In the

Supreme Court of the United States

John David Peterson,
Petitioner,

v.

Nevada County, California, et al,

Respondents.

On Petition for Writ of Certiorari from
The United States Court of Appeals
For the Ninth Circuit

PETITION FOR WRIT OF CERTIORARI

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Questions Presented

Similarly to the question presented in *Tolan v. Cotton,* 572 U.S. 650 (2014), Petitioner is asking this Court to intervene because the decision of the Ninth Circuit Court of Appeals reflects a *clear misapprehension* of summary judgment standards. Petitioner's competent evidence in opposition to a summary judgment was ignored, and further, both the District Court and the Court of Appeals failed to draw reasonable factual inferences in favor of Petitioner.

Parties To The Proceeding

Petitioner

John David Peterson

Respondents

Nevada County, California, a county government and the operator of the Nevada County Sheriff's Department.

Related Cases

None

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United States Constitution

Federal Statutes

Petition for a Writ of Certiorari

John David Peterson respectfully petitions the United States Supreme Court for a writ of certiorari to review the denial by the United States Court of Appeals for the Ninth Circuit of a Petition for Rehearing of Decision of the United States Court of Appeal for the Ninth Circuit affirming a summary judgment of dismissal by the United States District Court for the Eastern District of California in the matter of John David Peterson *v. Nevada County, California*, et al (C.A. Case No. 23-16146; Civil Case No. 2:19-CV-0949-JAM-JDP).

Opinions Below

The Decision of the United States Court Of Appeal for the Ninth Circuit denying a Petition for Rehearing was filed January 27, 2026. Appendix 3. The Decision of the United States Court of Appeals for the Ninth Circuit affirming the decision of the United States District Court for the Eastern District of California was filed January 8, 2026. Appendix 24-34. The Judgment of Dismissal of the United States District Court for the Eastern District of California was filed on August 1, 2023. Appendix 86. The Decision and Order of the United States District Court for the Eastern District of California was filed on August 1, 2023. Appendix 38-96.

Jurisdiction

The jurisdiction for this petition for a writ of certiorari is based upon 28 U.S.C. §1257(a). The date of the judgment to be reviewed is August 1, 2023.

Relevant Constitutional Provisions

Seventh Amendment

In Suits at common law, where the value in controversy shall exceed twenty dollars, the right of trial by jury shall be preserved, and no fact tried by a jury, shall be otherwise re-examined in any Court of the United States, than according to the rules of the common law.

The Federal Issues Were Raised In The Appellate Court

The Question Presented is based upon Petitioner's allegations in his Second Amended Complaint and have been raised by Petitioner at every stage of proceedings in the courts below.

STATEMENT OF THE CASE

This action is about inadequate municipal policies and practices at the Nevada County, California Sheriff's Department ("NCSD") jail that resulted in repeated deliberate indifference to serious medical conditions of patient-detainees. This deliberate indifference almost caused the death of Petitioner.

The evidence shows that Nevada County not only had wholly inadequate policies for confirming the medical fitness of patient-detainees before release, but that Nevada County routinely overrode the policies and practices of its jail medical provider and released patient-detainees from custody regardless of medical fitness.

Further, Nevada County, with knowledge of serious patient-detainee medical conditions, would release the patient-detainee without any transfer of medical care, any ambulatory assistance or transport, or medical discharge instructions.

Simply put, Nevada County engaged in medical dumping of patient-detainees.

The Second Amended Complaint

Petitioner's Second Amended Complaint ("SAC") contains four municipal causes of action under *Monell v. Department of Social Services of New York*, 436 U.S. 658, 98 S.Ct. 2018 (1978) (*"Monell"*).

The First Cause of Action is against Nevada County, California ("Nevada County") and it alleges that Nevada County[1]:

> (1) failed to have constitutional policies regarding the release of patient-detainees with serious medical problems;
>
> (2) failed to adequately train its jail officers to confirm that patient-detainees are medically fit for release and whether they will need ambulatory assistance, transport, discharge instructions, and/or transfer of care to another medical provider at the time of release; and
>
> (3) failed to enforce the jail medical provider's policies and practices regarding the release of patient-detainees with significant medical conditions requiring a transfer of medical care, ambulatory assistance or transport, and providing patient-detainees with medical discharge instructions.

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[1] The Second Cause of Action named Wellpath Management, Inc. ("Wellpath"), the contract medical provider at the Nevada County jail. Wellpath filed for bankruptcy in November 2024, while this case was on appeal. At the time of bankruptcy, there were hundreds of medical claims by patient-detainees. Wellpath was also seriously under-insured. The Ninth Circuit dismissed Wellpath from the appeal on June 27, 2025. The allegations paralleled those against Nevada County.

The Third Cause of Action is against Nevada County and it alleges that its *de facto* jail policies, procedures, and practices were the "moving force" behind the violations of 42 U.S.C. §1983 by Wellpath Management, Inc., the contract medical provider at the Nevada County jail., as alleged in the Second Cause of Action.

The Fourth Cause of Action named Nevada County and Wellpath as co-conspirators in the knowing and willful release from custody of patient-inmates with serious medical conditions when they were not medically fit for release and regardless of whether they needed ambulatory assistance or transport or transfer of care to another medical provider, and without medical discharge instructions.

The Cross Motions for Summary Judgment

On May 26, 2023, and June 27, 2023, the parties filed cross motions for summary judgement under Federal Rule of Civil Procedure ("FRCP") Rule 56(a).

The District Court's Ruling

On August 1, 2023, the District Court held a hearing on the cross motions for summary judgment and issued a decision from the bench denying Plaintiff's Motion for Summary Judgment and granting Nevada County's Motion for Summary Judgment, and granting Wellpath's Motion for Summary Judgment on Counts two and Four, but denying judgment on the state law claim for medical malpractice. Appendix 38-96. Judgement was entered the same day. Appendix 35-37.

Notice of Appeal Timely Filed

Petitioner filed a Notice of Appeal on August 28, 2023, within the thirty day time limit of FRAP 4(a)(1)(A).

