South building one day; and then the next day, you would be in

the North building doing something different. That has changed since then. We now are more specialized in an area.

Q. Okay. Did your job change at all until 10 years ago when you started into mental health?

A. No.

Q. So it sounds like you did the general staff nurse position for about five years?

A. Yes.

Q. And for the past ten years, have your job responsibilities changed in mental health?

A. I have more responsibility, yes, than I did at the time.

Q. You have more responsibility in what sense?

A. In patient care and—you know, we have changed some of the—what shall I say? The schedules have changed. We have one nurse in mental health, and we work 12-hour shifts now where we used to work 8-hour shifts. So that meant more time, more responsibility in our area.

Q. Okay. And I want to—by the way, are your duties any different today than they were in December 2018?

A. No.

Q. Okay. So I want to get back to that in more detail. Let me check another thing off my list here. When did you first—are you an LPN?

A. Yes.

Q. When did you first become an LPN?

A. Well, it was written on there when I graduated, 2005.

Q. 2005 is when you started—

A. Okay.

Q. —with the Justice Center. Is that—

A. And I graduated that year.

Q. Okay.

A. I had only stayed at the nursing home maybe a month or two, and then I went to the Justice Center. So yes, that makes 15 years.

Q. All right. So I'm going to ask you about your—the situation in December of 2018. And it may or may not be different now, but let's try to focus on that time period. So at that time, were you working a 12-hour shift?

A. Yes.

Q. And generally, what time was your shift?

A. 7:00 a.m. to 7:30 p.m.

Q. And how many days a week were you working?

A. Three.

Q. Which particular days?

A. I work Wednesday, Thursday, and Sunday.

Q. When you were leaving shift, did you have typically some kind of turnover where you would pass things on to the oncoming nurse?

A. To the charge nurse in medical. I typically would go to her desk and report if there was anything going on that would be of interest to her in

mental health. At that point, there is no nurse in mental health.

The charge nurse takes over.

In that instance, you know, it would be leaving paperwork on her desk that was pertinent to what her responsibility would be in mental health at that point.

Q. So as staff nurse in mental health, to whom did you report?

A. To the charge nurse and, of course, to, you know, our director of nursing if there's any kind of issue.

Q. So let me just make sure we're clear on—in December 2008, you were a NaphCare employee, correct?

A. Yes.

Q. And maybe I should clarify that too. So you started in the Justice Center in 2005. Were you hired at that time by NaphCare to work in the Justice Center?

A. No. NaphCare was not our employer at that time. It was a company called Correctional Medicare—no Correctional Medical . . . I can't remember.

Q. Okay. And that was your direct employer?

A. Yes. And then the contract with NaphCare, I believe, was—how long have they been there? 13 years?

Q. Okay. So your prior employer when you were hired in 2005 lost the contract with the county?

A. Exactly, yes.

Q. You were then terminated from that employer?

A. Well, I would say—I wouldn't call it a termination. It was—automatically, we were offered to continue with NaphCare.

Q. Okay. So when your prior employer lost the contract, NaphCare got the contract with the county?

A. Yes.

Q. And then hired you?

A. Yes.

Q. Okay. So there was a smooth transition?

A. Yes.

Q. You have never been employed directly by Hamilton County, have you?

A. No.

Q. Or by the sheriff's department?

A. No.

Q. Okay. All right. So now let me go back and clarify in my mind. So December 2018, you were a NaphCare employee. Were the mental health nurses and medical nurses all NaphCare employees?

A. Yes.

Q. Okay. So in December 2018 as the staff nurse in mental health, you reported directly to the charge nurse of medical but also to the—did you say director of nursing?

A. Yes.

Q. And who is the director of nursing at that time?

A. I believe it was Kenya Lewis.

Q. Kenya Lewis?

A. Mm-hmm.

Q. Is that a female?

A. A female.

Q. How often did you work at the same time as Kenya?

A. Every day.

Q. What were her typical hours?

A. Her hours are basically when we first start first shift in the morning around 7:00, and I believe maybe around 3:00 or 4:00 or 5:00 sometimes.

Q. Where was her office?

A. Her office is in the medical area.

Q. And where is that in the jail?

A. It's in the North building on the second floor.

Q. Okay. And where was your office or desk as the staff nurse for mental health?

A. You mean from the medical area?

Q. If that's easier to explain, then yes.

A. It's next door. It's separated by maybe a 15—I'm sorry—maybe a 30-foot hallway.

Q. Okay. And what exactly—describe your office to us.

A. I don't have an office. We have a—an area that is open with one, two, three desks, and I occupy one of them.

Q. And what do you call that area?

A. The psyche area.

Q. The psyche area?

A. Mm-hmm.

Q. And where is the charge nurse for medical based?

A. She has a desk in a similar area in medical.

Q. Okay.

A. Which is, again, directly across from the hall.

Q. And what do you call that area?

A. The medical area.

Q. Okay. In a 12-hour shift as the staff nurse for mental health, did you supervise any employees?

A. No.

Q. What were your responsibilities as the charge—I'm sorry—as the staff nurse for mental health in December 2018?

A. During my entire shift?

Q. Yes.

A. Well, we—we have a morning med pass and a 2:00 med pass and an evening med pass during the 12-hour shift.

We also assist the doctor with the psychiatrist with patients. He sees patients, and we escort them from different areas to his office and back.

We also have emergencies where maybe one of my patients may say, I have chest pain. I will go to his cell and do an assessment. Of course, we have people who go in the restraint chair in my area, and that's pretty much a daily issue.

We will also visit on the female floor. We also have ladies who go in the chair, and that's on the third floor. We will attend to that.

I also give injections—monthly injections to patients who have orders for them. That's pretty much it. It goes on and on all day long.

Q. You mentioned a psychiatrist. Is the psychiatrist an employee of NaphCare?

A. Yes.

Q. And how often is the psychiatrist on site in the Justice Center?

A. Five days a week.

Q. Is it Monday through Friday?

A. Monday through Friday.

Q. And what are his or her hours?

A. He normally comes in maybe around 7:30 until—depending how busy in the afternoon, somewhere between 3:00 to 5:00 or 6:00.

Q. Is he available after hours for emergency?

A. After hours, he's available by phone. And we also have a corporate group of people from

NaphCare that we can—in the event that we could not reach the doctor, they are there as a backup if we need an emergency medication.

If we put someone in the chair, of course, we immediately call our doctor, Dr. Broderick, to ask him what he wants us to do with the person in the chair and give him the assessment and so on.

Q. Is it George Broderick?

A. George Broderick, yes.

Q. How long has he been the psychiatrist there?

A. He's been with us—I lose track of time—a year and a half maybe, maybe a little longer. Prior to that, we had Dr. Johansen.

Q. Do you remember which one it was in December 2018?

A. It was Dr. Johansen.

Q. Okay. How do you spell that last name?

A. J-O-H-E-N-S-E-N[sic].

Q. Scandinavian spelling?

A. Yes.

Q. First name?

A. Leland.

Q. Can you spell that?

A. L-E-L-A-N-D.

Q. And where was Dr. Johansen located in the Justice Center?

A. In the same office that Dr. Broderick has now, which is next to my desk.

Q. So you interacted frequently with the psychiatrist?

A. All day long, yes.

Q. Now, you said that after hours, there was also a corporate group. Describe that for me better. Who's this corporate group?

A. I don't interact with them that much. It's a link that we have, and we can send them a message. They're located in Alabama.

We can send them a message requesting a medication to be started that has been verified, for example, with the pharmacy, or if someone is—and here again, I don't use their services a lot, so I can't really give you an example.

But if there is like an emergency medication needed for someone in the chair, say—and the doctor would not be available for whatever reason, which he usually is, then you could go to them. And that would just be strictly a backup.

Q. Have you ever worked any shifts that were overnight?

A. Never.

Q. Okay. Have you ever had to call that corporate group as a backup?

A. No.

Q. You've never called that corporate group?

A. (Shook head.)

Q. Do you know whether calls to the corporate group must be logged in somehow?

MR. HOJNOSKI: I'd just object. I thought she said it was through an electronic portal not a phone call.

Q. That's a good point. So there must be some record of the electronic transmissions to corporate—to the corporate group, would you agree?

MR. HOJNOSKI: Objection, calls for speculation. If you know the answer.

A. I'm not sure.

Q. Well, let's talk about a related issue, then. So when you start a shift in December 2018, is there a computer on your desk?

A. Yes.

Q. And through that computer, are you able to access NaphCare medical records on particular inmates?

A. Yes.

Q. And I asked you when you leave a shift what you do for transition. When you start a shift, what do you do to get an understanding of what's been going on?

A. In my area?

Q. Yes.

A. Well, when I log in, I have a list of the patients who are in my area on that day because it changes quite frequently. And from that list, I'm

able to get my medications ready for distribution at morning med pass. What else?

Q. So are you able to access the medical histories for each of those patients in your area?

A. For a particular patient?

Q. Yes.

A. If I want to see what his medical issues are, et cetera, yes.

Q. Okay. There are people on suicide watch in your area, right?

A. Yes.

Q. So if you start a shift and there's someone on suicide watch that you've never encountered before, do you typically go to the records to look at their history?

A. Only if I have to. If there's no reason to, we don't just go into people's records just to look. If it's a person that maybe was brought that night, of course, I will look to see if they have medications ordered that I need to give them. Anything else is really not relevant. I'm not a counselor; I'm a nurse, so . . .

Q. That information isn't necessarily helpful to your job; it may be to the psychiatrist or the charge nurse, for example?

A. Yes.

Q. Okay. How far—let's say you start a shift and there's a patient in your area, and you're checking the records on the computer. Do those go back and include prior incarcerations?

A. Yes, if there's a medical record.

Q. Okay. So let's talk about that link again. If you wanted to contact corporate as the backup, describe for me how you would access that link.

A. You know, if the computer was in front of me, it's easy, but putting it into words—we have a link. It's called Statcare. And we can forward, let's say, a medication list from a local hospital.

And we can forward that to them and make a request to restart these medications for this patient as long as they are current and they are able to restart medication from their end. And that's about all the interactions I would have with them.

Q. So is Statcare the link?

A. Yes.

Q. So in progress notes—in the electronic progress notes, if we see a notation that says Statcare, does that mean that's a communication with corporate?

A. Yes.

Q. Are you familiar with the difference between therapeutic restraints on one hand and administrative or custody restraints on the other hand?

A. No.

Q. Have you ever heard those terms used?

A. Therapeutic restraints—I have heard it, but we don't use that. Our restraints are more—I can't explain it. Can you rephrase that?

Q. Let me ask you this way. The restraint chair that is used in the Hamilton County Justice Center, would you consider that a therapeutic restraint, administrative restraint, custody restraint, or can it be any of those depending on the purpose for which the inmate went into the chair?

A. I guess it could be either one.

Q. Can you give me an example of what a . . . of when the restraint chair would be used as a custody restraint?

A. I don't think that we have a custody restraint.

Q. Can you give me an example of when the restraint chair would be used as a therapeutic restraint?

A. When the patient needs a time-out and needs a quiet area to sit until he or she calms down, that would be considered therapeutic in my opinion.

MR. HOJNOSKI: Objection, speculation.

Q. And once they calm down, what's your understanding as to what happens with that inmate?

A. I didn't quite hear you.

Q. Once they calm down and they're in the restraint chair, is it standard procedure then to get them out of the restraint chair?

A. Yes.

Q. Why?

A. Well, if the patient has calmed down and states that he or she is ready to go about their normal activities without harming themselves or harming

someone else, then at that time, it's fairly safe to let them go back to their floor or their cell or to intake if that's where they came from.

Q. Are there risks to an inmate remaining in a restraint chair even after they've calmed down?

MR. HOJNOSKI: Objection.

A. Risks?

Q. Yes, health risks.

A. No.

Q. Blood clots, for example?

A. Pardon me?

Q. If an inmate is left in a restraint chair, is it a risk that they would develop blood clots?

MR. HOJNOSKI: Objection. You can answer if you know.

A. I don't know because I'm not—you know, I can't make a . . . I would think not.

In all my years in having people in the chair on a daily basis—you can imagine how many people I've seen in that chair—that has never occurred. I have never known of anyone having any kind of issues after being in the chair.

Q. Okay. And you mentioned earlier that it's a daily occurrence of someone being in a restraint chair, correct?

A. Pretty much so.

Q. Are most of those instances initiated by medical and mental health or by the corrections officers?

A. Always corrections. Corrections decides who goes in the chair and basically when they come out. We can make a—what is the word?

Q. Recommendation?

A. Suggestion.

Q. Okay.

A. I can make a suggestion, I think Mr. Smith is getting—you know, he's ready to come out of the chair. As far as I'm concerned, he's doing well. But ultimately, corrections makes the decision.

Q. Do you as staff nurse of mental health have the authority to order that an inmate go into a restraint chair?

A. No.

Q. You can only make a suggestion?

A. I can only make a suggestion. Maybe he should go in the chair. That's about as far as it goes.

Q. Does the charge nurse for medical have authority to order an inmate into a restraint chair if you know?

A. No.

Q. She can only make a suggestion?

A. Yes.

Q. To the correctional supervisor?

A. Corrections.

Q. And your understanding of that, of what you just testified to, as to who has authority is based on what?

A. It's the rule.

Q. A written rule or the practice that you've witnessed?

A. Well, mainly the practice, but I believe that it is written.

Q. You believe that it's written somewhere that the charge nurse for medical does not have authorization to order someone into a restraint chair?

A. I'm not sure, but it has always been the rule.

Q. Since you were hired by NaphCare approximately 13 years ago or so, have you ever received training in determining when an inmate should go into a restraint chair?

A. No.

Q. Have you ever received any training on written policies and procedures for use of the restraint chair?

A. Yes.

Q. Okay. How often have you received that type of training?

A. We have continued education. It's an ongoing thing.

Q. When would you say you last received any training relating to the use of the restraint chair?

A. Certainly within the last six months, I would think.

Q. And is this online training or in person?

A. It's online.

Q. What's your understanding as to whether a physician has to be notified if an inmate is placed in a restraint chair?

A. What is my understanding of that?

Q. Yes.

A. Well, I think it's a necessary thing. We need orders from the doctor, you know, as to what he wants us to do with the patient depending on what the condition is.

Q. Okay. So let me make sure I understand. So a corrections officer makes the decision to place an inmate into a restraint chair let's say for the inmate's safety.

A. Yes.

Q. Okay. It's your understanding that a physician must be contacted about that placement?

A. Yes.

Q. And who's responsible for making that call—that notification to the physician?

A. I am or the mental health nurse is.

Q. Okay.

A. Or the charge nurse if she is at that time taking care of mental health.

Q. And is that notification logged anywhere?

A. It is logged, yes. We usually put a note in the chart that Dr. Broderick was contacted and what orders he gave pertaining to that patient, which is usually how often we are going to check

on him in the chair, whether medication is needed to calm him down, that type of thing.

Q. Would that be in the progress notes of the electronic records?

A. Yes.

Q. Would it also be something on the restraint chair log?

A. No.

Q. Do you understand what the term "advanced clinical provider" means?

A. Well, the advanced clinical provider would be either our M.D. or our psychiatrist.

Q. When an inmate is placed into a restraint chair, what is your understanding as to your responsibility as the staff nurse in mental health for observing or checking on that inmate?

MR. HOJNOSKI: December '18, 10 years ago? Objection to form. Time frame.

Q. Just to remind you, we're talking mainly about that area, December of 2018. Okay? So let me go back and rephrase the question. And unless I state otherwise, I'm talking about December 2018 for all these questions.

A. Yes.

Q. So in December 2018, what was your understanding as to your responsibility for checking on or observing an inmate in a restraint chair?

A. At any time or that particular patient?

MR. HOJNOSKI: I don't think he's talking about Mr. Howell, just in general. Correct?

Q. In general.

A. Just in general. Well, the nurse who makes the initial assessment and starts the paperwork and . . . And I'm not sure that I understood your question, so let me know if I'm off. Make a physical assessment of the patient; checks the restraints, of course, you know, blood pressure, et cetera; make sure that the patient is comfortable; and calls the doctor and informs him that we have this person in the chair, whether he's agitated or he's calming down; does he need emergency medication; if he's a person who may be delusional and dangerous.

And the doctor then, you know, will tell us, you know, Check on him. Typically—and these are the new rules, by the way. So in 2018, it was different.

MR. HOJNOSKI: That's what he's asking you about, though.

A. Yeah. So that was—that would be a two-hour check. We would check on the patient every two hours and rely on the correction officers who check on them every 10 or 15 minutes.

And if something would happen that would require that we would go back and check on the patient before that time, then the corrections officer would let us know. And basically, that's about it.

Q. Okay. I want to go back and clarify we were in the right time frame. So you described an initial

assessment, physical assessment, making sure the restraints are on correctly, and then contacting the physician.

Those were all things that were in place as policy for December 2018, right?

A. Yes.

Q. Okay. And it's your understanding in December 2018 that once that assessment was completed, there was no requirement to check on that inmate again until the two-hour point?

A. Yes.

Q. Okay. And in the meantime, it was your understanding that the corrections officer would be responsible for checking on that inmate every 10 or 15 minutes?

A. Yes.

Q. And you were relying then on the corrections officer to notify you if there was a problem identified during one of those 10-or 15-minute checks?

A. Yes.

Q. And what's your understanding as to what you were supposed to do at the two-hour mark?

A. At the two-hour mark, you go and check and make sure that the patient is okay in the chair. Sometimes they go to sleep. We let them sleep. We do not wake them up if they're sleeping. And basically, just keep an eye and make sure that there is nothing going on that would be alarming until the next check.

But, you know, four hours is a pretty long time to be in the chair. A lot of them are released sooner than that. Sometimes longer.

Q. At the two-hour mark, did you have any responsibility for ensuring that they got a limb rotation, limb exercise?

A. No. This is not our responsibility. This is at the discretion of the COs depending on the behavior. And if the situation is going to escalate or they feel that it's going to escalate, then it would not be advised to release the patient.

Q. What's the purpose of limb exercise at the two-hour point?

A. It's for circulation.

Q. And what could happen with circulation if they're not offered that opportunity?

MR. HOJNOSKI: Objection. Outside the scope of—

A. Well, I'm not a doctor—

MR. HOJNOSKI: Let me finish my objection before you—objection.

Outside the scope of your licensure, which I think is what you were answering anyway. Go ahead. You can answer.

A. After two hours, I'm not sure because I'm not a doctor, and I can't really make that—you know, but let's just say that in all the years I've worked there, we've never had an issue with anyone having problems after being in the chair.

Q. You don't have an understanding as an LPN that if a person is sitting in a chair too long, they could develop blood clots?

A. It's a possibility, but, you know, here again, it's from one individual to another.

Q. What is your knowledge of sickle cell disease?

A. I'm not very familiar with it. We have had patients who have it. I don't know that much about it.

Q. Tell me what you do know about it.

A. Well, it's a blood disease that causes pain, and it's typically treated with just a little bit analgesics and hydration. There's really not much that is done for it.

Q. So one of the signs and symptoms is pain, you said?

A. From my very limited experience, it's usually a complaint of pain.

Q. Do you know where that pain usually manifests itself?

A. No.

Q. Do you know what typically initiates a sickle cell crisis?

A. No.

Q. Have you ever responded in the Justice Center to an inmate having a sickle cell crisis?

A. No.

Q. Before December 2nd, 2018, which is when Mr. Howell was incarcerated for this particular

scenario, do you believe you had ever encountered him before?

A. No.

Q. His records, though, would have been available to you through your computer when he was in mental health?

A. Yes.

Q. At some point, did you learn that he had at least two prior instances where he was transported from the Justice Center to UC Hospital for a sickle cell crisis?

A. No.

Q. You never knew that before he passed away; is that—

A. No.

Q. Do you believe you had any interaction with him before December 9th when he was brought to mental health?

A. No.

Q. What I'd like to do is now have you describe what you remember—first of all, let me ask this. Do you have an independent recollection of Mr. Howell?

A. No, I don't.

Q. Okay. So you don't have any recollection of the incident that occurred other than what you read on statements?

A. Correct.

Q. What do you believe was the purpose of your first interaction with Mr. Howell?

A. He had been brought to mental health in the chair, and he was in the restraints. And while doing my med pass, I stopped to check on him at the two-hour or so. And he was, as I recall, belligerent, yelling, and threatening staff, and I continued my med pass.

Q. Okay. You said he was belligerent as you recall. Now, are you recalling this from your mind, or are you recalling this from something that you have read?

A. No. I remember stopping by, and he was very belligerent.

Q. So you do have some memory of the incident?

A. Somewhat, but only of that because I had—I did not check his records or he was unknown to me other than he was in the chair.

Q. Okay. So you believe that your first encounter with him was when you went to check on him in the chair at around the two-hour point?

A. Yes.

Q. Have you since learned that it was much earlier than the two-hour point?

A. I'm not sure.

Q. When you say he was belligerent, describe that for me.

A. He was in the chair and he was yelling. The corrections officers were with me. I was with—I

usually have two corrections officers doing med pass with me.

And we looked—we had an enclosed area with the chair in it. And I looked at him, and he was very hostile, which is nothing unusual when people are in the chair. In fact, it's the usual thing. And at that point, rather than to continue to escalate, you just kind of walk away for a while.

Q. Do you remember anything that he said?

A. Nothing in particular. The usual, you know, obscenities and so on. That is typical of people in the chair.

Q. Were the obscenities directed at you?

A. Staff in general.

Q. Okay. Was he complaining of pain?

A. Not that I recall.

Q. Was he complaining that he couldn't feel his legs?

A. No.

Q. Was he asking to be let out of the chair?

A. Not that I recall, no.

Q. What was his demeanor in the chair?

A. An angry man.

Q. Was he sitting upright or was he slouched?

A. Well, they—you have to sit upright because you are in restraints. So you're sitting upright.

Q. Describe his physical features to me.

A. I would not recognize him.

Q. What was his race?

A. He was a black male.

Q. Would you say he was more or less 45 than 200 pounds?

A. I have no idea. I don't remember.

Q. Would you say he was more or less than 6 feet tall?

A. Don't know.

Q. Going back a minute, were you involved at all in the decision-making process to put him into a chair?

A. No.

Q. Were you present when the decision makers placed him into the chair?

A. No.

Q. In other words, were you involved in any discussion about whether to put him into a chair?

A. No.

Q. Do you know who made the decision to put him in the chair?

A. I do not. I was not there.

Q. So when you had this first encounter with him, what was your understanding as to why he was in the chair?

A. I had been told that there had been an incident in medical and that he was placed in the chair

and brought from medical to mental health, and that's it.

Q. Did you contact the physician about him being in the chair?

A. No, I did not. I believe that the charge nurse did that. The initial nurse usually calls the doctor.

Q. And who do you believe was that initial nurse?

A. I believe that was the charge nurse since it happened in medical.

Q. And who was the charge nurse that night—that afternoon?

A. I can't think of her name now.

Q. Christina Jordan?

A. Christina.

Q. You mentioned your understanding that there had been an incident in medical, and that's why he was placed in the chair.

What is the basis of your understanding?

A. It was just what was said to me.

Q. By whom?

A. In passing. I don't remember. It was probably the charge nurse. Maybe another nurse said we're—you know, that—bringing this guy in the chair, which, you know, he had a fit in medical, that type of thing. He's belligerent, horrible, and that was that.

Q. Do you remember having a conversation with anyone else—whether it was a corrections

officer, nurse, or anyone else—before you left your shift about Mr. Howell?

A. When I left my shift, I gave the documentation to Christina. And there really was nothing to report other than I had seen the patient briefly, and he continued to be agitated, and pass on the paperwork as I leave.

Q. And the paperwork you're talking about is the chair log?

A. Yes.

Q. Okay. And how many encounters did you have with Mr. Howell that day?

A. Just that one.

Q. Just that one. I believe from the chair log, it was about 18:10. Does that sound right?

A. It's approximate because we don't carry the log with us when we're walking around. It stayed at the desk. So I would have documented when I went back to the desk.

Q. And the time you put down, is that the time you were at the desk or the time you're estimating that you were with the inmate?

A. I would think it was approximate. It's been a while, so I'm not sure if it was the time on the clock or if it was an estimation of the time that I saw him.

(Plaintiff's Exhibit 28 marked.)

Q. Let me hand you what I'm marking Exhibit 28. Let me know when you've reviewed it and you're ready to answer questions about it, please.

A. Okay.

Q. Are you familiar with this form?

A. Yes.

Q. Is this the restraint chair log that we've been talking about today?

A. It is.

Q. Okay. The top five lines or so has some handwriting. Is that your handwriting?

A. No.

Q. Do you believe that to be Christina Jordan's handwriting?

A. That would probably be Christina.

Q. And this is a NaphCare form, correct?

A. It is, yes.

Q. How long had this form been used in the Justice Center prior to December 2018?

A. I really could not answer that question. It's been a while.

Q. Years, probably?

A. Yes.

Q. Okay. I mean, it's something definitely that you were familiar with?

A. Definitely, yes.

Q. Okay. So a little more than halfway down, there's a section that says, Inmates in Restraints, slash, Seclusion Must Be, and then there are five bullet points. Do you see that?

A. Methods to avoid? Is that the one you're looking at down here?

MR. HOJNOSKI: Right here.

A. Oh, here, Inmates in Restraints/Seclusion. Yes. But the rules have been changed several times, and these have never been updated. So . . . here it is.

Q. Well, okay. Let's go with the first bullet point. So inmates in restraints/seclusion must be observed and monitored at least every 15 minutes. Did I read that correctly?

A. Yes.

Q. Was that the rule in December 2018?

A. No.

Q. What was the rule?

A. The rule was every two hours for medical personnel. For corrections, I believe it was every 15 minutes.

Q. And what's the basis of your understanding that this form—that this rule was not applicable in December 2018?

A. It was not.

Q. But what's the basis of your understanding? Is there something in writing that you've seen?

A. I'm sure that I did see something in writing, but off the top of my head, I'm not sure where, but that was the rule at the time. It was every two hours.

Q. When had it changed?

A. I don't recall.

Q. Did the rule used to be, sometime before December 2018, that an inmate in restraints had to be observed and monitored at least every 15 minutes?

MR. HOJNOSKI: In medical? Objection.

Q. Well, that was going to be my next question, but—

A. In medical? I don't recall ever checking someone every 15 minutes for the duration of the stay. It's impossible to do unless you stayed with the patient the entire time.

Q. Okay. So your understanding is that has never been your responsibility as the staff nurse in mental health to observe an inmate in restraints at least every 15 minutes?

A. Prior to that date.

Q. Prior to December 2018, right?

A. No, we never—we never did check every 15 minutes.

Q. Okay.

A. Unless we had the time. Here again, it is not cast in stone. Even though we had a two-hour—I didn't know this here (indicating). I had seen the patient a half hour after Christina because I was doing my med pass, and it was convenient to check on him again.

There is no—nothing cast in stone that it has to be every two hours. It would be unreasonable. It could be a little longer. It could be a little less. It

could be—sometimes we have emergencies. We get extremely busy, and so it's a little bit flexible, but we try to keep it, you know, on the up and up.

Q. Were you unusually busy that night?

A. I don't recall.

Q. Okay.

A. We're always busy.

Q. Let me go back and clarify. I appreciate what you said. But it's your understanding that it was never the rule before December 2018 that you were required to check an inmate in restraints at least every 15 minutes; is that right?

A. I can't say it never was the rule, but I don't ever remember checking on someone every 15 minutes.

Q. Okay. And there again, you're now, as I understand, talking about the practice. I understand it was never your practice to check at least every 15 minutes.

A. It was not the rule.

Q. It was not the rule?

A. No.

MR. HOJNOSKI: We've been going about an hour. Can we take a short break to use the restroom?

MR. KIRCHER: Yeah, we can.

MR. MCGRAW: It is 10:10, and we are going off video.

MR. KIRCHER: 11:10.

(A brief break was taken.)

MR. MCGRAW: All right. We are back on video at 11:26 p.m.[sic], and to clarify the video, we went off at 11:10, not 10:10.

Q. (By Mr. Kircher) All right. Ms. Arthur, we're back on the record, and you're still under oath. Do you understand that?

A. Yes.

Q. Okay. Is there anything from your prior testimony today that you think you need to correct?

A. No.

Q. Okay. So let's get back to looking at Exhibit 28. And we talked about the first bullet point that says, Observed and monitored at least every 15 minutes.

Let me ask you about the next one, that mental health must give access to toileting needs at least hourly. Do you believe that was a rule in December 2018?

MR. HOJNOSKI: Objection. For the record, you added the words mental health from the document. You can answer if you know.

Q. Well let me back up. Do you believe it was a rule in December 2018 that inmates in restraints must be given access to toileting needs at least hourly?

A. I don't believe it was because it is at the discretion of the officers here, again, depending on the behavior of the inmate. And if it causes a risk to their safety or the safety of others to release them temporarily to go to the bathroom, then it's a no.

Q. So you believe that second bullet point, whether or not it was a rule, applies to corrections officers and not to mental health staff?

A. It applies to—

MR. WELCH: Objection. Sorry. Objection. Go ahead.

A. —to corrections officers.

Q. Can you tell me your understanding of why that bullet point is on a NaphCare form that—

A. I have—

Q. —you're required to sign?

A. I don't know.

Q. The next bullet point says that inmates in restraints must be provided range of motion exercises at least every two hours.

Is it your understanding that that was a rule in December 2018?

A. Here again, it is at the discretion of the officers. It was a rule, but depending on their safety and the safety of the patient, they decided whether it would be done.

I've seen it done many times where the legs of the inmates would be taken out of the restraints so they could move their legs, but I have also seen where it was not possible because the patient was too hostile.

Q. Is it your understanding that that bullet point applies to corrections officers and not to mental health staff?

A. Exactly, yes.

Q. The next bullet point says that inmates in restraints must be given access to fluids at least every two hours while awake.

Is it your understanding that that was a rule in December 2018?

A. It was a rule, and that's very easy to apply, so we do this regularly.

Q. Who is "we"?

A. The corrections officers and the nurses. If an inmate says, I'm thirsty, can I have some water, we give it to them.

Q. So it's your understanding that that bullet point applies to both mental health staff and corrections officers?

A. Yes.

Q. Okay. The next bullet point says that inmates in restraints must be provided vital sign check every shift and PRN?

A. Yes.

Q. Is it your understanding that that was a rule in December 2018?

A. It was.

Q. And that bullet point was a rule for mental health staff or corrections officers or both?

A. Mental health staff.

Q. All right. Then we've got a chart here, and it's got an entry at 17:43. Do you see that?

A. Yes, I do.

Q. Does that appear to be an entry made by Christina Jordan?

A. I would think it was, but I was not there, so I can't state an opinion.

Q. The next entry is yourself, correct?

A. It is.

Q. And that's at 18:20, correct?

A. Yes.

Q. And you've got the codes A, L, and Z; is that right?

A. Yes, sir.

Q. And what you're noting is that Mr. Howell was alert, angry, yelling, threatening, and showing no signs or symptoms of distress; is that right?

A. Yes, sir.

Q. And you have signed it at the bottom of the page?

A. I did.

Q. On the second page, is any of the writing yours?

A. No.

Q. Okay. Go back to the first page. And right in the middle of the page, do you see where it says, Observation codes?

A. Yes.

Q. What does it say right after observation codes?

A. 15-minute intervals.

Q. Okay. And it's your understanding that that applies to whom?

A. I'm not sure because, for what it's worth, these were written for every facility in the country. NaphCare has many, many, many jails all over the country, and they all have their own rules per site. So that doesn't—it's kind of a generic type of form, if you will, and so we never really went by that.

Q. If you wanted to find out what the written rules were for the—for NaphCare employees at the Hamilton County Justice Center in December 2018, where would you look?

A. I think that you would go to the health service administrators. I'm sure that she has records of what was the norm at the time, because as I said, this is—you know, it differs from site to site, and that was why this did not apply to us at the time. We were doing two hours.

Q. Is the health service administrator a NaphCare employee or a county representative?

A. She is NaphCare.

Q. And where is she located?

A. She is located in the medical department on the second floor.

Q. Okay. What's her name?

A. Maria Perdikakis.

Q. Spell the last name, please.

A. I think it's P-E-R-D-I-T-or K-A-K-I-S. I may be a little wrong, but anyway, her first name is Maria.

Q. How long has she been in that role?

A. I'm not good with dates, you know. Probably five years, maybe.

Q. Okay.

A. She was there at the time.

Q. All right. And you believe that she's the one who could affirmatively say what the rules were in December 2018 for NaphCare employees?

A. I believe so.

(Plaintiff's Exhibit 29 marked.)

Q. I'm going to hand you Plaintiff's Exhibit 29. Feel free to read whatever you want. I'm not going to ask you about the entire document.

A. Okay. (Examining document.)

Q. Are you ready for some questions, or do you need to look at it first?

A. No questions.

Q. I'm sorry?

A. Pardon me?

Q. May I ask you questions, or are you still reviewing it?

A. You may.

Q. Okay. Have you ever seen this document before?

A. I'm sure I have.

Q. What do you understand it to be?

A. Well, this is about the restraint rules.

Q. Whose restraint rules?

A. Who?

Q. You said they're about the restraint rules. Whose document is this?

MR. HOJNOSKI: Objection. If you know. I don't want you to guess what it is if you don't know.

A. I'm assuming that it is NaphCare—from NaphCare.

Q. Do you understand this document to represent NaphCare's rules that were in place in December of 2018 for restraint and seclusion?

MR. HOJNOSKI: Objection, speculation. If you know, you can answer.

A. I'm not sure that it would be in place in 2018. It says up here 2014, and, you know, NaphCare changes their policies on a regular basis. Sometimes it's difficult to follow.

Q. Okay. Well, I'm going to tell you that it was given to us by your attorney as the policies and procedures which were in place in December 2018. Okay?

A. Okay.

Q. So let's—with that assumption, let's go forward here. So do you see the heading that says, Procedure, about a quarter of the way down the page?

A. Yes.

Q. And then underneath that, it says, Restraint procedures?

A. Yes.

Q. Let's go to number 3 where it says, With regard to clinically ordered restraints, the following policies and procedures apply. Now, let me stop there. What is a clinically ordered restraint?

A. I don't know because we do not have clinically ordered restraints since corrections decides who goes in the chair and when. With—the medical department does not make that decision, so clinically indicated therapeutic restraints . . . I don't know.

Q. Does NaphCare psychiatrists have authority to place an inmate in a chair? Let me—to order an inmate into a chair?

MR. HOJNOSKI: At the Hamilton County Justice Center?

Q. Yes.

A. At the Hamilton County Justice Center . . . Not really. I have seen it when we have a patient who needs an injection, and the psychiatrist will say, Can you put Mr. Jones in the chair so we can give him an injection, and then release him immediately. That's for safety issues. But to place him in the chair when he's misbehaving, it's always corrections.

Q. Okay. So let's go down to—we just started into number 3. Okay? And there's a subparagraph A and lowercase Roman numeral 1 that says, The application of any clinically ordered restraints

must be ordered by an advanced clinical provider either in writing or via telephone consultation.

And your understanding is that—

A. No.

Q. —it doesn't apply to the Hamilton County—

A. To Hamilton County.

Q. And then two paragraphs later, lower Roman numeral 3, that says, The advanced clinical provider, in consultation with the nursing and/or mental health staff, may authorize additional restraints not to exceed six hours, or as permitted by law, with appropriate continued nursing reassessment and monitoring.

Again, it just doesn't apply to the Hamilton County Justice Center, right?

A. (Reading) The advanced clinical provider, in consultation with the nursing . . .

Well, if we keep a patient longer than six hours in the chair, we call the doctor again to let him know that Mr. Smith is still in the chair. And if nothing is needed—here again, medications—then that's all we need to do. He has been notified.

Q. Let's go down to the bottom of this page to paragraph E, and that says, The physical care of the patients in restraints will be monitored regularly by the ordering advanced clinical provider and health care staff as outlined below.

Now, let me stop there. What's your understanding of health care staff?

A. Well, you know, the advanced clinical provider, here again, is not going to go and check on the patient in the chair. The nurse does that. And at the time, it was every two hours.

The liquids? Yes, we definitely make sure that the patients are hydrated. If they're asking for it, then they need it. And check the restraints, of course, you know, injuries or anything like that.

But at the time, here again, it was every two hours, not 15 minutes.

Q. Well, and then right down there, E, lowercase Roman numeral 2, says, Observation for signs of circulatory or respiratory distress, abrasions, irritation, injury, or other dysfunction will occur every 15 minutes while the patient is in restraints.

And again, your testimony is that that doesn't apply to mental health staff in the Hamilton County Justice Center?

A. Not at the time. But we rely on the corrections officers to make the observations. And if something abnormal occurs, then they let us know.

Q. Go to the next page, please, Roman numeral—I'm sorry. It's letter I, lowercase I. It's about a quarter of the way down the page. It says, A nurse will schedule and implement a review of the patient in restraint every 15 minutes for the duration of the restraint. Do you see that?

A. Yes.

Q. And your testimony is that does not apply in December 2018 in the Hamilton County Justice Center?

A. No.

Q. And underneath that, letter J, it says, Nursing and/or mental health staff will communicate verbally with the patient in restraints every 15 minutes to access the need—probably should say "assess" the need—for continued restraint unless continued restraint is ordered by an advanced clinical provider. Do you see that?

A. I see that.

Q. And your testimony is that that was not a rule that applied to NaphCare employees in the Hamilton County Justice Center in December 2018, right?

A. No.

Q. So I'm right, though, correct?

A. (No response.)

Q. No, it didn't apply—

A. No.

Q. —is what you're saying? I'm sorry. I think there's some confusion on the record. I am correct that that did not apply, yes?

A. Yes.

Q. Okay. Thank you.

All right. So you made the one entry on Exhibit 28, and what time did you leave shift that day?

A. 7:30.

Q. Okay. And so you gave Exhibit 28 to Christina Jordan when you left?

A. Yes.

Q. Where had it been: on your desk?

A. On my desk.

Q. And why did you give it to Christina Jordan?

A. Because when I leave mental health at 7:30, there is no night shift in mental health. At this point, the medical charge nurse takes over. Any documentation like this or anything—anything important that I need to make sure that she's aware of I will give to her before I leave, a short report, if you will.

Q. Do you remember having any conversation with Christina Jordan about Mr. Howell?

A. Not that I recall, no. And if I did, it was probably, okay, he's still in the chair; here's the paperwork. That was it.

Q. Do you remember giving her any other paperwork at the same time, or was this probably the only thing you gave to her?

A. I don't remember.

Q. So when you left shift, who did you understand was responsible for monitoring Mr. Howell in the restraint chair?

A. The charge nurse or really any other nurse working the night shift. Anyone can go and check on the patient. If the charge nurse is busy, she can delegate to one of the staff nurses, Can you go and check on Mr. Howell?

Q. Someone from NaphCare should have checked on him at the two-hour mark, right?

A. Ideally, yes.

Q. Well, that was the rule, wasn't it—

A. It was the rule.

Q. —according to you?

A. Mm-hmm.

MR. KIRCHER: Thank you, Ms. Arthur. I appreciate you being here. I don't have any further questions.

MR. HOJNOSKI: John, do you?

MR. WELCH: Yeah, I might have a couple.

