No. 19-4060

UNITED STATES COURT OF APPEALS
FOR THE SIXTH CIRCUIT

JEFFREY D. MANN, JOHN T. BRAGG, ERIC PASTRANO,
Plaintiffs-Appellants,

v.

OHIO DEPARTMENT OF REHABILITATION AND CORRECTION, VARIOUS UNKNOWN DOCTORS, NURSES AND OTHER HEALTH CARE PROVIDERS, VARIOUS UNKNOWN STATE OFFICERS,
Defendants,

MONA C. PARKS, JANICE DOUGLAS, ANDREW D. EDDY, ANNETTE CHAMBERS-SMITH, GRAFTON CORRECTIONAL INSTITUTE HEALTH CARE ADMINISTRATOR,
Defendants-Appellees.

On Appeal from the United States District Court for the Southern District of Ohio
No. 2:18-cv-01565-GCS-EPD
Hon. George C. Smith

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure and Sixth Circuit Rule 26.1, counsel for Plaintiffs-Appellants certifies they are individuals and not a subsidiary or affiliate of a publicly owned corporation, and no publicly owned corporation has a financial interest in the outcome of this case.

Dated: January 22, 2020

/s/ Jennifer Wedekind
Jennifer Wedekind

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STATEMENT IN SUPPORT OF ORAL ARGUMENT

This case raises important questions about prisoners' constitutional right to health care. In particular, this case addresses the Plaintiffs-Appellants' right to curative treatment for Hepatitis C virus ("HCV") pursuant to the medical standard of care, a question this Court has not yet had the opportunity to address in light of medical advances in the past decade. Oral argument would materially advance this Court's resolution of these issues of law and fact. Plaintiffs-Appellants therefore respectfully request oral argument in this appeal under Federal Rule of Appellate Procedure and Sixth Circuit Rule 34(a).

JURISDICTIONAL STATEMENT

Jurisdiction is proper in this case under 28 U.S.C. § 1331. This appeal arises from final judgments entered on July 25, 2019 and September 26, 2019, dismissing a civil action brought under 42 U.S.C. § 1983 in the U.S. District Court for the Southern District of Ohio. Judgment, R. 53, Page ID #682; Judgment R. 59, Page ID #711. Plaintiffs-Appellants timely filed a Notice of Appeal on October 24, 2019. Notice of Appeal, R. 60, Page ID #712.[1]

STATEMENT OF ISSUES ON APPEAL

1. Whether the district court erred in dismissing Plaintiffs' Eighth Amendment claims when Plaintiffs sufficiently alleged that (1) Defendants knew that untreated chronic HCV leads to progressive and irreversible liver damage; (2) Defendants deliberately denied treatment for Plaintiffs' chronic HCV; and (3) Defendants' denial is in contravention of the current medical standard of care, and based on a blanket policy and the cost of treatment rather than individualized medical determinations.

2. Whether the district court erred in dismissing Plaintiffs' Eighth

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[1] Plaintiffs-Appellants do not appeal the district court's Order dismissing Defendant Ohio Department of Rehabilitation and Correction from this action. Similarly, Plaintiffs-Appellants do not appeal the district court's Order dismissing Various Unknown Doctors, Nurses and Other Health Care Providers Responsible to Provide Health Care for Ohio Prisoners, or Various Unknown State Officers Responsible for Promulgation of ODRC Medical Policies.

Amendment claims against Defendants Eddy and Grafton Correctional Institute Health Care Administrator based a theory of *respondeat superior* when Plaintiffs sufficiently pleaded claims against both Defendants in their official capacities.

STATEMENT OF THE CASE

I. Nature of the Case

Medical advances in the last decade have rendered chronic HCV a curable disease. The current medical standard of care provides that all patients with chronic HCV should be treated without delay, regardless of the progression of the disease, with minor exceptions not relevant here. Notably, delays in treatment may decrease the benefit of that treatment.

Plaintiffs-Appellants Jeffrey D. Mann, John T. Bragg, and Eric Pastrano seek medical treatment for their chronic HCV. Each has requested treatment for chronic HCV, and each has been denied treatment based solely on a policy promulgated and implemented by Defendants and applicable to all prisoners in the Ohio Department of Rehabilitation and Correction ("ODRC"). As a result, all Plaintiffs suffer from symptoms including fatigue, jaundice, pain, and reduced liver function, and are subject to progressive and irreversible liver damage.