Submission of the Record to the Ninth Circuit Court of Appeal

Pursuant to the rules of the Ninth Circuit Court of Appeal, each Party submitted their evidence (deposition transcripts, documents, etc.) in the form of an "Excerpt of Record" which was cited as [ER page number(s)] in the briefs. Petitioner has retained citations to the Excerpt of Record in this Petition in case the Court wants to examine the evidence.[2]

Decision of the Ninth Circuit Court of Appeal

The Ninth Circuit Court of Appeal issued a Memorandum ruling on January 8, 2026, that affirmed the decision of the District Court. Appendix 24-34.

Petition for Rehearing

Petitioner timely filed for a rehearing on January 22, 2026. Appendix 4-23. However, this was denied on January 27, 2026, without statement of reason. Appendix 3. This Petition followed.

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[2] Petitioner's Excerpt of Record contains eight volumes. Due to the large size, the Clerk of this Court advised that Petitioner's Excerpt of Record not be included in the Appendix because it was available through PACER, if needed.

FACTUAL SUMMARY

This Petition seeks review of the summary judgment in favor of Nevada County on Counts 1, 3, and 4 of the SAC.

These Counts are focused on the inadequate policies, practices, and procedures of the Nevada County Sheriff's Department for the delivery of medical care to patient-detainees at the Nevada County jail (collectively "Policies").

These inadequate Policies, plus a lack of training of jail officers, resulted in a dysfunctional and dangerous operational relationship between the jail correctional and medical staffs. Consequently, patient-detainees with serious, even life threatening medical conditions, were released from custody without ever having received medical care at the jail and without being transferred to an outside qualified medical provider upon release. Furthermore, patient-detainees were denied ambulatory assistance or transport to a medical provider and they were not given medical discharge instructions. As a result, Petitioner almost died and was permanently disabled.

In support of Petitioner's *Monell* claims, Petitioner pleaded a second instance in which Nevada County's inadequate Policies caused serious harm to a patient-detainee who, just like Petitioner, was released without having received any *medical treatment*, transfer of care to another medical provider, or any ambulatory assistance or transport. This is the *Howie* incident that occurred just eight months prior to Petitioner's incident. See SAC ¶ 39. This is where we begin the story.

A. The Deliberate Indifference to Christopher Howie's Medical Care

On January 11, 2018, Christopher Howie, a person with mental disabilities, was attacked by NCSD Deputy Adam Grizzell while he was handcuffed in the booking area at the WBCF. Deputy Grizzell slammed the Mr. Howie's head against a wall several times, then tackled him to the ground, shattering his right knee. [ER-V.5, 901-902; Howie Depo., pp. 12:10 to 13:2] Other NCSD officers watched the attack on video and then, instead of assisting him, shackled both hands and feet. [ER-V.5, 903-905; Howie Depo., p. 14:20 to 16:22] Despite the obvious serious injury to Howie's leg that left him unable to stand on his own, he was placed in a holding cell where he was dumped onto his knees. [ER-V.5, 906; Howie Depo., p. 17:1-19]

Howie asked for medical attention each time he was visited by Wellpath medical staff, but he received no medical treatment. [ER-V.5, 907-909; Howie Depo., p. 18:6 to 20:24] Wellpath staff even falsified medical entries, making ludicrous entries like he "Appears Well" and has a "Steady" gait. [ER-V.5, 916-927; Howie Depo., pp. 27:5 to 38:6]

The next morning, Nevada County and Wellpath personnel put Howie into a wheel chair and left him in the booking area of the jail. Howie repeatedly asked Nevada County and Wellpath personnel to take him to the local emergency room, but they repeatedly refused. [ER-V.5, 909-910; Howie Depo., pp. 20:3 to 21:18] Neither County jail nor Wellpath staff arranged to have Mr. Howie's medical care transferred to another medical provider. Further, neither County jail nor medical staff offered to arrange transport for Mr. Howie to an emergency room, despite the obvious fact that he

could not stand or walk. [ER-V.6, 1214-1215; Declaration of Christopher Howie ¶¶ 4, 6-7, 9-10]

Obviously, Mr. Howie was never given medical discharge instructions. Instead, around midday, he was rolled in his wheelchair out the back door of the jail. The back door is a large, heavy door controlled by jail staff just a few feet away in the booking area. Howie was then told to get out of the wheelchair. Howie had to crawl onto the curb and was then handed his cell phone and left him to fend for himself. [ER-V.5, 911-912; Howie Depo., pp. 22:4-23:14] Howie was eventually taken by the Nevada County fire department to the local hospital. [ER-V.5, 911-912; Howie Depo., p. 22:23 to 23:10] At the hospital, Mr. Howie was diagnosed with a serious proximal fracture of his right knee requiring surgical repair. [ER-V.7, 1556; Dr. Witt Expert Report 02/17/2023, p. 12]

B. The Deliberate Indifference to Petitioner's Medical Care

During his booking at the Nevada County jail on September 5, 2018, just eight months after the Howie incident, Petitioner told the Wellpath nurse doing the medical intake that he had been "roughed up" during his arrest and had scrapes on his right shin, plus injuries to his shoulders and clavicle, and a pain level of "8/10". [ER-V.2, 194, 200-202; Peterson Depo., Vol. 1, 61:9-14, 67:4 to 69:16] [ER-V.4, 868-873; Falltrick Depo., p. 21:19 to 26:6] [ER-V.6, 1180, 1183; Jail Medical Records, p. CFMG 006, 009]

Petitioner first reported symptoms of the infection (erythema, pain, warmth) on his lower right leg to medical staff on the morning of September 6, 2018. A nurse took a pen and circled

the area of erythema. [ER-V.2, 210-211, 213-217, 219-221, 223-226, 267-271; Peterson Depo., Vol. 1, pp. 77:23 to 78:7; 80:14 to 84:13; 86:25 to 88:17; 90:10 to 93:12; 134:13 to 136:12; 136:13 to 138:1] Later on the morning of the 6th, the pain increased and the erythema on Petitioner's right lower leg grew markedly in size and became a deeper red and warm to the touch. The nurse again marked the rapidly increasing infection by drawing another circle around the enlarged area. Petitioner was seen again that afternoon. The area of erythema expanded to include his knee, the color of the infection darkened, and the pain, warmth, and tenderness increased. [ER-V.2, 210-211, 213-217, 219-228, 267-272; Peterson Depo., Vol. 1, pp. 77:23 to 78:7; 80:14 to 84:13; 86:25 to 95:13; 134:13 to 136:12; 136:13 to 138:1; 139:4-21] [ER-V.4, 807-808; Boucher Depo., pp. 16:7-17:16] [ER-V.6, 1193-1195, 1202, 1209; Jail Medical Records, pp. CFMG 061-063, 071, 084]