CROSS-EXAMINATION BY MR. WELCH:

Q. Hi, Ms. Arthur. I'm John Welch. I represent Sheriff Neil and the Hamilton County Sheriff's Office. Okay?

A. (Nodded.)

Q. I have a few follow-up questions for you just to kind of summarize so that I understand. So if you can't hear me, if I ask you a question that you don't understand, just let me know. All right?

A. Yes. You're kind of far.

Q. Yeah, I am kind of far, and I'm fairly soft-spoken, so I'll try to keep my voice up. But if you can't hear me, you let me know—

A. Okay.

Q. —or just say, Speak up. All right?

A. Okay.

Q. As I understand it, your first encounter with Mr. Howell was on the psyche unit?

A. Yes.

Q. Okay. You were not present when Mr. Howell was evaluated down in medical; is that right?

A. No, I wasn't.

Q. At the time of your encounter with Mr. Howell, though, you were aware that he had been evaluated in medical; is that correct?

A. Yes.

Q. One of the things you had said before is that when an inmate or a patient is put into a restraint chair, a nurse or an LPN, someone from medical will take vital signs.

A. Yes.

Q. Is that correct?

If we look on Exhibit 28, at the top, I see some vital signs listed there. Do you see that?

A. Yes.

Q. I understood it may not be in your handwriting.

A. It's not my handwriting.

Q. But it does appear that vital signs were taken?

A. They were taken.

Q. And we don't have to go over all the numbers, but as you look at those numbers, are those—is it fair to say those vital signs are stable?

A. (Examining document.) Let's see. (Reading) 56, 90. I can't see the first . . . Slightly elevated. But when someone is angry and agitated, then, you know, the blood pressure will go up and the pulse.

Q. Okay.

A. Yes, when people are agitated, it goes up.

Q. So an inmate or a patient like Mr. Howell who was agitated—and you used a couple of other words to describe him—would these vital signs be unusual or concerning to you from a vital sign standpoint?

A. No. We—usually, we check, you know, just before we take them out of the chair because by then, they have come down. It is elevated when—so it's not cause for concern at the time, no.

Q. Understood. You had said earlier that inmates or patients in restraint chairs is something that you see often on the psyche unit?

A. Almost daily basis, and sometimes multiples in one day.

Q. Yeah. And how many years have you worked on that unit?

A. Well, I thought it was 18 years. I don't know why—longer than—but it appears it's 15.

Q. And you were asked some questions about the time that patients or inmates are in restraint chairs. Are there occasions where inmates are in these chairs longer than four hours?

A. Yes.

Q. Sometimes less than four hours?

A. A lot of times less than four hours. You know, two hours is kind of the average, but—you know, for people to simmer down, so to speak. We have had cases where people stayed longer than six hours, yeah.

Q. Sure. Depending on the circumstances?

A. Depending on the behavior and how dangerous they are to themselves.

Q. If we go back to Exhibit 28 in the notations that you made at 18:20—I know you were asked about this, but that's in your handwriting?

A. That's my handwriting, yes.

Q. And you noted A for alert, right?

A. Alert.

Q. And then you noted an L, and that was for angry, yelling, threatening?

A. Yes.

Q. Which is what you described before?

A. Yes.

Q. You also noted Z, no signs or symptoms of distress. Do you see that?

A. Yes.

Q. What does that mean to you, just in general?

A. Well, I mean, distress would be difficulty breathing, maybe perspiring, signs of discomfort in the patient, and I did not see anything like that.

Q. Okay. And you observe or check on these patients or inmates in restraint chairs every day—

A. Yes.

Q. —you go to work, right?

A. Yes.

Q. Based on what you have written here and the recollections that you do have, would it be fair to say that when you observed Mr. Howell, you did not believe that he had a serious medical condition?

A. No. No, nothing that caught my attention at all.

MR. WELCH: I think that's all the questions I have for you. Thank you.

MR. KIRCHER: No follow-up.

MR. HOJNOSKI: We'll read.

MR. MCGRAW: We are going off video at 11:51.

(Whereupon, signature was requested, and the deposition concluded at 11:51 a.m.)

_____

PIERETTE ARTHER

RESTRAINT AND SECLUSION POLICY

SECTION 10: MEDICAL-LEGAL ISSUES

Restraint and Seclusion

Policy Revised: 09/19/2014

NCCHC Standard: Restraint and Seclusion (J-I-01)

ACA Standard: Use of Restraints (4-ALDF-4D-21)

Purpose

To establish criteria and procedures for the application and use of therapeutic restraints and/or seclusion with patients who require them for clinically indicated reasons, and to establish procedures for health staff to follow when dealing with custody ordered restraints.

Policy

Restraints and/or seclusion will be used for the safety of a person and the security of the institution. Restraints and/or seclusion are not to be used as punishment or for the convenience of staff. They are to be used only when less restrictive means are not effective.

Procedure

Restraint Procedures

1) Before considering the use of clinically indicated therapeutic restraints, staff will attempt to assist the patient by less restrictive interventions, including, but not limited to:

a) Talking to the patient in a calm manner in an attempt to de-escalate the situation;

b) Placing the patient in therapeutic seclusion without resorting to the use of therapeutic restraints, if possible;

c) Offering medication if ordered by an advanced clinical provider; and

d) Administering emergency medication if ordered by an advanced clinical provider.

2) When feasible, staff will encourage patient compliance during the application of restraints by calmly explaining the restraint procedure, reasons for the decision to restrain and the behavior required to terminate the use of restraints.

3) With regard to clinically ordered restraints, the following policies and procedures apply:

a) Patients are to be restrained only in situations in which, due to self-destructive or violent behavior, there is imminent threat of substantial bodily harm to the patient, to others, or to property as a consequence of the patient's mental or physical illness; and less restrictive means have been proven to be ineffective or have been tried and not achieved their objective.

i) The application of any clinically ordered restraints must be ordered by an advanced clinical provider either in writing or via telephone consultation.

ii) A physician order can be obtained at any time for clinically indicated reasons

and is to specify the type of restraint, emergency or PRN medication if appropriate, and any other special considerations for a maximum duration of no more than six (6) hours or as permitted by law.

iii) The advanced clinical provider, in consultation with the nursing and/or mental health staff, may authorize additional restraints not to exceed six (6) hours, or as permitted by law, with appropriate continued nursing reassessment and monitoring.

b) Only authorized restraints may be used on patients who are experiencing mental or physical crisis. These must be designed specifically for restraint.

c) Clinically ordered restraints will be applied by security staff.

d) Patients will not be restrained in a manner which could jeopardize their health.

i) Potentially harmful objects that might interfere with the restraints will be removed from the patient while he/she is restrained.

ii) Clothing should be removed as soon as possible to minimize the possibility of patient self-injury with a hidden object, and the patient provided a suicide-resistant gown/blanket. If possible, same-sex staff should remove the patient's clothing. Every effort will be made to ensure patient dignity.

iii) The patient is not to be restrained in an unnatural position (for example. hog-tied, face-down, spread-eagle).

iv) An advanced clinical provider may issue an order to modify the standard position due to medical reasons or otherwise. This will be clearly documented on the physician order sheet and in progress notes.

e) The physical care of the patients in restraints will be monitored regularly by the ordering advanced clinical provider and health care staff as outlined below:

i) Liquids will be offered at least once every two (2) hours while the patient is awake;

ii) Observation for signs of circulatory or respiratory distress abrasions, irritation, injury, or other dysfunction will occur every 15 minutes while the patient is in restraints;

iii) Monitoring of extremities for color, temperature, and pulse will occur every 15 minutes while the patient is in restraints;

iv) Vital signs will be monitored and recorded every shift and/or as needed;

v) Meals will be provided which may consist of foods not requiring use of utensils;

vi) Elevation and lateral turning of the patient's head will occur when providing food or liquid to prevent aspiration;

vii) With the assistance of the correctional staff range of motion exercises will be provided every two (2) hours while the patient is awake; and

viii) Toileting needs are to be offered hourly.

f) PRN orders for therapeutic restraint are expressly prohibited.

g) Every effort will be made to minimize the length of time it is necessary to keep a patient in restraints.

h) Prior to the end of the restraint period, security and treatment staff will consult to evaluate any further needs of the patient and may consider a transfer order to inpatient psychiatric treatment or any other appropriate medical intervention.

i) A nurse will schedule and implement a review of the patient in restraint every fifteen (15) minutes for the duration of the restraint. If the patient appears to be asleep at the scheduled review time, it is permissible to document on the Restraint/Seclusion Observation Log by the registered nurse that the patient was reviewed, appeared to be in no distress, and the decision was made not to disturb the patient. The circulation and respiration status will continue to be observed every fifteen (15) minutes.

j) Nursing and/or mental health staff will communicate verbally with the patient in restraints every fifteen (15) minutes to access the need for continued restraint unless con-

tinued restraint is ordered by an advanced clinical provider.

k) Restraints can be removed when a patient is clinically assessed by the advanced clinical provider, or nursing/mental health staff in consultation with the advanced clinical provider, to no longer be a risk of harm to self or others, is no longer agitated, and able to verbalize the ability to maintain control of his/her behavior.

l) Restraints must be removed at the time-limited conclusion of the physician's order if an order to continue therapeutic restraints has not been obtained.

m) Restraints will be removed by security staff with the assistance of health care staff, if requested. Sufficient security staff will be present when therapeutic restraints are removed to provide patient control as needed.

n) The shift commander is responsible for coordinating the security aspects of the therapeutic restraint process.

4) With regard to custody-ordered restraints:

a) Patients placed in custody restraint for security reasons may be restrained per facility standard operating procedures.

b) The security staff will notify the nursing staff in order to:

i) Review the health record for any contraindications to restraints or necessary accommodations.

ii) Initiate health monitoring of the patient with all documentation to be maintained on the Restraint/Seclusion Observation Log.

iii) Contact the appropriate advanced clinical provider if clinically indicated.

iv) The nurse will notify mental health staff.

c) Should the health care staff note improper use of restraints which may jeopardize the health of a patient, all concerns will be immediately relayed to the appropriate institutional authority.

Seclusion Procedures

1) Before considering the use of clinically indicated therapeutic seclusion, staff will attempt to assist the patient by less restrictive interventions, including, but not limited to:

a) Speaking with the patient in a calm manner in an attempt to de-escalate the situation;

b) Offering medication if ordered by an advanced clinical provider; and

c) Administering emergency medication if ordered by an advanced clinical provider.

2) Whenever feasible, staff will encourage patient compliance with therapeutic seclusion by calmly explaining the seclusion procedure, the reasons for the decision to use therapeutic seclusion, and the behavior required to terminate the use of therapeutic seclusion.

3) With regard to clinically ordered therapeutic seclusion, the following policies and procedures apply:

a) The Health Services Administrator, an advanced clinical provider, or mental health staff will be notified when a patient in placed in therapeutic seclusion with documentation included in the patient's health record.

b) Patients are to be secluded only in situations in which, due to self-destructive or violent behavior, there is an imminent threat of substantial bodily harm to the patient, to others, or to property as a result of the patient's mental or physical illness; and less restrictive means have been proven to be ineffective or have been tried and not achieved their objective.

c) Therapeutic seclusion is a less restrictive means to achieve the objective of patient stabilization and will be considered prior to the use of therapeutic seclusion.

4) The physical care of the patients in therapeutic seclusion will be monitored regularly by health care staff as outlined below:

a) If liquids are not available in the seclusion room, liquids should be offered at least once every two (2) hours while the patient is awake.

b) Meals will be provided which may consist of foods not requiring use of utensils.

c) If a toilet is not available in the seclusion room, toileting needs are to be offered hourly.

d) PRN orders for therapeutic seclusion are expressly prohibited.

e) Every effort will be made to minimize the length of time it is necessary to keep a patient in therapeutic seclusion.

f) Prior to the end of the restraint period, security and treatment staff will consult to evaluate any further needs of the patient and may consider a transfer order to inpatient psychiatric treatment or any other appropriate medical intervention.

g) Nursing staff and/or institutional staff, when more appropriate, the mental health staff will schedule and implement a review of the patient in therapeutic seclusion at irregular intervals of fifteen (15) minutes and at least every eight (8) hours by a qualified health care professional for the duration of the seclusion. If the patient appears to be asleep at the scheduled review time, it can be documented on the Restraint/Seclusion Observation Log by nursing or the mental health staff that the patient was reviewed, appeared to be in no distress, and the decision was made not to disturb the patient.

h) Therapeutic seclusion can be removed when a patient is clinically assessed by the advanced clinical provider or nursing/mental health staff in consultation with the advanced clinical provider, to no longer be a risk of harm to self or others, is no longer agitated, and able to verbalize the ability to maintain control of his/her behavior.

i) The patient will be removed from therapeutic seclusion by security staff with the assistance of health care staff, if requested.

j) The shift commander is responsible for coordinating the security aspects of the therapeutic seclusion process.

Documentation Procedures

1) The Restraint/Seclusion Observation Log will be initiated immediately.

2) Documentation by medical and/or mental health staff is to include the following information:

a) The patient's behavior immediately prior to the decision to use restraints or seclusion;

b) The clinical justification for the use of restraints or seclusion rather than less restrictive interventions;

c) Documentation of physician notification;

d) The type of restraint or seclusion ordered;

e) The patient's behavior during application of restraints or seclusion;

f) Date and time that restraints or seclusion were applied;

g) Progress note updates;

h) The justification to remove the patient from restraints or seclusion;

3) Documentation pertaining to the use of physically immobilizing restraints or seclusion must be written prior to the staff exiting the site upon completion of their shift.

4) Physician orders for restraints will indicate the objective for initiation of the application of restraints (e.g., protection of self or others), type of restraint, date and time procedure initiated, and duration of the order.

5) The advanced clinical provider must be consulted at a minimum of six (6) hour intervals for the duration of the restraint.

Quality Assurance Review

1) The application of therapeutic restraints and seclusion will be an annual component of the NaphCare CQI program.

State Regulations

1) Recognizing that state regulations may regarding the use of restraints and seclusion may differ between states, each NaphCare, Inc. facility will, in conjunction with the corporate office, create an addendum to this policy as necessary to conform to state regulations regarding the use of restraints and seclusion.

Relevant Forms

Restraint-Seclusion Observation Log

References

Restraint and Seclusion (J-I-01).
National Commission on Correctional Health Care: Standards for Health Services in Jails, 2014.

Use of Restraints (4-ALDF-4D-21).
American Correctional Association: Performance-Based Standards for Adult Local Detention Facilities, Fourth Edition, 2004.

American Correctional Association: Standards Supplement, 2014.

DEPOSITION OF CURTIS EVERSON, M.D.
(DECEMBER 18, 2020)

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

_____

KARLA HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

_____

Case Number: 1:19–cv–00373

Before: Kelly GREEN, RPR, Notary Public.

CURTIS EVERSON, M.D.,

CURTIS EVERSON, M.D., a witness herein, having been duly sworn, was examined and testified as follows:

CROSS–EXAMINATION

BY MR. KIRCHER:

Q. Good afternoon, Dr. Everson. My name is Konrad Kircher. And along with Ryan McGraw, we represent the estate of Cornelius Howell in a lawsuit that's been filed against NaphCare and certain county defendants.

How are you today, sir?

A. So good so far.

Q. Okay. Good. Would you please give us your full name.

A. Curtis B. Everson.

Q. Dr. Everson, I was given Exhibit 37 which is, as I understand it, is a curriculum vitae that you have prepared recently or updated recently; is that right?

(Plaintiff's Exhibit 37 marked.)

A. Yes.

Q. All right. Thank you for doing that because that will certainly speed things up. Is that a true and accurate reflection of your educational and professional background to date?

A. Yes, for myself, yes.

Q. All right. So that's all we need to do with that. I see that you have been employed by NaphCare since 2013; is that right?

A. Yes.

Q. And what–what is your current title?

A. Medical director.

Q. And how long have you held that title for NaphCare?

A. Since May of 2013.

Q. All right. So you were hired in as the medical director?

A. Yes.

Q. And what are your daily duties in that role?

A. It's to oversee, basically, clinical care, which is basically taking care of the inmates personally, and overseeing my nurse practitioner.

Q. Okay. And did you say nurse practitioner, singular?

A. Yes. Well, it's now two. I have a women's health nurse practitioner and a general medical nurse practitioner, adult medicine.

Q. Okay. What are your typical hours?

A. It's highly variable, but mostly it's going to be about 9:00 to 5:00, 9:00 to 6:00, 9:00 to 7:00.

Q. Is that 9:00 a.m. to 5:00 or 6:00 p.m.?

A. Yes.

Q. And during those hours, are you physically located in the Hamilton County Justice Center?

A. Yes, the majority of the time.

Q. Okay. When you're not in the Justice Center while on duty–well, I guess, are you basically on duty 24/7?

A. You could say, yes. When I'm not on call–usually, my nurse practitioner alternates call with me. So when we're–when we're both out of the building, one of us will take call.

Q. Okay. So when you–when you said that you're mostly in the Justice Center between 9:00 to 5:00 and 9:00 to 6:00, during those hours, where would you be if you were not in the Justice Center, for example?

A. Probably trying to get lunch locally.

Q. Okay. All right. But as far as providing medical services, that's–you do that in the Justice Center, correct?

A. That's correct, yes.

Q. Okay. Let's talk a little bit about the organizational chart. I guess, let's work upwards. To whom do you report?

A. I report to Maria, and then I also report to a corporate medical director. There is an Eastern states corporate medical director and an overall corporate medical director. So there's, like, basically, two immediate and one that's kind of over everything. And so I have, like, three different bosses.

Q. You mentioned Maria. Do you mean Maria Perdikakis?

A. Yes.

Q. Okay. And we've met her. So do you report to her in the administrative chain?

A. Yes.

Q. She doesn't direct you in the provision of your medical services, does she?

A. Can you be more specific with regards to that question?

Q. No. I better throw it back to you, so–but let's leave Maria aside for a minute. You then mentioned something about Eastern corporate?

A. Yes. There's a medical director that covers the eastern half of the United States for NaphCare

who–who is my boss, who directs certain things–who puts certain protocols into place that we tend to have to follow.

Q. Okay. Where is that person located?

A. In Alabama.

Q. And is that person a medical doctor?

A. Yes.

Q. So when that medical doctor provides you with a certain protocol about medical services, does Maria Perdikakis have any input into that?

A. Maria can then suggest–make suggestions or–or do what she would want to do locally.

Q. Okay. Is it your understanding that Maria is fairly autonomous in her local role?

A. As far as what Maria does, Maria can tell you more what she does. I can only tell you what I see. So I really couldn't comment more on what she's able to do and can't do. I know that, basically, she's my boss. If she says, You can't do this, then I can't do it.

Q. Okay. All right. So I think you said you have three bosses. I think we've talked about two now. Who is the third one?

A. The other one is the overall NaphCare medical director, and he's over both the east and west of the United States.

Q. And where is that person located?

A. He's also in Alabama.

Q. All right. Okay. Now let's talk about the organizational chart going down. So what role–or what positions do you oversee?

A. I oversee my nurse practitioners.

Q. Okay. And you have two of those?

A. Yes.

Q. What about nursing staff employed by NaphCare in the Hamilton County Justice Center?

A. Nursing staff is under Maria and Kenya.

Q. Okay. And that's Kenya Lewis?

A. That's correct.

Q. Director of nursing?

A. Yes.

Q. Okay. NaphCare also employs a psychiatrist in the Hamilton County Justice Center; isn't that right?

A. That's correct.

Q. And what is your relationship to that position in the organizational chart?

A. Basically, he is a person that I make recommendations to if I can make recommendations locally, but he has a boss also in Alabama that is over him.

Q. And is Maria one of his bosses as well?

A. That, I don't know, so I couldn't say. But Maria has local control over everything local here at Hamilton, as far as I'm aware of.

Q. Are you and the psychiatrist peers in the organizational chart; in other words, on similar levels?

A. He is a provider just like I'm a provider and my nurse practitioners are providers, but I basically am the person who makes recommendations locally medically.

Q. Do you have any involvement in overseeing mental health services of NaphCare?

A. The mental health is overseen by the corporate people in Alabama.

Q. I guess what I'm trying to understand is are the medical services in Hamilton County Justice Center provided through you, your nurse practitioners, and Kenya Lewis's nurses; whereas, mental health services are provided through the psychiatrists and Pierette Arthur, for example?

A. Pierette is a nurse, and so she's under the nurses that–that's managed by Kenya. The psychiatrist is a provider that is also directed with regards to psychiatric issues from Alabama.

Q. Okay. What have you done to prepare for this deposition, Doctor?

A. I looked at your Exhibits 36 through 39.

Q. Okay. Have you looked at any other documentation?

A. No.

Q. Okay. Have you reviewed any deposition transcripts?

A. No.

Q. Have you talked to anyone other than Mr. Hojnoski about what you would be asked in this deposition?

A. No.

Q. Let's go back to the concept of autonomy for the Cincinnati office. So it's my understanding that your corporate office in Alabama prescribes certain protocols, and that in early 2018, the Cincinnati office decided to develop its own protocols for restraint chairs. Is that consistent with your understanding?

A. No, not that I'm aware of.Basically, most of the protocols are–are dictated from Alabama, and we basically try to enforce those protocols.

Q. Okay. What's your understanding as to what authority Cincinnati has to deviate from corporate policies and protocols and develop its own policies and protocols?

MR. HOJNOSKI: Objection, speculation. You can answer if you know.

A. That, I don't know of–of our ability to deviate from what they want without their–without their approval.

Q. Okay. I guess I should go back and establish some foundation. Have you, in your role as medical director, been involved in developing protocols for the Cincinnati office?

A. We have been involved in some development of protocols where there hadn't been any that

existed and then submitted for approval to the corporate office.

Q. Okay. And my question was whether you had been involved, and you answered by saying "we" have been involved. Who did you mean by "we"?

A. Well, basically, my nurse practitioner and I, we collaborate on what would work best for us because we–we work as a team.

Q. Okay. Let me–there was–I didn't share this exhibit with you. It was used in a previous deposition, and I apologize for that.

MR. KIRCHER: Bob, I'm going to show him Exhibit 34.

MR. HOJNOSKI: Can you give me one minute? My other exhibits are on my computer, and I just got to sign–my battery is about to die. I just need to go get a charger.

MR. KIRCHER: Tell us when you're ready.

(A brief break was taken.)

Q. (By Mr. Kircher) All right.

Dr. Everson, I've got the top of a document on the screen. It was used in a prior deposition as Exhibit 34. Do you recognize this as a corporate policy?

A. It has the–the way that the policies look, yes.

Q. Were you familiar with this particular policy on Restraint and Seclusion?

A. Probably.

Q. All right. So this is developed by the folks in Alabama and then promulgated out to the different branches; is that right?

A. That's correct.

Q. Okay. And so when I was asking you before about autonomy, this is an example of what I was referring to. Can the Cincinnati office choose to modify this for its own–for its own particular role?

A. If there are things that cannot necessarily be done, it'll be something that Maria may decide to change in conjunction with the jail.

Q. Okay. And–all right. So now let's look at Plaintiff's Exhibit 36. And I think you have that in front of you, don't you?

A. Yes.

MR. KIRCHER: All right. Kelly, I'm going to–I'd like to stop sharing, so I'm going to–all right. Now we're back.

Q. (By Mr. Kircher) Are you–have you seen Exhibit 36 before your preparation for this deposition?

A. I can't necessarily say if I may have seen it before, but it seems like it might be the first time I'm seeing this.

Q. Okay. And this is from Kenya Lewis, and she says, Happy Valentine's Day, staff. There has been some recent changes to the restraint chair policy. And her email is dated February 14th, 2018.

Do you remember being aware of any changes to the restraint chair policy at that time?

A. I can't say at that time, but there's been many changes to the restraint chair policy.

Q. And what's your understanding as to why those changes have been made?

A. Periodically–

MR. HOJNOSKI: Objection. You can answer if you know.

A. Periodically–

MR. SCHAFFER: I'll join in the objection. Thank you.

A. Periodically, things get reviewed, and so things are updated or changed for better practice.

Q. Do you remember that this particular change decreased the frequency of NaphCare staff's checks on inmates that were in restraint chairs?

A. I think I remember something to that, but I'm not a hundred percent certain.

Q. Were you involved in developing a lesser frequency of those checks?

A. I don't think I made that decision. Q. Were you asked for any input?

A. That, I don't recall.

Q. Were you ever involved in determining whether this new policy reflected in Plaintiff's Exhibit 36 was followed with regard to the care provided to Cornelius Howell while he was in the restraint chair?

A. Can you state that plainer?

Q. Let me try. So Kenya Lewis in Exhibit 36 in the second sentence says, When a person is put in the restraint chair, we will–we will check the restraints and obtain vitals as normal. Then in two hours, the person must be rechecked.

So my question is did you ever determine whether that policy reflected in that sentence was followed in the case of Cornelius Howell?

A. I think the documentation kind of points that out, I think.

Q. I didn't hear what you said. It points what, please?

A. It points to the time periods of when that person was checked, so it would–it would be in the documentation.

Q. Right. And did you ever look at that documentation to determine whether the policy had been properly implemented?

A. I can't necessarily say when I looked at it as far as that part. In general, we do a review of things that could be done better, and so that may have been in one of the things I may have commented about.

Q. That would be in the documents we're going to look at if, indeed, you had reviewed that, right?

A. It may. It may.

Q. Well, are you able to say now whether Cornelius Howell was checked by a NaphCare employee two hours after he was placed in the restraint chair?

A. I would have to actually look at the time signatures; then I could tell you.

Q. And we can all do that, but you don't recall ever looking into that issue?

A. I could have; but again, I don't recall it right now.

Q. Okay. And you don't recall right now without looking at the documents whether or not he was checked two hours after being placed in the chair, right?

A. No, I don't.

Q. Okay. All right. Let's turn to something else. What is a Medical Audit Committee?

A. That, I'm–we don't have a Medical Audit Committee.

MR. HOJNOSKI: Look at the top page of that, 38.

(Plaintiff's Exhibit 38 marked.)

A. I don't–I don't think we call it that. It may be under something else that we call it, but I don't–I don't recall it being labeled as that.

Q. Okay. And you're looking at Exhibit 38, correct?

A. Yes.

Q. That at the top says, NaphCare, Incorporated, Hamilton County Justice Center, Medical Audit Committee Minutes, correct?

A. Yes, that's what it says.

Q. All right. And it shows that you were an attendee as medical director for NaphCare; is that right?

A. Yes.

Q. And do you recall participating in quarterly meetings of this type?

A. We have quarterly meetings that meet with the sheriff on a routine and regular basis, and it discusses a multitude of different things that we do at the jail.

Q. Such as the number of ER runs in the previous three months, the number of clinic calls, things like that?

A. That's correct.

Q. The census numbers, the number of inmates on certain dates, all of the–all those statistics, right?

A. That's correct.

Q. But what you're–what you're taking issue with is that you have never called them Medical Audit Committees; is that right?

A. That's correct. They call–what we call it is MAC meeting, M–A–C meeting. So I guess if you say Medical Audit Committee or–I guess that would be the MAC–the MAC meeting that we have. But I know it as a MAC meeting. I don't–I don't–I've never recalled it as a Medical Audit Committee at all.

Q. Okay. Do you know whether MAC stands for anything other than Medical Audit Committee?

A. I never knew it stood for Medical Audit Committee. But the only thing I said is–I only know that these type of things we call it as a MAC

meeting, but I never knew it as a Medical Audit Committee meeting.

Q. Okay. Well, I'll just refer to it as a MAC meeting, then.

A. Okay.

Q. So what's your–what's your understanding of the purpose of a MAC meeting?

A. It is to give information to the sheriff and his designees, information with the ongoings of the health care at the jail.

Q. So NaphCare presents the information to the sheriff and his staff?

A. That's correct.

Q. And we see the attendees on the top of this Exhibit 38. Is that typically who attends those meetings?

A. The last three on the right–hand side of the group from the NaphCare, they don't typically attend, and the . . . I'm not for certain about Sampson. Some of the people on the left, they changed. They're not always the same. And so I'm not for certain who Captain Sampson is, but the others, I think, are usually there at those meetings.

Q. Okay. Let's look at those last three on the right column. The first one, Brad McLane, Chief Operating Officer, Administration, where is his office?

A. In Alabama.

Q. Okay. Do you know why he attended this particular meeting?

A. No, not at all.

Q. Was it because of the death of Cornelius Howell?

A. No, not at all. I'm not for certain, you know, why that happens; but he periodically comes to Cincinnati to either meet with the sheriff or to discuss things with the staff here. But, no, it wasn't about the death.

Q. Okay. And Emily Feely–

A. At least–at least I don't think so.

Q. Okay. Emily Feely, Chief Medical Officer, where is her office?

A. In Alabama. The last three are all in Alabama.

Q. Okay. And was Emily Feely one of your bosses at that time?

A. Yes.

Q. Did I freeze up, or did the . . .

THE REPORTER: No.

MR. KIRCHER: Okay.

THE REPORTER: He answered yes.

MR. KIRCHER: I'm sorry. I didn't hear that. Mine must have frozen.

Q. (By Mr. Kircher) Okay. So she was one of the–the answer was yes, she was one of your bosses at the time?

A. Yes.

Q. Okay. And Gina Savage, Senior VP of Administration, also headquartered in Alabama?

A. Yes.

Q. Do you know why–Do you know why Dr. Feely or Gina Savage were at this meeting?

A. Nope. Again, they periodically come up to Cincinnati to meet with the staff to discuss, you know, certain things, different things.

Q. Okay. Do you keep notes in this meeting–in these meetings?

A. No, because most of this–most of this information has already been done and it's already been produced. It's just a summary of what has happened in the previous three months.

So there's no notes to really keep other any–other than mental notes from what is said in the meeting from the sheriff and the designees there.

Q. It indicates that the secretary of the meeting is Sherry Richmond. Is she the one who prepares these minutes, as far as you know?

A. Yes.

Q. Does she circulate the minutes for approval?

A. She passes out the packets, and we go through the packets.

Q. Okay. All right. Let's leave this exhibit for a minute. How did you first learn of the death of Cornelius Howell?

A. By phone call.

Q. Phone call from whom?

A. I can't remember who it was, but it was a phone call. It could have been from Maria. It could have been from one of the nurses.

Q. And do you remember–

A. But that's–

Q. –approximately–

A.–that's what I think because this has been such a long time ago, so . . .

Q. Okay. And do you remember approximately when you got the phone call compared to when he was found unresponsive?

A. No. I don't necessarily know when I got the phone call compared to then, no, I don't.

Q. In other words, he–I think he was found unresponsive around 21:45 or something like that. Do you believe you received the call that same evening?

A. That, I–that, I don't know if I got the call that he died that same evening or later. Usually, when there's a death, I get notified pretty quickly afterwards. So I can't say in this particular case when that happened.

Q. And is there a standard procedure that you follow as the medical director after a death in the jail regarding an investigation, review of the circumstances?

A. After each death, we try to do like a QA type of thing to see what we can do better to make

improvements so that we may not have an adverse event occur.

Q. And when you say QA, do you mean quality assurance?

A. Yes.

MR. HOJNOSKI: Objection as to privilege. You can go ahead.

A. Yes.

Q. Okay. And in the Cornelius Howell case, what was the first steps that you–what were the first steps that you took with regard to the QA–Q and A–QA process?

A. I kind of go through the chart and look at the chart and fill out the form that is on the back of Exhibit 38, page 34.

Q. All right. And–well, let's see. Does that have a date on it as to when you did that?

A. 12/10.

Q. Okay. So you believe you reviewed the chart on December 10th of 2018 and then filled out this form soon after that?

A. Yes.

Q. And then once you filled out this form, what involvement did you have afterwards in reviewing the circumstances of the death?

A. You mean like right then, or are you talking about, you know, months later or weeks later or . . .

Q. Well, so it would have been, what, a month or so later you would have reviewed the coroner's report, right?

A. Yes. It takes about–it takes about eight weeks for it to come back, yes.

Q. Okay. So that's something else you did after filling out this report. Is there anything else you did after filling out this report besides reviewing the coroner's report?

MR. HOJNOSKI: Objection in terms of any contact with legal departments, of course; but if it's anything else, you're free to–you're free to testify to that.

A. We just, you know . . . Do we . . .

MR. HOJNOSKI: Anything privileged–if the corporate legal department is connected in any way is privileged, but if there's anything else you did locally that's not part of that–you know, that's consistent with the MAC meeting or whatever's in there, you can testify to.

A. Okay. No, just the–you know, just this, our paperwork, and then our regular policies.

Q. Okay. And the paperwork here in Exhibit 38 was for the purpose of informing the sheriff's department, right?

A. It is the–it is for the–it's for the purpose of . . .

MR. HOJNOSKI: Just pause for a second. Konrad, just so I'm clear, you said Exhibit 38 which is the entire MAC packet that takes–you know, consists of three months of data and things, so I

just want to be clear what you're asking him about.

Q. Yeah. So you pointed us to page 34 of Exhibit 38, and–

A. Yes.

Q. –and that was included in the materials that were given to the sheriff's department at the MAC meeting, right?

A. That's correct.

Q. Okay. And the purpose of providing that to the sheriff's department at the MAC meeting was to give the sheriff's department information about what happened to Cornelius Howell, correct?

MR. HOJNOSKI: Objection. If you know.

A. The purpose is–for this form being filled out is a policy that I have to do according to NaphCare. What they do with it after that is up to NaphCare.

Q. Okay. You're following a corporate policy to fill out that form, right?

A. That's correct.

Q. No lawyer asked you to fill out that form, did they?

A. No.

Q. Okay. At any time in the process, did you review any video from within the Justice Center to determine whether any NaphCare personnel did their jobs correctly?

A. A video, I did not review, no.

Q. Did you review any videos of Cornelius Howell while he was in the restraint chair?

A. No, I didn't.

Q. All right. Let's stick with Exhibit 38, then. Do you have an independent recollection of this meeting?

A. At this time, the only thing I have is basically what I did on that day, which is what's written.

Q. I'm sorry?

A. Only thing I have memory–wise is what's written down. I don't remember a whole bunch after that.

Q. Okay. And what I'm asking is did . . . Let's see. I'm looking at the first page of Exhibit 38. I guess it doesn't say where in the Justice Center this meeting occurred. Do you recall where it occurred?

A. All the MAC meetings are held at the sheriff's department.

Q. In what department, please?

A. Sheriff's department conference room.

Q. Okay. And so do you–do you have an independent recollection of sitting in that room and discussing this MAC meeting for this particular period?

A. No, I don't really remember, there's so many of them. So, no, I don't remember specifically.

Q. Okay. Fair enough. So let's go to the bottom of the first page of Exhibit 38, and it runs onto the top of the next page where it–it's under the cate-

gory of Health Care Utilizations, and it has numbers for October, November, and December 2018. Do you see that?

A. Page 38?

Q. No. Page 1 of Exhibit 38.

A. Okay. Okay. Okay. All right.

Q. So the bottom of page 1 is section III(c) that has Health Care Utilitizations, and it carries onto the next page.

A. Okay.

Q. And it's–

A. All right.

Q. So looking at those data, does December 2018 look any busier than any other month, or was it kind of average?

A. When you say busy, you know, busy is all relative. It always feels the same.

So I can't necessarily say by that. The numbers here don't tell you all the efforts that's put into taking care of the individuals, so I can't necessarily answer that question.

Q. Okay. But it's up to NaphCare to staff your company properly, isn't it, to meet the demand?

MR. HOJNOSKI: Objection.

A. That's–that's something that NaphCare has to answer. I couldn't answer that.

Q. Well, you are the medical director of NaphCare in the Hamilton County Justice Center, right?

A. That's correct, but that's something that you might have to ask Maria about.

Q. Okay. So you don't have anything to do with staffing of the–of the medical care there?

A. No. That's all Maria.

Q. Okay. If you–if you feel you and your nurse practitioners are just getting slammed and you can't keep up with the workload–well, have you ever had that situation?

A. Being so slammed that we can't keep up? Basically, I think we do a pretty good job taking care of our individuals. So I'm sure that if we ever had an issue where it is unbearable, that that would kind of affect our license and our ability to continue to provide for our family. So either we would either communicate that up the chain or either quit.

Q. And since you've been employed there since 2013, you feel you're adequately staffed; is that right?

A. I would probably say that that's something that you would have to ask more NaphCare as far as what they need to do and ask the sheriff's department because they all do studies with regard to those type of things; and so that's something that you will have to ask the sheriff's department and NaphCare.

Q. You, as medical director in the Hamilton County Justice Center, don't have an opinion as to whether or not you're adequately staffed to provide medical services?

MR. HOJNOSKI: Objection, overbroad, vague. You can answer if you have an answer.

A. Basically, the only thing I'm . . . I do is try to do the best job we can given objectives of taking care of the individuals.

Q. All right. Have I given you a full opportunity to answer that question, Doctor?

A. I would say, again, you will have to ask NaphCare and the sheriff's department with regard to staffing.

Q. Yeah, and we can, but I'm asking you. And I just want to know have I given you now a full opportunity to answer that question?

MR. HOJNOSKI: Subject to my objection of overbreadth, vagueness, irrelevance. You can answer if you have a different answer.

A. Again, those would be the people you'd have to ask the question to.

Q. You don't have an answer, then?

A. That's–again, I would say you have to ask them.

Q. All right, Doctor, well, the record will reflect I've given you about six opportunities to answer that question, so we'll move on.

If you go to page 4, you'll see a section G, as in golf, that says, Sentinel events. And this reflects that Cornelius Howell was the only death in the last quarter of 2018, right?

A. Yes, I think that's what it shows.

Q. Approximately how many deaths are there per year on average in the Justice Center?

A. That, I don't–

MR. SCHAFFER: Objection.

MR. HOJNOSKI: Same objection.

A. That, I don't know or recall. (Audio glitch and reporter clarification.)

Q. Well, the report that you showed us on page 34 of this Exhibit 38, how many times have you filled out a form like that?

A. More than three.

Q. More than five?

A. Possibly. It depends on what–what it shows. Not per year, I don't think, but I'm sure they got stats on that.

Q. So since you've been medical director at the Hamilton County Justice Center, you've filled out more than three of those, right?

A. Yes.

Q. Have you filled out more than ten of those?

MR. HOJNOSKI: Objection, speculation.

A. Like I said, I don't know. You have to look at the stats. They keep records of all of that.

Q. Well, but I'm asking you, Doctor. You've been doing that job every day since 2013. I'm just asking you.

A. The numbers–the numbers I don't necessarily know, so I can't tell you what–how many I've done. I know I've done more than one. I know I've done more than two. I've done more than three in the last past seven, eight years. So I

can't necessarily give you an accurate number of how many there had been.

Q. But that's the best you can do is that you've done more than three?

A. Deaths aren't my favorite thing.

Q. I didn't ask you anything about your favorite thing. I asked you how many of those reports have you filled out.

A. That, I don't know. I said that too.

Q. And more than three is the best answer you can give me?

A. I filled out more than three. I don't know the number–don't recall the number.

Q. All right. Let's go to page seven of Exhibit 38. Are you there?

A. Yes.

Q. Okay. And on the top, the heading is Hamilton County Justice Center December '17, dash, December '18, Statistical Comparison Report. Do you see that?

A. Yes.

Q. And let's take the first line. So Average Population, that means the number of inmates in the Justice Center at a given time, right?