Defendants are medical and administrative professionals with ODRC or Grafton Correctional Institution, where Plaintiffs are housed. Each bears direct responsibility for the promulgation, interpretation, and/or application of the policy

under which Plaintiffs were denied treatment for chronic HCV. Defendant Annette Chambers-Smith is the Director of the ODRC.[2] Notice of Substitution, R. 24, Page ID # 502. Defendant Dr. Andrew Eddy is the Director of the ODRC "Collegial Review Committee," and Defendant Mona Parks is the Chief Medical Officer for ODRC. Complaint, R. 6, Page ID #241 ¶¶ 7-8. Dr. Eddy's signature appears on Defendants' HCV policies. *See* Complaint Ex. L, R. 6, Page ID #370; Complaint Ex. M, R. 6, Page ID #381.

Defendant Dr. Janice Douglas is the Chief Medical Officer at Grafton Correctional Institution, where Plaintiffs are housed. Dr. Douglas is responsible for providing medical care, including treatment for chronic HCV, to Plaintiffs. Complaint, R. 6, Page ID #248 ¶ 52. Defendant Grafton Correctional Institution Health Care Administrator (GCIHCA) is the individual responsible for oversight of the provision of health care, including treatment for chronic HCV, at Grafton Correctional Institution.[3] Complaint, R. 6, Page ID #247 ¶ 51.

Under their policy, Defendants will not even consider providing Plaintiffs with curative treatment unless and until their chronic HCV has irreversibly and

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[2] Ms. Chambers-Smith replaced prior ODRC Director Gary Mohr, and was subsequently substituted into this action. Notice of Substitution, R. 24, Page ID #502.

[3] The GCIHCA was substituted into this action pursuant to Fed. R. Civ. P. 25(d) after prior GCIHCA David Hannah left the role. Notice of Substitution, R. 24, Page ID #502-03.

substantially damaged their livers. This policy stands in direct contravention of the medical standard of care. Further, under Defendants' HCV policy, Defendants rely on tools that are known to be ineffective at estimating the progression of the disease, and which could in result in further delaying consideration for treatment. Defendants' policy is based not on medical considerations, but on the cost of treatment.

II. Factual Background[4]

A. Hepatitis C

HCV is a chronic disease that, left untreated, results in irreversible liver damage and death. According to the Centers for Disease Control ("CDC"), in 2015 nearly 20,000 people in the United States died of HCV, though that number could be exponentially higher. Complaint Ex. E, R. 6, Page ID #271. Chronic HCV is "insidious" and if untreated it can progress, causing serious liver damage, without

[4] This factual background is based on the Complaint, and documents attached to the Complaint, including information from the Centers for Disease Control and the American Association for the Study of Liver Diseases. At this motion to dismiss stage, the allegations in the Complaint must be taken as true and construed liberally in favor of the Plaintiffs-Appellants. *See Westlake v. Lucas*, 537 F.2d 857, 858 (6th Cir. 1976); *Taxpayers United for Assessment Cuts v. Austin*, 994 F.2d 291, 296 (6th Cir. 1993). *See also Cates v. Crystal Clear Techs., LLC*, 874 F.3d 530, 536 (6th Cir. 2017) (holding that "the law is clear" that courts may consider documents attached to the complaint when determining whether dismissal is proper) (internal quotation marks omitted).

any outward signs or symptoms. *Id.*, Page ID #273; Complaint Ex. N, R. 6, Page ID #392.

HCV is transmitted through exposure to blood or bodily fluids containing the virus. Complaint Ex. E, R. 6, Page ID #271. It is most commonly transmitted through injection drug use, needlestick injuries in health care settings, birth to an HCV-infected mother, or receipt of donated blood or organs prior to 1992, when screening first became available. *Id.* According to the CDC, approximately 15% to 20% of people who contract HCV will clear the virus spontaneously, while 75% to 85% of people who contract HCV will develop chronic HCV. *Id.*, Page ID #270. There is no vaccine to prevent HCV. Complaint Ex. F, R. 6, Page ID #285.