Medical staff *never medically treated* Petitioner and did not even contact the on-call physician, or send Petitioner to the local emergency room. [ER-V.2, 215, 274-277, 295; Peterson Depo., Vol. 1, pp. 82:10-17; 141:1 to 142:1, 142:14 to 144:7; 162:20-22] [ER-V.7, 1558; Dr. Witt Expert Rpt. 3/17/23, p. 14, Opinions 5-9] On the morning of September 7th, Petitioner, escorted by a jail officer, limped from his cell to the infirmary. The medical staff drew yet another circle around the still enlarging area of redness (now up to his lower thigh) and ordered an x-ray of his right leg. Petitioner was radiographed at the jail at between 11 am and 12 noon on the 7th. He was not told the results of the radiograph. [ER-V.2, 229-231; Peterson Depo., Vol. 1, pp. 96:11 to 98:15] [ER-V.6, 1200; Jail Medical Records, p. CFMG 069] Nothing further was done by medical staff. [ER-V.2, 215, 274-277, 295; Peterson

Depo., Vol. 1, pp. 82:10-17; 141:1 to 142:1, 142:14 to 144:7; 162:20-22] [ER-V.7, 1558; Witt Expert Rpt., p. 14, Opinions 5-9] Petitioner was still *not given any treatment* for the now life threatening infection. Escorted by a jail officer, he limped back to his cell.

At about 3:45 pm on the September 7, 2018, Nevada County jail Officer Ryan Stanley contacted Wellpath's on-site Health Services Administrator ("HSA") Laurie Adams to check on Petitioner's medical fitness for release. Officer Stanley testified that Adams said Petitioner was medically clear for release. [ER-V.5, 1049-1053; Stanley Depo., pp. 66:22 to 70:22]

In sharp contrast, HSA Adams testified that she told Officer Stanley that there was no 5150 psych "hold" and that she did not say that Petitioner was medically fit for release. [ER-V.4, 695-700, 702-703, 705-707, 714-716, 745-759; Adams Depo, pp.14:14 to 19:11; 21:22 to 22:4; 24:13 to 26:11; 33:6 to 35:12; 64:16 to 78:1]

Officer Stanley then had Petitioner escorted from his cell to booking by Officer Shannon Malloy. Petitioner limped badly as he walked from his cell to the booking area. He did not say anything to Officer Malloy about his condition because everyone could see that he was limping badly. [ER-V.2, 223, 229-230, 232, 275-277; Peterson Depo., Vol. 1, pp. 90:2-3, 96:11-97:14; 99:1-11, 142:14 to 144:7] [ER-V.3, 320-321, 377-379; Peterson Depo., Vol. 2, pp. 9:19 to 10:2; 66:10-68:22] The jail medical record noted Petitioner had a "pronounced limp", thereby corroborating his testimony [ER-V.6, 1212; Jail Medical Record, CFMG-087]

Petitioner testified that he was limping badly when he came into the booking area to obtain his

clothes from Officer Stanley who was at the booking desk opposite the door. Petitioner further testified that he walked with a "pronounced" limp as he went to the changing room (just off booking), and then back to the desk to ask Officer Stanley if he could use the phone. Petitioner testified that Officer Stanley must have seen him limping as he came into booking, got his clothes, and came back to the booking desk for permission to use the phone. [ER-V.2, 222-223, 229-230, 232, 275-280, 290-291; Peterson Depo., Vol. 1, pp. 89:12 to 90:4, 96:11-97:14, 99:1-11; 142:14 to 147:1, 157:22-158:10] [ER-V.3, 320-321; 323-324, 377-378, 384-386; Peterson Depo. Vol. 2, pp. 9:19 to 10:2, 12:2 to 13:19; 66:10-67:2, 73:3 to 75:12] When Petitioner asked to use the phone to try to get a ride, Officer Stanley was rude and said "make it snappy". Petitioner was not able to reach anyone, so after a couple of minutes he was "buzzed" out the door by Officer Stanley. [ER-V.2, 277-279; Peterson Depo., Vol. 1, pp. 144:18 to 146:15] [ER-V.3, 384-386; Peterson Depo. Vol. 2, p. 73:3 to 75:12] Petitioner felt that Officer Stanley "was just throwing me out of the – throwing me out of there" even though he "needed like a – doctor, or an ambulance, or something." Petitioner was intimidated by Officer Stanley and made to feel worthless. Petitioner did not ask for help with the large double exit doors because it was obvious that he was not going to get any help if he asked. [ER-V.2, 277-280, 290-291; Peterson Depo., Vol. 1, pp. 144:23 to 147:8; 157:22 to 158:10] [ER-V.3, 321, 323-324, 380-381; Peterson Depo., Vol. 2, pp. 10:8-20, 12:2 to 13:19; p. 69:8 to 70:5.]

Upon leaving the jail, Petitioner started walking towards the local hospital. He struggled for about a mile to a gas station. [ER-V.2, 237-241; Peterson Depo., Vol. 1, p. 104:2 to 108:2] [ER-V.3, 327; Peterson Depo., Vol. 2, p. 16:9-18] By the time

he got there he was in such pain and had such a high fever that he could not go any further. He borrowed a phone and called 911. The paramedics arrived and took Petitioner to the local emergency room. [ER-V.2, 241-242; Peterson Depo., Vol. 1, pp. 108:2 to 109:14.]