A. I take that to be what they say, yes.

Q. And the first category is December '17. That means December of 2017, there were an average of 1,570 inmates in the Justice Center, right?

MR. HOJNOSKI: Objection. Only if you know what those numbers refer to.

A. Again, I don't know the whole thing. That's something that Maria and Sherry can kind of tell you what those–what that information is; but I would say on average, that's what they're trying to say.

Q. Okay. Do you review these statistics before or during these MAC meetings?

A. During the MAC meetings.

Q. Okay. And during the MAC meetings, do you have an understanding as to what they are?

A. In general.

Q. Okay. So let's stay with that line. The next category would indicate the number of inmates on average during December 2018, right?

A. Yes.

Q. And then the last category is average number of inmates during November 2018, right?

A. Yes.

Q. Okay. So the middle column is the current month, December 2018, and it's being compared to one year before on the left and one month before on the right, correct?

A. Yes.

Q. And what we see is that in December 2018, the number of inmates was less than it had been a year ago and less than it was a month ago, right?

A. Yes.

Q. Okay. Let's go down to line 12 on that same page. It says, Mental Health Referrals. Do you see that?

A. Yes.

Q. And the number of mental health referrals in December 2018, the middle column, is 231, right?

A. Yes.

Q. That's more than a hundred less than a year before, correct?

A. Yes.

Q. And then, for example, just–I'm trying to orient us to this. Go down to line 17, Emergency Room Trips. In December 2018, there were 57 emergency room trips, correct?

A. Yes.

Q. Which is one (audio glitch) prior month, right?

A. I missed that.

Q. It was–it's one more than the prior month?

A. Yes.

Q. And eight less than the prior year?

A. Yes.

Q. All right. And then the next page, please. This has every month during 2018 listed; is that right?

A. Yes.

Q. Okay. And so for December 2018, we've got the numbers of each of these categories on the left, correct, compared to every other month in 2018, right?

A. Yes.

Q. If you go down about 10 lines, under the category of Clinical Visits, there's a line that says, Seen by Medical Staff. Do you see that?

A. Okay.

Q. And if you compare–if you look at December's number, which is 19,142, it's maybe at the–it's in the bottom half of the range compared to the other months, isn't it?

A. It's on the lower end, yes.

Q. Okay. All right. Go to the next page, please, page 9 of Exhibit 38. It's a document entitled Monthly Health Services Report 2018. Do you see that?

A. Okay.

Q. And the category on the left says, Clinic Visits, and it's got a number of different reasons for an inmate going to a clinic, right?

A. Yes.

Q. And about two–thirds of the way down, there's a category that says, Hemotology/Sickle Cell. Do you see that?

A. Yes.

Q. Do you know for how long Hemotology/Sickle Cell has had its own category?

A. No.

Q. Has it been as long as you've been medical director?

A. That, I don't know. I don't know.

Q. Would you agree that sickle cell issues with inmates are not unusual in the Justice Center?

MR. HOJNOSKI: Objection. You can answer if you know.

A. I wouldn't say they're unusual.

Q. Okay. It's certainly something that the medical and nursing staff should be able to address, right?

A. I feel they should be able to address it.

Q. Okay. All right. Let's go to page 17 of Exhibit 38. So if we're all on the same page, it's headed October '18, HCJC ER Log. Are we on the same page?

A. Okay.

Q. And there's a big white space on the left side which indicates that the inmates' names have been redacted. Do you understand that?

A. Yes.

(Audio glitch and reporter clarification.)

Q. In the middle of the page, there's a category that says, Reason. Do you see that, Doctor?

A. Yes.

Q. And that would be an indication of the reason an inmate was sent to the emergency room during October 2018; is that right?

A. Yes.

Q. And towards the bottom, there appears to be a sickle cell crisis October 17th, 2018, and then another one October 20th, 2018. Do you see that?

A. Yes.

Q. And what does that tell us? That someone on NaphCare's staff recognized that an inmate was having a sickle cell crisis and ordered that individual transported to the emergency room?

A. It meant that that person was having symptoms that was thought to be a person in sickle cell crisis, and so they were sent to the hospital.

Q. And what symptoms would justify an emergency room run?

MR. HOJNOSKI: Objection.

A. There could be anything that could be saying that there's sickle cell. It's going to be depending on the person's experience and the patient's symptoms that they're exhibiting.

Q. And could symptoms (audio glitch) the risk of death?

A. Say that again?

Q. Okay. Let me withdraw that question and go about it this way.

So these inmates who are sent to the emergency room for sickle cell symptoms, was that because they could not be adequately treated in the Justice Center?

A. They are sent to the hospital to get treatment that we may not necessarily be able to give in the Justice Center.

Q. Okay. And does sickle cell present a risk of death?

A. Having sickle cell–

MR. HOJNOSKI: Go ahead.

A. Having sickle cell can be a death sentence just by having it because you can sickle pretty much at almost any time.

Q. Okay. All right. Let's go to page 22, please, of that same exhibit. And this page is headed December '18 HCJC ER Log. Do you see that?

A. Yes.

Q. And it appears here that there were three transports of inmates to the emergency room for sickle cell crisis in the few weeks after Cornelius Howell's death, right?

MR. HOJNOSKI: Objection.

A. I see three after December 27th–27th and after.

Q. Right. Okay. And then right in the middle of that page, there's one that says, Mental status change. And other places on this log have altered mental status. What do those mean?

A. It could be a variety of things, but you would probably recognize it as a person not necessarily thinking and acting appropriately.

Q. And why do–why are those persons sent to the emergency room?

A. For further evaluation.

Q. Can you give us–can you be any more specific about a person not acting appropriately indicating a mental status change?

A. That would be something that would depend on a person's experience and interactions with individuals during their–during their–during their exposure to people who don't act or behave or think appropriately.

So that's going to be–that's going to depend on the person that you're talking to and their experience. So that's something that's going to be something that's not easily described.

Q. Well, let's say an inmate is playing a game during recreation with other inmates, and he loses and he gets angry. And he's not typically an angry guy, but he gets angry because he lost this game. Is that a mental status change which justifies an emergency room visit?

A. No, I don't think it is. That's a behavior problem because he got angry inappropriately during a game.

Q. And I agree with you, and I'm trying to think of situations that would justify an ER run; and I–and I'm not a medical professional, so I don't have an understanding.

A. That's the reason I said it depends on their experience.

Q. Well, is it something that would concern the NaphCare employee that maybe the person is on drugs? Is that what that's all about?

MR. HOJNOSKI: Objection, speculation.

A. Drugs is something that can make you have behaviors that are not–not appropriate.

Q. These mental status changes, what's the NaphCare employee concerned about that would lead them to send the person to the emergency room?

MR. HOJNOSKI: Objection, speculation.

A. Again, everybody's going to have–

Q. (Inaudible.)

A. Everybody's going to have a–

Q. Again, I'm–go ahead.

A. Everybody's going to have a different level of experience. So what one person thinks a person should be sent out for is going to be different from what somebody else thinks someone should be sent out for.

Q. Okay. So it just basically comes down to a judgment call on the part of the NahCare employee?

A. It's the experience.

Q. Okay. All right. Let's go onto the–to Exhibit 37, then. No, not 37, I'm sorry. 39.

(Plaintiff's Exhibit 39 marked.)

Q. And the heading of this one says, Mortality Meeting Minutes. What is a mortality meeting?

A. They basically kind of discuss the deaths that have occurred at the Justice Center.

Q. And are these regular, or do they just occur when there is a death?

A. It usually occurs when it's a death.

Q. So this particular one, April 10, 2019–no, I'm sorry. So am I correct that the original mortality meeting was held on January 9th, 2019, with regard to Cornelius Howell?

A. I believe so.

Q. And then what we're looking at with this exhibit is this is the updated minutes after the coroner's report was incorporated; is that right?

A. I believe so.

Q. Okay. So it looks like you attended the original meeting January 9th, 2019, correct?

A. I think so, yes.

Q. Do you have an independent recollection of that meeting?

A. No.

Q. Do you know whether you provided any–any oral presentation at that meeting?

A. That, I don't remember at all.

Q. Do you know–

A. I probably did.

Q. –whether you were asked . . .

A. Go ahead.

Q. You probably did or did not?

A. I might have. I might have. I don't recall.

Q. Do you remember whether you were asked any questions?

A. No, on that–I don't know anything–I don't remember that kind of stuff, no.

Q. On page 1 under Information, there are some entries for Cause of Death, Contributory Cause of Death, Manner of Death. Those are all right from the coroner's report, aren't they?

A. I believe so, yes.

Q. Okay. And I think the comment is as well. Are they bold–faced because that's new information since the original meeting?

A. That, I don't–I don't know. That was something you have to ask Maria or Sherry.

Q. Okay. Go to the bottom of page 2, please of Roman numeral V, that says, Staff Treatment, colon. Do you see that?

A. Yes.

Q. And then at the top of the next page, there's a lower case A, and it says, Patient received proper nursing treatment. Who made that determination?

A. That is probably going to be Maria or Kenya.

Q. Okay. Did you have any involvement in making that determination?

A. I don't believe so, but I don't recall.

Q. Did you ever determine how many times a nurse checked on Cornelius Howell while he was in the restraint chair?

A. That–I can't necessarily say what I did back then.

Q. Did you ever determine whether he was given any fluids during the four hours that he was in the restraint chair?

A. I don't recall him getting fluids, but I can't necessarily say what he–what he got.

Q. Did you draw any conclusions from the fact that he did not get any fluids in those four hours?

A. I don't think I wrote anything about that.

Q. Do you have an understanding as to whether that's consistent with NaphCare policies that he did not receive any fluids in the four hours he was in the restraint chair?

A. I would have to go back to review the policy.

Q. You don't know?

A. Not right off the top of my head.

Q. Is it important for a person who may be in a sickle cell crisis to receive fluids?

MR. HOJNOSKI: Objection.

A. Fluids help.

MR. SCHAFFER: Object to form.

Q. Go ahead, Doctor.

A. I said fluids help.

Q. Why?

A. It helps with hydration.

Q. Do you have any opinion as to whether the failure to provide fluids to Cornelius Howell foreclosed any chance that he had at survival?

MR. SCHAFFER: Object to form.

A. I don't have any separate opinion on that.

Q. Separate from what?

A. From–from–from what I've already written as far as my assessment.

Q. Okay. Well, you didn't write anything about fluids, did you?

A. I didn't recall writing anything about fluids, no.

Q. All right. Let's go to page 8 of this exhibit. And we're now on your handwritten report, right?

A. Right.

Q. Okay. I'm looking at the category Roman numeral III, Differential Diagnosis. And let's just make sure we can read your writing. First, PE, do you mean pulmonary embolism?

A. That's correct.

Q. And the next one is aortic dissection?

A. Yes.

Q. Next one is rupture of previous cardiac surgery site?

A. Yes.

Q. The fourth one is myocardial coronary occlusion?

A. Yes.

Q. And then the last one is brain bleed or stroke?

A. Yes.

Q. Okay. I understand what a differential diagnosis is, but I'm not–I don't understand the context of your report. Who would have developed or

should have developed this differential diagnosis and when?

A. What do you mean? I mean, basically, a differential–what do you mean?

Q. Well, is this–when he presented to medical after the fight and he was complaining about his back and legs, are you saying that this is the differential diagnosis that should have been developed at that time?

A. The differential diagnosis is–this is part of a report of a death summary. So basically, the differential diagnosis of what caused his death is what the differential of what could have possibly caused his death.

Q. Okay. And you're getting–that's your own opinion? Because this doesn't come from the coroner, does it?

A. Not at all. This was done way before we got the coroner's report.

Q. So this is you, on December 10th, doing your own forecast of what you believe the cause of death may be?

A. It is the summary of the death and the possibilities of what could have caused his death.

Q. And you don't have sickle cell crisis on there, do you?

A. Sickle cell crisis is at the bottom in number 7.

Q. Under Probable Cause of Death?

A. Yes.

Q. Okay. You didn't list it as a deferential diagnosis because you were listing it as a probable cause?

A. No. It wasn't listed because a pulmonary embolism is a blood clot. When people have sickle cell disease, they form blood clots. Okay? And that's what causes their death.

So if you have a sickle cell crisis, you're going to start developing sickle cells. And sickle cells start to adhere to themselves. They form clots. If they get big enough, you get a pulmonary embolism.

And it depends on where in their body it occurs. It can go–it could be a clot in one of the heart vessels which leads to a heart attack. That's how you get your myocardial infarction.

Q. Okay. Thank you for clarifying that. Now I–now I understand.

Let's read that number 7 just to make sure it's clear. 33–year–old black male with sickle cell and cardiac ventricular surgery who underwent extreme exertion and altercation just prior to death, period. The probable cause was due most likely as a complication of sickle cell disease or previous cardiac surgery.

Did I read that correctly?

A. That's correct.

Q. Okay. When you–when you saw the coroner's report, what did you then conclude, if anything?

A. That we were right on with the probable cause of his death.

Q. Okay. So this number 7 is what you believe was his cause of death?

A. Yes.

Q. Okay. All right. Then the next page, Roman numeral VIII, you've got a category that says, Retrospective review of any existing data which might have suggested preventive health measures for this case. Do you see that?

A. Yes.

Q. Explain these to us, please.

A. All right. So basically, this is information where we're looking at something that we can possibly point to or use as teaching points that can help improve our care of our inmates.

Q. Okay. So let's go through this first one. History of sickle cell disease with extreme back pain and history of extreme exertion. Why did you write that down in that category?

A. Well, the thing is that a person who has sickle cell disease–what causes them to sickle would be the lack of oxygen. So when you exert yourself, you use up your oxygen quite a bit, so that will precipitate a sickle cell crisis.

His back pain is going to be one of the signs or symptoms that could possibly occur when you're having a crisis. That could happen there. And then again–again, it's brought on by exertion, by using up all the oxygen he has, causing the cells to sickle.

Q. So the fact that he presented with extreme back pain shortly after extreme exertion from the

fight would be consistent with him being in a sickle cell crisis; is that right?

A. No. No, I didn't say that. I'm saying that basically his exertion could have used up his oxygen that could have caused his cells to start to sickle. But he also continued to exert himself, from the notes, I believe. That could have also continued to use up the oxygen that made things even worse.

Q. Okay. And I appreciate your clarification. Let (audio glitch) the question, not saying–not putting words in your mouth, just asking you whether it's true. Is it true that Cornelius Howell presenting with extreme back pain after extreme exertion from a recent fight would be consistent with him having a sickle cell crisis?

MR. HOJNOSKI: Objection.

A. Not–not necessarily. You know, it's a possibility. That's the reason why we were trying to use it as a teaching point.

Q. But it could be consistent with various things, but it would also be consistent with a sickle cell crisis, right?

MR. HOJNOSKI: Same objection.

A. It could be a symptom that a person with sickle cell who's in crisis could have.

Q. Okay. The next line, the respiratory rate of 22, why did you note that here?

A. Well, the thing is that's an abnormal vital sign. And so with an abnormal vital sign, it's something that you want to take note of and you

might want to kind of go back and kind of reassess.

That's–basically, it's just an abnormal vital sign that sometimes can point to things. And it's just one of the things that we can use to say, hey, you know, this is what happened to this person. He–this is one of the things that were abnormal. You know, you want to kind of follow up on some things.

Q. What did NaphCare staff do in response to the reading of a respiratory rate of a 22?

A. That, I didn't–I didn't recall seeing anything written down on that, so I can't respond to that.

Q. The next one says, History of depression rated 7 out of 10 on psychological intake screen; is that right?

A. Yes.

Q. Why did you note that here?

A. Well, you know, this is a guy who was, what, 30–something years old.

MR. HOJNOSKI: 33.

A. 33 years old, so he–you know, he's had sickle cell for, you know, all his life. And, you know, you–you can kind of know what can kind of bring on a crisis.

And if he was depressed, you know, maybe, you know, he knew what he was . . . You know, it's hard to speculate, but the thing is that the guy had–had some symptoms that could go along with depression; and, you know, sometimes you

might have to kind of look into the reasons why he scored what he scored.

Q. I guess I'm not following you. How should that have been taken into account when he presented to medical after the fight?

A. Well, the thing is that it is–it's one of the things that were sticking out to me when I go back and look at the chart. And so I'm looking for things that are abnormal that we can use for teaching points that we can kind of say, hey, you know, we need to look at these things, we need to look at those things, that type of deal as a teaching point.

Q. What should have been done better with regard to the history of depression when Cornelius Howell presented to medical after the fight?

MR. HOJNOSKI: Objection.

MR. SCHAFFER: Objection, hindsight.

A. I can't necessarily say what they should have done after the fight, but, you know, when you are incarcerated and when you're fighting, when you're hyped up, when your respiratory rate is fast, when you're excited, angry, irritable, you know, there's a lot of different things that can kind of come to mind, but you really can't do a whole bunch until the person kind of calms down.

That's when you can recheck the respiratory rate, making sure that he's doing well, making sure that he's there mentally; but you really can't do a whole bunch when they're hyped up.

So the whole goal is to us to bring issues out to make them aware that we can use as teaching points to make us better.

Q. Okay. The next one is, Refusal of medical care. Why did you put that here?

A. Well, he refused being seen. You know, sometimes when people are hyped up an they want to refuse, there's certain things that you might want to do to kind of help the person kind of understand that, hey, you know, this is not going to be good for you if you refuse because you could have certain issues occur.

And so, basically, it's to show that. And then as it shows under number 9, that there was no form there. So basically, we needed a form if the person really wants to refuse. And because he was not really compliant with it, it wasn't filled out.

But still, you have to kind of follow the paperwork and get witnesses that show that the person refused care and that he understands why he's refusing.

Q. So let's go to that number 9. It says, Review of missing data which could be helpful in cases of this nature. I think you just explained number 1. And then number 2 says, Decisions not to proceed with further medical evaluation. What does that mean?

A. That–now that I think–now that I go back and look at that, I can't remember fully what I meant about that, but basically . . . I can't remem-

ber what I said–what I meant about that two years ago.

Q. Well, would one of them be the failure to follow up on the respiratory rate of 22?

A. No. Anything–it could have been that. I don't know what it would have, could have been. That was two years ago. I don't remember. If you asked me a month, two months, three months, six months from there, I probably would have been able to tell you; but now, I don't really remember.

Q. The next one says, Consideration of medical causes to psychiatric issues. What do you mean by that?

A. Basically, a lot of times, before you want to say that things are psychiatric, you want to make sure they're not necessarily medical.

Q. So rule out medical causes first before considering psychiatric issues?

A. You want to–you want to consider your medical issues as a possible–as a possible cause versus a psychiatric cause right off the bat.

Q. And that's because medical causes present a more imminent risk of serious harm or death, right?

A. Not–

MR. SCHAFFER: Objection, foundation.

A. Not necessarily.

Q. Well, why do you want to consider medical causes first?

A. Because that's something that you can pretty much do something about. The psychiatric causes sometimes are going to be something that may take a little bit more time to really cause you some issues sometimes, not always.

Q. Let's go to the next category. It's Roman numeral X, and it says, Recommendations for modifications and protocol procedure or approach to patient health care management which might result from this review.

And number 1 says, In all psychiatric/abnormal behavior patients, always consider medical condition causes first before assuming solely psychiatric issues only. And I think you've explained this, haven't you?

A. Yes.

Q. Let me just back up a second. Was Cornelius Howell presenting a mental status change from what you learned?

A. It actually was going to be more behavior. But again, that's just–that's just my thought at this point in–just from looking at it. So I can't necessarily say it's truly a mental status change.

The person that would be able to tell you the mental status change would be the people who were on site at the time.

But basically going from the descriptions, it sounded more like a behavior similar to what you were describing earlier about a person who was–just broke out into a fight.

Q. Okay. Number 2 says, Educate nurses on normal vital signs and appropriate follow–up of abnormalities, correct?

A. Yes.

Q. And is it–was it your conclusion that the respiratory rate of 22 was an abnormal vital sign that should have gotten more attention?

A. It's an abnormal vital sign. But in his particular case, he was just out of a fight; he was still kind of hyped up. So his respiratory rate of 22 can be considered an acceptable finding, but you want–you might want to kind of–kind of see if it's going to come down once he calms down.

Q. Did he have any other abnormal vital signs when he presented after the fight?

A. From what I wrote down, that was the only one that stuck out to me; and that's–I think that's the only reason why I included that, I think.

Q. Okay. Then next, number 3 says, Educate nurses on sickle cell signs and symptoms and triggers to crisis; is that right?

A. Yes.

Q. And why did you put that here?

A. Because, again, this is meant as a document to look at what happened and how we can improve the care of our patients. And so that was one of the things that we can always continue to do, is strive to educate our employees on how we can better take care of our patients.

Q. Was Cornelius Howell presenting with a sickle cell crisis when he came to medical after the fight?

A. That–

MR. HOJNOSKI: Objection.

A. That, I don't know what he presented with. Basically, the people on site would probably be a better–could give you more information on what he presented with, because, you know, he was in the middle of a fight, he was hyped up, his mind or his–he just wasn't wanting to cooperate, so I can't necessarily say.

Q. Well, you believe he died from sickle cell disease, right?

A. I think I put it that he had complications of sickle cell disease.

Q. The next category, number 11, says, All information on TechCare; is that right? A. Yeah, it's intake care. Basically, yes, all the information I do this from came from the TechCare documents.

Q. Is TechCare the internal software, medical software?

A. It's the software that the medical record is kept in, yes.

Q. Okay. So other than the medical charting, would there be any other notes of yours regarding evaluation of the–of the death?

A. Where?

MR. HOJNOSKI: Other than his death summary, you mean?

MR. KIRCHER: Yes.

A. No, this is it.

Q. (By Mr. Kircher) Okay. Did you–did you conclude when Cornelius Howell died?

A. No.

Q. Do you have an opinion as to when he died?

A. No.

Q. Okay. Did anyone call you and get your approval for putting Cornelius Howell into the chair?

A. No.

Q. Does NaphCare's policy require physician approval for an inmate to be placed into the chair for mental health observation?

A. The policy does not allow for us to put inmates in the chair, so I can't necessarily say that we put people in the chair.

Q. Okay. So, for example, Christina Jordan had absolutely no authority to order Cornelius Howell into the restraint chair; is that what you're saying?

A. What I'm saying is–

MR. HOJNOSKI: Objection.

A. What I'm saying is–(Reporter clarification.)

A. What I'm saying is that medical does not put people in restraint chairs. That's solely a corrections procedure.

MR. KIRCHER: All right. Let's take a short break, and then I will come back and finish up.

(A brief break was taken.)

Q. (By Mr. Kircher) Okay. We're back on the record, Doctor. We were talking earlier about the inmates who were suspected of being in sickle cell crisis and they're sent to the emergency room.

And we had–I'd asked you something like why are they sent to the emergency room; is there–are there services that the jail can't provide.

Explain that in a little more depth. Why are inmates suspected to be in sickle cell crisis sent to the emergency room?

A. It's for treatments and further evaluation that may not be able to be administered at the Justice Center.

Q. What are those treatments that can not be provided at the Justice Center?

A. It can be SAT labs that will be available within minutes versus many hours that helps us make a decision on the treatment of an individual.

It can be radiographic studies that can give us a quicker indication of other issues that may not necessarily be a sickle cell crisis that can be causing the individual problems. It's those type of things.

Q. Okay. And as the Justice Center is waiting for the ambulance to take the inmate to the emergency room, what do NaphCare employees

do for that inmate suspected to be in sickle cell crisis?

A. It could be a variety of different measures, but it depends on the situation. It depends on the location. It depends on the whole situation. So it's a variety of different things that could occur. So there's no particular formula that you–that you have to use.

Q. Well, fluids is an easy one, right?

A. If the person's spitting stuff out at you, you can't necessarily do that. If the person's not cooperative, you can't do that orally.

Q. But that's something that in every situation, while you're waiting for the ambulance with an inmate suspected to be in sickle cell crisis, offer them fluids, right?

A. Fluids is one thing, yes. You can.

Q. Okay. And it's an important one, isn't it, hydration?

A. Hydration helps. But again, there's a lot of different things that you do for a sickle cell person that can be beneficial. But each case is different, so there's a lot of different things you can do.

Q. Was anything done for Cornelius Howell to combat suspected sickle cell crisis?

A. At the time that they found him, he was dead, so you can't do anything with that.

Q. What about the time he presented from–presented to medical after the fight complaining, you know, of back pain, with a high respiratory

rate, did–was anything done to treat him for suspected sickle cell crisis?

A. For a person who was in a fight, who was hyped up, was non–compliant, the only thing you can do first of all is help get the person to be a little bit calm, a little bit compliant with your wishes.

So for anybody, whether he's in sickle cell crisis or not, I think those things were done appropriately. So to answer your question, those things were done.

Q. Were you aware that Cornelius Howell was sliding out of the restraint chair–or wheelchair and rolling around on the ground complaining that he couldn't feel his legs?

A. That part I don't remember reading. I don't remember reading that part.

MR. KIRCHER: All right. I don't have anything further. I don't know if Mr. Schaffer has anything for you or not, Doctor.

MR. SCHAFFER: No, I don't at this time. Thank you.

MR. HOJNOSKI: We'll read. (Whereupon, signature was requested, and the deposition concluded at 2:50 p.m.)

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CURTIS EVERSON, M.D

DEPOSITION OF DANIEL ERWIN
(DECEMBER 29, 2020)

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

KARLA HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

Case Number: 1:19-cv-00373

Before: Kelly GREEN, RPR, Notary Public.

DANIEL ERWIN,
a witness herein, having been duly sworn,
was examined and testified as follows:

CROSS-EXAMINATION BY MR. KIRCHER:

Q. Good afternoon, sir. My name is Konrad Kircher, and along with Ryan McGraw, we represent the family of Cornelius Howell in a lawsuit against NaphCare, the county, and some other defendants.

Would you please give us your full name?

A. Yeah. It's Daniel Erwin.

Q. And Mr. Erwin, I understand you're in the Army now; is that correct?

A. Yes, sir.

Q. What is your rank?

A. I'm a private first class.

Q. All right. May I call you Pfc. Erwin? Is that okay?

A. Yeah, that's fine.

Q. All right. So have you ever given a deposition before?

A. I have not.

Q. Let me ask you to follow a few ground rules especially because this Zoom platform can cause some problems.

A. Okay.

Q. First of all, everything that we say is being taken down by the court reporter, so it's important that you give an audible answer. If you say uh-huh or uh-uh or you just nod your head, I'm going to ask you whether that was a yes or no. I'm not being rude; I'm simply trying to make sure we have an accurate record. Do you understand that?

A. Yes, I do.

Q. Thank you. Also, if I ask a question which is confusing or unclear or you didn't hear it because of noise on this platform, please let me know. I'll be

happy to rephrase it or repeat it so that you can understand the question.

If you do understand—if you do answer a question, I will assume that you understood it; is that fair?

A. Yes, it is.

Q. Finally, then, please allow me to finish my question before you begin answering. That way, the court reporter doesn't have to take down two people talking at once.

Similarly, I will do my best to allow you to finish your answer before I ask the next question. If I ever cut you off, it will have been inadvertent; I thought you were done with your answer. And I would like you to bring to my attention that you had more to say so that you can finish your answer. Will you do that for me?

A. Yes, I will.

Q. What, if anything, have you done to prepare for this deposition?

A. I have looked over the exhibits that were given to me, all the paperwork that my lawyer has forwarded to me. I have it actually in front of me right now. We've gone over it and talked about it numerous times, and that's—that's basically it.

Q. Okay. Yesterday, I sent to your lawyer four exhibits to use—that I'm going to use today. One is the policy and procedure for use of restraints. Another one is the Restraint Chair Form. Another one is the Hamilton County Sheriff Investigation Report of the death investigation,

and then the last one was your Answers to Interrogatories and Admissions.

Were those among the documents that you have reviewed—

A. Yes.

Q. —before the deposition?

A. Yes, they were.

Q. Okay. And were there any other documents besides those that you reviewed?

A. I glanced over Deputy Collini's deposition, but I didn't get too in detail with it.

Q. Okay. Were there certain parts of his testimony that you read in particular?

A. I just glanced over it. I didn't get into detail.

Q. Okay. All right. Any other documents that you recall reviewing?

A. Let's see. You mentioned the Restraint Chair Form, my statement, the log form, and the—my deposition, correct?

Q. When you mean your deposition, you mean your statement?

A. My—yeah, my admissions.

Q. Oh, yeah, yeah. Okay. All right. Good. And other than talking to John Welch, have you talked to anyone else about this deposition?

A. I have not.

Q. So let's briefly cover your educational background. Where did you graduate from high school?

A. I went to Roger Bacon High School in the city of St. Bernard in Cincinnati, Ohio. I graduated in 2008.

Q. 2008? Have you had any formal education since that time?

A. I went to school in—University of Toledo for a few years. I went until I turned 21 and came back home to Cincinnati and went to the police academy at Butler Tech.

Q. Did you—when did you—did you withdraw from Toledo?

A. Yes, I did, because I knew what I wanted to do. I wanted to become a police officer.

Q. Okay. And how far did you get at Toledo?

A. I left in 2012.

Q. So did you come close to graduating?

A. I have enough credits for an associate's degree.

Q. And what were you majoring in there?

A. Criminal justice.

Q. Were you asked to leave the University of Toledo?

A. I was not.

Q. Okay. It was voluntary on your part?

A. Yes, sir.

Q. And let's then from that point—well, so you withdrew from Toledo, and you went right to the corrections academy?

A. No. I went to the police academy at Butler Tech. It is—I went to the day academy, so six months of going through learning the Ohio Revised Code, going through vigorous training for becoming a police officer—a certified police officer in the state of Ohio. So this wasn't—

Q. Okay.

A. This wasn't part of—I wasn't with Hamilton County at this time.

Q. All right. Let's pick up your employment history, then, once you graduated from the police academy.

A. Hamilton County came to one of our PT days on Friday. I was talking to one of those sergeants that was working there. He no longer works there. I believe he's still at OPOTA.

But he came and saw us, and I started talking to him because, you know, I wanted to become a police officer, and Hamilton County was a very well accredited department to work for in Cincinnati. And since I'm from there, you know, I knew the county and knew the area.

Q. So did you apply to the Hamilton County Sheriff's Department at that time?

A. I did.

Q. And were you hired?

A. Yes, I was.

Q. Okay. When were you first hired by the sheriff's department?

A. I first got a notification from them around—around August of 2012, I believe, because I graduated from the police academy in June of 2012. And then it was a letter stating that I was going to attend the corrections academy in 2013 of February.

Q. Okay. And did you, in fact, attend the corrections academy, then, in early 2013?

A. I did.

Q. And after finishing the corrections academy, where were you placed within the sheriff's department?

A. So I did two weeks on first shift for my FTO training and then, after that, did two weeks on second shift; and then that's where I ended up for the rest of my career, on second shift in the—in the North building—or, I'm sorry, the South building.

Q. Okay. Of the Justice Center, right?

A. Yes.

Q. Okay. And then that's from—from what period of time until what period of time were you a corrections officer in the Justice Center?

A. I was a corrections officer for my whole career there. I went from the South building down to intake; and then I went from intake back to the South building, and then I got moved to the North building, and that's where I ended up staying for the rest of my career.

Q. Okay. So you started as a corrections officer—you know, after you finished your field training

and so forth, when did you actually start as a corrections officer?

A. I want to say that was anywhere between—what would that be? I want to say sometime in April.

Q. Of 2013?

A. Yes, of 2013, yes.

Q. Okay. And you left when?

A. I left September of 2019.

Q. Why did you leave the sheriff's department?

A. I felt—I felt stuck there. I didn't like where I—where I was. The Army was something that I've also always wanted to do, and I found the opportunity to do it and—and I'm doing it now. So I've always wanted to serve my country as well, you know.

Q. And so you enlisted in the Army then September 2019?

A. Yes.

Q. Okay. And where are you based now?

A. I'm in Fort Drum, New York.

Q. What's your—in the Marines, we called it MOS, and I think that you use the same term—

A. Yes.

Q. —but I think we have different—different numbers. I was an 0302 infantry officer. What are you?

A. I'm 11 Bravo—or, I'm 11 Charlie, so I'm a mortarman—infantry mortarman.

Q. Great. Where do you get—where are you out in the field in New York?

A. We—so when we go back, I'll be in quarantine for two weeks; but after that, in March, we will be doing our tables. So we'll go out with our mortar guns and go out with the rest of the company and get recertified on our guns, our mortar systems, so . . . And we'll be out there for two—two to three weeks out in the field.

Q. When I was in, we had 60mm and 81mm mortars. Is that what you still have, or have they updated since then?

A. We have 60s, 81s, and 120s.

Q. 120s. We didn't have 120s. Above that, we had howitzers. Well, great. You know, congratulations. I loved the infantry, and what's odd is that most of my troops were in the Marine Corps infantry so that they could get out and become police officers, sheriff deputies, or corrections officers. You're doing it the other way around.

A. I'm doing it the opposite way, yes. Yes, sir.

Q. Well, good for you.

All right. So let's say, as a corrections officer prior to December 2018, how often did you work with Deputy Collini?

A. I was with Deputy Collini for two years. We—I was sent down to the psych unit because my supervisors knew how I, you know, handled inmates; and they knew I, you know, did a very good job with talking to inmates and, you know, talking them down, deescalating, you know,

their behaviors. And they thought that the psych unit was a perfect fit for me.

And so that's how I got to know Deputy Collini and Deputy Pierani, and I worked with them for the rest of the time I was there at Hamilton County.

Q. You started that answer by saying you were with Deputy Collini for about two years. What do you mean? Does that mean you were always assigned to the same shift with him?

A. Yes. We were in different off—day groups. So two days I wasn't working with them; but the rest of the time before I did—or before I went on my off days, he was—he was there as well.

Q. Okay. I think understand what you were saying. So you—what were you—let's say in December 2018, what were the five days a week that you were working?

A. Our—we were in different off—day groups, so when I worked—so we were on a 5 and 2 schedule. So I would be on 5 days and off 2; and then every fourth week, I had 2 weekends off.

So I worked Monday through Friday, had Friday, Saturday, Sunday off; and then the following week—I'm sorry. I worked Monday through Friday, had Saturday, Sunday, and Monday off; worked Tuesday through Sunday, and then had Monday, Tuesday off. So then it flip—flopped.

So those two off—days that they had, because they had the same off—day group, I was with two, I guess you would say, replacement people.

But the majority of time that I was working at psych, I was with Deputy Collini.

Q. So would it be fair to say that maybe three days a week, you were working the same shift with Deputy Collini?

A. It was—it was four, four days a week.

Q. Four days a week. Okay. And were you—in December 2018, were you the one who always handled the mental health unit?

A. I mean, I was—I was working there. I wasn't the most senior officer there, so I was still—I was still learning how to work that psych unit.

Q. Psych unit. Okay. And as I understand it, during an 8-hour shift, you rotated—like, for 2 hours and 40 minutes, you would be the housing officer; 2 hours and 40 minutes, you'd be in the control center; and then 2 hours and 40 minutes, there was another shift. Is that right?

A. Yes. So since being a new officer, I would be the housing officer first for the 2 hours and 40 minutes. Then I'd go to suicide watches if we had any. And then if we didn't, I would be the secondary housing officer for 2 hours and 40 minutes. And then for the last 2 hours and 40 minutes of my shift, I'd be in the control room.

Q. Okay. The suicide watches, did those include restraint chair checks?

A. Yes. If we had anybody that came up from intake or from another floor or from a CERT call-out.

(Reporter clarification.)

A. So if the CERT team was activated, they would go in the restraint chair.

Q. Okay. And tell us what team you're talking about. You said a CERT team?

A. Yeah, the Corrections Emergency Response Team I was also a part of.

Q. Okay.

A. So if a—if an inmate came in—came down from one of those, the suicide watch shift would also observe the inmate in the restraint chair as well.

Q. All right. So getting back to Deputy Collini for a minute. Did you two become friends?

A. Yes. Me, Deputy Collini, and Deputy Pierani all became friends.

Q. Did you do things together outside of work?

A. Yes, we did.

Q. Give us some examples.

A. We would go to concerts at Riverbend together. I like country music. They like country music. We would go—we'd go to one each—one another's houses, you know, had barbecues. So it became like a family, working with those two guys.

Q. Okay. If I recall correctly, Deputy Collini was in the Army prior to becoming a corrections officer; is that right?

A. Yes, he was.

Q. Did he have some influence on you joining the Army?

A. He told me—he told me about the Army, although he wasn't infantry. He was—I believe he was 88M, which is a—the heavy truck drivers, I believe.

But ultimately, my main deciding factor was my grandfather. He fought in World War II in the Pacific. He was in the Army. And I looked up to him, so he was my main deciding factor of joining the Army.

Q. Okay. All right. Well, I want to ask you about the night that Cornelius Howell died. And we've talked about some documents that you've reviewed and that I sent to your attorneys and we've exchanged back and forth.

But before we talk about any documents, I want to exhaust your independent recollection. And what I mean by independent recollection is things that you remember from that night that you're not relying on documents for.

In other words, if you have an image of Cornelius Howell in your mind, you know, whether he was on the floor or in a restraint chair, or you remember having a conversation with him. You know, there's an image in your mind of that conversation.

So that's what I mean by independent recollection is things that you remember where you don't need a document to help you. Do you understand what that means?

A. Yes.

Q. Okay. So let me ask you first, do you have any independent recollection of the events of that evening?

A. I do not. There was so much going on before that, it's—you know, I can't recall any sort of, you know, independent recollection of—of what happened that night.

Q. Okay. When you say there was so much going on before that, what do you mean?

A. Going on the radio, the radio traffic of the fight that he was involved with. That's what I mean about that.

Q. Okay. So do you have some recollection of the traffic that was on the radio?

A. So I was—I was in—I was in B Pod, and then, you know, one of the rover—I can't remember who it was, but one of the rovers was there and . . . You know, the fight—the signal went over the radio. And then my partner left, the rover left, and, you know, it was just people calling for supervisors and all that.

That's what—that's the only thing I can recall because, I mean, it was just a very hectic, you know, situation call going over the radio.

Q. What's your understanding of the first contact you had with Cornelius Howell?

A. It was in the medical psych ward. Everybody was around, just standing there. I saw him, and that's—that's—that's all—that's all that I can recall from, you know, my first interaction with him.

Q. Were you in the medical sally port when he entered?

A. No. I was—he was already there, and I was walking through the nurse's station, and that's when I first was in contact with him.

Q. Okay. And were you asked to come to the medical sally port?

A. I was not. Normally, when signals happen, inmates are taken to medical to be checked and cleared. But since I'm so—within proximity of medical, we normally go down there because, you know, some things can happen.

So, you know, inmates, you know, don't calm themselves down, so, you know, it's nice to have that presence of all of us there, you know, just—just, you know, for everybody's safety.

Q. Okay. And when you arrived in the medical sally port, what was Cornelius Howell doing?

A. He was—he was in the chair getting checked by the nurses, the nursing staff. And that's—that's all I can remember from that.

Q. Do you remember which nurses were checking him?

A. I do not.

Q. Prior to that evening, did you work frequently with a nurse named Christina Jordan?

A. Normally, when the nurses are on our floor, they're either checking people in restraints or they're giving certain people different medications. And during med pass, they come over and distribute the meds to the inmates on our floor,

but I don't really work with one certain nurse individually.