HCV is significantly more prevalent in the prisoner population than in the general population. Between 12% and 35% of prisoners in the United States have chronic HCV, compared to approximately 1.3% of the general population. Complaint, R. 6, Page ID #243 ¶ 17 (citing Howard J. Worman, *Diagnosis and Treatment of Chronic Hepatitis C in Incarcerated Patients*, 10 AM. MED. ASS'N J. ETHICS 102 (2008)). It is likely that between 6,360 and 18,550 ODRC prisoners have chronic HCV. *Id.*, Page ID #244 ¶ 27.

Untreated chronic HCV causes fibrosis, or scarring, of the liver. Complaint, R. 6, Page ID #242 ¶ 14; Complaint Ex. P, R. 6, Page ID #170. It also leads to cirrhosis, which causes the liver to stop functioning properly. *Id.* According to the

CDC, HCV is also a leading cause of liver cancer in the United States. Complaint Ex. E, R. 6, Page ID #273; *see also* Complaint Ex. N, R. 6, Page ID #155.

The progression and severity of liver damage is measured in stages: F0 (healthy liver); F1 (liver damage; slight scarring); F2 (moderate scarring); F3 (serious scarring; blood flood to the liver affected due to damage); F4 (extensive scarring/cirrhosis). Complaint Ex. P, R. 6, Page ID #410. According to the American Association for the Study of Liver Diseases ("AASLD"), patients at Stages F3 and F4 are considered to have "advanced liver disease." Complaint Ex. I, R. 6, Page ID #302. Fibrosis may not progress linearly, and patients over the age of 50 "may progress slowly for many years followed by an acceleration of fibrosis progression." *Id.*, Page ID #307.

Doctors evaluate the stage of fibrosis using a variety of tests, such as liver biopsy, vibration-controlled transient liver elastrography, and blood tests, including the AST to Platelet Ratio Index ("APRI") score. *See id.*, Page ID #306-07. An APRI score of less than 0.5 generally indicates probable fibrosis; a score between 0.5 and 1.5 generally indicates moderate to severe fibrosis; and a score of more than 1.5 generally indicates cirrhosis. *See* Complaint Ex. K, R. 6, Page ID #123.

However, according to the AASLD, "[n]o single method" of measuring the degree of fibrosis "is recognized to have high accuracy alone, and each test must be interpreted carefully." Complaint Ex. I, R. 6, Page ID #307. For example, the

APRI score is not "sensitive enough to rule out substantial fibrosis." *Id.* Further, liver biopsies are invasive and may cause complications, and sampling errors may limit test performance. *Id.*, Page ID #306. Indeed, according to the AASLD, the "most efficient approach to fibrosis assessment is to combine direct biomarkers and vibration-controlled transient liver elastography."[5] *Id.*, Page ID #307.

B. Treatment For Chronic HCV And The Standard Of Care

Antiviral medications are the only treatment for HCV. Complaint Ex. F, R. 6, Page ID #285. Prior to 2014, the only treatments for HCV were Interferon and Ribavirin, which required weekly injections and pills. *Id.*, Page ID #281.A course of treatment caused numerous adverse side-effects, and was not usually successful. *Id*.

Treatment for chronic HCV has evolved substantially in the last decade, with the advent of Direct-Acting Antiviral ("DAA") therapy. *See* Complaint Ex. E, R. 6, Page ID #275. According to the CDC, DAA therapy is successful in curing more than 90% of patients with chronic HCV. *Id.; see also* Complaint Ex. F, R. 6, Page ID #283. It is provided through oral medications only, and has very few side effects. Complaint Ex. F, R. 6, Page ID #281. And DAA treatment regimens are,

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[5] Vibration-controlled transient liver elastography is "a noninvasive way to measure liver stiffness and correlates well with measurement of substantial fibrosis or cirrhosis in patients with chronic HCV infection." Complaint Ex. I, R. 6, Page ID #307.

on average, only 12 weeks long. *Id.*, Page ID #283.

In response to these dramatic medical advances, the Infectious Diseases Society of America and the AASLD promulgated "evidence-based, expert-developed" standards for the routine treatment of HCV, known as the AASLD Guidelines. *See* Complaint Ex. E, R. 6, Page ID #275; *see also* Complaint Ex. G, R. 6, Page ID #287-96; Complaint Ex. I, R. 6, Page ID #300-08.