Petitioner was in serious condition when he arrived at the hospital and was "out of it" for about the first week. [ER-V.2, 242-243; Peterson Depo., Vol. 1, pp. 109:15 to 110:14] [ER-V.5, 1407, 1411, 1422, 1458; Peterson Medical Record, p. 1, 5, 16, 23, 52] [ER-V.7, 1560; Witt Expert Report 2/17/2023, p. 16, Opinion No. 15.] Petitioner was treated for severe bacteremia and sepsis with antibiotics and *was in the hospital for six weeks*. [ER-V.2, 286; Peterson Depo., Vol. 1, p. 153:11-25] [ER-V.6, 1407, 1411, 1422, 1458; Peterson's hospital medical record, p. 1, 5, 16, 23, 52] Petitioner suffered permanent loss of muscle tissue and will always have a significant pain and a limp. Petitioner is now unable to do the construction work that he used to perform. [ER-V.2, 246-250; Peterson Depo., Vol. 1, pp. 113:13 to 117:21] [ER-V.7, 1559; Witt Expert Report 2/17/2023, p. 15, Opinion Nos. 10-11

C. The Medical Expert Testimony

The visible signs of Petitioner's infection are known as cellulitis which can spread rapidly and is considered an "urgent" medical matter. [ER-V.3, 512-513; Dr. Witt Depo., 5/24/2022, pp. 120:5 to 121:25] [ER-V.7, 1557; Dr. Witt Expert Report 2/17/2023, p. 13, Opinion Nos. 1-3] The origin of the cellulitis is not medically important, thus, the x-ray of Petitioner's leg was medically irrelevant. What was medically crucial was to start antibiotic treatment as soon as possible. [ER-V.3, 514-515, 526-527; Witt Depo., 5/24/2022, pp. 122:20 to 123:16; 134:25 to 135:15] [ER-V.7, 1559-1560; Witt Expert

Report 2/17/2023, pp. 13-14, Opinion Nos. 1-5;] Wellpath Physician Assistant Amanda Tirpak, who took the x-ray, was licensed to treat cellulitis and she should have given Petitioner antibiotics immediately. She was also qualified to open and drain the abscess. Tirpak should have treated the cellulitis or transferred him to another medical provider immediately. [ER-V.3, 517-518, 520-522; Witt Depo., May 24, 2022, pp. 125:21 to 126:20; 128:19 to 130:12] [ER-V.7, 1557-1560; Witt Expert Report 2/17/2023, pp. 13-16, Opinion Nos. 3-14]

Further, Dr. Witt opined that releasing Petitioner from custody with his obvious serious medical condition, with nowhere to go, no medical discharge instructions, no transfer of care, and no ambulatory assistance or transport, violated the professional standard of care in multiple respects and "cannot be understood" from a medical perspective. He called it medical "dumping". [ER-V.3, 521-523, 536-538; Witt Depo., 5/24/2022, pp. 129:19 to 131:12; 144:4 to 146:13] [ER-V.4, 661-667; Witt Depo. 3/29/2023, pp.115:20 to 121:25] [ER-V.7, 1557-1560; Witt Expert Report 2/17/2023 pp. 13-16, Opinion Nos. 3, 6-9, 12-14.]

Dr. Witt opined that the NCSD was deliberately indifferent to both Howie and Petitioner. [ER-V.4, 661-667, 669-671, 674-678; Witt Depo., March 29, 2023, pp. 115:20 to 121:25, 123:11 to 125:11; 128:24 to 132:9] [ER-V.3, 539; Witt Depo., 5/24/2022, pp. 147:4-25] [ER-V.7, 1558-1560; Witt Expert Report 2/17/2023, pp. 14-16, Opinion Nos. 8-9, 12-14.]

D. Neither Nevada County nor Wellpath Made Any Policy Changes After the Howie Incident

Despite the glaring failures of Nevada County to provide medical care to Howie in January 2018, Nevada County made no changes to their inadequate Policies for: (a) checking the medical fitness of patient-inmates in preparation for custodial release; and

(b) transferring medical care to another medical provider as necessary, providing ambulatory assistance or transport, and ensuring that medical discharge instructions had been provided. As a consequence of the inadequate Policies, it was only a matter of time before the next incident occurred. This turned out to be Petitioner's medical crisis eight months later in September 2018. Even after Petitioner's incident, Nevada County still did not make any changes to its inadequate Policies. [ER-V.6, 1397-1401; Answers of Nevada County to Peterson's Interrogatories, Set Two, Interrogatories Nos. 12 & 14.]

THE DISTRICT COURT RULING

Appendix 38-96

The District Court erroneously ruled, without any legal authority, that the evidence of Mr. Howie's incident in January 2018 could not be used to support Petitioner's *Monell* claims against Nevada County. Instead, it appeared to rule that the evidence of the Howie incident was barred because Howie had entered into a settlement agreement with Nevada County. The Court gave no legal explanation for this theory and examination of the Howie settlement agreement reveals no confidentiality or other provision restricting the future use of the evidentiary facts of the Howie incident. The District Court then implied that without the second instance of harm from Nevada County's patient-inmate discharge Policies, Petitioner could not proceed under a *Monell* theory of municipal liability.

The District Court next ruled that Petitioner could not show any deliberate indifference because jail medical staff had seen Petitioner nine times over two days. The District Court ignored Petitioner's evidence that, despite the obvious serious and spreading infection, medical staff *failed to provide any treatment* for Petitioner; i.e., the District Court failed to distinguish between *observing* a medical condition and *treatment* of that condition as required by the professional standard of medical care. A jury could find medical negligence for failing to treat within a reasonable period of time. However, a jury could also find that failing to treat a rapidly spreading infection over two days and then releasing the patient without transfer of his care to another medical provider, or even telling the patient that he had an infection and needed treatment as soon as possible, was deliberate indifference. This was a

jury question that the District Court improperly misappropriated to itself.

Next, the District Court ruled that there was no evidence of deliberate indifference by Nevada County jail officers. It arrived at this decision without any discussion of two critical areas of evidence.

First, the District Court ignored the glaring problem with the Nevada County jail procedure for checking whether a patient-detainee was physically fit for release. As the time for release nears, the booking officer is supposed to call the medical staff to verify that the patient-inmate is physically fit for release. As described in jail officer testimony, if medical staff said that the patient-detainee was fit for release, the booking officer would check a box for "medical" on a "Release Check List". In stark contrast, the head of the medical staff testified that the purported "medical" check by Nevada County was not about physically fitness, but whether the patient-detainee was being evaluated for a 5150 mental health hold. Even further, the jail nursing staff testified that jail officers would contact medical staff only to tell them what time a patient-inmate was going to be released, and not to ask if the patient-inmate was physically fit for release.