Q. Do you know Christina Jordan, though? Do you know who I'm talking about?

A. No, I do not. I mean, if you could—if you showed me a picture of her, I could remember her; but, I mean, I tried to stay away from the nursing staff because I don't—I mean, I'm not—I'm not involved with the medical, so I don't need to be down there. It's not my expertise.

Q. Do you know Pierette Arthur?

A. Yes, I do.

Q. And how do you know her?

A. She's our main—she's our psych nurse that we deal with in the—at the—at the psych unit.

Q. Okay. So you work more closely with her than with the medical nurses; is that right?

A. Yes.

Q. Okay. All right. So going back, you said that nurses were checking him, I think you said. Did you hear any conversation that they were having?

A. I was more focused on him just because I learned that he stabbed his cellmate with a pencil. So I was more focused on him, you know, trying to gauge his—you know, his demeanor, his body language, because that's why I ultimately went down there is, you know, for—you know, for security reasons. But, you know, that's all from what I can recall.

Q. Okay. And I respect that you were focused on him and his demeanor and so forth, but I'm not sure you answered my question. Did you hear any conversation between the nurses?

A. They were—they were talking about what to do with Cornelius, but that's all I can, you know, recall from that.

Q. Okay. There was some talk about sending him to the hospital, wasn't there?

A. There was—there was talks between our supervision—my supervision and the nursing staff of the possibility of him going out to the hospital, but there was no—there was no definitive answer from what I could hear of him going out.

Q. Who were the people involved in your supervision? That's a bad question. Let me rephrase that.

You said there was discussions between the nurses and your supervision. Which individuals were you referring to when you said your supervision?

A. It was . . . I honestly can't recall who was on shift that night. I know the one—the only supervisor that I was talking to was Sergeant Franklin because he was the intake—excuse me. He was the intake supervisor on that night.

Q. Okay. Do you remember anyone saying—let me put it this way. Do you remember anyone making the decision not to send him to the hospital?

A. I do not. I just, you know, overheard people talking about it, but I couldn't pinpoint a certain individual saying that—you know, giving the definitive answer of sending him out or not sending him out.

Q. Do you have an understanding based on what you overheard as to why he did not go to the hospital?

A. I do not. I just knew that, you know—you know, they were talking about it, and, you know, whoever made the final decision not to send him out—you know, I was more concerned of, you know, transporting him down to the psych unit to be placed in the restraint chair, so . . .

Q. So while you were in the medical sally port and this conversation was going on, was Cornelius Howell sitting in a chair?

A. He was—he was sitting but slumped over in the chair; and then at some point, he ended up on the floor. My attention was drawn elsewhere, so I did not see him go down on the floor; but then when I turned around, he was on the floor in the medical sally port.

Q. The chair that you're referring to, was it a wheelchair?

A. It is a restraint chair with soft restraints.

Q. Okay. So he was in the restraint chair at that time but not—not fastened in?

A. No. He was—he was in like a regular—not folding chair but a—I don't know how to describe it. He

was just in a regular chair at that point. He wasn't in the restraint chair.

Q. Okay. That's what I thought. All right. So when you say he was slumped over before he went to the floor, was he—was he saying anything?

A. Not from what I can remember.

Q. Did he appear conscious?

A. He was.

Q. What read did you get from his body language when he was slumped over?

A. When he was—he was heavy breathing, which is understandable because, you know, he was, you know, involved with—in a fight, so he was very worked up.

And then, you know, he just kept on looking around at all of us. So that's—mainly, what I could get from him is, you know, he was—he was still excited. So that's what I was gauging from him.

Q. When he was looking around at all of you, what did you read in his eyes?

A. What I could read is like he was still excited. He was still emotional. He was still—he was still worked up. So, you know, the best thing for that is, you know, just to, you know, have him calm down so, you know, we'd be able to work with him.

Q. When he was looking around at all of you, did it seem like he was looking around for a fight? Was he looking around for help? Was he looking around

in desperation? Any other characterization you could come up with?

MR. WELCH: I'll go ahead and just object to that question on form, but you can go ahead and answer, Danny, if you can.

A. I was going to say that I think he was just looking around to gauge where he was. Since he was excited, you know, still worked up, I feel like he was—he was trying to figure out where he was.

Q. Okay. I just want to—before we talk about what he did on the floor, let me just clarify one thing about when you say he was slumped over. You know, as some inmates, I assume, you know, take a body posture of slumping and kind of an attitude of, This is all bullshit, man—

A. Yeah.

Q. —you aren't talking about that kind of slumped over, are you?

A. No, I'm not.

Q. Okay. All right. So now he slides down onto the floor. Or, I guess you didn't see him—you didn't see how he got to the floor, correct?

A. Correct.

Q. Okay. When you did notice him on the floor, describe his posture.

A. He was just—he was laying—laying on the floor. He wasn't really in some sort of position to say—per se. He was just, you know, kind of sprawled out on the floor.

Q. Was he face up? Face down? On his side?

A. He was more on his side.

Q. And was he moving around, or was he stationary?

A. For the most part, he was stationary, from what I recall.

Q. And who was around him at that time?

A. I can't say. I can't recall who was all around. There was so many of us in that sally port, I can't pinpoint who was there and who wasn't.

Q. The conversation that you described about whether to send him to the hospital, did that occur when he was in the chair, when he was on the floor, or continually?

A. The conversations I was hearing was continuous while I was in the medical sally port, because it was going back and forth between, like I said, my supervision and the nursing staff of whether to send him out or not.

Q. Okay. All right. When he was on the floor, was he saying anything?

A. From what I can recall, I don't believe he was saying anything.

Q. Was he making any noises?

A. From what I can recall, I don't believe he was making any noises.

Q. And what was your perception as to why he was on the floor?

A. So my attention was drawn elsewhere; and when I turned around, I was surprised he was on the floor. And from that, I don't know what would lead me to believe why he'd be on the floor. He might have slipped on the floor—or, slipped to the floor since he was slumped over. That was my only assumption.

Q. Okay. Was it your perception that he was on the floor as, you know, a protest or as a resistance to being placed in the chair?

A. At that point, there was no talks to put him in the restraint chair. He—I believe that he was on the floor because he slipped off of the table that's right next to him that he was sort of slumped or hunched over on. But there are some inmates that do do that, that, you know, just would try to protest or would do those sort of things to get their way.

Q. But that's not what you thought Cornelius Howell was doing, right?

A. Yes.

Q. That's correct?

A. Yes.

Q. Okay. A couple times, you said your attention was diverted somewhere else. Where was your attention diverted to?

A. I was—I was trying to comprehend the conversations between, you know, our—my supervision and the medical staff. That—and I don't know who else I was talking to, but I was talking to

somebody else. And then when I turned around, that's when I saw him on the floor.

Q. Okay. So what happened next? He's on the floor. Then what happened?

A. We got him up to sit in the chair again, and then I think that is when talks of putting him in the restraint chair happened; and then that's when I believe we ended up getting the restraint chair to place him in.

Q. Who was involved in the discussions about whether to place him in the restraint chair?

A. I can't recall that. It was just once—once somebody says, you know, Go get the restraint chair, we get the restraint chair. It normally comes from our supervision, but I do believe the medical staff can order an inmate in the restraint chair as well.

Q. And in this particular situation, do you have an understanding as to who made the decision to put Cornelius Howell in a restraint chair?

A. That, I can't recall.

Q. Were you told to go get the restraint chair?

A. Well, since working at the psych unit, I believe I was one of the people that went and got the restraint chair. I don't—can't remember if I brought it down already or it was standing by in the hallway, but, you know, from—from that, I can't recall.

Q. Who gave the order to get the restraint chair?

A. That, I can't recall. I heard, Go get the restraint chair, so, you know . . . I can't recall.

Q. Do you have an understanding as to why he was placed in the restraint chair?

A. It was either one of two things, just because it was—you know, we were going to send him out possibly to the hospital or—or sending him out in the restraint chair van, or he was going to be placed in the restraint chair and to stay at medical just to be observed or go down to the psych unit. That was my four understandings of as to why the restraint chair was ordered.

Q. And your understanding, is that based on the conversations you overheard or just standard procedure?

A. It's a little bit of both. From what I was hearing from both sides, the possibility of him going out in the restraint chair van or just for, you know, reasons for his behavior. That's what I can—that's what I deciphered from.

Q. Okay. Did you help transport him to mental health?

A. Yes, because that was—that was where I was working that night.

Q. Okay. And once you transported him to mental health, what did you do?

A. We put him in—I believe it was cell 6 that—because we had two restraint chair cells. And then our—I believe it was Pierette that checked him out. And, you know, that was—she checked the restraints, checked him, and that was it.

Q. And did you leave then?

A. Yes. I believe I went back into B Pod.

Q. Okay. After that point, did you have any contact with Cornelius Howell other than doing checks on him?

A. I did not.

Q. And how many checks did you do on Cornelius Howell that evening?

A. I did the normal rounds. I can't—I can't give you a definitive number, but I did my checks on Cornelius Howell.

Q. You didn't do them every 10 minutes, did you?

A. From what I can recall, there was, you know, the normal stuff going on. I could have done them from—anywhere from 6 minutes from each other to 10 minutes to 15 minutes from each round.

Q. Okay. But you've had full access to the video of that night, right?

A. I've watched—I watched some, but I haven't watched the full four hours of it.

Q. Okay. Well, you weren't responsible for the full four hours of checks, right?

A. I was not.

Q. Okay. Have you watched the portions of the film for the period of time that you were responsible for?

A. I watched some of it. I haven't watched all.

Q. And you know that the film shows you checking on him a total of six times, right?

A. I haven't counted each check. I watched some of it. I haven't watched it all.

Q. You logged in that you were checking on him every 10 minutes, didn't you?

A. I did.

Q. But you weren't, in fact, checking on him every 10 minutes, correct?

A. I was checking on him anywhere from 6 minutes to 10 minutes of it or 15 minutes of it—of each check. You know, things go on on our unit. You know, sometimes it's not always up to 10 minutes on the dot.

Q. Do you have Exhibit 6 with you, the Restraint Chair Form?

A. Yes, I do.

Q. Before—so the first three lines have his name, the reason in the chair, the time placed in the chair. Do you see those first three lines?

A. Yes, I do.

Q. Does your handwriting appear anywhere in those first three lines?

A. On the third at 1800.

Q. Okay. You're down in the blocks. I'm just—I'm talking about up in the introductory part where—

A. Oh.

Q. So let's take it—let's take it line by line. So at the very top, do you see where it's typed in

Restraint Chair Form, and above that, it says A-6?

A. Mm-hmm.

Q. Is A-6 your writing?

A. It is not.

Q. The next line, it says, Inmate name and number. Is that your handwriting?

A. I don't believe it is.

Q. Okay. Below that, it says—I can't even read that, but something's circled, and then it says, Reason in chair: Per medical uncooperative for his safety. Is that your handwriting?

A. I don't believe it is.

Q. Okay. The next line where it says, Time placed in chair, 1740, is that your handwriting?

A. I don't believe it is.

Q. Okay. So now let's go down to this block that's the first hour of observed behavior. You're with me, right?

A. Yes.

Q. The first two entries at 1740 and 1750 are not yours, are they?

A. They are not.

Q. Then the ones for 1800, 1810, 1820, 1830, and 1840 are; is that right?

A. That is right.

Q. And the first one—for 1800, what is the observed behavior?

A. It says, Yelling in chair.

Q. And then the next four all say, Chair; is that right?

A. Yes, it is.

Q. And then you've got your initials on the right side of each of those five entries; is that right?

A. That is correct.

Q. And what are your initials?

A. DBE.

Q. D—I'm sorry. What's the middle initial?

A. David Boyd Edward.

Q. Okay. All right. Then if we go to the second hour, what's the first time entry there?

A. 1850.

Q. And then what's the next time entry?

A. It says 10.

Q. That's a one—zero?

A. Yes, it is.

Q. And both of those are your entries, right?

A. Yes.

Q. And the observed behavior is chair?

A. Yes.

Q. Now, that would be—between 1800 and 1910, that would be seven checks, correct?

A. That is correct.

Q. You didn't do seven checks between that time, did you, sir?

A. From—from what I recall, you know, watching the video, there's only a few checks that I, you know, recall watching from the video.

Q. You didn't do seven checks between 1800 and 1910, did you, sir?

A. From what I recall from the video, from what I saw, I can't give you a correct number of checks that I did.

Q. But it was less than seven, wasn't it?

A. From what I recall, you know, looking at the video, the short video, I can't give you a correct number.

Q. Why can't you give us a correct number?

A. Because I didn't watch the full four hours of video. I only watched the—a certain amount.

Q. Why didn't you watch the full four hours?

A. I only watched a little bit of the video. I didn't watch the full four hours.

Q. Why not?

A. I watched the first—first hour and tried to figure out which—which checks they were and who was doing the checks. I didn't watch the full four hours.

Q. Why didn't you watch the first—the full four hours?

A. I was just trying to watch where I was doing the checks. I couldn't give—I couldn't figure out how many checks I did.

Q. You read Deputy Collini's testimony, didn't you, sir?

A. I did not. I glanced over it. I didn't read in description of his testimony.

Q. Did you glance over the part where he admits that his entries on the Restraint Chair Form are false?

A. I didn't get into the detail of his testimony.

Q. Your entries are false just like his, aren't they, sir?

A. From my understanding, they're—you know, I was checking on Cornelius from anywhere from 6 to 10 minutes to 15 minutes.

Q. Then why were you recording that you were doing it every 10 minutes?

A. There are things that go on on the psych unit that, you know—you know, if I was checking on him and then something happened, I may have missed a check and forgot to write on it. I wasn't trying to mislead anybody or I wasn't trying to fabricate a document.

Q. So let's look—go back to Exhibit 6. And let's say, for example, you're recording at 1820 that he's in the chair. Okay?

A. Mm-hmm.

Q. What time did you actually write that into the form?

A. It says 1820.

Q. I know that's what it says, but I'm asking what time did you actually sit down and make that entry on the form?

A. It could have been anywhere from 1810 to 1830, but I did check on him in between those two times.

Q. Why didn't you put the accurate time that you checked on him?

A. Like I said, like, there's things that go on on the psych unit where, you know, my attention is drawn elsewhere; and I may not have been precise on the form, but I wasn't trying to be misleading.

You know, it's—the things happen on our floor where my attention gets drawn elsewhere, and I may have gotten away from the form, but I—that was not my intention to mislead anybody on this form.

Q. I didn't ask about your intention. I asked about what time you actually entered that and why you didn't put the accurate time. So in your Answers to Admissions, you admitted that you saw him at approximately 6:06 p.m.; in other words, 1806. Why didn't you enter 1806 instead of 1810?

A. Like I said, my attention was drawn elsewhere, and, you know, it wasn't trying to be misleading. You know, trying to keep up on the form, you know, my attentions were drawn elsewhere. So I wasn't trying to be misleading on this form at all.

Q. Where was your attention drawn?

A. The other suicide watches or we were doing med pass or other people came down. We were placing other inmates in disciplinary pods or we were dealing with something in C Pod.

Q. But despite all that, the policy is that you're supposed to check on people in the restraint chair every 10 minutes, right?

A. The policy, it does state that, but it's also a guideline. You know, it's just under the circumstances that . . . You know, things happen down on the psych unit, and the attention is drawn elsewhere, and it may not be precisely at 10 minutes, but it's just some sort of—it's a guideline that you follow.

Q. It's flexible depending on the circumstances. Is that your testimony?

A. It is flexible upon the circumstances.

Q. So going back to Exhibit 6, this Restraint Chair Form where you're making the entries every 10 minutes is how you did it every night; is that right?

A. This could have—

MR. WELCH: Objection. Go ahead. You can answer.

A. This could have been an extenuating circumstance, but that is not how every night it happens down there.

Q. How was this night different than any other that you worked?

A. This night could have been different by—

Q. No, I'm not asking you how it could have been. I'm asking you how it was different

A. This night was different from any other night due to the fact of what—what all went on beforehand and during the—during the—during the day of the shift, what was going on at psych that night. But it was just one of those nights, one of those—those nights where, you know, my attention was drawn somewhere else, and I just wanted to kind of keep up on the paperwork.

Q. Well, explain that to me better. So all those things that you say were going on, please give me the details on that. Like, one thing you said was in the day beforehand. What did you mean?

A. The day beforehand, I think I meant before he came down, just what he was all involved with, the fight with him—his cellmate, him going down, everything going on. I believe one of our disciplinary inmates was threatening all of us as well, so we had to deal with that up—along with him, everything else in C Pod, doing med pass as well.

Q. Okay. So you mentioned the fight that Howell was in. How often is there a fight in the Justice Center?

A. It is . . . A fight like that is rare. There's only been a few other instances where I can remember an inmate using a pencil for—as a weapon against his cellmate or against, you know, a corrections officer. It's very rare for that kind of fight. But, you know, it's—it's maybe a—you know, a few times a week, you know, there was

a fight with inmates either inmate—inmate or inmate—officer.

Q. By 1740 that evening, the fight was over, right?

A. Yes, it was.

Q. So how did the fight affect your ability to monitor Cornelius Howell every 10 minutes after 1740?

A. It didn't affect my ability. It was just everything going on on our unit that may have drawn my attention. But I didn't stray away from checking on him, you know, over the night that he was in our—in our custody.

Q. What else was going on in the psych unit besides Cornelius Howell—

A. We had—

Q. —that evening?

A. We had med pass going on; we had, you know, our disciplinary pod and D Pod; you know, we had to do all those hour outs. I believe we were actually packed.

You know, it's just everything going on from there. There was other signals called in the—in the buildings. All that—all that kind of regular stuff on our unit.

Q. Yeah, regular stuff. Med pass is regular, right?

A. It is, but sometimes, you know, very—very different, hit or miss. Depends on who was working that night. You know, it can go very smoothly, or it can be very—very sporadic as well.

Q. How many suicide watches did you have at the time that Cornelius Howell was in the restraint chair?

A. From that, I can't—can't recall. I don't know how many we had.

Q. Do you think it was more than normal?

A. I can't remember how many we had that night.

Q. And how often are you supposed to check on inmates on suicide watch?

A. That is the—it's 10 minutes as well.

Q. Do you do those at the same time that you do the restraint chair checks?

A. We do.

Q. You said something about an inmate in disciplinary making threats. Is there any documentation of that that you've seen?

A. I don't recall.

Q. Who was the inmate?

A. From that, I can't remember.

Q. What was he doing?

A. He was—I can't recall. He was either threatening not to give the trays back during chow or, you know, yelling at us, threatening us. Once he's on his hour out, you know, he's going to do something, but I can't recall specifically.

Q. Okay. But that would be in a log someplace, right?

A. It would be. We'd probably notify our supervisor; but from that, I can't recall if, you know, we did or not.

Q. So any unusual events that evening that prevented you from checking on Cornelius Howell would be documented somewhere, correct?

A. It would be or—yeah, it would be; but from what I can remember, I don't know if we did or not that evening.

Q. So let me just go back to this Exhibit 6. So every time you worked a shift where you were checking on an inmate in a restraint chair, you made sure that you logged in the checks every 10 minutes, correct?

A. I made sure that there was either what's in those 10—minute intervals or thereabout.

Q. All right. And I'm asking you about the log entries, not whether you did the checks or not. The log entries every shift show every 10 minutes being logged in, right?

A. Every 10 minutes or, you know, 1 or 2 minutes, between those times.

Q. So you're saying that on some occasions, you would put—like, instead of 1810, 1820, 1830, 1840, you would put maybe 1802, 1814, something like that?

A. That is correct, because . . . That would be . . . That would be how we would log it.

Q. So on those nights, you would accurately record the times that you did the checks?

A. To the best of my knowledge, yes. But on this form, I . . . On this form, it does show that 10 minutes every—check every 10 minutes.

Q. But it's not accurate, is it?

A. I was trying to make the checks every 10 minutes. I was . . . And that's what the document shows.

Q. The document shows that you were trying to make the checks every 10 minutes?

A. The document shows that I was doing the checks every 10 minutes. And I wasn't trying to be misleading on this.

Q. All right. Let's go down, and let's just complete our understanding of this form. So in the middle of the form, there's handwriting that says, Sleeping, doesn't want. Is that your handwriting?

A. That is not.

Q. Okay. Then under the 3-hour block, the first four entries are yours, aren't they?

A. That is—that is correct.

Q. And that's 2000, 2010, 2020, and 2030, right?

A. That is correct.

Q. And all four say, Chair, correct?

A. That is correct.

Q. When you did these checks, describe for us how you did them.

A. I would go into A Pod where the restraint chair cell is, look in the window, the small little window that we have in the door, and observe the inmate, and then go back and write down on the form.

Q. And when you looked through the window, what—did you see Cornelius Howell from the front, back, or side?

A. It would be from his left side.

Q. So you would see his left side?

A. Yes.

Q. Were you able to make eye contact with him?

A. I believe at that point, he appeared to be sleeping.

Q. On every check?

A. From when I took over at 2000, that's what he appeared to be, sleeping.

Q. Did you ever offer him water?

A. I did not because he appeared to be sleeping.

Q. Did you ever ask him whether he needed to use the restroom?

A. From that, I can't recall. It was either that because he appeared to be sleeping or he never asked.

Q. Did you ever attempt to initiate any conversation with him after 1800?

A. I can't recall. I don't believe I did.

Q. Your entries that say chair, what does that mean?

A. That means he's sitting in the chair or sleeping in the chair, looking around in the chair, looking out the window in the chair.

Q. It could be any of those?

A. It could be any of those.

Q. Why didn't you write sleeping in the chair or looking around in the chair?

A. That, I can't recall. It was just—it's just how I notated it.

Q. Is that how you were taught to notate this form?

A. It was not.

Q. How were you taught to notate this form?

A. It was more of, you know, on the—on-the-job training. You know, just write—write what you feel is, you know—is correct.

Q. What about being descriptive?

A. That's just how I notated it.

Q. Well, weren't you taught to be descriptive with the entries?

A. There wasn't really a correct or incorrect way for—that I was taught to write on this. It was just write—write what you see.

Q. Well, we'll look at the policy in just a second, but if there—there is video of you and Deputy Collini sitting at a table together after Cornelius Howell is found dead. Are you aware of that?

A. I'm not.

Q. And isn't it true that what you two were doing was filling out this Restraint Chair Form to indicate you had checked on him every 10 minutes?

MR. WELCH: Objection. You can go ahead and answer, Dan.

A. No, I don't recall that.

Q. Are you denying under oath that you and Deputy Collini sat down after Cornelius Howell's death and filled out this Restraint Chair Form?

A. I am not.

Q. You're not denying that?

A. I'm not.

Q. Okay. All right. Let's look at Exhibit 2. And do you remember ever seeing this before the death of Cornelius Howell?

A. They would give us policies and procedures, and we would review them, read them, and sign off on them.

Q. Do you believe that you—you signed off on this one at some point?

A. Yes.

Q. Do you believe you were aware of these policies and procedures before the death of Cornelius Howell?

A. Yes.

Q. Would you please go to page 3. And there's a heading that says Roman numeral VI, Restraint Chair. Do you see that?

A. Yes.

Q. And if we go down to paragraph B, as in boy, the second sentence says, Upon placement in the restraint chair, a member of the health—trained staff must examine the inmate every 10 minutes. Do you see that?

A. I do.

Q. What's your understanding as to who health-trained staff are?

A. My understanding from that sentence is a—is a member of either the corrections staff or medical staff.

Q. Okay. Did it include you when you were a corrections officer there?

A. Yes, since this is—we have—we hold the restraint chair cells.

Q. Okay. The next paragraph, C, says, All log entries shall be complete noting the condition of the inmate and his or her activities at the time or any significant developments. Were you aware of that policy?

A. Yes, I was.

Q. And do you believe that simply noting "chair" complies with this policy?

A. I do.

Q. Does "chair" note the inmate's activities such as sleeping, looking around, things like that?

A. I do. It's because it says any significant developments. There wasn't any significant developments from when he was in the chair.

Q. Okay. You see the "or" in front of the words "any significant developments"?

A. I do.

Q. Nevertheless, you believe that simply writing "chair" complies with this policy?

A. I do.

Q. Do you know whether Cornelius Howell was ever considered for limb rotation?

A. Counsel, can you repeat that question?

Q. Yeah. So I was referring to paragraph D, as in dog, that talks about an inmate has to be offered the opportunity for a limb rotation every two hours.

Do you know whether Cornelius Howell was ever considered for that opportunity?

A. I cannot recall; however, every—every circumstance is different. So whether he was asleep or yelling, he was . . . Every circumstance, you know, is different.

Q. But I'm asking specifically about Cornelius Howell. Were you involved in any way with any decision to offer him limb rotation at two hours?

A. I do not believe so.

Q. Were you aware of anyone considering him for limb rotation at the two—hour mark?

A. I cannot recall.

Q. Then the next paragraph—well, not the next one—F, that says, The restrained inmate must be considered for removal from the restraint chair at least hourly, and it goes on, but there's no minimum time an inmate can be restrained in the restraint chair.

Are you aware of anyone who considered Cornelius Howell for removal from the chair prior to the four-hour mark?

A. I cannot recall.

Q. Okay. Let's go to Exhibit 10, which is the Hamilton County Sheriff Investigation Report. Do you have that?

A. Yes, I do.

Q. Okay. If you go to page 4 of that document, about halfway down starts the summary of the investigator's interview with you, right?

A. Yes.

Q. Give me just a second here. So if you go to the paragraph that starts, Deputy Erwin advised Deputy Barth, do you see that paragraph?

A. I do.

Q. And the fourth line down, there's a sentence that starts, Deputy Erwin advised his understanding was inmate Howell was going to be placed in the restraint chair and sent out to the hospital. Is that accurate as to what you told Deputy Barth?

A. It was—it was discussed that he was going to go out to the hospital, so it was—at one point, it was considered he was going to go out, but . . .

Q. Well, did you tell Deputy Barth that it was your understanding that Howell was going to be sent to the hospital?

A. I believe—

MR. WELCH: Objection. Go ahead. Object. Sorry. Go ahead and answer.

A. I believe from my understanding that it was at some point, he was going to go out to the hospi-

tal; but after that—after the decision was made that he was—he was not going out, it was—you know, it was my assumption that he was going to go be placed in the restraint chair at psych.

Q. Towards the end of that paragraph, there's a sentence that says, Inmate Howell was apologetic after he was placed in the chair, which is the norm; is that accurate?

A. Yes. When inmates go in the chair, they're normally apologetic.

Q. And that's what Howell's demeanor was, right?

A. Yes.

Q. And then the next sentence says, Deputy Erwin advised inmate Howell had no complaints after he was placed in the chair but was grunting a little bit; is that accurate?

A. Yes.

Q. Then the first sentence of the next paragraph says, Deputy Erwin advised he heard a nurse say inmate Howell was going to the hospital which led him to believe inmate Howell was going to the hospital due to refusing treatment because something was wrong with him, and he needed to be looked at further to be assessed. Is that accurate?

A. Yes. With the discussion of them talking to our supervision that he should go out to the hospital, it was my assumption that he was going to the hospital. But when the determination from the medical staff warranted him not going to the hospital, he was going to come to us at psych.

Q. I'm missing page 5 on my exhibit. Let me try to reload that. Okay. So on the next page, page 5, there's a paragraph that starts, Deputy Erwin advised he heard a nurse. Do you see that paragraph?

A. I do.

Q. The last sentence there says, Deputy Erwin advised he was upset about the situation because he thought inmate Howell should have gone to the hospital. Is that accurate?

A. From my determination from the discussions between our supervision and the nursing staff, they were talking about him going out to the hospital.

But when it was determined that he wasn't going out, it was my assumption that he was coming to us. So I believed that there was nothing else that warranted him to go to the hospital.

Q. Did you tell—

A. But at the—

Q. I'm sorry. Go ahead.

A. But at the time, it was perceived that he was going to the hospital, and so it was what I thought was—you know, he was going out for—for him refusing medical treatment. So at the time, I thought it was something more; but after that determination from the medical staff, it was, you know, not a thought from me.

Q. Did you tell Deputy Barth that you were upset about the situation because you thought Howell should have gone to the hospital?

MR. WELCH: Objection. Go ahead. You can answer.

A. At the time I told Barth because they were so adamant about him going out, and then they determined that it was—it didn't warrant him to go out to the hospital. So I just told him how—you know, what I thought was going—was going to happen, so . . .

Q. I may have messed up that question. I was assuming that Deputy Barth was the person authoring this report, and I'm not sure that's accurate now. Whoever's the author of this report—let me rephrase the question. Did you tell the author of this report that you were upset about the situation because you thought inmate Howell should have gone to the hospital?

MR. WELCH: Same objection.

Q. Is your answer the same?

MR. WELCH: Sorry. Same objection, but you can—you can answer it again, Dan.

A. I think I told the authorization of this report how I told—was talking to Deputy Barth about it from what I recall.

Q. All right. Let's go to . . .

MR. KIRCHER: Well, I'll tell you what. Hey, John, let's take—let's take five minutes.

MR. WELCH: Okay.

MR. KIRCHER: Then I'll finish up after that.

MR. WELCH: Okay.

(A brief break was taken.)

Q. (By Mr. Kircher) All right. Pfc. Erwin, it's my understanding that you want to correct or modify an answer.

A. Yes, that is correct. Counsel, I might have misunder—misinterpreted one of your questions about me and Deputy Collini going back and—after the fact that Cornelius Howell was deceased, going back and fabricating the log sheet. That was—that's incorrect. We would do nothing like that, so I just want to say that—that we would not do that.

Q. And you're now stating under oath that you did not sit down with Deputy Collini after Cornelius Howell's death and fill out that record?

A. Yes, that is correct. We did not.

Q. And you are now denying that you did that?

A. Yes.

Q. All right. Let's look at Exhibit 40. And do you remember answering these questions?

A. Yes.

Q. And do you remember that—you know, they go through and they say, Admit that at so and so a time, you observed Cornelius Howell. Do you remember going through that process?

A. Yes.

Q. And there were six times that are shown on the film that you admitted observing Cornelius Howell, right?

A. Yes.

Q. And then on the fifth page of the document, number 29, we say that, Other than those six times, admit that you did not observe Mr. Howell. And you said you can't admit or deny that request, right?

A. Yes.

Q. And in the next request, we said, If you don't admit that previous request, then tell us why. And you said, There are records indicating additional times of checks or observations. And in number 31, we asked you to explain that answer, and you said, See the Restraint Chair Form. Do you remember doing all that?

A. Yes.

Q. So if we make the jury watch all four hours of that video, do you believe they are going to see you check on Pierre Howell, Cornelius Howell, more than six times?

A. That . . . From what I watched from the video, we saw the first few times that I went in and checked on him. Now, the restraint chair log has my checks split up, so I can't—since I didn't watch all four hours, I can't say that I did or didn't check on Pierre for those four hours.

Q. I'm going to ask the question again. Okay? Do you believe if the jury watches all four hours of that video, they are going to see you check on Howell more than six times?

A. From those six times, I believe that, from what I watched, they can see that the—that I checked on Pierre those six times.

Q. Okay. Do you think they'll see any more than those six times?

A. I can't say that they will or will not because I did not watch the full four hours.

Q. And you've had the opportunity to do that, though, haven't you, to watch the four hours?

A. I did.

Q. And in responding to this document where we asked you to admit that you did not do—you did not check him any more than six times, you didn't bother to look at all four hours to answer that question, did you?

A. I did not.

MR. KIRCHER: Okay. I don't have any further questions. Bob, do you have anything?

MR. HOJNOSKI: I do not. Thank you.

MR. WELCH: We'll read it.

(Whereupon, signature was requested, and the deposition concluded at 4:14 p.m.)

/s/
Daniel Erwin

DECLARATION OF GRETEL C. STEPHENS (MARCH 11, 2021)

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

KARLA HOWELL AS ADMINISTRATRIX OF THE ESTATE OF CORNELIUS PIERRE HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

Case No. 1:19-cv-00373

Before: Douglas R. COLE, Judge,
Stephanie K. BOWMAN, Magistrate Judge.

DECLARATION OF GRETEL C. STEPHENS, M.D.

I, Gretel C. Stephens, M.D., pursuant to 28 U.S.C. § 1746 declare under the penalty of perjury that the following is true and accurate:

1. I am a Deputy Coroner at the Hamilton County Coroners Office.

2. On December 10, 2018, I performed the post-mortem examination of the body of Cornelius Pierre Howell.

3. The documents attached to this Declaration as Exhibit A are true and accurate copies of the postmortem examination of Cornelius Pierre Howell, death record, and my opinions. The document attached to this Declaration as Exhibit B is a supplemental report I authored at the request of counsel in this matter.

4. Attached to this Declaration as Exhibit C is a copy of my curriculum vitae.

5. The opinions rendered in Exhibits A and B to this Declaration are held to a reasonable degree of medical probability based upon my knowledge, training, and experience.

/s/ Gretel C. Stephens, M.D.

Date: March 11, 2021

EXHIBIT A

Death Record
HAMILTON COUNTY CORONER'S OFFICE
Cincinnati, Ohio

Case No. CC18-04361

Reported By: Detective Mike Stock

Case Type: Autopsy Case

Case Reported: 12/09/2018

Agency: Hamilton County Sheriffs Office

Time Reported: 11:58 pm

Reported To: Dylan Wical - Gretel C. Stephens, M.D.

Name of Deceased: Cornelius Pierre Howell

Address Street & No.: 2860 Harrison Avenue

City/State: Cincinnati, Ohio

Zip Code: 45211

Marital Status: Single

Age: 33

Birth Date: 08/26/1985

Sex: Male

Race: Black

Found dead at:
900 Sycamore Street, Cincinnati, Ohio, 45202

Injured at:
1000 Sycamore Street, Cincinnati, Ohio 45202

Date: 12/09/2018

Next of kin notified by: Hamilton Co. Sheriffs Office

Date: 12/09/2018

Pronounced dead by: Dr. Gretel C. Stephens

Date: 12/09/2018

Time: 11:23 pm

Postmortem examination by: Gretel C. Stephens, M.D.

Date: 12/10/2018

Dis position of body: Buried

Location: Spring Grove Cemetery, Cincinnati, Ohio

Date: 12/20/2018

Funeral Director: Walker Funeral Home –
1013 E. McMillan Street, Cincinnati, Ohio 45206

IMMEDIATE CAUSE OF DEATH

Due to (A) Sickle crisis following physical altercation – MINUTE

Due to (B) Hemoglobin SC – INBORN

Part II. Other significant conditions contributing to death but not related to the terminal disease condition given in Part (A).

Increased pulmonary fibrosis due to tobacco smoke exposure

Manner of Death: Homicide E960 E970.l

Death Certificate Distribution: BVS Date: 03/05/2019

/s/ KB Looman
Acting Coroner of Hamilton County, Ohio

Hamilton County Coroner
The Frank P. Cleveland, M.D.
Institute of Forensic Medicine,
Toxicology and Criminalistics
3159 Eden Avenue, Cincinnati, Ohio 4521902299
Office: 513-946-8700 Fax: 5130946-8727

CORNELIUS PIE RRE HOWELL CC18-04361

Opinion

Diagnoses:

1. History of Hemoglobin SC with history of sickle crises and acute sickle crisis (engaged in a physical altercation prior to onset of terminal sickle crisis):

A. Few petechial hemorrhages of the conjunctivae

B. Uniform dark red discoloration kidneys with sickled red blood cells in the markedly congested vessels

C. Uniform dark red discoloration of the liver and spleen with increased firm texture with sickled red cells distending the markedly acutely congested sinusoids:

i. Areas of retracted cicatrization involveing the liver.

D. Acute circulatory failure:

i. Pulmonary and cerebral edema

ii. Acute passive congestion of the liver and spleen

iii. Acute hemorrhagic gastritis.

E. Cholecystectomy for cholecystolithiasis,

remote

F. Red-brown discoloration of some peripancreatic lymph nodes

G. History of aseptic necrosis of the hip.

2. History of physical altercation with cell mate at the Hamilton County Criminal—Justice Center 12/9//2018 with subsequent complaints of back pain and later found unresponsive in a restraint chair:

A. Abrasions of the left side of the lower lip and ventral lower legs without other gross injuries found.

3. History of prior tobacco smoking:

A. Chronic bronchitis and mild black discoloration of the pulmonary lymphatics

B. Increased pulmonary fibrosis.

4. History of attention deficit/hyperactivity disorder.

5. Moderate cervical vertebral osteoarthritic changes with mild changes of the remainder of the spine.

6. History of multiple prior stab wounds in December 2017:

A. Healed oversewn, pledget-reinforced area of the ventral margin of the right ventricular myocardium at the septum.

B. Healed median sternotomy with wires.

C. Fibrous adhesions of the pericardium, ventral left pleura, and peritoneum.

Cause of Death: Sickle crisis following physical altercation due to hemoglobin SC.

Contributory Cause of Death: Increased pulmonary fibrosis due to tobacco smoke exposure.

Manner of Death: Homicide.

Comment: Although the injuries from the altercation at the jail which occurred prior to his sickle crisis were not major, his increased physical exertion is thought to have led to his sickle crisis making his manner of death medically a homicide, even though the investigative information suggests that Mr. Howell was the initial aggressor in the altercation and the other participant's actions were primarily in self-defense.

/s/ Gretel C. Stephens
Gretel C. Stephens, M.D.
Deputy Coroner, Forensic Pathologist
Hamilton County, Ohio

3/6/2019
Date

POSTMORTEM EXAMINATION OF THE BODY OF CORNELIUS PIERRE HOWELL

A postmortem examination of the body of an adult black man identified by is jail identification wristband which is left on the body as Cornelius Howell is performed at the Hamilton County Morgue on Monday, December 10, 2018. The examination is conducted by Gretel C. Stephens, M.D., and is begun at 9:45 a.m.

EXTERIOR OF THE BODY:

The body is that of a well-developed, well-nourished adult man that weighs 151.5 pounds as received clothed in broad transverse gray and light gray striped jail attire of shirt and pants; a pair of short white socks with gray souls; and a pair of black, blue and white small plaid boxer shorts. The body measures 69 inches in length. The body mass index is 22.37 kilograms per meter squared. The body appears compatible with the stated age of 33 years. The body is cool to touch. Rigor mortis is fully fixed in the extremities and jaw. Livor mortis extends over the posterior surface of the body, except in the areas exposed to pressure

The scalp hair is black, is arranged in corn rows and measures 4 inches in length. Black with minimal gray facial hair up to 1 inch in length is also present. The irides are round and the corneas are clear. The pupils are bilaterally equal and 4 millimeters in diameter. The sclerae and conjunctivae show a few petechial hemorrhages and early tache noire. The nose shows no remarkable alteration. The ears show a singly pierced left earlobe. The lips and gums show an area of abrasions of the left lower lip. The teeth

are natural and in good repair. The neck is supple, without masses, and the larynx is in the midline.

The thorax is well-developed and symmetrical. The breasts are normally developed and symmetrical male breasts without palpable masses. The abdomen is relatively flat. The external genitalia are those of a normal circumcised adult penis with bilaterally descended testes which are at the upper limits of normal size. The anus and back are unremarkable.

The upper and lower extremities are well-developed and symmetrical without absence of digits. There is mildly increased scaling of the skin of the lower legs and feet.