Second, the District Court ignored Petitioner's evidence that Nevada County jail staff observed him limping badly as he went to and from the infirmary over two days and then from his cell to booking when he was being released. Instead, the District Court accepted as true, Nevada County jail officer testimony that they never saw Petitioner limping. This is the epitome of a triable issue of material fact that only a jury can decide, but which the District Court took upon itself to decide in direct violation of

the rules for summary judgment.

The District Court also ignored Petitioner's uncontested evidence that Nevada County had no policy or practice regarding the transfer of medical care for patient-inmates post release, or for providing ambulatory assistance or transport to a medical facility, or for ensuring that the patient-inmate had received medical discharge instructions.

The District Court did not directly discuss Petitioner's Third and Fourth causes of action, presumably because they were dependent upon the deliberate indifference alleged in the First and Second Causes of action.

Finally, the District Court, after dismissing the federal claims, declined jurisdiction of the state claims.

ARGUMENT

I. Applicable Law

A. Right to Jury Trial

There is a right to a jury trial in all civil cases under the Seventh Amendment to the United States Constitution. All civil cases include causes of action that are created by Congress, which includes cases brought under 42 U.S.C. 1983. *Tull v. United States,* 481 U.S. 412, 417, 107 S.Ct. 1831, 1835 (1987).

Under our constitution, the jury must be maintained as the fact-finding body and "any seeming curtailment of the right to a jury trial should be scrutinized with the utmost care. *Beacon Theatres, Inc. v. Westover,* 359 U.S. 500, 501, 79 S.Ct. 948, 952, 3 L.Ed.2d 988 (1959), quoting *Dimick v. Schiedt,* 293 U.S. 474, 486, 55 S.Ct. 296 (1935).

B. Summary Judgment

Summary judgment is appropriate only when "there is no genuine dispute as to any material fact." Fed. Rule Civ. Proc. 56(a). *Tolan v. Cotton*, 572 U.S. 650, 656-657, 134 S. Ct. 1861, 1866 (2014).

The moving party has the burden of showing the absence of a genuine issue as to any material fact, and for these purposes the material it lodged must be viewed in the light most favorable to the opposing party. *Adickes v. S.H. Kress and Co.*, 398 U.S. 144, 157, 90 S.Ct. 1598, 1608 (1970).

All of the competent evidence from the non-moving party to a summary judgment must be acknowledged and credited and all reasonable

factual inferences must be drawn in favor of the non-moving party. *United States v. Diebold, Inc.*, 369 U.S. 654, 655, 82 S.Ct. 993, 994, (1962).

If the court finds that a rational trier of fact could find for the nonmoving party, then summary judgment must be denied. However, the nonmoving party must submit evidence countering the moving party's evidence that is sufficient to enable reasonably minded jurors to draw an inference in favor of the nonmoving party. Evidence that is merely colorable or not of significant probative value will not suffice. *Anderson v. Liberty Lobby, Inc.,* 477 U.S. 242, 249-250, 106 S. Ct. 2505, 2510-2511 (1986).

C. Deliberate Indifference To Patient-Detainee Medical Care

"A policy of inaction or omission may be based on failure to implement procedural safeguards to prevent constitutional violations." *Tsao v. Desert Palace, Inc.*, 698 F.3d 1128, 1143 (9th Cir. 2012). Operating a jail without sufficient safeguards for detainee-patient medical issues constitutes a policy of inaction. See *Castro v. County of Los Angeles*, 833 F.3d 1060, 1075 (9th Cir. 2016) (*en banc*)

Although mere medical negligence is not actionable under §1983, an action for deliberate indifference will be sustained when a Appellant can "prove more than negligence, but less than subjective intent [to harm] – something akin to reckless disregard." *Russell v. Limitap*, 31 F.4th 729, 739 (2022). The *Russell* decision confirmed the rule laid out in *Gordon v. County of Orange*, 888 F.3d 1118, 1124-1125 (2018), that deliberate indifference is found where there is a "failure to treat a prisoner's condition [which] could result in further significant injury or the unnecessary and wanton infliction of

pain."

II. The Court of Appeal Decision

The Court of Appeal was supposed to conduct a *de novo* review of the District Court's decision granting summary judgment. However, the panel majority's Memorandum Decision ("Decision") failed to conduct a *de novo* review that, as required by law, evaluated all of the evidence on a particular factual issue and then decided whether there was a genuine issue of material fact for a jury. Instead, the majority's Decision, without citation to any of the evidence in the record on a particular factual issue, simply made unsupported factual conclusions upon which it dismissed all of Petitioner's claims.

In sharp contrast, the Dissent by Judge Paez points out how the majority ignored crucial evidence that raised factual issues for a jury to decide, thereby making summary judgment inappropriate.

The majority's Decision contains twelve issues of "material fact" where the competent evidence from both sides was never discussed, but nonetheless, the Court made a definitive factual ruling to support its legal conclusions in favor of summary judgment for Nevada County. These were detailed one-by-one in the Petition for Rehearing and they are repeated below.[3]

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[3] The majority denied the Petition for Rehearing, while Judge Paez voted for rehearing.

III. The Factual Misapprehensions

1. Plaintiff Reported Abrasions on His Right Leg During Booking

The Memorandum Decision ("Decision") on page 2 found that Petitioner stated "that he did not have any rashes/cuts/sores." This is false. Petitioner told the Wellpath nurse during booking that he had been "roughed up" at the hospital and that he had scrapes on his right shin, which was hurting. [ER-V.2, 194, 200-202] Nevada County did not refute this factual allegation, and thus, Petitioner's medical condition at the time of his booking is a genuine material fact for a jury.

2. Petitioner Requested Treatment For His Infection

The Decision erroneously concludes on page 5 that Petitioner never sought medical treatment.

It was Petitioner that first requested jail medical staff to look at his right leg. He was seen by medical at 9:38 am the morning after booking. The bright redness, tenderness to touch, and warmth on his right leg were noted in the jail medical record. Petitioner requested follow up care and was seen again by medical staff at 11:37 am, 2:25 pm, 3:57 pm, and 8:24 pm that same day. Petitioner testified that nursing staff circled the rapidly expanding area of infection at each of these visits. [ER-V.2, 210-211, 213-217, 219-228, 267-272; ER-V.6, 1193-1195, 1202, 1209]

3. Jail Officers Were Aware of Petitioner's Serious Medical Problem

At oral argument there was agreement expressed by the panel that there was a triable issue of fact regarding whether the County's jail staff saw Petitioner limping badly at the time of his release, but this contested fact was never mentioned in the Decision. Instead, the majority found on page 5 that jail staff "had no reason to be aware of the potential severity of his ailments." This finding goes directly against the evidence and opinion expressed by the panel at oral argument.

Contrary to the majority's Decision, Petitioner presented substantial evidence that jail staff were aware of the Petitioner's pain and limping, not just at the time of release, but over the two days that he was escorted to and from his cell to the jail infirmary. [ER-V.2, 222-223, 229-230, 232, 275-280, 290-291; ER-V.3, 320-321, 377-379] Thus, whether jail staff were aware of Petitioner's serious medical condition is a genuine question of material fact for a jury.

Petitioner further testified that just before his release, Officer Molloy walked about 300 feet alongside Petitioner from his cell to the booking area. Petitioner further testified that Officer Stanley had to have seen him limping badly as he came into the booking area because he was at close range and there was an unobstructed view across the short distance between the booking desk and the entry door from the cell block that he was escorted from by Officer Molloy. Moreover, Petitioner first had to limp to the booking counter to get his clothing, then limp to a room where he could change, then limp to the booking counter and get permission

to use the phone, then limp out the door when Officer Stanley hit the release buzzer. Petitioner testified that Officer Stanley was rude and told Petitioner to make it "snappy" when he asked to use the phone to find a ride. Petitioner further testified that he felt like Officer Stanley was "throwing me out of there". [ER-V.2, 223, 229-230, 232, 275-277; ER-V.3, 320-321, 377-379] The jail medical record noted Appellant had a "pronounced limp", thereby corroborating his testimony [ER-V.6, 1212] This evidence creates a genuine issue of material fact for a jury.

More importantly, the Decision ignored the real question of whether the County is liable for deliberate indifference when its policy and procedure is so inadequate that jail officers: (a) do not actually learn whether an inmate is medically fit for release; and (b) ignore obvious signs that an inmate is in pain and needs ambulatory assistance and/or transport. (See issues 7-13, below.)

4. Petitioner, Like Any Detainee, Relied Upon the Jail Medical Staff for Treatment

On page 5 of the Decision, the majority found that "[h]ere, Plaintiff received significant medical *attention* beyond what he requested.[4] (Emphasis added.) This is patently false.

[4] The majority used the word "attention" as opposed to the operative word in all relevant appellate decisions concerning medical deliberate indifference, which is "treat" or "treatment".

Petitioner was detained in a jail. It is self-evident that he had no ability to seek outside medical care and that he had to rely upon jail medical staff for medical care of his rapidly progressing infection. It was Petitioner that reported his infection the morning after his booking and it was Petitioner that went to the jail infirmary seeking medical *treatment* and continued to seek treatment for two days. Instead, jail medical only *monitored* his rapidly spreading infection, but *never treated* it. In fact, Petitioner was never told by medical staff what was wrong with him or what treatment he needed, or that he even needed to see a doctor. That is why the SAC alleges that the failure to provide medical discharge instructions to patient-detainees is a simple, *but crucial policy* failure. Petitioner and Mr. Howie before him never received any medical instructions, let alone discharge instructions on what they needed to do, and not do, upon release to take care of their medical condition. Very disturbingly, the Decision on page 5 completely ignores the issue of discharge instructions when it found that Petitioner "did not ask medical staff or officers (who had no reason to be aware of the potential severity of his ailments) for transport upon his departure."

Furthermore, Petitioner, like most detainees, are afraid of jail staff and have learned not to "rock any boats." Petitioner testified that he felt that Officer Stanley "was just throwing me out of the – throwing me out of there" even though he "needed like a – doctor, or an ambulance, or something." Petitioner testified that he was intimidated by Officer Stanley and made to feel worthless. Peterson did not ask for help with the large double exit doors because it was obvious that he was not going to get any help if he asked. [ER-V.2, 277-280, 290-291; Peterson Depo., Vol. 1, pp. 144:23 to 147:8; 157:22 to

158:10] [ER-V.3, 321, 323-324, 380-381; Peterson Depo., Vol. 2, pp. 10:8-20, 12:2 to 13:19; p. 69:8 to 70:5.]

5. Petitioner Did Not Receive Medical Treatment

Contrary to the majority's decision on pages 2, 5-6, Petitioner testified that he was *never treated by jail medical*. There is no treatment noted in the jail medical record. Defendants claimed that the x-ray of Petitioner's leg on the second day was "treatment". However, that characterization was solidly refuted by Petitioner's medical expert, Dr. Witt, who opined that an x-ray is a diagnostic tool, not a treatment, and in obvious cases of cellulitis, the only treatment option was antibiotics. Dr. Witt explained that the x-ray served no *medical treatment purpose*. Dr. Witt further opined that the failure to treat with antibiotics for two days went far beyond medical malpractice and was clearly deliberate indifference to Petitioner's urgent medical need. [ER-V.3, 609-610; ER-V.7, 1557-1560]

The majority took it upon themselves to act as both medical experts and the trier of fact when it found on page 5 of the Decision, without citation to any part of the factual record, that "Petitioner received significant medical attention beyond what he had requested." As just explained in item No. 2, above, Petitioner did seek treatment of his infection because he was in significant pain and he observed the infection spreading rapidly. Furthermore, Petitioner's medical expert explained that Petitioner did not receive any medical "treatment" for the glaringly obvious cellulitis. Dr. Witt explained that making observations in the medical record about the rapidly spreading infection and the x-ray given a few hours before release were diagnostic measures, not

treatment. Treatment for cellulitis consists primarily of prescribing antibiotics, plus keeping the patient quiet and the infected area clean and elevated. [ER-V.3, 512-513; ER-V.7, 1557] The origin of the cellulitis is not medically important. However, what is crucial is to start antibiotic treatment as soon as possible. [ER-V.3, 514-515, 526-527; ER-V.7, 1559-1560]

The Decision went even further into error on pages 6-7 by holding that "given Petitioner was *attended to by medical personnel nine times in two days*, no triable issue of fact was presented that the medical personnel were deliberately indifferent to Petitioner's medical needs." (Emphasis added.) This is pure hubris. First, the majority failed to distinguish between *diagnosis and treatment*. Second, the majority has no authority to substitute itself in place of the jury to decide whether the failure to provide any *treatment* of a rapidly spreading, potentially lethal infection for two days constituted deliberate indifference. This is a question of material fact that is the *sole province of a jury*.