IDENTIFYING MARKS AND SCARS:

There is a median sternotomy pigmented scar with satellite suture scars. There are two short transverse pigmented scars of the upper abdomen to the right and left of the inferior end of the sternotomy scar. There are three transverse short scars which show outer pigmentation and pale centers involveing the left pectoral area. There is a transverse short pigmented scar of the medial left pectoral area. There are two oblique vertical short pigmented scars of the right medial and lower right medial abdomen. There is a pigmented, slightly arcuate linear short scar of the right medial presacral area of the back. There are two vertical pigmented scars of the dorsal and right upper shoulder. There is a small transverse pale scar of the right medial dorsal lower neck. There is an oval, pigmented scar of the ventral left thigh. There are four small pale scars of the area of the ventral right mid-leg. There are a cluster of irregular

small pigmented scars of the area of the right dorsal mid-arm at the elbow.

CC18-04361 PAGE 2 OF 4

EVIDENCE OF MEDICAL THERAPY:

A pair of AED pads is attached to the torso along with its receptacle which is retained for return to the Hamilton County Justice Center facility. The left wristband present is a thick plastic with white insert and photographic identification wristband listing the name as "HOWELL, CORNELIUS".

EXTERNAL AND INTERNAL EVIDENCES OF INJURY:

Head and Neck:

There are abrasions of the left lower lip without deeper injury to the face, neck or head.

Torso:

There are two roughly parallel vertical short linear abrasions of the dorsolateral left mid torso.

Upper and Lower Extremities:

There is a longer irregular abrasion of the right anterior tibial skin and there is a short oval abrasion of the left anterior tibial skin.

INTERNAL EXAMINATION:

Body Cavities

No generalized fibrous adhesions involveing the pericardial sac and ventral left pleural cavity. Areas of adhesion also involve the peritoneal cavity. No abnormal collections of fluid are within any of the body cavities. All body organs are present and in

normal anatomical position. The anterior abdominal panniculus averages 0.6 centimeter in thickness.

CARDIOVASCULAR SYSTEM:

The heart is 380 grams and appears somewhat dilated. The expected size of the heart for his body size is up to approximately 309 grams. The pericardial surfaces are involved in generalized fibrous adhesions. There is an apparent healed in pledget which is oversewn in the right ventricular epicardium adjacent to the interventricular septal epicardium. No defect is identified beneath it, and no pale cicatrization is shown. The coronary arteries arise normally, follow the usual distribution, and are patent, with no atherosclerosis and no thrombi. The chambers and valves exhibit the usual size-position relationships and are unremarkable except for a somewhat dilated appearance of the entire heart. The atrial septum shows no patent foramen ovale. The ventricular septum shows no septal defect. The myocardium is red-brown and firm, without focal abnormalities. The thickness of the left ventricular compact myocardium is 15 millimeters in the slightly dilated state. The interventricular septal thickness is also 15 millimeters in the somewhat dilated state. The aorta and its major branches arise normally, follow the usual courses, are widely patent, and show no significant atherosclerosis. The venae cavae and their tributaries return to the heart in the usual distribution and are free of antemortem thrombi.

RESPIRATORY SYSTEM:

The right lung is 340 grams and the left lung is 300 grams. The upper airway contains minimal edema fluid. The mucosa is yellow-tan and smooth. The

pleural surfaces are smooth, glistening and intact with fibrous adhesions involveing the ventral left pleural surfaces. The pulmonary parenchyma exudes moderate edema fluid and is without focal lesions. The pulmonary vasculature is unremarkable.

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HEPATOBILIARY SYSTEM:

The liver is 2,020 grams. The hepatic capsule is smooth, glistening and intact, covering a dark red-brown markedly homogeneous but-congested appearing parenchyma with areas of irregular retracted scarring involveing the superficial hepatic parenchyma in areas of increased cicatrization and other areas of more normal hepatic texture. The gallbladder is chronically surgically absent with a few fibrous adhesions in the area. The extrahepatic biliary tree is patent, without evidence of calculi.

ENDOCRINE SYSTEM:

The pituitary gland is at the upper limit of normal size. The thyroid gland shows no remarkable alteration. No enlargement or other alteration of the parathyroid glands is found. The adrenal glands are unremarkable. The pancreas has the usual lobulated appearance and the ducts are clear, but the parenchyma is slightly darker and slightly more brown than usual.

DIGESTIVE SYSTEM:

The esophagus is lined by a gray-white, smooth mucosa. The gastric mucosa is arranged in decreased rugal folds, is focally hemorrhagic and the lumen contains 1,200 milliliters of yellow brown thin mush containing apparent fragments of potato and greens

such as spinach. The small and large intestines are unremarkable. The vermiform appendix is present and unremarkable.

GENITOURINARY SYSTEM:

The right kidney is 150 grams. The left kidney is 200 grams. The renal capsules are smooth, thin and semitransparent, and strip with ease from the underlying homogeneous dark, red-brown, firm cortical surfaces. The cortices are sharply delineated from the medullary pyramids, which are also dark red-brown. The calyces, pelves and ureters are unremarkable. The urinary bladder contains 100 milliliters of amber urine. The mucosa is gray-tan and smooth.

The prostate gland and seminal vesicles are unremarkable. The testes are at the upper limits of normal in size and are otherwise normal to palpation and are not removed.

RETICULOENDOTHELIAL SYSTEM:

The spleen is 680 grams and has a smooth, irregularly retracted, intact capsule covering a deep red-purple, moderately firm, congested-appearing parenchyma. The regional lymph nodes appear normal except for mild gray discoloration of the pulmonary hilar lymph nodes and dark red-brown discoloration of a few small lymph nodes along the pancreas. The exposed bone marrow is red-purple and homogeneous, without focal abnormalities. The thymus is still pinkran and is 30 grams.

MUSCULOSKELETAL SYSTEM:

The bony framework shows normal bone strength and shows moderate vertebral osteoarthritic changes which are worst in the cervical spine. The supporting

musculature appears robust. The soft tissues show no remarkable alteration although adipose tissues are reduced compared to American average.

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NECK:

Examination of the soft tissues of the neck, including the strap muscles, and thyroid gland reveals no abnormalities. The large vessels in the neck show no remarkable alteration. The hyoid bone and larynx are intact. The tongue shows remarkable alteration.

HEAD AND CENTRAL NERVOUS SYSTEM:

The brain is 1,530 grams. The dura mater and faix cerebri are intact. The leptomeninges are thin and delicate and show vascular congestion. The cerebral hemispheres are symmetrically swollen. The structures at the base of the brain, including the cranial nerves and blood vessels, are intact and free of abnormalities other than compression with notching of the uncinate gyri by the tentorium and crowding of the cerebellar tonsils at the foramen magnum. Coronal sections through the cerebral hemispheres reveal no focal lesions within the cortex, subcortical white matter, or deep parenchyma of either hemisphere. The ventricles are of approximately normal size. Sections through the brain stem and cerebellum reveal no focal abnormalities.

MICROSCOPIC EXAMINATION:

Heart: The section shows marked venous vascular congestion with multiple sickled forms identifiable within the vessels. The sections also show fine fibrous epicardial adhesions with remaining chronic inflammation.

Lungs: The sections show marked vascular congestion, edema, areas of atelectasis, areas of increased fibrosis, chronic bronchitis, chronic emphysemae with small blebs, mild anthracotic pigment deposition, and sickling of cells within the markedly congested and distended small vessels. Polarized examination fails to show foreign crystalline deposition.

Liver: The sections show extreme acute passive congestion with sickling of the cells distending the congested sinusoids. There are also areas of chronic triaditis and mild hepatocellular unrest.

Spleen: The section shows extreme acute passive congestion with sickled red cell forms distending the sinusoids.

Kidneys: The sections show extreme venous vascular congestion and congestion of the capillaries of the glomerular tufts with sickling of the red cells discernible. There is mild arteriolar sclerosis and a few glomeruli are hyalinized.

Pituitary: The sections show marked vascular congestion with sickling of the cells in the most congested areas.

Brain: The section shows vascular congestion with sickling of the cells in the most congested vessels and changes consistent with edema.

LABORATORY EXAMINATIONS:

Laboratory examinations were requested and the results attached.

03/06/2019 njb

[. . .]

HAMILTON COUNTY CRIME LABORATORY

The Frank P. Cleveland, MD. Institute of Forensic Medicine, Toxicology and Criminalistics
3159 Eden Avenue, Cincinnati, Ohio 45219-2299
Crime Laboratory 513-946-8750 Fax 513-946-8772

ANAB ACCREDITED ISO/IEC 17025 FORENSIC TESTING LABORATORY

TOXICOLOGY REPORT

SUBJECT NAME(S): Howell, Cornelius Pierre
FILE #: CC18-04361
SUBMITTING AGENCY: Hamilton County Sheriffs Office
DATE REPORTED: 02/02/2019

RESULTS:
Headspace Gas Chromatography:

Item 1-7

Specimen Peripheral blood-A

Results Ethyl Alcohol

Concentration Negative

Immunoassay Screen (ELISA) **Presumptive**:

ELISA Screen: Amphetamine, Barbiturates, Benzodiazepines, Buprenorphine, Cannabinoids, Carisoprodol, Cocaine/Metabolites, Fentanyl, Methadone, Methamphetamine, Naltrexone, Opiates, Oxycodone, Tramadol, Tricyclic Antidepressants, Zolpidem.

Item # 1-10
Specimen Serum
Results Cannabinoids
Concentration Positive

NOTE: ELISA POSITIVE RESULTS are PRELIMINARY ONLY, and are NOT considered a positive finding in the absence of a confirmatory analysis, as listed below. Presumptively positive ELISA results may not confirm.

Cannabinoids Confirmation (GCMS*):

Item # 1-7
Specimen Peripheral blood-A
Results Marihuana (THC)
Concentration 0.003 mg/L

Item # 1-7
Specimen Peripheral blood-A
Results Marihuana Metabolite (THC-COOH)
Concentration < 0.005 mg/L

General Drug Screen (GCMS*):

Item# 1-8
Specimen Peripheral blood-B
Results Diphenhydramine
Concentration Present

General Drug Confirmation (GCMS*):

Item# 1-7
Specimen Peripheral blood-A
Results Diphenhydramine
Concentration <0.100 mg/L

Vitreous Electrolytes:

Item #	Specimen	Results	Concentration
1-11	Vitreous	Sodium	153 mmol/L
1-11	Vitreous	Chloride	126 mmol/L
1-11	Vitreous	Potassium	8.4 mmol/L
1-11	Vitreous	Urea Nitrogen	10 mg/dL
1-11	Vitreous	Creatinine	0.7 mg/dL
1-11	Vitreous	Glucose	<20 mg/dL
1-11	Vitreous	Ionized Calcium	1.27 mmol/L

* Gas Chromatography / Mass Spectrometry

/s/ Robert G. Topmiller
Robert G. Topmiller
Forensic Scientist III

EXHIBIT B

Jim Ginocchio
Assistant Hamilton County Prosecutor

Re: Cornelius Pierre Howell (deceased)

In the death of Cornelius Pierre Howell, the autopsy showed that the death was caused by sickle crisis which had followed a documented physical altercation. Contributing to his death was pulmonary fibrosis due to his prior tobacco smoke exposure. He was known to have Hemoglobin SC with prior history of at least one sickle crisis.

The time frame involved in his death would have taken minutes once the sickling began. in review of his records, he apparently had continued to be excited and physically active, rolling on the floor and sliding out of the wheelchair in which he had been placed and resistant to medical intervention. Increased activity would have made him even more likely to sickle and increased the rapidity with which his sickling occurred. Once the process began, his blockages would have continued, worsened and become more severe with more activity. I listed the length of time that this took to occur and cause his death as "Minutes" for the death certificate information since his autopsy slides confirmed extensive small vessel plugging and distention by sickled red blood cells in multiple vital organs.

The notations of his actions while in the restraint chair indicate that he had continued to yell and be active until no further activity is documented for him. He had been placed in the chair at 1740-1743 hours and the first notation was at 1743 with notations of his being alert and yelling continued through 1800

hours and 1820 hours. After that no further activity was noted and he was found to be pulseless at 2145 hours. As noted by responding Cincinnati Fire EMS, he was cold and his arms and legs were stiff on their arrival at the patient at 2157 hours which stated to be due to being in rigor mortis in the EMS note. This also suggests that his death occurred in the restraint chair much earlier and closer to the time he was last noted to be moving and yelling than the time he was discovered to be without pulse or respirations.

/s/ Gretel C. Stephens, M. D.
Deputy Coroner for Hamilton County Ohio

EXHIBIT C

CURRICULUM VITAE

GRETEL C. STEPHENS, M. D.
Phone: (513) 946-8700
Email: gretel.stephens@hamilton-co.org

EDUCATION:

Graduate:

University of Tennessee Medical School, Memphis, Tennessee September 1970 — June 1974 (M.D. June 1974)

Student Fellow, Pathology, University of Tennessee 1972 — 1974

Residency in Pathology (Anatomic and Clinical), University of Tennessee and City of Memphis Hospitals 1974 —1978

Undergraduate:

University of Tennessee, Knoxville, Tennessee September 1965 — March 1969

Memphis State University, Memphis, Tennessee June 1969 — August 1970

APPOINTMENTS:

Adjunct Assistant Professor of Pathology, University of Cincinnati College of Medicine 2005 through August 2008 and March 2015 through present.

Deputy Coroner, Hamilton County Coroner's Office, State of Ohio 2005 — present

Assistant Medical Examiner of Washington, Unicoi, Greene, and Carter Counties in Tennessee through 2005

Assistant State Medical Examiner, State of Tennessee 1999 to 2005

Assistant Professor of Pathology, Quillen College of Medicine, East Tennessee State University, July 1999-June 2005

Medical Director, Woodbury Clinical Laboratory, Lebanon and Chattanooga, Tennessee, 1995 through June 1998

Adjunct Professor of Pathology, Quillen College of Medicine, East Tennessee State University, September 1996 — March 1997 and July 1998 — July 1999

Clinical Assistant Professor, Vanderbilt University Medical School, Department of Pathology, through September 1994

APPOINTMENTS (CONTINUED):

Deputy Chief State Medical Examiner, State of Tennessee October 5, 1994-June 30, 1995

Assistant Davidson County Medical Examiner, State of Tennessee November 19, 1983 — September 30, 1994

Medical Director, Upton Cytology Laboratory, 1979-1983

Medical Director, Medical Group Clinical Laboratory, 1978 — 1979

Laboratory Director, Doctor's Hospital of Memphis July 1, 1978-June 30, 1979

Instructor to medical students and MT and MLT students at the University of Tennessee, Memphis, 1974 — 1978

Assistant Shelby County Medical Examiner, State of Tennessee July 1976 — June 1978

HOSPITAL
APPOINTMENTS:

Pathologist, Nashville Memorial Hospital October 1983 — June 1986

Pathologist, St. Joseph Hospital, Memphis, Tennessee August 4, 1979 — September 30, 1983

Laboratory' Director, Doctor's Hospital of Memphis July 1, 1978 — June 30, 1979:

Consultant in Pathology, Oakville Memorial Hospital July 1977 —June 1978

PROFESSIONAL
AFFILIATIONS:

College of American Pathology, 1982 — 2007
American Medical Association, 1982 — present

OFFICES HELD:

Secretary-Treasurer, Memphis Society of Pathologists, 1983.

LICENSURE:

2005-present Ohio
1974-2005 Tennessee

CERTIFICATIONS:

American Board of Pathology:

1994 Special Qualification as a Specialist in Forensic Pathology

1979 Anatomic and Clinical Pathology

PUBLICATIONS:

1. Harlan, Charles W., Bell, J.S., Stoskof, M.K., Harlan G.C.: "Sudden Unexpected Death in the Swimming Pool." Journal of the Tennessee Academy of Science, Volume LIV, No. 2, April, 19789; Page 68. (Also, oral presentation by C.W. Harlan to Annual Meeting of Tennessee Academy of Science, November, 1978). Abstract. Academy of Science, July, 1979.

2. Harlan, Charles W., Bell, J.S., Harlan, G.C.: "Typhoid Fever; Report of a Case." Journal of the Tennessee Academy of Science, Volume LIV, No. 2, April, 1979, Page 67. (Also, oral presentation by C.W. Harlan to Annual Meeting of Tennessee Academy of Science, November, 1978). Abstract. (Paper submitted to the Tennessee Pathologist, June, 1979).

3. Ferslew, KE, Hagardorn, AN, Harlan, GC, McCormick, WF: "A Fatal Drug Interaction Between Clozapine and Fluoxetine." J. Forensic Sci. 1998 Sept 43 (5): 1082-5.

4. Burrows, DL, Hagardorn, AN, Harlan, GC, Wallen ED, Ferslew, KE: "A Fatal Drug Interaction Between Oxycodone and Clonazepam." J. Forensic Sci. 2003 May 48 (3): 683-6.

5. Burrows, DL, Nicolaides, A, Stephens, GC, Ferslew, KE: "The Distribution of Sevoflurane in a Sevoflurane-Induced Death." J. Forensic Sci. 2004 Mar 49 (2): 394-7.

6. Burrows, DL, Nicolaides, A, Stephens, GC, Ferslew, KE. "Sevoflurane Analysis in Serum by Headspace Gas Chromatography with Application to Various, Biological Matrices." Journal of Analytical Toxicology, Vol. 28, Sept 2004: 418-421.

DECLARATION OF LIEUTENANT ANDREW GUY (MARCH 11, 2021)

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

KARLA HOWELL AS ADMINISTRATRIX OF THE ESTATE OF CORNELIUS PIERRE HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

Case No. 1:19-cv-00373

Before: Douglas R. COLE, Judge,
Stephanie K. BOWMAN, Magistrate Judge.

DECLARATION OF LIEUTENANT ANDREW GUY

I, Andrew Guy, pursuant to 28 U.S.C. § 1746 declare under the penalty of perjury that the following is true and accurate:

1. I am a lieutenant in the Internal Affairs Section of the Hamilton County Sheriffs Office.

2. The documents attached to this Declaration are true and accurate copies of the Internal Affairs

Investigation Report and attachments relative to the in-custody death of Cornelius Pierre Howell, IA#78-18, dated December 9, 2018.

Respectfully

/s/ Lt. Andrew Guy

Date: 3/11/2021

Memorandum

From the desk of:
aguy@sheriff.hamilton-co.org
Office (513) 946-6652

To: Chief Mark Schoonover
Date: December 9, 2018
Re: In Custody Death-Cornelius Howell IA# 78-18

On December 9, 2018 the Internal Affairs Section was notified of an in Custody death that occurred on North 21 A Pod, Cell #6 at approx. 2147 hours. I was advised that the Corrections Administration had been notified as well as CIS personnel.

The deceased is identified as Cornelius Howell, NI/13, DOB 8/25/85, SSN ------ and had apparently been incarcerated at the Hamilton County Justice Center since 12/2/18 for Criminal Damaging and Aggravated Menacing.

Upon my arrival to the Hamilton County Justice Center at approximately 2300 hours I was met by CIS Investigators Michael Stock, Matthew Wissel, Larry. Powers, and Heather Sanderson. We all responded to the decedent's location in A Pod on North 21. Once on post, investigators were met by Captain Kerr, Sgt. Hunt, Sgt. Franklin, Sgt. Timon, and. Deputy Spence.

Upon our arrival to North 21, the scene was secured and all inmates were locked in their cells. Captain Kerr and Sgt. Franklin advised investigators that at approximately 1700 hours the victim, Cornelius Howell was taken to medical after he got into a fight with his cellmate Demarcus Grant. While at medical being checked out, inmate. Howell was yelling and sliding out of the wheelchair and complaining about

back pain. Howells handcuffs were moved to the front by Deputies so he could be evaluated. Inmate Howell complained to Naph Care medical staff about back pain and wanted to lie down on the floor as he continued to slide out of the chair. He would not cooperate with the medical staff and eventually laid flat on the floor. Naph Care medical staff attempted several tests on him and attempted to give him medication but he spit it out. Naph Care nurse Christina Jordan told Howell he was not going to the hospital and she wanted him to urinate in a cup, He refused to urinate in a cup and Nurse Jordan made the decision that inmate Howell was having a mental health issue. Nurse Jordan then said she wanted Inmate Howell placed in the restraint chair for his safety. Howell was not combative with Deputies while being placed in the restraint chair. The nurse then checked the restraints to make sure they were not too tight and Howell was then wheeled down to. North 21 and placing in A Pod, cell 3. Inmate Howell was then checked on by Deputies every 10 minutes by the housing officer looking through the cell door window.

Captain Kerr and Sgt. Franklin then went on to state that Sgt. Hunt came back to North 21 at approximately 2145 hours to remove inmate Howell from the restraint chair so he could be placed in cell 1. Inmate Howell was asked by Sgt. Hunt if he was ready to come out of the chair and he did not respond. After no response, inmate Howell was then shaken and given a sternum rub. Medical staff was then called on. the radio to respond to. North 2 Ito check on Howell. Naph Care nurses responded and felt inmate Howell's arm and then requested Howell be removed

from the restraint chair. Howell was then removed from the restraint chair by Deputies and a Naph Care nurse began performing CPR. Paramedics and firefighters from the Cincinnati Fire Department arrived a short time later but did not perform life saving measures. The paramedics felt inmate Howell's arm and said it was cold and told the medical staff to stop performing CPR on Howell and pronounced him deceased. At that time the area was secured and the notification process began along with CIS and Internal Affairs.

Detectives from CIS then. went into. A Pod and began to view the body for any obvious signs of foul play and made notification to the Coroner's Office for them to respond. Hamilton County Coroner Investigator Hatfield responded and arrived on scene at approximately 12:43AM to assist in the investigation. I secured from the scene at approximately 1:45 AM to allow CIS to complete their interviews with Corrections Personnel.

In March of 2019 both the Hamilton County Coroner's Office and detectives from the Hamilton County Sheriff's Office completed their investigations.

I reviewed the completed investigation by CIS personnel and at the time of their initial examination of the body and interviews, it was still unclear on what actually caused Howells death.

I also reviewed the completed report generated by the Hamilton County Coroner's Office. The Coroner ruled inmate Howells death a homicide. The report and final determination of death was made by Dr. Gretel Stephens after toxicology results. Doctor Stephens report states that she believes inmate Howell

died of a Sickle Cell crisis that was brought on by the fight with his cellmate.

At this time the Internal Affairs Section has reviewed both completed investigations and concurs with their findings.

/s/ Mark Schoonover
Chief Deputy
4-4-19
(Concur)

Respectfully submitted,

/s/ Lt. Andrew Guy

Detective Mike Stock Case Summary

HAMILTON COUNTY SHERIFF
INVESTIGATION REPORT

Offense No. 1286018
Complainant: Cornelius Howell
Address: 1000 Sycamore Street (HCJC)
Type of Offense or Investigation: Death Investigation
Date of Offense or Incident: 12/09/18

--Details of Investigation--

On 12/09/18, at 2206 hours, Detectives Stock, Wissel, and Powers, along with Evidence Technician Sanderson, were directed by Lt. Stapleton to respond to the Hamilton County Justice Center for the report of an inmate death. Detectives arrived on scene at 2258 hours and were met by Sgt. Henn.

Investigators proceeded to the North Building, Psych Unit (G21). Present upon detective's arrival were Sgt. Timon, Sgt. Henn, Sgt. Hunt, and Capt. Kerr. The deceased was I in face u on floor in A pod. He was identified as Cornelius Howell, male, DOB of _____ SSN ------- 5'09", and extremely thin. He was incarcerated pending a criminal damaging and aggravated menacing charges. He was wearing and inmate uniform, plaid boxer shorts, and white socks.

Evidence Technician Sanderson photographed the scene. Detectives Stock, Wissel, and Powers began conducting interviews. Sgt. Hunt provided Detective Stock with a handwritten log. He identified the nurses,

who were on post, as Christina Jordan, Melissa Tucker, Ben Carl, Rose Kerrence, and Jen Carpenter. Sgt. Hunt identified the officers working the post as Erwin, Pierani, and Collini.

The times listed were as follows:

- 2145 — On post N21
- 2147—G100
- 2148 — G100 on post
- 2150-911
- 2151 — Spence, Henn, Franklin
- 2154 — Lt. Buchanan no contact
- 2154 — Capt. Kerr contacted
- 2154 — Engine 3 Medic 3
- 2156 — CFD on post
- 2156 — Sgt. Timon calling D1
- 2157 — Assessment stopped on him
- 2205 — Medic 3 off post no transport
- 2211 Engine 3 off post
- 2244 — Capt. Kerr on post

On December 10, 2018, at 0023 hours, Detectives Powers and Wissel conducted an interview of Corrections Officer Dominic Pierani at the Hamilton County Justice Center on floor 1-M of the North Building.

Deputy Pierani advised he has worked for the Hamilton County Sheriff's Office for 16 years all of which have been in the Corrections Division. He started his shift on 12/9/18 at 1500 hours working on North 21 (N-21), which is the mental health unit. His first post was acting as the suicide watch officer. He was to perform those duties until 1740 hours when he and the other two officers rotate posts. Deputy Pierani advised he did not switch at 1740 hours because there was an inmate in medical being placed

into the restraint chair. He responded to the medical unit (N-22) to assist in placing the inmate into the restraint chair, When he first arrived at the medical unit, he observed inmate Howell lying on his stomach on the floor in the sally port. Inmate Howell was complaining his back hurt and was moaning a lot. He did not complain of any other pain. Deputy Pierani assisted in placing inmate Howell into the restraint chair, while he was still handcuffed in the front. Deputy Pierani then removed the handcuff from inmate Howell who said "ow". Inmate Howell didn't complain of anything while being put in the restraint chair. Deputy Pierani advised inmate Howell complied with all verbal commands and no force was used to get him in the chair.

Deputy Pierani advised inmate Howell was then wheeled in the restraint chair down the main hallway to N-21 from N-22. Inmate Howell let out a few more moans, while being transported. Deputy Pierani advised after he chained the restraint chair to the wall in cell 6 he had no further contact with him until Sgt. Hunt came on post to remove him from the chair.

Sgt. Hunt came on post with Deputy Collini to remove inmate Howell from the restraint chair so he could be placed in cell 1. Inmate Howell was asked if he was ready to come out of the chair and he did not respond. Deputy Pierani then shook inmate Howell before giving him a sternum rub. There was no response by inmate Howell. Deputy Pierani then called a George 100 on the radio for medical to respond. Medical staff responded and felt inmate Howell's arm. They then requested he be removed from the restraint chair. Sgt. Hunt and Deputies Pierani and Collini removed inmate Howell from the restraint chair. One of the

nurses then began performing CPR. Deputy Pierani advised he did not know the nurse's name. He stood by in the pod and awaited further direction. Deputy Pierani advised additional officers arrived. Paramedics and firefighters arrived in the pod but did not perform life saving measures. One of the paramedics felt inmate Howell's arm and said it was cold before telling the medical staff to stop what they were doing.

Deputy Pierani advised he stayed around A-pod until he was dismissed and told to write a statement. He went into the mental health offices and wrote out a statement and had no further contact with inmate Howell.

Detective Wissel then showed Deputy Pierani a copy of the restraint chair form. He advised he did not fill any of it out. Deputy Pierani was then shown a copy of the daily report log for N-21. He verified at 1801 hours he made an entry of medical staff on housing unit. Deputy Pierani advised the medical staff was on post for med pass and it lasted about 15 to 20 minutes. The med pass was done by Nurse Pierette Arthur. Deputy Pierani confirmed his last entry into the log occurred at 2032 hours, and shortly after, he became the housing officer. Deputy Pierani verified all the log entries, which ended with "DP", were entered by him. He also advised nothing out of the ordinary except inmate Howell being placed in the restraint chair occurred on 12/9/18.

On 12/10/18, Detective Stock interviewed Deputy Brian Barth at the Hamilton County Justice Center, in reference to the death of inmate Cornelius Howell. Barth was assigned to 2nd shift, 1500 hours to 2300 hours, and was working as the Medical Rover (G45).

At approximately 1700 hours, he transported inmate Demarcus Grant from North 42 to medical, after he had been involved in a fight. Inmate Cornelius Howell was also taken to medical. While Grant was being tended to by the medical staff, Barth could hear Howell yelling. Barth observed Howell sliding out of the wheelchair and complaining about back pain. Howell was not cooperating with medical staff. He wanted to lie on the floor. Medical requested a urine sample from Howell but was unable to obtain the sample from him, due to lack of cooperation.

Deputy Barth was advised to retrieve the restraint chair from North 21 (Psych). He placed the chair next to Howell in the sally port. Barth assisted in placing Howell in the chair. Howell was not combative. Deputy Barth stated that Howell was passive resistant. The nurse checked the restraints, so they weren't too tight, and Deputy Barth wheeled him down the hall, placing him in cell three, in A pod, on North 21. Barth advised he had no further contact with Howell.

On 12/10/18, at 0002 hours, Detective Stock interviewed Sgt. Justin Hunt at the Hamilton County Justice Center in reference to the death investigation of inmate Cornelius Howell. Sgt. Hunt is assigned to the North Building on second shift as G90. He has been employed by the Hamilton County Sheriff's Office for seventeen years.

Sgt. Hunt stated on 12/09/18, at approximately 1700 hours, he was contacted by the officers assigned to North Building G42 advising him about a fight between two inmates. He advised to take the involved inmates to the medical unit (G22) to be evaluated. Sgt. Hunt responded to medical where Inmate Demarcus Grant was being seen in the treatment

room for a superficial stab wound. Deputy Barth and Deputy Spence were also present. Deputy Spence is a jail investigator and photographed the injury. Inmate Grant advised he was involved in a fight with his cellmate Cornelius Howell. Howell attempted to stab Grant with a pencil leaving a minor injury.

Cornelius Howell was in the secured entry area of medical in a wheelchair waiting to be seen. He was yelling and stating he was in pain. He was handcuffed because of being involved in a fight. Inmate Howell was stating he could not feel his legs. Inmate Howell then slid out of the chair to the floor. Staff placed him back into the wheelchair and took him to the sally port area of medical.

After Inmate Grant was seen by medical, he was placed in the secured exit area of medical to await transport to South 22, pending a disciplinary hearing for the fight. Inmate Howell continued yelling that his legs wouldn't work. He continued to slide out of the wheelchair. Sgt. Hunt stated inmate Howell was using his legs to push with. Staff moved inmate Howell's handcuffs to the front so he could be evaluated. Inmate Howell complained about back pain and wanted to lie down on the floor as he continued to slide out of the chair. He would not cooperate with the medical staff and eventually laid flat on the floor. He stated he was involved in a fight and his back hurt. The medical staff attempted several tests on him and to give him medication. He spit the medication out.

The nurse, Christina Jordan, told him he was not going to the hospital and she wanted him to urinate in a cup. He refused to urinate in a cup and Nurse Jordan made the decision inmate Howell was

having a mental health issue. Sgt. Hunt asked Nurse Jordan if she wanted him to get the restraint chair. She said she wanted inmate Howell in the chair for his safety. Sgt. Hunt had someone get the chair from the psych unit (G21). Sgt. Hunt went into the Local Control Unit to speak with Lt. Buchanan. They discussed administrative segregation due to the stabbing. Inmate Howell was then transported to G21.

Sgt. Hunt went to G21 several minutes later to have another inmate removed from the restraint chair. While in G21, Sgt. Hunt started a log for inmate Howell's time in the restraint chair.

Approximately four hours later, at approximately 2145 hours, while on rounds, Sgt. Hunt responded to G21 to physically check the suicide watches. Sgt. Hunt also responded to remove inmate Howell from the restraint chair and put him in cell one in A Pod. He approached cell six, opened the door, and yelled for inmate Howell, who looked like he was sleeping. Deputy Pierani attempted a sternum rub on inmate Howell with no response. Sgt. Hunt went to inmate Howell's right side and shook his shoulder. Inmate Howell was stiff. Sgt. Hunt told Deputy Pierani to call G100 of a medical emergency. Sgt. Hunt walked out into the pod area. He then walked back into the pod and checked vitals. Sgt. Hunt then obtained a blank piece of paper and started a log. He then provided that log to Detective Stock.

Once Deputy Spence arrived, Sgt. Hunt called for Sgt. Timon to also respond. Once Sgt. Timon arrived, he and Deputy Spence began investigator duties. Sgt. Hunt then described how the chair is used. There are no handcuffs on this chair. Soft restraints are used to secure the inmate to the chair,

which is secured to the wall. He then explained the chair is used for out of control inmates or inmates who are a threat to themselves or others. Sgt. Hunt confirmed that medical requested inmate Howell be put in the chair.

On December 10, 2018, at 0054 hours, Detectives Powers and Wissel conducted an interview of Corrections Officer Daniel Erwin at the Hamilton County Justice Center on floor 1-M of the North Building.

Deputy Erwin advised he has been employed with the Hamilton County Sheriffs Office for the last 5 years and 8 months, all in the Corrections Division. He started his shift on 12/9/18 at 1500 hours working on North 21 (N-21) as the housing officer. He advised at 1740 hours he would normally switch to the suicide watch officer but went to medical instead to assist with placing an inmate in the restraint chair.

Deputy Erwin advised Deputy Barth transported the restraint chair from N-21 to medical. Deputy Erwin went through the psych offices and through the medical offices to get to the medical sally port. When he arrived at medical, he observed inmate Howell lying on the floor of the sally port on his right side handcuffed in the front. Deputy Erwin advised his understanding was inmate Howell was going to be placed in the restraint chair and sent out to the hospital. He heard inmate Howell making noises and was told he had refused medical treatment. Deputy Erwin advised he saw a half broken pill on the floor about a foot from inmate Howell's toes. He observed the pill when he bent down to put inmate Howell in the restraint chair. He advised inmate Howell was not combative but reluctant to get in the chair. Deputy Erwin had to bring inmate Howell up to get

him in the chair properly. Inmate Howell was apologetic after he was placed in the chair, which is the norm. Deputy Erwin advised inmate Howell had no complaints after he was placed in the chair but was "grunting a little bit."

Deputy Erwin advised he heard a nurse say inmate Howell was going to the hospital, which led him to believe inmate Howell was going to the hospital, due to refusing treatment, because something was wrong with him, and he needed to be looked at further to be assessed. Deputy Erwin advised a nurse then checked the straps of the restraint chair and inmate Howell was wheeled to psych cell 6. Deputy Erwin stated he had no further contact with inmate Howell.

Detective Wissel showed Deputy Erwin the restraint chair form. Deputy Erwin advised the form was started by Sgt. Hunt and his first entry was at 1800 hours. He stated all the entries with "DBE" at the end were made by him. Deputy Erwin stated all his checks on inmate Howell were conducted by looking through the cell door window. He was asked to clarify what he saw when he wrote "chair" on the form. Deputy Erwin provided the additional description of inmate Howell's behavior.

- 1810 — looked at him
- 1820 — was looking out the exterior window
- 1830 — was looking down feeling defeated, saw him blinking
- 1840 — appeared to be sleeping
- 1900 — appeared to be sleeping
- 1910 — appeared to be sleeping
- 2000 — appeared to be sleeping
- 2010 — appeared to be sleeping

- 2020 — appeared to be sleeping
- 2030 — appeared to be sleeping

Detective Wissel then showed Deputy Erwin the daily log report. Deputy Erwin advised all the entries from 2106 to 2154 hours were made by him. The entries mostly ended with "DBE #349".

Deputy Erwin stated he switched to the LC officer at approximately 2030 hours. He stayed in the LC after inmate Howell was found unresponsive. He advised there was nothing out of the ordinary except for what occurred with inmate Howell.

Deputy Erwin advised he heard a nurse say inmate Howell was going to the hospital prior to being placed in the restraint chair. He was talking to Sgt. Franklin and heard several people talking about inmate Howell going to the hospital but was unsure if it was other corrections officers or nurses. Deputy Erwin advised he was not told by any of the nursing staff or any supervisor that inmate Howell was going to the hospital. Deputy Erwin advised he was upset about the situation because he thought inmate Howell should have gone to the hospital.

Deputy Ashley Roettker and Deputy Brian Barth both witnessed the behavior of inmate Howell while in medical. Inmate Howell continued to fall out of the wheelchair and be uncooperative with staff until medical staff advised he be placed in the restraint chair. Barth assisted in placing him in the restraint chair with other officers. Deputy Roettker witnessed Howell being placed into the chair from the medical unit control room. There was no force necessary to place Howell in the chair. A copy of Barth's and Roettker's written and taped statements are contained in the case file.

Coroner Investigator John Hatfield arrived at 0045 hours. He photographed the body and prepared it for transport. Deputy McClendon, Badge #577, arrived on scene with inmate William Herms (1671353) and inmate Raymond Morris (1674471). The transport unit and Investigator Hatfield left the scene at 0117 hours.

On 12/10/2018, at 0141 hours, Detective Stock and Detective Powers interviewed inmate Demarcus Grant at the Hamilton County Justice Center, located at 1000 Sycamore Street, Cincinnati, Ohio 45202. Demarcus Grant is further described as male, DOB _____, black hair, brown eyes, 5'08", 150 lbs., SSN ---------- and last known address before his incarceration was 2058 Auburn Avenue #25, Cincinnati, Ohio 45232.

The interview started by Detective Stock reading and showing Demarcus Grant his Miranda warnings. Demarcus acknowledged he understood his rights and agreed to speak to detectives. Demarcus signed the Hamilton County Sheriff's Office Advice of Rights form. This waiver of rights form is available with this case file. The interview was also audibly recorded and is on file.

Detectives asked Demarcus Grant why he was incarcerated. Grant advised he was locked up for charges his girlfriend had on him. Grant stated "she said I broke into her house". Grant advised he was from the Avondale neighborhood. Grant advised he has been locked up about two weeks.

Grant stated he had an altercation with Cornelius Howell after Howell claimed he stole a pencil from under his bed. Grant stated Howell told him to come

into the cell, and he then closed the cell door behind him, as he entered the cell. Grant advised he knew the altercation was going to happen when Howell closed the door behind him. Grant further stated the altercation began with Howell stabbing him with a pencil in the side. Grant said he struck Howell in the face about five times busting his lip. Grant advised at that point he felt he was winning the fight and began to hold Howell until the officer broke up the fight. Grant stated after they were separated he was told to sit in the pod area by the officer. Grant asked another inmate "did he stab me". The inmate stated he did and handed him the pencil tip. Grant stated during the fight Howell never hit the floor or hit his head on anything in the cell.

Detectives asked Grant if he noticed anything odd about Howell. Grant stated "he acted a little weird". Grant stated Howell, at times, appeared to talk to himself. Grant was asked if he ever heard Howell complain about pain in the past with cellmates. The only time Grant heard him complain was in medical after the fight. Grant continued with "I heard him complaining about his legs hurting from the other room in medical".

Detectives told Grant about Cornelius Howell's death after the fight. Grant appeared to be very upset stating he did not do anything to cause Howell's death. Grant advised the incident was just a fight between two people. Grant could not believe Howell had passed. Grant advised he did not slam Howell or do anything that would cause Howell's death. Grant was very upset and emotional stating it was just a fight.