There are serious factual issues for a jury about whether: (a) any medical treatment was provided, (b) the County's medical policies and practices were adequate; and (c) the jail officers saw Petitioner limping and/or otherwise knew that Petitioner had a significant medical problem at the time of release. A jury could easily find that County was deliberately indifferent to Petitioner's urgent need for medical care.

6. Petitioner Knew That He Needed Medical Attention When He Was Released

Contrary to the finding by the majority on page 5, Petitioner knew that he needed immediate medical attention and he testified that when he left the jail he started walking to get to the hospital. [ER-V.2; 237, 241-242]

7. The County Did Not Have Adequate Policies and Procedures for Releasing Patient- Detainees

The majority ruled on page 5 that the County maintained adequate policies for taking care of inmate medical needs, including adequate procedures for medically clearing inmates for release and for requesting further medical support for an inmate they determined required medical assistance. The majority never discussed any of the contrary evidence that Petitioner presented that questioned every aspect of the County's medical policies and practices for the release of patient-detainees.

Jail medical staff testified that when jail officers would call about an inmate's release, the medical staff understood that this only related to whether the inmate was on a 5150 hold, and not whether the inmate was physically fit for release. However, jail officers said that they called for medical, not mental, fitness for release. [ER-V.5, 1049-1053;-V.5, 1122-1125; ER-V.6, 1405; ER-V.4, 695-700, 702-703, 705-707, 714-716, 745-759] This is a crucial factual conflict that must be decided by a jury.

Jail medical staff also testified that they had no knowledge of the County's "Release Check List" or

even that jail officers were supposed to call to confirm an inmate's physical fitness for release. PSUF 20-24. [ER-V.4, 695-700, 702-703, 705-707, 714-716, 745-759; 773-780; 831-832; ER-V.5, 1171-1172]

In fact, jail medical staff (PA Tirpak and nurses Boucher and Tindall) testified that it "is not at all up to medical when an inmate gets released. That's up to custody. No matter what the medical issues they have, its up to custody when they are released." Nurse Tindall testified that there was no medical consideration involved in deciding when an inmate was released. The jail officers would call medical and tell them what time the inmate was being released, *regardless of physical fitness*. [ER-V.4, 695-700, 702-703, 705-707, 714-716, 745-759; ER-V.4, 773-780; ER-V.4, 831-832; ER-V.5, 1171-1172]

Furthermore, the failure to treat Petitioner with antibiotics when PA Tirpak clearly saw Petitioner's infection, followed by the County releasing Petitioner onto the street to fend for himself, was outrageous. These facts provide strong circumstantial evidence upon which a jury could infer that Wellpath and the County conspired to medically dump inmates with serious medical issues to avoid costs of treatment.

8. The County Did Not Have Adequate Policies and Procedures for Providing Transfer of Medical Care to Another Provider, Ambulatory Assistance, or Medical Discharge Instructions

The majority also found on page 5 of its Decision that the County's policies and practices that "maintained discretion to request further medical

support for an inmate that they determined required further assistance" were constitutionally adequate.

However, medical staff testified that they had no knowledge of Nevada County's "Release Check List". Further, PA Tindall testified that there was no medical discharge process like in a hospital and no procedures to transfer medical care to another provider at the time of release. She also testified that if an inmate needed ambulatory assistance, that was up to jail staff to handle at the time of release. [ER-V.5, 1171-1172]

The testimony of jail medical staff directly controverts the majority's factual finding. Clearly, this is a matter of factual contention that only a jury is qualified to sort out.

9. The County Did Not Make Any Changes to its Policies and Practices for the Release of Inmates with Serious Medical Conditions after the Howie Incident

The majority on page five ignored the admitted fact that the County did not make any changes to its policies or practices for determining fitness for medical release after the Howie incident. [ER-V.6, 1397-1401]

10. Howie's Release from Custody Was Eerily Similar to Petitioner's Release and It Put the County on Notice About the Inadequacy of its Medical Release Policy and Practices

Petitioner included the Howie incident as an example of the County's: (1) inadequate policies and practices for checking with jail medical on inmate

fitness for medical release and coordinating release to minimize any impact on a patient-detainee's condition; 2) failure to adequately train County jail officers to learn whether an inmate needs transfer of medical care to another medical provider, or provide a patient-detainee with ambulatory assistance or transport, and to ensure that the patient-detainee has been given medical discharge instructions. Obviously, Nevada County jail staff were not trained to even ask a patient-detainee who was in a wheelchair or limping badly if they needed transport from the jail.

The Howie incident is a glaring example of just how dangerous it is when a county jail fails to have adequate medical policies and practices for release. It demonstrates how a single instance of medical policy and practice failures can cause serious injury or even death that meet the "patently obvious" requirement of *Connick v. Thompson*, 563 U.S. 51, 63-64 (2011) ("*Connick*") for holding a municipality liable under §1983 without further proof of pattern of violations. It is just common sense that a patient-detainee's physical fitness be properly checked before release to avoid further serious injury or death. This takes a nominal amount of time and expense and does not create an undue burden on municipalities.

The majority never discusses any of the grounds asserted by the trial court about the Howie evidence being inadmissible, in particular, because Howie had settled his action. Thus, it must be assumed that the trial court's objection to the Howie evidence was without merit. In contrast, the dissent by Judge Paez (see Decision, note 2) agreed that Petitioner's arguments on this issue were correct.