On 12/10/19, HCJC Investigators Keeton and Jones conducted interviews of all of the inmates housed

on North 42 in reference to the fight that occurred between Cornelius Howell and Demarcus Grant. Some of the inmates knew that the two had a fight and some didn't hear or see anything. The ones that knew of the fight didn't see the fight. They heard the fight and saw both inmates as they exited the cell breathing heavy. A report was generated and a copy is contained in the case file. There is also a separate investigation into the incident by HCJC Investigator Randy Spence. A copy of that report is also contained in the case file.

On 12/10/18, Detective Stock contacted John Hatfield and inquired about a preliminary cause of death. He advised there was no obvious cause of death determined from the autopsy. There were no signs of trauma or substantial bodily injury. The autopsy would rely on lab and toxicology results.

On 03/14/19, Detective Stock received the final Coroner's Report from the Hamilton County Coroner's Office. The death was ruled a homicide. According to Dr. Stevens, the fight between Howell and Grant, even though instigated by Howell, caused Howell to have Sickle Cell Crisis, which led to his death. It is also believed that Grant acted in self-defense and there were no physical injuries from the fight that led to his death.

RA

Deputy Randy Spence #683 Case Summary

HAMILTON COUNTY SHERIFF
INVESTIGATION REPORT

Offense No. _____
Complainant: Cornelius Howell
Address: 1000 Sycamore St. Cincinnati, Ohio 45202
Type of Offense or Investigation: Death
Date of Offense or Incident: December 9, 2018

--Details of Investigation--

On December 9, 2018, Sergeant Justin Hunt Badge #163, Hamilton County Sheriff's Office, Jail Services, called this investigator at approximately 1910 hours and requested that I respond to the Medical Unit of the Hamilton County Justice Center, located at 1000 Sycamore St. Cincinnati, Ohio 45202,

Sergeant Hunt stated to this investigator that two inmates were involved in a physical altercation on North 42 and one inmate was possibly stabbed with a pencil.

Suspect / Victim #1 — Inmate Cornelius Howell (JMS 1676106), is described as a male black, D.O.B. 5'00", 185 lbs. CTL #2165340, residing at 868 Adams St. Cincinnati, Ohio 45232,

Suspect / Victim #2 — Inmate Demarcus Grant (JMS 1675862), is described as a male, black, D.O.B. 5'08", 150 lbs. CTL #2776897, residing at 2058 Auburn Ave. #25 Cincinnati, Ohio 45232,

On December 9, 2018, Jail Services Investigator Deputy Randal Spence Badge #683 interviewed two individuals while at the Justice Center.

Interview 1 — Deputy Michael Itskin Badge #1690, 1000 Sycamore St. Cincinnati, Ohio 45202, (513) 946-6707.

Deputy ltskin submitted a written statement via the Jail Management System at 1756 hours.

Deputy ltskin states he was assigned to North 42 as the Local Control Officer, Deputy Itskin states at approximately 1700 hours, an inmate in cell 30 called into the booth. Deputy ltskin states the inmate advised there was a fight. Deputy Itskin states Deputy Shane Adams Badge #1708 responded to cell 30, where inmates Cornelius Howell and Demarcus Grant were fighting. Deputy ltskin states the two inmates separated as soon as Deputy Adams arrived. Deputy Itskin states there was no force used in this incident. Deputy ltskin states inmate Grant was stabbed with a pencil in his side. Deputy Itskin states Deputy Adams observed the tip of the pencil sticking out of inmate Grant's side, Deputy ltskin states both inmates were transported to medical for further evaluation and F-pod inmates were locked down pending an investigation.

Interview 2 — Inmate Demarcus Grant (JMS 1675862)

While in Medical, inmate Demarcus Grant states his cellmate, inmate Cornelius Howell called him into their cell. Inmate Grant states Howell questioned him about taking something of his. Inmate Grant states he removed his shirt due to the tone of Howell's voice. Grant states that Howell attempted to strike him and he moved. Grant states he was stabbed in the

lower back with a pencil. Grant states both inmates continued to engage in a physical altercation.

While in Medical, I attempted to gather Cornelius Howell's version of the incident. Howell wouldn't answer questions. Howell continued to voice complaints about his back and legs. Howell would appear to be focused then appear to zone out and mumble. I took pictures of Howell to document any injuries sustained in the altercation and decided to wait until the following day to question Howell on his version of the incident. I also responded to North 42, cell 30 to take pictures for documentation of the cell.

Sergeant Justin Hunt requested that I question Demarcus Grant in regards to Cornelius Howell's behavior over the past couple days since they were cellmates.

Interview 3 — Inmate Demarcus Grant (JMS 1675862)

Inmate Grant states that inmate Cornelius Howell normally kept to himself. Inmate Grant states Howell was walking with a book as if he was reading, but Grant states it appeared as if Howell was having a conversation with someone or himself.

Howell was placed into the restraint chair by Registered Nurse Christina Jordon due to not cooperating with Medical Staff and for Howell's safety.

Chronological Recording of Events:

December 9, 2018

- 1700-Sgt. Justin Hunt #163 advised of physical altercation on North 42, cell 30.
- 1707-Sgt. Justin Hunt #163 arrives in Medical.

- 1710-Jail Investigator Deputy Randal Spence #683 assigned.
- 1720-Lt. Brad Buchanan #1379 notified.
- 1730-Inmate Grant cleared by Medical with superficial wound from pencil.
- 1740-Inmate Howell uncooperative with Medical and placed into the restraint chair for his safety per Registered Nurse Christina Jordan.
- 1740-Inmate Howell escorted to North 21, cell 6.
- 2145-Sgt. Justin Hunt #163 arrives on North 21 for rounds and to remove Howell from restraint chair.
- 2147-Medical Emergency Staff called to North 21 for an unresponsive inmate in the restraint chair.
- 2148-Medical arrives on North 21.
- 2150-911 notified.
- 2150-Medical Staff requests Howell be removed from the restraint chair and moved to the day area. Medical Staff begins their assessment and CPR started.
- 2151-Jail Investigator Deputy Randal Spence #683, Sgt. Christopher Henn #1026 and Sgt. Jesse Franklin #1626 on post.
- 2152-Deputy Brandi Terry #1326 assigned crime scene log and Deputy Ashley Roettker #1301 directed to retrieve window covers.
- 2154-Lt. Brad Buchanan #1379 is called and no contact is made.
- 2154-Capt. Kerr is notified

- 2154-Cincinnati Fire Engine #3 and Medic #3 arrive at the North Building loading dock.
- 2156-Cincinnati Fire Engine #3 and Medic #3 arrive on North 21.
- 2156-Sgt. Kelly Timon #1365 notifies District 1 Supervisor.
- 2157-Cincinnati Fire advises Medical Staff to stop assessing Howell.
- 2205-Cincinnati Fire Medic #3 off post.
- 2211-Cincinnati Fire Engine #3 off post.
- 2244-Capt. Kerr arrives on post.
- 2311-C.I.S. Det. Stock, Det. Powers, Det. Wissel and Det. Sanderson arrive.
- 2311-LA. Lt. Guy arrives.

December 10, 2018

- 0045-Hamilton County Coroner's Office Investigator John Hatfield arrives on post.
- 0113-Deputy Ryan McClendon #577, Coroner's porter William Herms (JMS1671353) and Coroner's porter Raymon Morris (JMS-1674471) arrive on post.
- 0117-Deputy McClendon and Coroner's porter's Herms and Morris off post with Howell enroute to the Coroner's Office.
- 0240-C.I.S. Detectives off post,

On December 9, 2018, Inmate Cornelius Howell (JMS 1676106) was found unresponsive while in the restraint chair located in cell 6 on North 21. After AED, CPR and the action of medical staff, The Cincinnati Fire Department advises the medical staff to stop

lifesaving treatment. Howell is pronounced dead. The Hamilton County Coroner's Office, The Criminal Investigation Section and Internal Affairs arrive on post and began their investigation.

33 Pictures were taken by this Investigator.

HAMILTON COUNTY
INTERDEPARTMENTAL CORRESPONDENCE

To: All Corrections Personnel
From: Major C. Ketteman
At: HOC
Subject: Roll Call/Briefing Information
Date: January 11, 2019

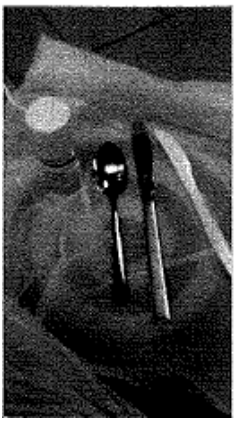
TO BE POSTED FOR SEVEN DAYS FOLLOWING THE BRIEFING PERIOD

Inmate Package Delivery

Please ensure the receipts sent to the units with books mailed in for inmates are signed and returned to the mail clerks. We keep these receipts as proof the books have in fact, been delivered to the inmate. If the inmate is no longer on your unit, make sure both the receipt and the books are returned to the mail clerks.

Inmate Searches

It has been stressed more times that most of us can count about just how important searching inmates returning to your unit is to everyone's safety and security. Last week a hospital return was caught with medial utensils when returned to the Justice Center. For everyone's safety, make sure you are doing your pat downs.



Restraint Chair Policy Updates

The following are the major changes of the Restraint Chair Policy:

— Male inmates in the restraint chair will be placed in B-pod on G-21.

— Female inmates in the restraint chair will be placed in A-pod on G-31.

— When an inmate in the restraint chair is due for his/her two(2) hour limb rotation, the building supervisor will be notified. That supervisor shall respond to the location to verify the limb rotation occurs and documented.

— Medical will be checking on the inmate in the restraint chair every 15 mins.

BRIEFING NOTES COMPILED BY M. Bidwell

HAMILTON COUNTY JUSTICE CENTER
CRIME SCENE LOG

Jail Investigator: Deputy R. Spence #683
Date: December 10, 2018
Victim: Cornelius Howell

_____

Name Agency/Unit Bailee #1/ Employee ID #
Time on post Time off post

Dominic Pierrani (HSCO Badge #209/Employee ID #12657)	21:47	22:57
Matthew Collini (HCSO Badge #157/Employee ID #18991)	21:47	22:57
Daniel Erwin (HCSO Badge #349/Employee ID #19699)	21:47	22:57
Brian Barth (HCSO Badge #1318/Employee ID #21776)	21:48	22:56
Sgt. Justin Hunt (HCSO Badge #163/Employee ID #12649)	21:48	22:03
Brandi Terry (HCSO Badge #1326/Employee ID #21783)	21:48	22:49
Ashley Roettker (HCSO Badge #1301/Employee ID #21681)	21:48	22:00
Sgt. Christopher Henn (HCSO Badge #1026/Employee ID #12027)	21:49	22:43
Nurse Melissa Tucker (Naph-Care LPN)	21:49	22:02
Nurse Karence Rose (Naph-Care RN)	21:50	22:00
Nurse Christine Jordan (Naph-Care RN)	21:50	22:00
Sgt. Jesse Franklin (HCSO Badge #1626/Employee ID #18029)	21:50	22:12

Randy Spence (HCSO Badge #683/ Employee ID #20419)	21:50	22:00
Nurse Ben Curl (Naph-Care LPN)	21:51	22:00
Nurse Jen Carpenter (Naph-Care Paramedic)	21:53	22:03
Sgt. Kelly Timon (HCSO Badge#/Employee ID#)	21:56	22:17
Emily Vanderyt (HCSO Badge #791/ Employee ID #20751)	21:56	21:59
Engine 3 Cincinnati Fire Department	21:56	21:59
Medic 3 Cincinnati Fire Department	21:57	21:59
Randy Spence (HCSO Badge #683/ Employee ID #20419)	22:02	22:15
Sgt. Kelly Timon (HCSO Badge #1365/ Employee ID #13479)	22:40	22:41
Randy Spence (HCSO Badge #683/ Employee ID #20419)	22:40	22:41
Sgt. Kelly Timon (HCSO Badge #1365/ Emplovee ID #13479)	23:01	23:03
Heather Sanderson (HCSO CIS)	23:15	23:38
Sgt. Kelly Timon (HCSO Badge #1365/ Employee ID #13479)	23:25	23:41
Lt. Andy Guy (HCSO IA)	23:25	23:38
Det. Stock (HCSO CIS)	23:41	23:49
Heather Sanderson (HCSO CIS)	23:41	23:49
Lt. Andy Guy (HCSO IA)	23:41	23:49
Det. Powers (HCSO CIS)	23:44	23:49
Det. Wissel (HCSO CIS)	23:44	23:49
Randy Spence (HCSO)	0:24	0:26

John Hatfield (HCCO)	0:43	1:05
Lt. Andy Guy (HCSO IA)	0:43	1:15
Heather Sanderson (HCSO CIS)	0:43	1:15
Randy Spence (HCSO Badge #683/ Employee ID #20419)	0:43	1:17
John Hatfield (HCCO Coroner)	1:12	1:17
William Herms (Dead Run Porter JMS 1671353)	1:13	1:17
Raymon Morris (Dead Run Porter JMS 1674471)	1:13	1:17
Ryan McClendon (HCSO Badge #577/ Employee ID #12429)	1:13	1:16

{ RESTRAINT CHAIR FORM
Omitted Is Because It is Reproduced at App.233a }

[. . .]

CRITICAL INCIDENT

Name: Grant, Demarcus (1675862) and Howell, Cornelius (1676106)
Subject: Mutual Fight / Grant (1675862) stabbed with pencil.
Investigator: Sgt. Hunt #1634
Date Incident Occurred: 12/9/2018
Time Incident Occurred: Approx. 1700 hours.
Location of Incident: N-42-F-30

12/9/2018

1700 - Approximately time that N-42 advised Sgt. Hunt of physical altercation that happened in cell 30.

1707 - Sgt. Hunt on post in medical.

1710 - Jail Investigator Deputy Spence assigned.

1720 - Lt. Buchanan notified.

1730 - Inmate Grant (1675862) cleared by medical with superficial wound from pencil.

1740 - Inmate Howell (1676106) uncooperative with medical staff and placed into restraint chair for his safety per Charge Nurse Christina Jordan.

Major Findings:

Incident is still under investigation. Inmate Grant, Demarcus (1675862) gave a statement that his cellmate, Howell, Cornelius (1676106) called him into their cell and questioned him about taking something of his. Grant stated he took his shirt because of the tone of voice used by Howell. He stated Howell tried to punch him and he moved and was stabbed with a pencil, in his lower left back area. He

stated that they both continued to fight after that. Once Deputy Adams got to the cell, they had separated. Both we're taken to medical. Medical staff removed the sharpened tip of the pencil that had broken off during the altercation and treated Grant's wound. Howell was brought to medical and complained of many injuries and was noncompliant with medical staff. Per Charge Nurse Christina Jordan, he was placed into the restraint for his safety due to his continuous yelling and rolling around on the ground.

Staff Witnesses:

Deputy S. Adams #1708

Deputy M. Itskin #1690

Nurse Christina Jordan

Recommendations:

Both are being written up for disciplinary action. inmate Howell will be housed on N-21 pending further investigation and mental health evaluation. Possible Administrative Segregation status for Howell pending investigation. Jail Investigator Spence will continue investigation on 12/10/18 due to Howell's behavior status.

Investigation began:

Approximately 1700 hours. 12/9/2018

Investigation completed: On going.

Date: 12/09/2018 Report 1 of 1

HAMILTON COUNTY SHERIFF'S OFFICE – CORRECTIONS DIVISION

Jail Incident Report

Re: Cornelius Howell (1676106)

Incident Id: 345916
Incident Location: CJC - N22
Incident Datetime: 12/09/2018 17:30
Incident Type: Non Routine Restraint Use
Incident Datetime: 12/09/2018 17:30
Note: No force used.
Staff Preparing Report: ROETTKER, ASHLEY
Report Datetime: 12/09/2018 17:55
Supervisor Notified: SGT. HUNT
Datetime Notified: 00/00/0000 00:00

Incident Details:

On December 09, 2018, 1, Deputy Roettker, was assigned as the local control room officer on N-22. At approximately 17:30, inmate Howell, Cornelius (1676106) was brought down to medical due to an altercation on his housing unit. Per RN Christina Jordan, Howell was placed into the restraint chair for being uncooperative with medical staff. RN Christina checked and cleared the restraints. Howell was then taken down to N-21.

Sgt. Hunt on post.

Characteristics:

Restraint Chair

[. . .]

Date: 12/09/2018 Report 1 of 1

HAMILTON COUNTY SHERIFF'S OFFICE – CORRECTIONS DIVISION

Disciplinary Incident Report

Incident Id: 345917
Incident Location: CJC - N42
Incident Type: Inmate Fight/Disturbance
Staff Preparing Report: ITSKIN, MICHAEL
Supervisor Notified: SGT. HUNT
Incident Datetime: 12/09/2018 17:00
Note: No force used.
Report Datetime: 12/09/2018 17:56
Datetime Notified: 00/00/0000 00:00

Incident Details:

On December 9, 2018, I, Deputy Itskin, was assigned as LC officer on G-42. At approximately 1700 an inmate in cell 30 called into the booth via ringmaster claiming they were fighting. Deputy Adams immediately went to F-pod, cell 30, where inmate Howell, Cornelius (1676106) and inmate Grant, Demarcus (1675862) had been fighting. The two inmates separated themselves as soon as Deputy Adams arrived. No force was used. Inmate Grant had been stabbed with a pencil in his side. The tip of the pencil was observed by Deputy Adams sticking out of him. Both inmates were transported to medical for further evaluation. The entirety of F-pod was locked down pending investigation from a jail investigator.

Sgt. Hunt notified.

Dep. M. ltskin #1690

Characteristics:

Inmate Fight or Disturbance

Violations:

Datetime	12/09/2018 18:14
Number	5
Part	5
Item	c
Violation Description	5.c Fighting
Status	Charged

Datetime	12/09/2018 18:17
Number	5
Part	5
Item	k
Violation Description	5.k. Disruption of facility operations.
Status	Charged

Date: 12/09/2018 Report 1 of 2

HAMILTON COUNTY SHERIFF'S OFFICE – CORRECTIONS DIVISION

Jail Incident Report

Incident Id: 345920
Incident Location: CJC - N42
Incident Datetime: 1210912018 17:00
Incident Type: Critical Incident
Note: No force used.
Staff Preparing Report: HUNT, JUSTIN
Report Datetime: 1210912018 20:26
Supervisor Notified: LT. BUCHANAN
Datetime Notified: 0010010000 00:00

Incident Details: Critical Incident

Name: Grant, Demarcus (1675862) and Howell, Cornelius (1676106)

Subject: Mutual Fight / Grant (1675862) stabbed with pencil.

Investigator: Sgt. Hunt #163

Date Incident Occurred: 12/9/2018

Time Incident Occurred: Approx. 1700 hours.

Location of Incident: N-42-F-30

12/9/2018

- 1700-Approximately time that N-42 advised Sgt. Hunt of physical altercation that happened in cell 30.
- 1707-Sgt. Hunt on post in medical.
- 1710-Jail Investigator Deputy Spence assigned.

- 1720-Lt. Buchanan notified.
- 1730-Inmate Grant (1675862) cleared by medical with superficial wound from pencil.
- 1740-Inmate Howell (1676106) uncooperative with medical staff and placed into restraint chair for his safety per Charge Nurse Christina Jordan.

Major Findings:

Incident is still under investigation. Inmate Grant, Demarcus (1675862) gave a statement that his cellmate, Howell, Cornelius (1676106) called him into their cell and questioned him about taking something of his. Grant stated he took his shirt because of the tone of voice used by Howell. He stated Howell tried to punch him and he moved and was stabbed with a pencil in his lower left back area. He stated that they both continued to fight after that. Once Deputy Adams got to the cell, they had separated. Both were taken to medical. Medical staff removed the sharpened tip of the pencil that had broken off during the altercation and treated Grant's wound. Howell was brought to medical and complained of many injuries and was non-compliant with medical staff. Per Charge Nurse Christina Jordan, he was placed into the restraint for his safety due to his continuous yelling and rolling around on the ground.

Staff Witnesses:

Deputy S. Adams #1708
Deputy M. Itskin #1690
Nurse Christina Jordan

Characteristics:

Inmate Fight or Disturbance
Critical Incident

Recommendations:

Both are being written up for disciplinary action. Inmate Howell will be housed on N-21 pending further investigation and mental health evaluation. Possible Administrative Segregation status for Howell pending investigation. Jail Investigator Spence will continue investigation on 12/10/18 due to Howell's behavior status.

Investigation began:
Approximately 1700 hours. 12/9/2018

Investigation completed: On going.

Characteristics:

Inmate Fight or Disturbance
Critical Incident

Date: 12/09/2018 Report 1 of 1

HAMILTON COUNTY SHERIFF'S OFFICE – CORRECTIONS DIVISION

Jail Incident Report

Re: CORNELIUS HOWELL (1589616)

Incident Id: 272045
Incident Location: CJC-S41
Incident Datetime: 01/29/2016 09:30
Incident Type: Critical Incident
Note: No force used.
Staff Preparing Report: ELSASSER, FRITZ
Report Datetime: 01/29/2016 09:33
Supervisor Notified: LT REED
Datetime Notified: 00/00/0000 00:00

Incident Details:

Name: Howell, Cornelius (1589616)

Subject: Inmate sent out to UCER by county van

Investigator's Name and Rank: Sgt. F. Elsasser #1501

Date of Incident: 1/29/16

Location of Incident: L-41 / G-22

Chronological Recordings of Events:

- 0831-Inmate Howell (1589616) sent to Medical from L-41.
- 0930-Sgt. Elsasser advised that per Medical, Howell needs to go to UCER by county van.
- 0945-9K39 P. Miller and inmate Howell out to UCER.

Major Findings in Investigation:

Inmate Howell was sent to Medical from L-41 due to complaints related to Sickle Cell. Per Medical, Howell needs further evaluation from UC Hospital and was to be transported by county van.

Staff Interviewed:

Deputy Straughn and Deputy Jessica Jones

Investigation Started: 0930

Investigation Completed: 0945

Date: 12/09/2018 Report 1 of 1

HAMILTON COUNTY SHERIFF'S OFFICE – CORRECTIONS DIVISION

Jail Incident Report

Re: CORNELIUS HOWELL (1589616)

Incident Id: 275408
Incident Location: CJC-N12
Incident Datetime: 03/12/2016 09:55
Incident Type: For Informational Purposes
Note: No force used.
Staff Preparing Report: BUCKMEIER, TRAVIS
Report Datetime: 03/12/2016 13:09
Supervisor Notified: SGT. SCHOLZ
Datetime Notified: 00/00/0000 00:00

Incident Details:

On March 12, 2016, I, Deputy Buckmeier, was assigned to N12. At approximately 0950 hours, inmate Howell, Cornelius (1589616) informed myself and Deputy Brotherton that he had a sickle cell issue and felt that he needed medical attention due to him experiencing intense pain. I informed medical, who requested to see Howell. Howell was taken to medical for evaluation. At 1250 hours, I called medical and was informed that Howell would not be returning to work on this day due to his condition.

Sgt. Scholz notified.

Date: 12/09/2018 Report 1 of 1

HAMILTON COUNTY SHERIFF'S OFFICE – CORRECTIONS DIVISION

Jail Incident Report

Incident Id: 275409
Incident Location: CJC-N22
Incident Datetime: 03/12/2016 13:32
Incident Type: Critical Incident
Note: No force used.
Staff Preparing Report: SCHOLZ, TIMOTHY
Report Datetime: 03/12/2016 13:34
Supervisor Notified: LT. TOELKE
Datetime Notified: 00/00/0000 00:00

Incident Details:

Name: Howell, Cornelius # 1589616

Subject: ER Run by Intake

Investigators Name & Rank: Sgt. T. Scholz # 134

Date of Incident: 3/12/16

Location of Incident: G-12/G-22

Recordings of Events:

- 0950: Deputy Buckmeier was approached by inmate Howell about not feeling well. He informed Deputy Buckmeier that he has Sickle Cell.
- 0952: Medical was notified and Howell was transported to Medical for evaluation.
- 1300: Per Nurse Angie Howell is to be transported to UCER by Intake for further treatment.

- 1311: Inmate Howell is enroute to UCER with 9K 39C T. Mullens.

Major Findings:

None at this time.

Staff Involved:

Deputy Buckmeier
Deputy J. Harris
Deputy Dallas

Nurse Angie

December 11, 2018 10:30

Hamilton County Jail Management System (JMS)
Demographics – 1676106 HOWELL, CORNELIUS

JMS No: 1676106
Control No: 2165340
Date Admitted: 12/2/2018 05:18:30
Last Name: HOWELL
First: CORNELIUS
SSN: [redacted]
Age: 33
Address: 868 Adams St
City: CINC
State: OH
Zip: 45232

Arresting officer: WATKINS S
Badge No: 580
Agency: CPR8
Arrest Date/Time: 12/02/2018 03:38
Location of Arrest: 420 KINGS RUN DR

Booking Type: City Original Arrests
Bond Type: No Bond
Bond Amount: $,00
Charge: CRIM DAMM2, AGG MENACING M1
Acct. Class: General Population

Sex: MALE
Race: BLACK
Age: 33
Height 500
Weight: 085
Eye: BROWN
POB: AL

Hair: BLACK
Citizenship: US

Religion: CHRIST
Education: 10
Marital: SINGLE
Occupation: NO

December 11, 2018 10:30

Hamilton County Jail Management System (JMS)
Contacts – 1676106 HOWELL, CORNELIUS

NEXT OF KIN

Relationship: Sibling

Last Name: HOWELL

First: AYANA

EMERGENCY CONTACT

Relationship: Grandparent

Last Name: STARWORTH

First: GERALDINE

PHYSICIAN

Last Name: UC

EMPLOYER

Company Name: UNEMPLOYED

OTHERS

Last Name: NONE

December 11, 2018 10:31

Hamilton County Jail Management System (JMS)
Charges – 1676106 HOWELL, CORNELIUS

Section: 2909-06
Description: CRIM DAMAGING OR
Case Type: Municipal
Case: 18 CRB 31190 A
Disposition: Awaiting Trial

Section: 2903-21
Description: AGGRAVATED MENA
Case Type: Municipal
Case: 18 CRB 31190 B
Disposition: Awaiting Trial

December 11, 2018 10:31

Hamilton County Jail Management System (JMS)
Classification – 1676106 HOWELL, CORNELIUS

Classification Reason

Scheduled Reclassification

Acct. Class

General Population

Reclassification Date

01/10/2019

Security Level

Medium

Housing Type

General

Special Consideration

GP per MED Lawrence OK ANY DETAIL PER KL-MEDICAL 12/5/18

DETAIL EXTRA 12/6/18 DETAIL WORKER-1ST SHIFT KITCHEN

December 11, 2018 10:31

Hamilton County Jail Management System (JMS)
Release Information –
1676106 HOWELL, CORNELIUS

Released Date: 12/09/18 21:57

Release Reason: Death

Release Auth By: WITHERS

Comments: Death occurred on 12/09/2018 21:57

December 09, 2018 21:57

Hamilton County Jail Management System (JMS)
Demographics – 1676106 HOWELL, CORNELIUS

JMS No: 1676106
Control No: 2165340
Date Admitted: 12/2/2018 05:18:30
Last Name: HOWELL
First: CORNELIUS
SSN: [redacted]
Address: 868 Adams St
City: CINC
State: OH
Zip: 45232

Arresting officer: WATKINS S
Badge No: 580
Agency: CPR8
Arrest Date/Time: 12/02/2018 03:38
Location of Arrest: 420 KINGS RUN DR

Booking Type: City Original Arrests
Bond Type: No Bond
Bond Amount: $,00
Charge: CRIM DAMM2, AGG MENACING M1

Sex: MALE
Race: BLACK
Age: 33
Height 500
Weight: 085
Eye: BROWN
POB: AL
Hair: BLACK
Citizenship: US

Religion: CHRIST
Education: 10
Marital: SINGLE
Occupation: NO

Hamilton County SO Folder Information Sheet
Jacket No: 325544

HAMILTON COUNTY SHERIFF'S OFFICE,
CINCINNATI, OHIO
BUREAU OF IDENTIFICATION
Folder Information Sheet

Date of 12-02-2018
Photo:

JMS No: 1676106

Last Name: HOWELL

FirstName: CORNELIUS

Middle Name: PIERRE

Control No: 2165340

Alias1:

Alias2:

Alias3:

Alias4:

Race: BLACK

Sex: MALE

Date of Birth:

Place of Birth: ALABAMA

Control No: 2165340

SSN:

Age: 33

Height: 509

Hair Color: BLACK

Hair Style: Medium

Weight: 85

Eye Color: BROWN

Home Address: 714 GRRENWOOD DT

City: CINC

State: OHIO

Zip: 45232

Phone:

Employer:

Occupation: STOCKER

Address:

City:

State:

Zip:

Phone:

Fingerprint Class:

FBI No: 8152HD4

BCI No: C618839

Charges: 2909.06 MIS-MISDEMEANOR

2903.21. MIS-MISDEMEANOR

Emergency Contact:

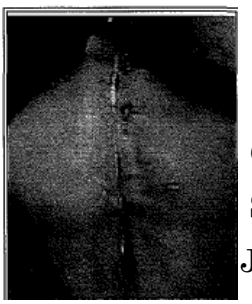
Relation:

Name: NONE

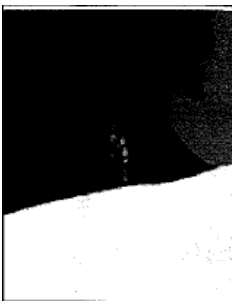
Address:

Phone:

Control #: 2165340



SCAR ON CHEST
CHEST
SURGERY (12/2017)
JMS:1666942



SCAR ON NECK
HEAD
SCAR FROM FIGHT
JMS:1394681

Detective Mike Stock Interview Summary

HAMILTON COUNTY SHERIFF
INVESTIGATION REPORT

Case No: 1286018
Complainant: Cornelius Howell
Address: 1000 Sycamore Street
Type of Offense of Investigation: Death Investigation
Date of Offense or Incident: 12/09/18

-- Details of Investigation --

Interview Summary — Deputy Brian Barth

On 12/10/18, Detective Stock interviewed Deputy Brian Barth, at the Hamilton County Justice Center, in reference to the death of Inmate Cornelius Howell. Barth was assigned to 2nd shift, 1500 hours to 2300 hours, and was working as the Medical Rover (G45).

At approximately 1700 hours, he transported Inmate Demarcus Grant from North 42 to Medical after he had been involved in a fight. Inmate Cornelius Howell was also taken to Medical. While Grant was being tended to by the Medical Staff, Barth could hear Howell yelling. Barth observed Howell sliding out of the wheel chair and complaining about back pain. Howell was not cooperating with Medical staff. He wanted to lay on the floor. Medical requested a urine sample from Howell but was unable to obtain the sample from him.

Deputy Barth was advised to retrieve the restraint chair from North 21 (Psych). He placed the chair next to Howell in the sallyport. Barth assisted in placing Howell in the chair. Howell was not combative. Deputy Barth stated that Howell was passive resistant. The nurse checked the restraints so they weren't too

tight and Deputy Barth wheeled him down the hall, placing him in cell three, in A pod, on North 21. Barth advised he had no further contact with Howell.

RA

Detective Larry Powers Interview Summary

HAMILTON COUNTY SHERIFF
INVESTIGATION REPORT

Case No: 1286018
Complainant: Cornelius Howell
Address: 1000 Sycamore Street
Type of Offense of Investigation: Death Investigation
Date of Offense or Incident: 12/09/18

-- Details of Investigation --

Interview Summary — Deputy Matthew Collini

Deputy Matthew Collin' has an address of [redacted] Cincinnati, Ohio [redacted], phone number of (513) [redacted], and is employed by the Hamilton County Sheriff's Office assigned to the Corrections Division with six years of service.

On 12/10/2018 at 0000 hours, Detectives Wissel and Powers interviewed Deputy Collini at the Hamilton County Justice Center on floor 1-M, located at 1000 Sycamore Street, Cincinnati, Ohio 45202. Deputy Collini advised he started his shift at 1500 hours on George 21 in the North Building Psych Unit. Deputy Collin' stated he worked the local control room of the unit from 1500 hours to 1740 hours. Deputy Collini further advised every two hours and forty minutes, he and his co-workers rotate post. At 1740 hours, Deputy Collini switched to housing officer. Deputy Collini explained his duties as housing unit officer is passing meds and feeding. Deputy Collini further stated at 2020 hours he switched to the suicide watches and the chair. Deputy Collini advised they did feeding before he switched at 1730 hours.

Deputy Collini advised he had no dealings with Mr. Howell until 2020 hours. Deputy Collini stated he was in the focal control room when Mr. Howell arrived at the unit at 1720 hours in the chair from medical. Mr. Howell was placed in A pod cell six in the unit. At this point, Deputy Collini further advised they did not know the name of the inmate in the chair. Deputy Collini stated Mr. Howell's demeanor was silent and he wasn't thrashing like other people in the chair. Deputy Collini advised Mr. Howell was saying "let me out let me out". Deputy Collins advised Mr. Howell appeared to be sleeping, during his rounds every ten minutes, leading up to 2150 hours. Deputy Collini stated at approximately 1950 hours Mr. Howell was looking at the cell door window. Deputy Collini advised Mr. Howell's head appeared to be down more than earlier at 2040 hours. Deputy Collini stated Sgt. Hunt responded to the unit at that same time to remove Mr. Howell from the chair. Deputy Collini was assisting Sgt. Hunt with taking Mr. Howell from the chair, when we noticed Mr. Howell was unresponsive. Deputy Collini stated Sgt. Hunt then advised him to get the nurse. Deputy Collini stated Sgt. Hunt also called for George 100 over the radio before he could reach medical. Deputy Collini arrived with the nurses to the scene and they advised us to remove Mr. Howell from the chair. At which time, Deputy Collini assisted getting Mr. Howell out of the chair and he left the scene. Deputy Collin' then responded to 1-M as advised by supervision.

The interview with Deputy Matthew Collini concluded at 0019 hours.

RA

Detective Matt Wissel Interview Summary

HAMILTON COUNTY SHERIFF
INVESTIGATION REPORT

Case No: 1286018
Complainant: Cornelius Howell
Address: 1000 Sycamore Street
Type of Offense of Investigation: Death Investigation
Date of Offense or Incident: 12/09/18

-- Details of Investigation --

Interview Summary — Corrections Officer Dominic Pierani

On December 10, 2018 at 0023 hours, Detectives Powers and Wissel conducted an interview with Corrections Officer Dominic Pierani at the Hamilton County Justice Center on floor 1-M of the North Building.

Deputy Pierani currently resides at [redacted] Cincinnati, Ohio [redacted] and he has a phone number of (513) [redacted].

Deputy Pierani advised he has worked for the Sheriff's Office for 16 years all of which have been in the Corrections Division. He started his shift on 12/9/18 at 1500 hours working on North 21 (N-21), which is the mental health unit. His first post was acting as the suicide watch officer. He was to perform those duties until 1740 hours when he and the other two officers rotate posts. Deputy Pierani advised he did not switch at 1740 hours because there was an inmate in medical being placed into the restraint chair. He responded to the medical unit (N-22) to assist in placing the inmate into the restraint chair. When he first arrived at the medical unit, he observed

inmate Howell lying on his stomach on the floor in the sally port. Inmate Howell was complaining his back hurt and was moaning a lot. He did not complain of any other pain. Deputy Pierani assisted in placing inmate Howell into the restraint chair while he was still handcuffed in the front. Deputy Pierani then removed the handcuff from inmate Howell who said "ow". Inmate Howell didn't complain of anything while being put in the restraint chair. Deputy Pierani advised inmate Howell complied with all verbal commands and no strikes were given to get him in the chair. There were also no body manipulations to get inmate Howell in the chair.

Deputy Pierani advised inmate Howell was then wheeled in the restraint chair down the main hallway to N-21 from N-22. Inmate Howell let out a few more moans while being transported. Deputy Pierani advised after he chained the restraint chair to the wall in cell 6 he had no further contact with him until Sgt. Hunt came on post to remove him from the chair.

Sgt. Hunt came on post with Deputy Collini to remove inmate Howell from the restraint chair so he could be placed in cell 1. Inmate Howell was asked if he was ready to come out of the chair and he did not respond. Deputy Pierani then shook inmate Howell before giving him a sternum rub. There was no response by inmate Howell. Deputy Pierani then called George 100 on the radio for medical to respond. Medical staff responded and felt inmate Howell's arm. They then requested he be removed from the restraint chair. Sgt. Hunt and Deputies Pierani and Collini removed inmate Howell from the restraint chair. One of the nurses then began performing CPR. Deputy Pierani advised he did not know the nurse's

name. He stood by in the pod and awaited further direction. Deputy Pierani advised additional officers arrived. Paramedics and firefighters arrived in the pod but did not perform life saving measures. One of the paramedics felt inmate Howell's arm and said it was cold before telling the medical staff to stop what they were doing.

Deputy Pierani advised he stayed around A-pod until he was dismissed and told to write a statement. He went into the mental health offices and wrote out a statement and had no further contact with inmate Howell.

Detective Wissel then showed Deputy Pierani a copy of the restraint chair form. He advised he did not fill any of it out. Deputy Pierani was then shown a copy of the daily report log for N-21. He verified at 1801 hours he made an entry of medical staff on housing unit. Deputy Pierani advised the medical staff was on post for med pass and it lasted about 15 to 20 minutes. The med pass was done by Nurse Pierette Arthur. Deputy Pierani confirmed his last entry into the log occurred at 2032 hours, and shortly after, he became the housing officer. Deputy Pierani verified all the log entries which ended with "DP" were entered by him. He also advised nothing out of the ordinary except inmate Howell being placed in the restraint chair occurred on 12/9/18.

The interview with Corrections Officer Dominic Pierani concluded at 0046 hours.

RA

Detective Matt Wissel Interview Summary

HAMILTON COUNTY SHERIFF
INVESTIGATION REPORT

Case No: 1286018
Complainant: Cornelius Howell
Address: 1000 Sycamore Street
Type of Offense of Investigation: Death Investigation
Date of Offense or Incident: 12/09/18

-- Details of Investigation --

Interview Summary –
Corrections Officer Daniel Erwin

On December 10, 2018 at 0054 hours, Detectives Powers and Wissel conducted an interview of Corrections Officer Daniel Erwin at the Hamilton County Justice Center on floor 1-M of the North Building.

Deputy Pierani currently resides at [redacted] Cincinnati, Ohio [redacted] and he has a phone number of (513) [redacted].

Deputy Erwin advised he has been employed with the Sheriffs Office for the last 5 years and 8 months, all in the Corrections Division. He started his shift on 12/9/18 at 1500 hours working on North 21 (N-21) as the housing officer. He advised at 1740 hours he would normally switch to the suicide watch officer but went to medical instead to assist with placing an inmate in the restraint chair.

Deputy Erwin advised Deputy Barth transported the restraint chair from N-21 to medical. Deputy Erwin went through the psych offices and through the medical offices to get to the medical sally port. When he arrived at medical, he observed inmate

Howell lying on the floor of the sally port on his right side handcuffed in the front. Deputy Erwin advised his understanding was inmate Howell was going to be placed in the restraint chair and sent out to the hospital. He heard inmate Howell making noises and was told he had refused medical treatment. Deputy Erwin advised he saw a, half broken pill on the floor about a foot from inmate Howell's toes. He observed the pill when he bent down to put inmate Howell in the restraint chair. He advised inmate Howell was not combative but reluctant to get in the chair. Deputy Erwin had to bring inmate Howell up to get him in the chair properly. Inmate Howell was apologetic after he was placed in the chair, which is the norm. Deputy Erwin advised inmate Howell had no complaints after he was placed in the chair but was "grunting a little bit."