The Howie case proves just what Petitioner alleged in Count 1: that the County had inadequate

policies and practices. Just like Petitioner, Howie's medical care was never transferred to another medical provider, even though just like Petitioner, the need for transfer of medical care was obvious and urgent. Again, just like Petitioner. Howie was not given any discharge instructions, ambulatory assistance or transport to a hospital. [ER-V.5, 911-912; ER-V.6, 1214-1215]

The majority on page 5 tried to distinguish Petitioner's incident from that of Mr. Howie on the single ground that, while Howie sat in a wheelchair in booking, he asked to be taken to a hospital, but Petitioner did not. However, this misses the crucial point: if Nevada County had an adequate release policies and practices for patient-detainees, it would have taken Howie to the local emergency room immediately after he was jumped and injured by Officer Grizzel the night before. Instead, just like Petitioner, Howie's obvious, serious medical problem was ignored. Moreover, if the so-called "Release Check List" meant anything, then the jail booking officer would have called the jail medical and asked if Howie was physically fit for release, and if not, whether he needed ambulatory assistance or transport. Just like in Petitioner's case, the purported "Release Check List" was meaningless and ignored by jail officers. Thus, the Howie case shows that the jail officers were completely "inert" to the medical needs of patient-detainees with serious medical problems.

The parallel facts of what happened to Howie are undisputed. Moreover, it is obvious that the Howie and Peterson, whether looked at individually or collectively, show that it is "patently obvious" that the County's policies and practices are seriously inadequate and create such a serious risk of harm that a *Monell* violation should have been presented

to a jury for a factual determination.

Indeed, these inadequacies are so likely to lead to serious medical injury or death (an it almost did with Petitioner), that the single instance exception under *Connick* applies.

11. The County Failed to Adequately Train its Jail Staff How to Communicate and Coordinate with the Jail Medical Provider Regarding the Medical Status of a Detainee Set for Release

The majority Decision never actually discussed any of the Petitioner's factual allegations about the County's failure to train. It just ruled that Howie was inadmissible and that there was no deliberate indifference to Petitioner because he purportedly did not ask for further medical care when he was being released. This ignored the testimony and expert report of Petitioner's medical expert who opined that *neither the medical nor jail staffs were trained* in how to deal with inmates with serious medical conditions at the time of release. [ER-V.4, 650-653, 661-667, 671-674; ER-V.3, 521-524, 536-538; ER-V.7, 1557-1560]

As discussed below in item 12, Petitioner presented ample evidence that Nevada County jail staff and Wellpath medical staff had no idea what the "Release Check List" was supposed to accomplish. Nevada County jail staff testified that they were trained to call the medical staff and ask if a patient-detainee was medically for release. However, the medical staff testified to the opposite, and in fact, all of the medical staff, other than the HSA Lori Adams, testified that jail staff would simply call up medical and state that a patient-

detainee was going to be released regardless of medical condition.

If Nevada County had adequate Policies and Nevada County actually trained its jail staff in those policies, then why did all of the Wellpath medical staff testify that the jail staff did not follow any "Release Check List" and that jail staff would simply tell medical staff that a patient-detainee was going to be released? Petitioner's evidence created a triable issue of fact for the jury that Nevada County not only had an inadequate Policy, but that it *failed to train its staff* in any Policy that night have been adequate. How else could medical staff and jail staff present diametrically opposed testimony?

12. There Is a Jury Question Whether There Was a Working Agreement Between the County and Wellpath, or alternatively, that the County's Policies and Practices Were the Moving Force Behind Wellpath's Failures

The majority correctly states on page 7 of the Decision that a Petitioner must show "an agreement or meeting of the minds to violate constitutional rights". However, it fails to address the nature of the evidence that a Petitioner may present to show the existence of a conspiracy. And, the majority fails to discuss any of the significant testimony presented by Petitioner to support the Third and Fourth Causes of Action.

A Petitioner will rarely have a copy of a conspiratorial contract or a recording of a secret meeting where such an agreement is reached. That is why prior decisions of the Ninth Circuit have held that a plaintiff may prove a conspiracy by showing that the defendants have "by some concerted action,

intend[ed] to accomplish some unlawful objective for the purpose of harming another which results in damage." *Gilbrook v. City of Westminister*, 177 F.3d 839, 856 (9th Cir. 1999). Further, the Ninth Circuit has held that an unlawful agreement may be inferred from circumstantial evidence. *Mendocino Envtl. v. Mendocino City,* 192 F.3d 1283, 1301 (9th Cir. 1999).

Petitioner's evidence included the testimony of the Wellpath medical supervisor, Lori Adams, that when jail staff called to check on the medical fitness of an inmate for release (using the "Release checklist,", P Ex. 17), Wellpath understood that the County was not referring to the physical medical condition, but only to whether the inmate was on a 5150 hold. Nevada County jail staff testified just the opposite, that the call referred to the physical medical condition. However, when Petitioner took the depositions of Wellpath medical staff, they all testified that when jail officers called them about a release of an inmate, it did not matter what physical condition the inmate was in – the inmate was going to be released at the time stated by the Nevada County booking officer. [ER-V.4, 695-700, 702-703, 705-707, 714-716, 745-759; ER-V.4, 773-780; ER-V.4, 831-832; ER-V.5, 1171-1172]

A jury could reasonably infer from this circumstantial evidence that there was a "concerted action" (i.e. a wink-wink) between Wellpath and Nevada County to systematically deny patient-detainees with serious medical conditions the professional medical care that they are constitutionally guaranteed. Alternative, a jury could find that the County was the moving force behind the deliberate indifference of Wellpath's medical staff. This evidence should be presented to the jury and Petitioner allowed to argue both the

Third and Fourth Causes of action. Judge Paez's dissent in the Decision agreed that Petitioner's action based upon Nevada County being the moving force had both sufficient legal and factual basis to proceed to a jury.

CONCLUSION

The decision of the Ninth Circuit Court of Appeal reveals a *clear misapprehension* of summary judgment standards established by this Court. It failed to acknowledge and credit, and then draw all reasonable factual inferences from, the competent evidence submitted by Petitioner. Consequently, Petitioner has been denied his right to a jury trial.

Based upon the foregoing, Petitioner requests that this Court grant his Petition for Certiorari.

Respectfully Submitted,

s/ Patrick H. Dwyer
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Petitioner