Deputy Erwin advised he heard a nurse say inmate Howell was going to the hospital, which led him to believe inmate Howell was going to the hospital due to refusing treatment because something was wrong with him, and he needed to be looked at further to be assessed. Deputy Erwin advised a nurse then checked the straps of the restraint chair and inmate Howell was wheeled to psych cell 6. Deputy Erwin stated he had no further contact with inmate Howell.

Detective Wissel showed Deputy Erwin the restraint chair form. Deputy Erwin advised the form was started by Sgt. Hunt and his first entry was at 1800 hours. He stated all the entries with "DBE" at the end were made by him. Deputy Erwin stated all his checks on inmate Howell were conducted by looking through the cell door window. He was asked

to clarify what he saw when he wrote "chair" on the form. Deputy Erwin provided the additional description of inmate Howell's behavior.

1810: looked at him

1820: was looking out the exterior window

1830: was looking down feeling defeated, saw him blinking

1840: appeared to be sleeping

1900: appeared to be sleeping

1910: appeared to be sleeping

2000: appeared to be sleeping

2010: appeared to be sleeping

2020: appeared to be sleeping

2030: appeared to be sleeping

Detective Wissel then showed Deputy Erwin the daily log report. Deputy Erwin advised all the entries from 2106 to 2154 hours were made by him. The entries mostly ended with "DBE #349".

Deputy Erwin stated he switched to the LC officer at approximately 2030 hours. He stayed in the LC after inmate Howell was found unresponsive. He advised there was nothing out of the ordinary except for what occurred with inmate Howell.

Deputy Erwin advised he heard a nurse say inmate Howell was going to the hospital prior to being placed in the restraint chair. He was talking to Sgt. Franklin and heard several people talking about inmate Howell going to the hospital but was unsure if it was other corrections officers or nurses. Deputy

Erwin advised he was not told, by any of the nursing staff or any supervisor that inmate Howell was going to the hospital. Deputy Erwin advised he was upset about the situation because he thought inmate Howell should have gone to the hospital.

The interview with Corrections Officer Daniel Erwin was concluded at 0120 hours.

RA

Detective Larry Powers Interview Summary

HAMILTON COUNTY SHERIFF
INVESTIGATION REPORT

Case No: 1286018
Complainant: Cornelius Howell
Address: 1000 Sycamore Street
Type of Offense of Investigation: Death Investigation
Date of Offense or Incident: 12/09/18

-- Details of Investigation --

Interview Summary — Demarcus Grant

On 12110/2018 at 0141 hours, Detective Stock and Detective Powers interviewed Inmate Demarcus Grant at the Hamilton County Justice Center, located at 1000 Sycamore Street, Cincinnati, Ohio 45202.

The interview started by Detective Stock reading and showing Demarcus Grant his Miranda Warnings. Demarcus acknowledged he understood his rights and agreed to speak to detectives. Demarcus signed the Hamilton County Sheriff's Office Advice of Rights form. This waiver of rights form is available with this case file. The interview was also audibly recorded and is on file.

- Demarcus Grant is described as male black, 20 years of age, and address of 1000 Sycamore Street, Cincinnati, Ohio 45202.

Detectives asked Demarcus Grant what he was locked up for. Demarcus advised he was locked up for charges his girlfriend had on him. Demarcus stated "she said I broke into her house". Demarcus advised he was from the Avondale neighborhood. Demarcus advised he has been locked up about two weeks.

Demarcus advised he had an altercation with Cornelius Howell after Cornelius claimed he stole a pencil from under his bed. Demarcus stated Cornelius told him to come into the cell and he then closed the cell door behind him as he entered the cell. Demarcus advised he knew the altercation was going to happen when Cornelius closed the door behind him. Demarcus further stated the altercation began with Cornelius stabbing him with a pencil in the side. Demarcus said he struck Cornelius in the face about five times busting his lip. Demarcus advised at that point he felt he was winning the fight and began to hold Cornelius until the officer broke up the fight. Demarcus stated after they were separated he was told to sit in the pod area by the office. At that point, Demarcus asked another inmate "did he stab me". The inmate stated he did and handed him the pencil tip. Demarcus stated during the fight Cornelius never hit the floor or hit his head on anything in the cell.

Detectives asked Demarcus if he notice anything odd about Cornelius. Demarcus stated "he acted a little weird". Demarcus stated Cornelius at times appeared to talk to himself. Demarcus was asked if he ever heard Cornelius complain about pain in the past with cellmates. The only time Demarcus heard him complain was in medical after the fight. Demarcus continued with "I heard him complaining about his legs hurting from the other room in medical".

Detectives told Demarcus about Cornelius Howell's death after the fight. Demarcus appeared to be very upset stating he did not do anything to cause Cornelius' death. Demarcus advised the incident was just a fight between two people. Demarcus could not believe Cornelius had passed. Demarcus advised he did not

slam Cornelius or of anything that would cause Cornelius' death. Demarcus was very upset and emotional stating it was just a fight.

The interview concluded at 0206 hours.

RA

HAMILTON COUNTY
SHERIFF'S OFFICE

ADVICE OF RIGHTS

Name: Demarcus Grant
Date: 12/10/18
Time:0139
Place: HCJC

YOUR RIGHTS

Before we ask you any questions, you must understand your rights.

You have the right to remain silent.

Anything you say can be used against you in court.

You have the right to talk to a lawyer for advice before we ask you any questions and to have him with you during questioning.

If you cannot afford a lawyer, one will be appointed for you before any questioning if you wish.

If you decide to answer questions now without a lawyer present, you have the right to stop answering at any time.

WAIVER OF RIGHTS

I have read this statement of my rights/had this statement of my rights read to me (circle one or both) and I understand what my rights are as set forth above. No threats or promises have been made to me and I freely and voluntarily waive these rights. r am willing to answer at this time.

Signed /s/ Demarcus Grant

[signature not legible]

[signature not legible]

Witness /s/ M. Stod
Printed name

Witness /s/ L. Powers
Printed name

Time 0141

HCSO (Rev. 0311312013)

December 09, 2018 23:23

Hamilton County Jail Management System (JMS)
Demographics – 1675862 GRANT, DEMARCUS

JMS No: 1675862
Control No: 2776897
Date Admitted: 11/25/2018 15:42
Last Name: GRANT
First: DEMARCUS
SSN: [redacted]
Address: 2085 AUBURN#02/AV
City: CINC
State: OH
Zip: 45232

Arresting Officer: TRAUFLER-5
Badge No: 126
Agency: CPRS
Arrest Date/Time: 11/28/2018 15:00
Location of Arrest: 713 FROOME/AV CINC OH
Booking Type: City Original Arrests
Bond Type: No Bond
Bond Amount: $.00
Charge: FW BURGX2 18A28311, MW MEN 18B28041, PV WARR, MC ASSLT 18B18

Sex: MALE
Race: BLACK
Age: 20
POB: OH
Height: 508
Weight: 150
Eye: Brown
Hair: BLACK
Citizenship: US

Religion: NONE
Landline: (000) 000-0000
Education: 11
Martial: SINGLE
Occupation: NO

N42 Cell 30
Alteration

December 09, 2018 23:23

Hamilton County Jail Management System (JMS)
Inmate Summary – 1675862 GRANT, DEMARCUS

Case: 18 CRB 28041
Selection Description: MENACING M4
Court Date: 12/10/18
Location: JCA
B.T. C1
B.Amt. $5,0000
Disposition: Awaiting Trial

Admitted: 11/28/18
Time Start: 00/00/00
Sentenced: 00/00/00
Fine: $.00

Case: 18 CRB 18237
Selection Description: ASSAULT M1
Court Date: 00/00/00 00:00
Location: BERNAT
B.T. C1
B.Amt. $5,0000
Disposition: DISMISSED

Admitted: 11/28/18
Time Start: 00/00/00
Sentenced: 12/03/18
Fine: $.00

Case: 18 CRB 11067
Selection Description: THEFT M1F4
Court Date: 00/00/00 00:00
Location: BERNAT
B.Amt. $5,0000
Disposition: GUILTY

Admitted: 11/28/18

Time Start: 00/00/00
Sentenced: 12/03/18
Days: 60
Credit: 27
Fine: $.00
Sentence Cmts: 27 DYS CR ID# 1660322 TERM PROB

Case: 18 CRA 28040
Selection Description: BURGLARY F2
Court Date: 12/10/18 10:30
Location: JCA
B.T. C1
B.Amt. $5,0000
Disposition: IGNORED

Admitted: 11/28/18
Time Start: 00/00/00
Sentenced: 00/00/00
Days: 60
Credit: 27
Fine: $.00
Charge Cmts: IGNORED BY GJ 12/5/18

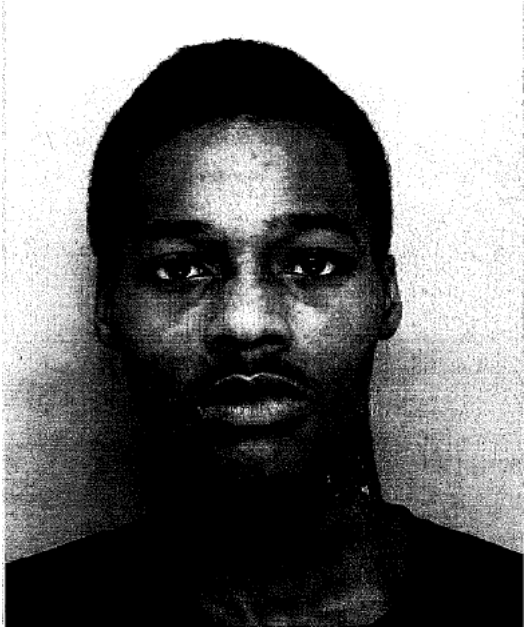
Case: 18 CRA 28311
Selection Description: BURGLARY F2
Court Date: 12/10/18 10:30
Location: JCA
B.T. C1
B.Amt. $5,0000
Disposition: IGNORED

Admitted: 11/28/18
Time Start: 00/00/00
Sentenced: 00/00/00
Credit: 27
Fine: $.00
Charge Cmts: IGNORED BY GJ 12/5/18

Mugshot – 1675862 GRANT, DEMARCUS

Inmate Detail

JMS No. 1675862
Control No. 2776897
Inmate Name. GRANT, DEMARCUS
Housing Location CJC-S21-A-6-002
Security Level Minimum
SRA MB20



Print Close

Hamilton County Jail Management System (JMS)
Housing History – 1675862 GRANT, DEMARCUS

Housing	DET-S22-WED-1-024
Arrival	11/28/2018 15:43
Departure	00/00/0000 00:00
House Change Reason	Initial intake housing

Housing	CJC-S32-F-18-001
Arrival	11/28/2018 14:03
Departure	12/05/2018 19:09
House Change Reason	
Status	Scheduled

Housing	CJC-N42-F-30-002
Arrival	12/05/2018 19:09
Departure	12/09/2018 18:24
House Change Reason	12/5/18 DETAIL EXTRA
Status	Scheduled

Housing	CJC-S21-A-6-002
Arrival	12/09/2018 18:24
Departure	00/00/0000 00:00
House Change Reason	lock in per Sgt. Hunt
Status	Unscheduled

BRIAN CARL BARTH
NARRATIVE STATEMENT

On December 9, 2018, I, Deputy Barth (Badge # 1318) was assigned to the medical at the Hamilton County Justice Center. At approximately 2150 a medical emergency was called on North 21. I responded just ahead of our medical staff and observed an individual in the restraint chair that appeared to be unresponsive. The medical team arrived and had him removed from the restraint chair where they began administering CPR. A squad run was called so I left to escort CFD Engine 3 and Medic 32 North 21.

At approximately 1700 this individual was involved in an altercation on North 42 F Pod Cell 30 that resulted in him stabbing another inmate with the pencil. I assisted in locking down the pod and escorted the individual that was stabbed to medical to be evaluated. While in medical, the above individual was brought down in a wheelchair. The individual refused to stay in the wheelchair and complained about leg, back pain. He was uncooperative with our medical staff's efforts to assess him. The call was made to place him into the restraint chair. I grabbed the restraint chair from North 21, brought it to medical, and assisted in putting him in it. Once the restraints were checked by the medical staff escorted him to North 21 A Pod Cell 6.

STATEMENT OF (check one):

☒ Incident Witness
Last Name: Barth First: Brian Middle: Carl
Address: 1000 Sycamore St,
State/City: Cincinnati/OH
Zipcode: 45202
Residence Phone: (513) [redacted]
Employer Phone: (513) 949-6705
Employer Name: Hamilton County Sheriff Office

ASHLEY E. ROETTKER
NARRATIVE STATEMENT

On December 9, 2018, I, Deputy Roettker, was assigned to work N-22 (medical). At approximately 1715 hrs., inmate Howell, Cornelius (1676106) was brought down to medical from N-42 due to an inmate fight. Once Howell was in the sallyport, he repeatedly was falling out of the wheelchair. He was sitting in and wouldn't sit up straight. He eventually slipped out of the wheelchair and onto the sallyport floor whining in pain. The decision was then made by medical staff to have Howell placed into the restraint chair. Officers in the sallyport placed him into the chair without incident. Howell was then taken to N-21 in the restraint chair.

At approximately 2145 hrs., as I was completing N22 Medpass with the nurse, a G100 was called on N21 for an unresponsive mail in the restraint chair. I responded to the unit to sell six to see Howell sitting in the chair. Nurse Kerrence and Christina arrived on post and told Deputy Pierani and Deputy Collini to take him out of the chair. Once Howell was laying on the ground outside of Cell 6, Nurse Christina started chest compressions. I was then told by Sgt. Henn to retrieve the window covers.

STATEMENT OF (check one):

☒ Incident Witness
Last Name: Roettker First: Ashley Middle: E
Address: 1000 Sycamore St,
State/City: Cincinnati/OH
Zipcode: 45202

CHRISTOPHER JOHN HENN
NARRATIVE STATEMENT

On 12-9-18, I, Sgt. C. Henn was the South building supervisor. I responded to N21 for an unresponsive inmate call via the radio. When I entered A Pod, later identified prisoner Howell, Cornelius (SMS 1076106) was laying on his back. Nurse Christine Jordan was performing chest compressions on him. Nurse Kerrence Rose was putting together the breathing apparatus. Nurse Ben Curl and Nurse Melissa Tucker were preparing to administer Narcan and take a blood sugar sample. I asked if they needed any assistance which they replied they were "OK". Nurse Ben applied the AED which advised to keep giving chest compressions. Nurse Jen Carpenter began chest compressions while Nurse Melissa gave "breaths" with the breathing apparatus. Cincinnati fire department personnel arrived in the advised that inmate Howell was cold and likely deceased.

STATEMENT OF (check one):

☒ Incident Witness
Last Name: Henn First: Christopher Middle: John
Address: 1000 Sycamore St.
State/City: Cincinnati/OH
Zipcode: 45202
Residence Phone: (513) [redacted]
Employer Phone: (513) 964-6707
Employer Name: Hamilton County Sheriff Office
Address: 1000 Sycamore St., CIN, OH 45202

MELISSA TUCKER
NARRATIVE STATEMENT

Victim: 1676106 Offender: Howell Cornelius
Incident Date: 12, 9, 18
Incident Location: North Building – A pod
Incident Time (tt:tt) 21:49

While doing a Medpass on N32, I heard "911 for unresponsive on George 21" over the radio. I immediately stopped Medpass and went to N21. Upon entering unit, I was directed to A Pod. Patient was lying prone on floor. Nurse Christina was giving compressions and Nurse Ben and Nurse Karen's were gathering supplies for Ambubag and oxygen. I knelt at patients head and opened airway with head tilt, chin lift and applied mask to give breath during CPR. Medic Jenny then arrived and took over compressions and direction of medical staff. Nurse Christina then took over for me. Medic Jenny started to administer Narcan. Nurse Ben retrieved the Narcan and I administered it to patients left nostril. I then went to medical office N22 to get paperwork ready for the squad. When I returned to N21 A Pod, squad was already on scene and CPR had stopped. I get paperwork to squad and left scene.

STATEMENT OF (check one):

☒ Incident Witness
Last Name: Tucker First: Melissa Middle:
Address: 1000 Sycamore
State/City: Cincinnati/OH
Zipcode: 45202
Employer Name: Naphcare
Employer Phone: (513) 946-6500
Address: same as above

MATTHEW ADARA COLLINI
NARRATIVE STATEMENT

I Deputy Collini was posted on G2. My only involvement with inmate Howell, Cornelius (1676106) was to check him and the other suicide watches once I took over at 2020 hrs. inmate Howell assumed to be asleep just like any other day. On my logs I put in chair at 2147. Sgt. Hunt came to take out of chair. Upon taking him out Howell seemed unresponsive. I then went to medical to get nurses. Once back I assisted by taking Howell out of chair and placing him on floor for medical.

STATEMENT OF (check one):

☒ Reporting Officer
Last Name: Collini First: Matthew Middle: Adara
Address: [redacted]
State/City: Cincinnati/OH
Zipcode: [redacted]
Residence Phone: (513) [redacted]
Employer Name: Hamilton County Sheriff Office
Employer Phone: (513) 946-6708
Address: 1000 Sycamore St., Cincinnati, OH 45202

DANIEL BARRETT ERWIN
NARRATIVE STATEMENT

On December 9, 2018, I Deputy Erwin, was assigned to G21. At approximately 2149 in George 100 was called on G21 on inmate Howell, Cornelius 1676106. Sgt. Hunt came down to assist with taking him out of the restraint chair. Upon doing so, he appeared to be unresponsive. Eight George 100 was called along with George base calling 911. Medical nursing staff arrived on post and immediately administered CPR. Medic 3 and Engine 3 arrived on port at 2154. When they arrived it was determined that he was already deceased. Both Medic 3 and Engine 3 left at 2205.

STATEMENT OF (check one):

☒ Reporting Officer
Last Name: Erwin First: Daniel Middle: Barrett
Address: [redacted]
State/City: [redacted]
Zipcode: [redacted]
Residence Phone: (513) [redacted]
Employer Name: Hamilton County Sheriff Office
Employer Phone: (513) 946-6708
Address: 1000 Sycamore St., Cincinnati, OH 45202

DOMINIC MARK PIERANI
NARRATIVE STATEMENT

I, Deputy Pierani, was advised an inmate was being placed in the chair in medical. Inmate identified as Howell, Cornelius # 167106. I assisted in securing the restraints and in cuffing Howell. Howell was escorted to psych in the chair. I secured the chair to the wall and locked the master lock. Around 2145 hrs., Sgt. Hunt came down to take Howell out of the chair. Howell did not respond. I attempted a start and Rob and got no response. Howell felt cold to the touch. Medical was told to respond, and 911 was called. I assisted in removing Howell from the chair, and placed him on the ground in A Pod day space. The medical staff took over.

STATEMENT OF (check one):

Last Name: Pierani First: Dominic Middle: Mark
Address: 1000 Sycamore St.
State/City: Cincinnati/OH
Zipcode: 45202
Employer Name: Hamilton County
Employer Phone: (513) 946-6708
Address: 1000 Sycamore St., Cnty, OH, 45202

JUSTIN HUNT
NARRATIVE STATEMENT

On December 9, 2008, I Sgt. Justin Hunt # 16, was working G90 N. building supervisor. An earlier incident involveing inmate Howell, Cornelius 1676106 occurred with him being involved in a physical altercation on N42. During the altercation he stabbed the other inmate with a pencil. Medical was assessing Howell and he was complaining of back pain and yelling and asked to lay on the ground. He was handcuffed in the front of his body and went from the wheelchair to the ground on his own powers. While on the ground he was yelling and complaining about back pain and rolling from side to side. Nurse Christine Jordan said that he should be in mental health and for him to be placed into the restraint chair for his safety and to be housed in mental health. He was placed into the restraint chair at approximately 1740 hrs. at approximately 2145 hrs. I, Sgt. Hunt, came on N21 post to check on Howell and remove him from the chair. Myself and Deputy Pierani spoke loudly to Howell who appeared to be sleeping. Howell did not respond. Deputy Pierani did a sternum rub and I shook his right shoulder. Deputy P Roney called G100 on the radio for medical response. I stepped out of Cell 6 and went to the sallyport to get paper to write on. Nursing staff arrived and 911 was called. I sat at the table and be pod and began taking times for my incident report.

Sgt. Justin L. Hunt #163
12-9-18 @ 2236

EMILY R. VAN DE RYT
NARRATIVE STATEMENT

On December 9, 2018, I Deputy E. Van de Ryt #0791 was assigned as L 25. A G100 was called on G21 for an inmate being unresponsive and that 911 was notified. Due to the North Building Rovers assisting on G21, I went down to the kitchen loading dock to escort the engine and medics up to G21. Upon the Medic 3 and Engine 3 arriving, I escorted engine 3 to G21 from the kitchen loading. I then went to the hallway to escort Medic 3 to G21. The individual was pronounced deceased and Medic 3 was ready to leave so I escorted Medic 3 back down to the kitchen loading dock. Upon arriving on the kitchen loading dock I realized that Sgt. Timon had parked vehicle 212 in the kitchen loading dock which prohibited Engine 3 from being able to leave. Once Medic 3 was off post I went back up to G21 to get the keys to 212 and also escorted Engine 3 back down to the kitchen loading dock. I moved vehicle 212 to the intake sallyport.

STATEMENT OF (check one):

☒ Incident Witness
Last Name: Van de Ryt First: Emily Middle: R.
Address: 1000 Sycamore St.
State/City: Cincinnati/Ohio
Zipcode: 45202

JESSE FRANKLIN
NARRATIVE STATEMENT

I Sgt. Franklin was assigned as the intake supervisor on 09 December 2018. I was in medical while inmate Howell was being seen by medical personnel. Howell was acting very strange for making noises, abnormal body movements and spitting up. The nurses asked him several times if you taken anything, which he stated he hadn't. The nurses asked if he had any medical conditions which he stated sickle cell. The nursing staff did take his blood pressure which they said was low and they also said that his blood sugar was a little low. The nursing staff was going back and forth to send Howell out to UCER. One of the nurses then stated that he attempted to hand oxycodone at one point. At that point the decision was made to not send him out to UCER. Then the nurses ordered him into the restraint chair. I assisted placing him into the restraint chair by taking control of his left arm.

STATEMENT OF (check one):

☒ Reporting Officer
Last Name: Franklin First: Jesse Middle:
Address: 1000 Sycamore St.
State/City: Cincinnati/Ohio
Zipcode: 45202

BRANDI L. TERRY
NARRATIVE STATEMENT

On December 9, 2018, I, Deputy Terry was assigned George 25, a rover for the North Building around the time of 1720 hrs. I went down to medical, George 22, after an inmate fight. While in the sallyport, inmate Howell, Cornelius (1676106) was in a wheelchair trying to be evaluated by medical staff. While in the wheelchair, he began to slip out of the chair, complaining of pain in his legs and back. After deliberation and Howell not cooperating with officers and nursing staff, it was decided by charge Nurse Christine that Howell be placed in the restraint chair. At approximately 2145 hrs., a George 100 was called for. George 21 an unresponsive mail in the chair. I responded to the unit to see Howell sitting in the chair in A Pod Cell 6. At that time Nurse Kerrence Rose and Charge Nurse Christine entered the cell. They advised Deputy P Ronnie and Colin and to lift Howell out of the chair and placed him on the floor. Christine began chest compressions. It was then Randall Spence told me to keep the crime scene log for any and everybody that entered the unit.

STATEMENT OF (check one):

☒ Incident Witness
Last Name: Terry First: Brandi Middle: L
Address: 1000 Sycamore St.
State/City: Cincinnati/Ohio
Zipcode: 45202

KERRENCE SHERRIE ROSE
NARRATIVE STATEMENT

Victim: 1676106 Offender: Howell Cornelius
Incident Date: 12, 9, 18
Incident Location: North Building – A pod
Incident Time (tt:tt) 21:49

Arrived on post patient noted to restraint chair Cell 6. Writer instructed corrections to remove patient from restraint chair and call 911. Patient removed from chair carried the sallyport floor CPR initiated. Writer gathers supplies and oxygen tank. Writer then checks for pedal pulse. Attempted to obtain blood pressure AED analyzing the no blood pressure obtain. Medical staff handed writer glucose meter blood sugar of 38 obtain. Medic 3 on scene care transferred at that time. Writer left scene.

STATEMENT OF (check one):

☒ Incident Witness
Last Name: Rose First: Kerrence Middle: Sherrie
Address: 1000 Sycamore Street
State/City: Cincinnati, OHIO
Zipcode: 45202
Residence Phone: (513) [redacted]
Employer Name: Naphcare
Employer Phone: (513) 946-6500
Address: 1000 Sycamore St. Cincinnati, OH 45202

CHRISTINA JORDAN
NARRATIVE STATEMENT

Victim: 1676106 Offender: Howell Cornelius
Incident Date: 12, 9, 18
Incident Location: George 21, A pod, cell 6
Incident Time (tt:tt) 21:47

I was in the medical pharmacy when at 2149 Nurse Ben came into the pharmacy and said there was an unresponsive in psych. Nurse Ben, Nurse Karen's and I brought the emergency equipment and went to George 21 and then was instructed by corrections to go to A Pod, Cell 6. Patient was in the restraint chair upon arrival. I checked for a cardioid pulse. I did not find one. Medical staff instructed corrections officers to take patient out of the restraint chair and for 911 to be called. Corrections officers placed patient supine on the floor. I initiated chest compressions while medical supplies were gathered by Nurse Ben and Nurse Karen's. Nurse Melissa arrived on the scene and started giving breaths. Medic Jenny arrived and took over chest compressions and I took over giving patient breaths from Nurse Melissa. Squad medic and Engine 3 arrived and report and care turned over to squad.

STATEMENT OF (check one):

☒ Incident Witness
Last Name: Jordan First: Christina Middle:
Address: 1000 Sycamore Street

BENJAMIN CURL
NARRATIVE STATEMENT

Victim: 1676106 Offender: Howell Cornelius
Incident Date: 12, 9, 18
Incident Location: North 21, A – cell #6
Incident Time (tt:tt) 21:59

After completing Medpass and placing my cart into the pharmacy, I heard a G100 called for an unresponsive on G21. Upon arrival, I was directed to A Pod Cell #6. Upon arrival to the cell, patient was still in the restraint chair. Medical staff requested that patient to be taken out of the chair and placed on the ground, while requesting 911 to be notified at the same time. Upon getting him to the ground, CPR initiated with breaths being given via Ambubag and oxygen AED was applied by this writer. Shock was not advised in CPR continued by medical staff. Narcan was requested to be administered. I handed a Narcan to Nurse Melissa. I then helped Nurse Christina with head tilt, chin lift for Ambubag breaths. Medic 3, Engine 3 arrived on port and engine took over care of patient.

STATEMENT OF (check one):

☒ Incident Witness
Last Name: Curl First: Benjamin Middle:
Address: 1000 Sycamore Street
State/City:
Zipcode: 45202
Residence Phone: (513) [redacted]
Employer Name: Naphcare
Employer Phone: (513) 946-6500

JENNIFER CARPER
NARRATIVE STATEMENT

Victim: 1676106 Offender: Howell Cornelius
Incident Date: 12, 9, 18
Incident Location: North Building a – pod
Incident Time (tt:tt) 21:49

I Jennifer Carper was assigned as the medical staff for intake. Upon returning from the restroom, I was told by my office or at the search wall that there was a George 100 and psych and unresponsive inmate. I decided to respond to the George 100 to assist medical staff. Once in the North Building I walked through medical to make sure the George 100 bag was brought to psych and then proceeded to go to G21 A Pod. While the inmate was lying supine with AED pad attached to his chest and Christine RN at inmate's had giving breaths with Ambubag, the AED advised no shockable rhythm and I initiated two minutes of CPR. During that time I asked for a dose of Narcan to be given and blood sugar to be checked. The AED advised to stop CPR to analyze and no shock was advised. I immediately resumed chest compressions. It was at that point City of Cincinnati Fire Department arrived and took patients care over. Nothing more to follow.

/s/ S. Jennifer Carper

STATEMENT OF (check one):

☒ Incident Witness
Last Name: Carper First: Jennifer Middle:
Address: 1000 Sycamore St
State/City: Cincinnati, OH
Zipcode: 45202
Employer Name: Naphcare
Employer Phone: (513) 946-6500
Address: Same as above

Sgt. Garry Keeton #396/Deputy Jessica Jones #1725

HAMILTON COUNTY SHERIFF
INVESTIGATION REPORT

Type of Offense or Investigation: Inmate fight
Date of Offense: December 9, 2018

--Details of Investigation--

On December 8, 2018, CIS Lt. Brian Stapleton advised me to conduct interviews with all inmates that were housed on North 42 F-pod of the Hamilton County Justice Center on the day of the incident. These (45) interviews are as follow:

Interviews on 12-10-18:

1205-Justin Smith (1674508) N4F3201-Commissary

Smith states he watched (2) guys fighting. States the (2) inmates had argued earlier. States he saw the pencil removed from inmate Grant.

1210-Timothy Foster (1670042) N4F3601-Commissary

States he heard an argument which woke him up, then he laid back down.

1214-Robert Parker (1675519) N4F1901-Commissary

States Grant and Howell had been getting into it since Friday(12-7-18). States he heard yelling. States Grant was making a scene in the pod. States Grant and Howell came out of cell #30, States Grant kept

hitting Howell after Howell had told Grant to stop. States he saw another inmate pull the pencil out of Grant's left side.

1223-Gregory Harper (1672095) N4F3801-Commissary

States he doesn't know anything.

1224-Markeese Shelton (1676117) N4F4002-Commissary

States he doesn't know anything.

1227-Richard Cunningham (1675012) N4F3602-Commissary

States he heard arguing coming from cell #30.

1230-Charles Lowry (1667675) N4F2601-Commissary

States Grant and Howell had previously fought before everyone in the pod told them to take into their cell if they wanted to fight. States Howell told Grant he didn't want to fight. States they went into the cell and fought for approximately 45 minutes. States Howell had told him he had heart surgery from when his uncle stabbed him on the street.

1236-Carl White (1676022) N4F3101-Commissary

States he heard a lot of screaming coming from cell #30 for approximately 4-5 minutes.

1241-Robert Norman (1673442) N4F3902-Commissary

States he was in his room sleeping.

1306-Tony Teschner (1672656) N4F3701-Kitchen 1st

States Grant and Howell had argued a couple of days prior to the incident because Grant kept closing the cell door while inside. States Grant complained about Howell's bad body odor. States on the day of the incident, the two had argued for about 10-15 minutes. States the fight happened in and out of the cell. States after the fight, Howell was having a hard time breathing while sitting on the bed. States he heard someone say that Grant had knocked out Howell.

1312-Brian Clark (1674904) N4F3301-Kitchen 1st

States the two were arguing outside of the cell. States Grant told Howell to come into the cell. States when the cell door opened, Howell was on the bed having a hard time breathing.

1319-Dontravis Britten (1665874) N4F3501-Kitchen 1st

States the two came out of the cell arguing. States they both went back into the cell and starting fighting. States he saw both inmates come out of the cell with Correction Officers.

Interviews on 12-11-18:

0847-Avery Snell-(1672279) N4F1801-Kitchen 1st

States he heard Grant and Howell arguing in the cell, States Grant had just gotten off of the telephone. States Howell didn't want to fight but Grant continued to get in a fighting stance on (3) occasions, so Howell did also. States Grant squared up on Howell first. States Grant told Howell, let's take it in the cell. States the two of them fought for approxim-

ately 10-15 minutes. States he heard Grant screaming. States Howell was out of it, breathing hard on the bed. States after all inmates were locked in, he could see Howell at the table gasping for air. States both inmates were compliant to the Correction Officers,

0857-Daniel Stolz (1672093) N4F2501-Kitchen 1st

States he was in his cell, but heard arguing. States Howell was breathing heavy when he came out of the cell.

0900-Joshua Jones (1672695) N4F2901-Kitchen 1st

Stated they were having problems. States he heard arguing in the cell, then saw them square up in the day area. States everyone told them to take in their cell if they were going to fight. States Howell didn't want to fight. States after the pod was locked down, he saw Howell having a hard time breathing.

0907-Timothy Young (1675712) N4F3302-Kitchen 1st

States he was sleeping. States he got up after the altercation and came downstairs. States he saw Howell on his bed breathing hard.

0911-Danny StClair (1670048) N4F2201-Kitchen 1st

States he was sleeping. States he woke up to arguing in the day area.

0915-Kenneth Dooley (1673097) N4F2201-Kitchen 1st

States Howell told Grant he didn't want to fight. States Howell kept walking away from Grant. States Grant kept instigating Howell. States they both went into the cell and fought for approximately (10) minutes. States after the fight, he witnessed Howell sit/fall back to the bed as the Correction Officers were trying

to pick him up. States Howell was having a hard time breathing.

0921-Thomas West (1675697) N4F2401-Kitchen 1st

States he heard arguing in the cell. States they came out of the cell, then went back in to fight. States both inmates were breathing hard when they came out of the cell.

0941-Calvin Hill (1674440) N4f3401-Kitchen 1st

States Howell was in the cell and Grant went in afterwards. States he heard arguing coming from the cell. States both inmates came back out of the cell and continued to argue. States they both went back into the cell, shut the door, and started arguing again. States he heard rumbling, soon after he heard fighting that lasted approximately (5) minutes. States the Correction Officers came in and took Grant out of the cell. States Howell stayed in the cell. Stated you could hear Howell breathing heavy, panting and eyes big.

0949-Nino Morgan (1672024) N4F2801-Kitchen 1st

States he was woken up by the fight (housed next door). States it seemed /sounded like they were fighting for approximately (8) minutes. States he worked with Howell in the kitchen and Howell never complained of anything while working the detail.

Interviews on 12-12-18

0604-Phillip Watley (1675984) N4F3502-Kitchen 1st

Stated he was sitting at the table watching others play chess. Stated they were in the cell arguing with

Grant doing most of it. Stated they came out of the cell continuing to argue. Stated he heard Howell tell Grant he didn't want to fight. Stated they went in and out of the cells several times before finally going back in and closing the door. Stated they were fighting for approximately 2-3 minutes. Stated he saw through the window Grant had Howell in a head lock. Stated the unit was then locked down by the Correction Officers.

0619-Antione Allen (1666682) N4F3702-Kitchen 1st

Stated he came out of his cell and went downstairs. Stated he could hear the scuffling which sounded like a full throttle fight. Stated Grant had a pencil in his side when they came out. Stated a lot of people had been picking on Howell. Stated Howell was breathing heavy when he was brought out into the day space area, Stated the fight lasted approximately 3-5 minutes.

0626-Joseph Dick (1674434) N4F3802-Kitchen 1st

States he heard screaming, so he came out of his cell. States he saw Howell and Grant come out of their cell screaming at each other, so he went back into his cell.

0644-Isaac Annang (1674266) N4F4001-Kitchen 1st

States he was in his cell sleeping.

0655-Brian Osgood (1672077) N4F3402 Kitchen 1st

States he was in his cell sleeping when screaming and yelling woke him up. States he never came out of his cell due to being locked down.

0659-Ronald Washington (1675775) N4F3202-Kitchen

States he was in his cell sleeping when he heard some banging. States he saw the Correction Officers

come out of the cell. States they brought Grant out of the cell and sat him on the bench. States Grant had a piece of pencil in his side and he was the one who took it out of his side.

0706-Andre Kahill (1675949) N4F3102-Kitchen 1st

States he was in his cell sleeping.

0710-Brandon Isfort (1673066) N4F2702-Kitchen 1st

States they squared up in the pod, then went into their room. Everybody told them to take it in their cell if they were going to fight. States he heard them fighting for approximately 3-4 minutes. States it looked like Howell got his ass beat.

0715-Kane Thompson (1675174) N4F2402-Kitchen 1st

States he was in the shower.

0718-Cyron Sledge (1673585) N4F2302-Kitchen 1st

States that squared up in the pod. States they were told to take it to their cell. States they were in the cell fighting for approximately 3-5 minutes. States Howell pushed the button for the Corrections Officer.

0723-Michael Williams (1675834) N4F2301-Kitchen 1st

States he was on the phone. States he heard arguing, then saw both Grant and Howell square up. States they took it to their cell and started fighting. States the Officers took both inmates out and then they were locked down.

0728-George Smith (1674108) N4F2202-Kitchen 1st

States Grant started screaming in the cell. States Grant came to the door and started yelling at Howell to come to the cell. States they squared up in the day area. States Grant went back into the cell and put his shoes on. States Grant came out of the cell and squared up again to Howell. States Howell was relunctant to fight Grant. States they went into the cell and fought for approximately 8-10 minutes. States Grant yelled he tried to stab me with a pencil, so I beat his ass. States Howell was leaning on the bed hurting. States they were then told to lock it in.

0739-Jeffrey Panno (1675962) N4F2102-Kitchen 1st

States he was sitting on the bench watching T,V. States he heard them arguing in their cell. States they came out into the day area arguing, then went back into the cell and started fighting for approximately 5 minutes. States he thinks the fight was over Howell wanting to use the restroom, but Grant wouldn't leave the cell so he could.

0937-Cordell Hogan (1673796) N4F2101-Kitchen 1st

States he was watching television. States he heard a commotion in Grant and Howell's cell. States they came out into the day area arguing. States they then squared up. States they were told to take it into their cell. States Grant went in and put on his shoes. Howell was reluctant to go in, but did. States they fought for approximately 5-10 minutes. States he kept hearing the button being pushed. States he heard Howell tell the Corrections Officer he was having a hard time breathing.

0943-Stephen Ball (1674538) N4F2001-Kitchen 1st

States he was in his cell when he heard arguing. States when he came out of his cell, they were in their cell. States he didn't hear anything else. States when he saw Howell, he looked distressed having a hard time breathing.

0948-Gregory Wilson (1675603) N4F1802-Kitchen 1st

States he was sitting in the day area watching television. States Grant and Howell went into the cell and started arguing. States he heard Howell say he didn't want any part of it. States Grant continued to say he wanted to fight. States they squared up in the day area, then went into the cell. States he heard them fighting in the cell for approximately 10-15 minutes. States Grant ran out of the cell stating he had got stabbed. States Howell was sitting on the bed looking distressed.

1017-Leonard Perry (1674313) N4F1701-Floor Porter

States they arguing in the day area. States they went into the cell and fought for approximately 3-5 minutes. States Howell was having a hard time breathing. States he cleaned the cell after he was told to do so.

1022-Anthony Tennyson (1675393) N4F2002
No Detail-Extra

States he was in his cell chilling when he heard some yelling and arguing. States he heard a lot of banging going on in cell #30 for approximately 5 minutes.

1026-Torrence Winbush (1676248) N4F2502-No Detail-Extra

States he was watching television when he heard arguing in their cell. States they came out into the day area and continued their arguing. States Howell told Grant he didn't have the energy to fight. States they then went back into their room and started fighting for approximately 5 minutes. States Howell was on the edge of the bed breathing hard, States he heard Howell tell the Corrections Officer he couldn't breathe. States Howell was compliant the whole time.

1033-Dakota Burd (1675359) N4F2802-No Detail-Extra

States Grant had been messing with Howell the previous day. States Howell had asked Grant to leave the cell so he could use the restroom. States they started arguing, so Grant went to the cell and put his shoes on. States they squared up in the day area before going into the cell and fought for approximately 5 minutes. States he saw Howell bleeding from the mouth while sitting on the bed. States Grant came out the cell saying he beat his ass,

1038-Christopher Lipka (1675027) N4F3901-Kitchen 1st

States he was sleeping in his cell and didn't hear anything.

1049-Steven Phifer (1674299) N4F1701-Floor Porter

States he was sleeping when he woke up to some screaming. States he saw Grant and Howell square up in the day area, then go into their cell. States he then went back into his cell.

1053-William Reliford (1675651) N4F2701-Kitchen 1st

States he was in his cell sleeping.

1100-John Brown (1664469) N4F1902-Commissary

States he was watching television when Grant and Howell started arguing. States they went into the cell, then came back out arguing. States they went back into the cell and started tusseling around. States he heard someone hit the button asking for help.

Hamilton County Sheriffs Office
Jim Neil Sheriff

MEDIA RELEASE

INMATE DEATH

Hamilton County Justice Center, December 10, 2018 – Hamilton County Sheriff Jim Neil reports the death of an inmate at the Hamilton County Justice Center.

On December 9, 2018 at approximately 5:00 pm, an altercation occurred between two inmates housed together on the 4th floor of the North building of the Justice Center. Both inmates were transported to the medical unit for evaluation of minor injuries sustained during this altercation.

Inmate Cornelius Howell, male/33, was evaluated for a cut lip and was placed in a restraint chair at the direction of the treating nurse. Inmate Howell Was not combative with staff and no force was used by Hamilton County Sheriff's Deputies.

Inmate Howell was found unresponsive at approximately 9:40 pm by corrections Officers doing rounds.

The Hamilton County Coroner's Office is conducting an autopsy to determine the cause of death. There was no immediate sign of trauma or injury to Mr. Howell Mr. Howell did have significant medical history prior to incarceration.

Cornelius Howell has been lodged at the Hamilton County Justice Center since December 2, 2018: He was arrested by the Cincinnati Police Department and charged with Aggravated Menacing and Criminal

Damaging; both Misdemeanor offenses Howell's last known address was in the 800 block of Adams Street, Cincinnati, Ohio 45215.

MEDIA CONTACT:

David Daugherty – ddauqherty@sheriff.hamilton-co.org or Office (513) 946-6439; Cell (513) 328-3100

Public Record Requests:

Jim Knapp jknapp@sheriff.hamilton-co.org or Jessica Jones jljones@sheriff.hamilton-co.org

Mugshot Requests:

ldentification@sheriff.hamilton-co.org or call (513) 946-6230

DECLARATION OF NATHANIEL R. EVANS, II, M.D. (MARCH 12, 2021)

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION AT CINCINNATI

KARLA HOWELL AS ADMINISTRATRIX OF THE ESTATE OF CORNELIUS PIERRE HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

Case No. 1:19-cv-00373-DRC-SKB

Before: Douglas R. COLE, Judge.

DECLARATION OF NATHANIEL R. EVANS, II, M.D.

I, Nathaniel R. Evans II, M.D., pursuant to 28 U.S.C. § 1746, declare the following is true and correct based upon my personal knowledge:

1. I am an adult person over the age of 21 years.

2. I have been retained as an expert in the case of *Karla Howell, As Administratrix of the Estate of Cornelius Howell.* Case No: 1:19-CV-00373-DRC-SKB

pending in the United States District Court for the Southern District of Ohio.

3. I am a medical doctor licensed to practice medicine in Pennsylvania and New Jersey. I am Board Certified in Internal Medicine and Addiction Medicine. A true and accurate copy of my CV is attached as Exhibit A.

4. A true and accurate copy of my Expert Report offered in this matter is also contained in Exhibit A, which accurately represents the materials I reviewed, the work I performed, and the opinions that I hold regarding the issues that I was retained to evaluate in this case.

5. All of my conclusions in this matter are made to a reasonable degree of medical and scientific certainty.

I declare under the penalty of perjury that the foregoing is true and correct.

/s/ Nathaniel R. Evans, II, M.D.

Executed on: March 12, 2021

Nathaniel R. Evans, II, M.D.

Delanco, New Jersey

Report of Medical Expert — August 31st, 2020

Case: Karla Howell vs Naphcare, Inc. et al

To whom it may concern:

I am a medical doctor (MD, The Johns Hopkins School of Medicine, 1973). I am Board Certified in Internal Medicine and Addiction Medicine. I am also certified by the National Commission on Correctional Health Care as a Certified Correctional Healthcare Provider (CCHP). From 1986 to December 31" of 2007, I provided physician and medical director services to the Burlington County New Jersey Corrections Department. In that position, I was responsible for all non-psychiatric medical services. During my twenty-one year tenure, the Burlington County Department of Corrections housed a population of 400 to 600 inmates and detainees. From 1986 to the end of 2007, I was directly responsible for developing all non-mental health medical policies and procedures at the Burlington County Correctional facilities. I hired, trained, monitored, and was directly responsible for all non-psychiatric physicians and nurses providing services at Burlington County Corrections Department. Additionally, I personally examined and treated inmates and detainees throughout the twenty-one year period. I am currently engaged in full-time clinical medical practice. I devote less than twenty percent (20%) of my professional time to providing medical expert services. I am familiar with the standard of care and reasonable practice of correctional healthcare. I charge $500 per hour for time I devote to case review and report preparation.

I have been asked to review records and video related to the above named case in order to determine if the nursing care provided to Cornelius Howell met the standard of care. Mr. Howell died on the evening or December 9th 2018 while sitting in a restraint chair at Hamilton County Justice center.

List of Documents I Reviewed prior to composing this report:

Plaintiff's First Amended Complaint Medical Records of Cornelius Howell

- Naphcare (NC 000001-000259)
- University Hospital (2 CH 000001-001082)- Oncology Hematology Care (3 CH 000001-000013)
- Good Samaritan Hospital (4 CH 000001-000356)
- Talbert House (5 CH 000001-000074)
- Cincinnati Children's Medical Center (6 CH 000001-000038)
- Medical Records received via Plaintiff's Counsel (POD 000001-002417)

Hamilton County Coroner Documents

- Hamilton Co Coroner Death Record, Autopsy, Tox Report (1 CH 000001000009)
- Hamilton Co Coroner Photos

Death Certificate of Cornelius Howell

Documents Received from Hamilton County Sheriff's Office

- Death Investigation Records (HCSO 000001-000241)
- Internal Affairs Recorded Interviews
  - Daniel Erwin
  - Matthew Collini
  - Dominic Pierani
  - Brian Barth
  - Ashley Roettker
  - Inmate Demarcus Grant

Surveillance Video (13 total)

- Camera No/Disc Name G42 / Sallyport 1st Floor — Camera Location: JC-N4-S3-259
- Camera No/Disc Name G21 Elevator — Camera Location: JC-N1-6-006
- Camera No/Disc Name North 42 Hallway — Camera Location: JC-N4-1-085
- Camera No/Disc Name 2nd Floor — Camera Location: JC-N2-1-047
- Camera No/Disc Name G21 Medical — Camera Location: JC-N2-S3-267
- Camera No/Disc Name G21 Disc No. 1-8 — Camera Location: JC-N2-S-265

Depositions Transcripts:

- Ashley Roettker
- Brian Barth
- Jesse Franklin
- Dominic Pierani

- Brandi Terry
- Pierette Arthur
- Christina Jordan
- Brad Buchanan
- Justin Hunt
- Matthew Collini

Deposition Exhibits No. 1-33
Naphcare Production of Documents
(NC 000001-002253)

- NC Medical Records of Cornelius Howell
- Personnel File of Christina Jordan
- Personnel File of Pierrette Arthur
- Incident Report
- Contract with Hamilton County
- 2017 Policy & Procedure Manual
- 2019 Policy & Procedure Manual

Naphcare Supplemental Document Production (NC 002254-002259) Plaintiffs Expert Reports

- Anthony Castillo, Jr.
- Martin H. Steinberg, M.D.
- Lori E. Roscoe, DNP, APRN, ANP-C, CCHP-RN

I have read the reports of plaintiffs experts, Martin H. Steinberg, M.D. and Lori E. Roscoe, APRN. Dr. Steinberg is a Professor of Medicine, Pediatrics, Pathology and Laboratory Medicine. Based upon my review of his credentials, he has had no experience working as a medical doctor or medical provider in a

correctional facility. Dr. Steinberg apparently has no firsthand knowledge of the challenges and complexities of working as a doctor or a nurse in a jail. Having worked as a doctor in a county jail for more than twenty years, I am very aware that hospital and clinic patients do not present the same set of challenges to medical providers as do patients who are incarcerated. Dr. Steinberg's experience in hospitals and clinics has not given him knowledge of the challenges that are unique to correctional medicine and nursing. Dr. Steinberg has theorized that Mr. Howell died of rhabdomyolysis. That theory is based on no proof.

On page four of his report, Dr. Steinberg accurately stated: "Death during acute pain episodes is uncommon. When it occurs, it is usually due to a cardiac event and the patient dies without warning; their collapse is sudden . . . ". Dr. Steinberg also wrote: "Sudden cardiac death in sickle cell disease is thought to most often result from arrhythmia, perhaps from lesions in the cardiac conduction system".

Dr. Steinberg mentioned in his report that Mr. Howell sustained a severe chest injury due being stabbed in his chest December of 2017. The stab wound punctured Mr. Howell's pericardium (the thin "envelope" in which the heart is located). That chest trauma may well have caused a subtle heart injury that could not have been recognized by medical providers, but that would have put Mr. Howell at risk for sudden cardiac death. Heart scarring (even microscopic scaring) due to the stab injury could have caused a subtle impairment of Mr. Howell's heart's conduction system and caused him to develop a fatal arrythmia without warning. It is likely that a silent (unsuspected) heart problem caused a sudden heart

arrhythmia that resulted in Cornelius Howell's sudden death.

On page four of his expert report, Dr. Steinburg also wrote: "Muscle pain, weakness, and dark urine characterize rhabdomyolysis. Mr. Howell had muscle pain and weakness; his urine was not examined". I submit that Dr. Steinberg cannot know that Cornelius Howell had weakness on December 9th, 2018. Further, during Mr. Howell's autopsy, by standard procedure, the pathologist would be expected to open Mr. Howell's bladder and inspect its contents. There is no record of dark urine having been detected in Mr. Howell's bladder. I disagree with Dr. Steinberg's statement that Mr. Howell likely died of rhabdomyolysis. I have seen several cases of patients who developed rhabdomyolysis in jail and patients who came to Emergency Departments after developing rhabdomyolysis. Rhabdomyolysis does not usually cause sudden death. In fact, after more than forty years of medical practice, I have never seen rhabdomyolysis cause sudden death. Cardiac arrhythmias, however, commonly cause sudden death.

Plaintiffs expert, Loria E. Roscoe, APRN made statements in her report that are either unsubstantiated or clearly false. She stated (on page 6 of her report): "Charge RN Jordan ordered Mr. Howell to be confined to the restraint chair". That claim is not only unsubstantiated, but Nurse Practitioner Roscoe herself (on page 4 of her report) documented that the Charge nurse Jordan testified under oath that corrections officers made the decision to confine Mr. Howell to a restraint chair. Licensed Practical Nurse Pierette Arthur (under oath) also stated her opinion that only corrections officers could give the order to

have an inmate put into a restraint chair. Officer Justin Hunt testified under oath during his deposition that he was in a position to order an inmate into a restraint chair. Ms. Roscoe acknowledged (on page 4 of her report): "There is conflicting testimony regarding who actually made the decision to place Mr. Howell in the restraint chair". It is unclear how Lori Roscoe concluded (page 6 of her report) that it was Nurse Jordan who ordered the restraint chair for Mr. Howell.

Plaintiff expert Lori Roscoe noted on page 3 of her report: "On December 2, 2018 Mr. Howell refused the Receiving Screening upon arrival". Despite having documented that Mr. Howell was uncooperative upon his arrival at the correctional facility on December 2nd, 2018, Lori Roscoe repeatedly wrongly states in her report that, on December 9th 2018, Mr. Howell's refusal to cooperate with nurses' efforts to evaluate him was: "not his usual temperament". That statement in her report is clearly false. She repeated the same false statement on page seven, page eight, and page nine of her report.

On page ten of her report, plaintiff's expert Roscoe wrote the following incorrect statement: "However, the releasing of a mental health patient from the restraint chair, seclusion, or any other therapeutic care should only occur with an order from a trained provider of medical or mental health who has evaluated the patient and determined that he/she/they is safe to be released." Contrary to Ms. Roscoe's statement, it is common, appropriate and within jails' policies for senior corrections officers (who are not trained providers of medical or mental health) to give the order to release individuals from restraint chairs and from seclusion. Ms. Roscoe's statement is false.

My review of the medical record of Cornelius Howell dating back to 2009 reveals that Mr. Howell had frequent Emergency Department visits for complaints of pain due to sickle cell crisis. Usually, his laboratory studies (done on blood drawn during those ER. visits) were normal. Mr. Howell's LDH blood test, which is typically abnormal in patients experiencing a sickle cell crisis, was usually normal during his Emergency Department visits. In a letter published in the journal Blood, Dr. Gregory J. Kato of the Sickle Cell Vascular Disease Section, Hematology Branch, National Heart, Lung and Blood Institute, National Institutes of Health wrote: "During vaso-occlusive crisis, LDH rises at least in part due to lysis of red cells." Cornelius Howell's normal LDH levels during his emergency visits suggest that he was not actually experiencing pain from sickle cell crises.

As of 11/24/2015, Cornelius Howell was taking Dilaudid 0.5 mg every three hours for pain. Cornelius Howell's UC Health Services note of 12/02/2015 stated that he was taking oxycodone 50 mg by mouth every four hours as needed for pain.

A medical progress note dated 03/12/2016 regarding Cornelius Howell states: "patient also noted with past history of abusing pain medications."

Cornelius Howell did not have sickle cell anemia. Anemia means that the cells in a person's blood are an abnormally low percentage of the total volume of the person's blood. During his multiple E.R. visits with complaints of pain, Cornelius Howell's blood tests showed that he was not anemic. The reticulocyte count, which is often elevated in a person with a sickle cell crisis, was normal in Mr. Howell, when tested during his emergency room visits. On every

such visit, Mr. Howell was seeking narcotic pain medication and he departed the hospital each time with a prescription for a narcotic medication, but usually with no objective evidence of illness.

Mr. Howell had a history of aberrant drug behavior. On at least one occasion, Cornelius Howell told medical providers that he needed a refill of his narcotic pain medication because his mother had beaten him up and stolen his medication. His sickle cell physician, Dr. Kim, was very concerned that Mr. Howell's social situation was too unstable and dangerous for opioid (narcotic) therapy. Dr. Kim changed Mr. Howell from Oxycodone to Methadone. When Dr. Kim refused to continue prescribing Oxycodone to Mr. Howell, Mr. Howell didn't agree and went to see another physician.

On December 18th, 2017, Cornelius Howell was hospitalized with a stab wound to his chest. He had been stabbed in the chest by his uncle. The stab caused an injury to his pericardium (the sac around his heart). The stab wound also caused life threatening bleeding into the sac around Mr. Howell's heart (his pericardium). Cornelius Howell required surgery for repair of the tear in his pericardium. It is likely that the pericardial injury did cause some degree of trauma to Mr. Howell's heart. Such trauma could have left him more susceptible to sudden cardiac death.

The medical record shows that Mr. Howell was not a consistently compliant patient. He did not maintain regular attendance at the Sickle-Cell clinic and he often missed appointments.

In March of 2018, Mr. Howell went to see Dr. Coyle at Good Samaritan Hospital for pain management

related to sickle cell anemia. In reviewing his records, Dr. Coyle noted that Mr. Howell would go to the clinic at UC claiming to be out of his narcotics when he should have had a remaining supply. He made note that Dr. Kim required urine drug screens and that there were five different occasions were Mr. Howell didn't have narcotics in his system, when he should have. Dr. Coyle reviewed records showing Mr. Howell having THC in his system and that he was using marijuana; Mr. Howell denied use of marijuana. Dr. Coyle felt that Mr. Howell had too many inconsistencies and concerns for the misuse of Oxycodone and offered a referral to pain management specialist, but offered to take over Mr. Howell's hematologic care. Mr. Howell stated he would look elsewhere for care. In September, 2018, Mr. Howell was admitted to UC Hospital for sickle cell pain crisis because he ran out of medications. The physician, Dr. Ias Abuall, MD noted that Mr. Howell was very angry upon the evaluation and demanded that he be placed back on Percocet. Percocet is a tablet medication containing Oxycodone.

As of December 2018, Mr. Cornelius Howell had a history of incarcerations. He also had a history of violent behavior. A Hamilton County Justice Center "Release of Responsibility" form for inmate Cornelius Howell includes the statement "refused receiving screen". The form was dated 12/02/2018 at 05:38. It was signed by Cornelius Howell and by Lawrence, EMT/P.

At about 5pm on December 9th, 2018, an altercation occurred between Mr. Howell and his cellmate, DeMarcus Grant. Other inmates in the cell block reported that the two men were having issues

prior to the fight. The record is not entirely clear as to who started the altercation. When the fight came to the attention of corrections officers, the officers escorted both men out of their cell and to medical. The roommate, Mr. Grant, reported that Mr. Howell had stabbed him with a pencil. Mr. Grant was evaluated for puncture wound. Mr. Howell was then brought into medical for evaluation. It is noteworthy that Mr. Howell's behavior was distinctly unlike that of a patient experiencing sickle cell crisis.

Having treated hundreds of patients with sickle cell pain during my long career in Internal Medicine and Emergency Medicine, I have never witnessed a sickle cell patient exhibit behavior that witness state Mr. Howell exhibited when he was brought to the medical at Hamilton County Detention Center on the afternoon of December 9th, 2018. Nurses and corrections officers concurred in their written reports and in their deposition testimony, that Mr. Howell to slid out of a wheelchair on to the floor, thrashed about, and resisted having vital signs taken by medical staff. Mr. Howell's behavior was much more in keeping with "acting out" behavior than the behavior of a patient who was experiencing an attack of pain due to a sickle cell crisis. Such "acting out" behavior typically is not a result of medical illness. None of the witnesses reported having heard Mr. Howell request to be taken to a hospital.

A "Restrained/Seclusion" observation log for Cornelius Howell documented at 5:43 p.m. on 12/09/2018 that the reason Cornelius Howell was put into a restraint chair: was "yelling", fell on floor, rolling around, non-compliant with medical care. Officer Justin Hunt stated under oath during his

deposition (page 73): "I do recall him rolling around, rolling from one side to the other side onto his stomach, onto his back, extending it." On page 78 of his deposition report, Officer Justin Hunt said about Cornelius Howell: "I can't just leave him laying here in the middle of the floor rolling around. He's rolling into — into chairs. He's rolling from side to side. He's bumping into chairs, a file cabinet. I can't have him doing that here. To my eyes, him rolling around side to side is — got a danger of harming himself some way, somehow". On page 79 of his deposition report, Officer Justin Hunt stated: "when it was decided that he's not going to the hospital and that, for his safety and for observation, he's going to be put into the restraint chair, the restraint chair was called for and brought down to the medical sallyport".

Mr. Howell was transported in a restraint chair from the medical section to the N21 unit of the Hamilton County Justice Center. Pierette Arthur, LPN was the mental health nurse in the N-21 unit when Mr. Howell arrived, and she reviewed the Restraint/Seclusion Observation Log for Mr. Howell that had been started by Charge Nurse Jordan. Nurse Arthur documented at approximately 6:20pm that Cornelius Howell was continuing to yell. Her work duty shift apparently ended at 7:00 pm. After nurse Arthur's work shift ended, it was the responsibility of corrections officers to monitor Mr. Howell's behavior several times per hour and notify medical of any concerns regarding Mr. Howell's medical condition.

At 9:45 pm, a Sergeant Justin Hunt arrived to see if Cornelius Howell could be released from restraint chair. Sergeant Hunt noted Mr. Howell to be unresponsive. EMS service was summoned. Mr. Howell

was removed from restraint chair and taken to the floor. CPR was initiated. Upon their arrival, emergency medical providers pronounced Mr. Howell dead.

Case discussion

Plaintiffs expert, Lori Roscoe wrote, "Charge RN Jordan expected that the officers in the unit would monitor the patients housed there after the mental health nurse left for the evening." That is an accurate statement by Ms. Roscoe and it was appropriate for Nurse Jordan to expect officers to monitor such inmates. Mr. Howell had been placed in a restraint chair because he exhibited behavior that was described as "yelling, fall on floor, rolling around, and non-compliant with medical care." As noted above, Officer Justin Hunt recognized that Mr. Howell's behavior (rolling about on a floor) was putting Mr. Howell at risk for injury. Based upon my twenty-one years of experience working in jails, Cornelius Howell was appropriately confined to a restraint chair for his own safety on December 9', 2018.

Nurse Roscoe describes Mr. Howell as having engaged in a vigorous altercation on December 9th. She notes that "he presented with a 10/10 pain in his legs and back, constricted pupils, diaphoresis and clammy skin. He laid on the floor and was uncooperative with the physical examination, although staff was unable to obtain his vital signs except temperature, which indicated that he was hypotensive." That statement is incorrect. Naphcare staff did NOT obtain Mr. Howell's temperature, because he would not allow them to. Staff did obtain some of Mr. Howell's vital signs. His respiratory rate was measured at 18, his pulse was measured at 90, and his blood

pressure was measured at 90/60. A blood pressure of 90/60 can be considered in the lower range of normal, it does not prove hypotension. True hypotension is usually associated with a pulse rate higher than 90.

Nurse Roscoe wrongly stated that in being uncooperative with medical evaluation on December 9th 2018, Mr. Howell was exhibiting behavior that was "not his usual temperament." As I noted above, that statement is directly refuted by the fact that he had refused medical assessment on December 2'. It was also refuted by Mr. Howell's medical record from prior his December 2018 incarceration. Dr. Kim noted on 9/20/2018 that Mr. Howell "was previously on hydroxyurea, but was noncompliant".

Nurse Roscoe wrote "charge RN Jordan sent Mr. Howard to the mental health unit, confined in a restraint chair, and asked LPN Arthur, the mental health nurse on duty in the unit, to do an evaluation of the patient, a gentleman she believed was suffering from a serious mental health condition, but whose abnormal presentation could also be related to a medical condition like sickle-cell disease.

I have not seen any evidence that Nurse Jordan felt that Mr. Howell had a "serious mental health condition or medical condition." That is a misrepresentation on the part of Nurse Roscoe. Based on many years of working as a medical doctor in a jail, I know that it is common for inmates to "act out", as it appears to me that Mr. Howell was doing. Such acting out behavior does not prove that Mr. Howell had a "serious psychological or medical condition".

Conclusion

The decision to put Cornelius Howell into a restrained chair was justified. Witnesses who observed Cornelius Howell after his altercation on December 9th, 2018 describe Cornelius Howell as thrashing around on the floor, bumping into things, and putting his own health at risk. Having seen many patients who required a restraint chair, I am certain that a person behaving as Cornelius Howell was behaving would not have been appropriately managed by just the application of handcuffs or putting Mr. Howell into a solitary cell.

On December 9th, 2018, Cornelius Howell had had multiple previous hospital visits for treatment of his pain complaints. In my review of the medical records and of witnesses' statements and depositions, I did not see any evidence that Cornelius Howell requested to be taken to a hospital on December 9th, 2018. I did not see any documentation that, on December 9th 2018, Cornelius Howell requested to be taken to a hospital. It is noteworthy that no witnesses described Mr. Howell as having asked to be taken to a hospital. To my awareness, no corrections officers and no nurses reported hearing Mr. Howell request to go to a hospital. In addition to the fact that his trashing around behavior did not suggest a sickle-cell crisis, the evidence that Mr. Howell apparently did not request to go to the hospital makes it all the more reasonable that he was not sent to the hospital. On the afternoon of December 9th, 2018, Cornelius Howell was being uncooperative with corrections and medical staffs at Hamilton County Justice Center. He was being self-destructive. He needed to be protected from injuring himself.

Restraint chairs are commonly used in jails. No one would have expected a 33-year-old to die sitting in a chair without apparent provocation. The medial record certainly suggests that Mr. Howell was agitated, when he was put into the restraint chair. Agitation should not cause death in a 33-year-old. It is my opinion that Mr. Howell had a preexisting cardiac susceptibility to arrhythmia that had not been recognized. The autopsy report of Mr. Howell did include the statement that he had cardiomegaly (an enlarged heart). More than likely, Mr. Howell had susceptibility to heart arrhythmia as a result of his cardiomegaly or as a result of the 2017 chest injury in which a blade punctured the thin envelope around his heart and apparently traumatized his heart causing bleeding into his pericardium (the sac around his heart). That incident from 2017 very likely caused a subtle change in Cornelius Howell's heart that made him susceptible to a fatal arrhythmia.

Nurses working in jails are usually very busy and they have very demanding work. They have multiple (often simultaneous) tasks. They must conduct scheduled checks of blood pressures and blood sugars in hypertensive and diabetic inmates. They must evaluate individuals who present to medical with new medical complaints (illnesses or injuries). They must monitor patients being held in cells in the medical unit. They must do nursing assessments on newly arriving detainees (brought to the jail by police) to determine if they are sufficiently medically stable to be kept in a jail. They must go out into the cell blocks and dispense medications. They must respond onsite at the cells of inmates who develop sudden medical

problems that make them unable to be immediately transferred to medical.

It is not surprising that a nurse may be delayed by an hour or so and not stick to a strict schedule of every-two-hour evaluation of a thirty-year old person in a restraint chair. No one would expect a 33-year-old man sitting in a restraint chair to suddenly die. Although it is sad that Mr. Howell passed away at a young age, his death cannot be reasonably be blamed on nurse Jordan or nurse Arthur. As I read the medical record, Nurse Jordan and Nurse Arthur were doing their jobs to the best of their abilities.

It was appropriate for nurse Jordan to rely upon corrections officers to observe Mr. Howell. Certain officers are specifically assigned to observe a small number of inmates and record their status at regular intervals. Unlike nurses, those officers typically do not have multiple simultaneously occurring demands for their time and attention when they are working.

Having reviewed the Hamilton Justice Center's chart documenting treatment of Cornelius Howell, I do not find that nurse Jordan or nurse Arthur deviated from the standard of care. The policy of every two-hour assessment of person in a restraint chair is a guideline, but not a mandate. It cannot be reasonably mandated in a setting where so many components of the nurse's duties are totally outside of the nurse's control and where such simultaneously occurring demands for time and attention can become almost overwhelming. It was the duty of the corrections officers to bring to nurse Jordan's attention any significant change in Mr. Howell's condition.

Respectfully submitted,

/s/ Nathaniel R. Evans, II, M.D
Nathaniel R. Evans, II, M.D., FACEP, CCHP

{ Curriculum Vitae Omitted }

DECLARATION OF JOSEPH E. KISS, M.D. (MARCH 15, 2021)

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION AT CINCINNATI

KARLA HOWELL AS ADMINISTRATRIX OF THE ESTATE OF CORNELIUS PIERRE HOWELL,

Plaintiff,

v.

NAPHCARE, INC., ET AL.,

Defendants.

Case No. 1:19-cv-00373-DRC-SKB

Before: Douglas R. COLE, Judge.

DECLARATION OF JOSEPH E. KISS, M.D.

I, Joseph E. Kiss, M.D., pursuant to 28 U.S.C. § 1746, declare the following is true and correct based upon my personal knowledge:

1. I am an adult person over the age of 21 years.

2. I have been retained as an expert in the case of *Karla Howell, As Administratrix of the Estate of Cornelius Howell,* Case No: 1:19-CV-00373-DRC-SKB pending in the United States District Court for the Southern District of Ohio.

3. I am a medical doctor licensed to practice medicine in Pennsylvania and Illinois. I am Board Certified in Internal Medicine with Subspecialty Certifications in Hematology, Oncology and Transfusion Medicine (Blood Banking). A true and accurate copy of my CV is attached as Exhibit A.

4. A true and accurate copy of my Expert Report offered in this matter is also contained in Exhibit A, which accurately represents the materials I reviewed, the work I performed, and the opinions that I hold regarding the issues that I was retained to evaluate in this case.

5. All of my conclusions in this matter are made to a reasonable degree of medical and scientific certainty.

I declare under the penalty of perjury that the foregoing is true and correct.

Executed on: 15 Mar 2021

/s/ Joseph E. Kiss, M.D.
Joseph E. Kiss, M.D.

4917 Canyon Creek Trail
Gibsonia, PA 15044

November 2, 2020

Robert W. Hojnoski, Esq.
REMINGER CO., L.P.A.
525 Vine St., Suite 1500 I Cincinnati, OH 45202

Re: Howell v NaphCare, et all
US Southern District of Ohio, Western Division
Case No.: 19-CV-373
Reminger File No.: 10087N

Dear Mr. Hojnoski:

Please allow this letter to serve as a summary of my expert opinions in this matter. All of my opinions are offered within a reasonable degree of medical certainty.

I am a board certified internist and hematologist and a Professor of Medicine at the University of Pittsburgh. In addition, I serve as the Medical Director for Clinical Apheresis and Blood Services at Vitalant Northeast Division, formerly known as The Institute for Transfusion Medicine in Pittsburgh, Pa. I hold subspecialty (board) certifications in internal medicine, transfusion medicine (blood banking), and both hematology and oncology. My primary academic and practice activities center on the field of "benign" hematology, with a strong emphasis on the management of anemias, coagulation, bleeding, and thrombotic disorders. In addition to seeing patients in an outpatient setting, I round as a consultant hematologist with hematology and internal medicine trainees in the hospital, and teach coagulation during a weekly teaching conference using patient histories and coagulation

laboratory test profiles. Many patients on our hospital service have sickle cell disease and are admitted with the full gamut of complications including pain crisis, acute chest syndrome, and iron overload. I also serve as the medical director of an active chronic red blood cell exchange program with 30 patients receiving regular treatment. I also participate in a weekly benign hematology conference at the University of Pittsburgh Medical Center (UPMC), lecturing on coagulation, anemia, and other hematology topics several times per year. In particular, I am considered to have specialized knowledge of blood platelets, coagulation, anticoagulant medications, and therapeutic apheresis. I also serve as Chairman of the UPMC Blood Usage Review and Transfusion Safety Committee and sit on the medical center's system-wide Patient Blood Management Committee that provides education and consultative services to UPMC physicians. I am regularly consulted by physicians, including those in my own specialty of hematology, regarding patients with unusual anemias and/or challenging coagulation/bleeding disorders. I have been engaged in these activities for over 30 years.

In formulating my opinions, I reviewed the materials listed below:

Naphcare Medical Records

Death Certificate of Cornelius Howell

Hamilton County Coroner Death Record, Autopsy and Toxicology Report

Hamilton County Coroner Photos

University Hospital Medical Records

Oncology Hematology Care, Inc., Medical Records

Good Samaritan Hospital Medical Records

Talbert House Medical Records

Deposition Transcripts of Ashley Roettker, Brian Barth, Jesse Franklin, Dominic Pierani, Brandy Terri, Brad Buchanan, Christina Jordan, Pierette Arthur, Matthew Collini and Justin Hunt

Deposition Exhibits No. 1— 33

Documents Received via Hamilton County Sheriff's Office

– Hamilton County Sheriff's Office Records

– Internal Affairs Recorded Interviews of Dominic Pierani, Matthew Collini, Daniel Erwin, Brian Barth, Ashley Roettker, Demarcus Grant

– Jail Surveillance Video

Plaintiff Expert Reports from Anthony Castillo, Lori Roscoe and Martin Steinberg, MD

I shall briefly summarize the relevant case history for the purposes of my review. Mr. Howell had hemoglobin SC disease with a clinical history of intermittent sickle pain episodes/crises involving his neck, back, and extremities treated with analgesics and anti-inflammatory medications. He had radiographic evidence of splenomegaly, sclerosis of the spine, and avascular necrosis involving the head of his left femur. His disease was complicated by an episode of hepatitis/transaminitis in November 2015 that resolved after red blood cell exchange transfusion with multiple units PRBCs and gallstones with laparoscopic cholecystectomy in 2016. In December 2017, he sustained a stab injury to the chest with hemopericardium and

cardiac tamponade requiring emergency open surgical drainage and repair of left and right ventricles.

On December 2, 2018 he was arrested and incarcerated at the Hamilton County Justice Center. On December 7, 2018, he complained of bone pain and was treated with increased fluids. On December 9, 2018 around 5:10 pm he was involved in an altercation with his cell mate, during which he stabbed his cellmate with a pencil and was struck by the cellmate multiple times, which included an injury to his lip. Thereafter he complained of pain in his neck and back and he was taken to the medical station and evaluated by Christine Jordan, RN. At 6:29 PM (5:29 PM EST) his pulse was 90, respirations 22, and BP 110/56. Her report stated she was unable to obtain a temperature. A second set of vital signs indicated pulse 90, respirations 18, BP 90/56, and 02 saturation 99%. The patient was reported to have a bloody lip, c/o back pain, moaning, yelling that has "sickle cell", and sweating. A blood sugar was 78. The patient refused a urine sample (to evaluate for narcotics and/or other illicit drugs to evaluate reason(s) for uncooperative behavior). He was reported to slide out of his wheelchair and was rolling around on the floor and complained that his "legs won't work." Nurse Jordan testified her impression was that he was having a psychiatric episode and that a member of the correctional staff recommended he be placed in a soft restraint chair to prevent harm to himself. He was placed in the chair at 5:43 pm with observation to be performed at 10 minute intervals and medical checks at 2 hour intervals. At 9:49 pm he was found without spontaneous respirations and without pulse and briefly received ACS protocol by the site personnel.

EMT arrived at 9:54 pm. They deemed any further attempt at resuscitation to be futile and the patient was pronounced dead at 11:23 pm on 12/9/2018.

Notable findings on autopsy by the coroner's office included uniform dark red discoloration kidneys with sickled red blood cells in the markedly congested vessels; uniform dark red discoloration of the liver and spleen with increased firm texture with sickled red cells distending the markedly acutely congested sinusoids — areas of retracted cicatrization involveing the liver; acute circulatory failure — pulmonary and cerebral edema, and acute passive congestion of the liver and spleen. Although microscopic sections of the heart were not described, additional details in the report included: History of multiple prior stab wounds in December 2017; Healed oversewn, pledget-reinforced area of the ventral margin of the right ventricular myocardium at the septum. The heart was enlarged and "somewhat" dilated. Also noted were fibrous adhesions of the pericardium, ventral left pleura, and peritoneum.

The Coroner's report lists sickle cell crisis following physical altercation due to hemoglobin SC as the cause of death. The report also listed "increased pulmonary fibrosis due to tobacco smoke exposure" as a contributory cause of death.

Medical Opinion

You have requested my evaluation of this case from the standpoint of the events that occurred on December 9, 2018 and the cause of death.

Crisis episodes occur in patients with hemoglobin SC disease and are typically less severe than patients

with hemoglobin SS. Mr. Howell had many over the course of his life, with episodes of pain involveing the neck, back, and extremities (usually his legs) developing over hours to days. His crisis episodes were relatively mild and were often self-managed. When he would seek medical care, they were generally managed with intravenous hydration and short acting intravenous narcotics, after which he was usually discharged with a limited supply of oral narcotics. Although Mr. Howell did complain of pain in his neck and back after the altercation, it was reasonable to attribute his symptoms to musculoskeletal injury resulting from the altercation itself. Furthermore, his combative/ uncooperative behavior as described did not fit with sickle cell crisis.

Mr. Howell's death was not discovered until 9:49 pm, 4 hours and 39 minutes following the incident and approximately 4 hours after being placed in the restraint chair. At 6:20 pm he was reportedly not in distress. Following this, staff reported that when he was checked through the cell window he was not moaning or complaining of pain, did not receive narcotics or any medications for pain control, and was assumed to be asleep. His lack of complaint of pain and discomfort during this time would be very unusual for patient's experiencing sickle cell pain crisis. Since he was apparently not checked physically during this time, it appears that he died suddenly, soon after being placed in the observation room. Sudden death, both in association with sickle crisis and without a crisis episode is well-described in the sickle cell literature. For example, in a study evaluating the circumstances of death, sudden (unexpected) death in hospital or at home was reported in 23.4% of all

deaths in patients with sickle cell disease.[Darbari 2006] Although the exact mechanism(s) is uncertain, extreme physical exertion, heat from high ambient temperatures, or hypoxic conditions (e. g., high altitude) can create physiologic stress which in the abnormal sickle hemoglobin leads to RBC sickling, sludging, and vaso-occlusion, resulting in acute organ ischemia. It is also known that in sickle cell disease, physical exertion acutely increases pulmonary artery pressure leading to right heart strain.[Machado 2007]

In this instance involveing a physically stressful altercation, the events described above coupled with increased oxygen demand from muscle, would set the stage for acute myocardial ischemia, an arrhythmic event, and cardiac arrest. Myocardial infarction in the absence of underlying coronary artery disease is reported in autopsy series of patients with sickle cell disease.[Martin 1996] Cardiac conduction defects including QT prolongation, first-degree AV block, and ventricular arrhythmias have also been reported. [Voskaridou 2012] It is possible that Mr. Howell's cardiac conduction system was scarred or damaged by the prior history of knife injury and surgical repair. In addition to an acute vaso-occlusive event, this could have contributed to his developing a lethal arrhythmia under the intense physiologic stress of a physical altercation.

Dr. Steinberg has offered opinions that it was acute rhabdomyolysis (not sickle crisis) that led to Mr. Howell's death. However, he also invokes sudden death and provides medical literature case reports describing sudden death in sickle trait and hemoglobin SE disease. I agree that with the very short interval between the physical altercation and his demise, by

definition the circumstances qualify as a sudden death. While there clearly is an association between sickle cell disease (including sickle trait) and the risk of rhabdomyolysis, myoglobin that leaks from skeletal muscle damage primarily leads to renal injury, the time course during which rhabdomyolysis evolves occurs more slowly over hours and days, and does not lead *per se* to sudden death as was seen in this case.

Mr. Howell suffered a sudden death cardiac event within a few hours after he was placed in the restraint chair. Given the circumstances leading to sudden death, even if Ms. Jordan had made the decision to transfer to University of Cincinnati Hospital for evaluation and management, I believe it is unlikely that there would be sufficient time for the usual measures employed in the management of sickle cell vaso-occlusive disease, including hydration with intravenous fluids and supplemental oxygen, to avert his death.

In summary, it is my opinion that as a result of SC hemoglobinopathy Mr. Howell died suddenly after his physical altercation with another inmate on December 9, 2018. Since he did not display usual symptoms and/or signs of sickle crisis, his sudden demise, although unfortunate, was an unexpected and unforeseeable event that could not have been prevented even if a decision had been made to transfer to a higher level of care.

I hold the above opinions to a reasonable degree of medical certainty and reserve the right to alter these opinions as new information becomes available.

Very truly yours,

/s/ Joseph E. Kiss
Joseph E. Kiss, MD
Medical Director
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{ Curriculum Vitae omitted }