The AASLD Guidelines provide that all patients with chronic HCV should be treated without delay, except for those with short life expectancies "that cannot be remediated by HCV treatment, liver transplantation, or another directed therapy." Complaint Ex. I, R. 6, Page ID #300. The AASLD Guidelines further state that treatment should be provided "early in the course of chronic HCV infection, before the development of severe liver disease and other complications." *Id.*, Page ID #301. Indeed, "[t]reatment delay may decrease the benefit" of that treatment. *Id*.

As such, the current medical standard of care for the treatment of chronic HCV is to treat all patients with DAAs, regardless of the stage of the disease. *See id.*, Page ID #300; *see also* Complaint, R. 6, Page ID #243 ¶ 24. This is the standard of care used by other state departments of correction, *see* Complaint Ex. K, R. 6, Page ID #338, and the U.S. Department of Veterans Affairs, *see* Complaint Ex. F, R. 6, Page ID #283.

Patients for whom HCV treatment is successful can no longer transmit the virus to others. Complaint Ex. I, R. 6, Page ID #304. As such, the AASLD has noted that "successful treatment of HCV infection benefits public health." *Id.*

The AASLD concludes:

> "[S]trong and accumulating evidence argue against deferral [of treatment] because of decreased all-cause morbidity and mortality, prevention of onward transmission, and qualify-of-life improvements for patients treated regardless of baseline fibrosis. Additionally, treatment of HCV infection may improve or prevent extraheptatic complications, including diabetes mellitus, cardiovascular disease, renal disease, and B-cell non-Hodgkin lymphoma, which are not tied to fibrosis stage. *Deferral practices based on fibrosis stage alone are inadequate and shortsighted*."

Id., Page ID #307 (citations omitted) (emphasis added).

C. Defendants' HCV Policy

Defendants have two medical protocols relating to HCV. First, Protocol A-6, "Liver Disease Chronic Care Clinic," governs periodic monitoring and evaluation of patients diagnosed with HCV. *See* Complaint Ex. M, R. 6, Page ID #381-87. Patients are evaluated at intervals ranging from monthly, for those whose disease is poorly controlled, to every 6-12 months, for those whose disease is under good control. *Id.*, Page ID #385.

Second, Protocol C-5, "Testing and Treatment Guidelines for Chronic Hepatitis C," governs screening and diagnosis, as well as the provision of treatment for chronic HCV. *See* Complaint Ex. L, R. 6, Page ID #370-80. Neither

protocol follows the medical standard of care of treating all patients with chronic HCV. Rather, to be considered for antiviral treatment under the policy, patients "must meet all the inclusion criteria and not have any exclusion criteria . . . ." *Id.*, Page ID #374.

"Inclusion criteria"—all of which must be met for patients to be *considered* for treatment—include, among other things:

- Patients must have a sentence with at least four years remaining.
- Patients who are over the age of 45, like Plaintiffs Mann, Bragg, and Pastrano, "must have an APRI of 1.5 or greater to be considered for [liver] biopsy and possible treatment."[6]
- Patients must have a detectable HCV viral load.
- Patients must undergo a liver biopsy with "results indicating the presence of liver fibrosis consistent with stage 3 fibrosis or greater . . . Individuals that do not demonstrate significant fibrosis on biopsy will not be treated."[7]
- Patients must sign a consent form and commit to lifelong alcohol and

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[6] As discussed, *supra*, an APRI score of 1.5 or greater indicates the patient has cirrhosis, or advanced liver damage and scarring. *See* Complaint Ex. K, R. 6, Page ID #123.

[7] As discussed, *supra*, Stage 3 fibrosis or greater indicates the patient has severe fibrosis or cirrhosis, or advanced liver disease. Complaint Ex. P, R. 6, Page ID #410.

substance abuse abstinence.

Id., Page ID #375 (emphasis in original).

"Exclusion criteria"—which bar patients from receiving treatment—include, among other things:

- Certain age ranges;
- Current or planned pregnancy;
- Substance or alcohol abuse, use, or possession, or unregulated tattooing in the past two years;
- A platelet count of less than 20,000/uL;
- Decompensated cirrhosis;
- Documented non-adherence to prior therapy, or failure to complete pre-treatment evaluations.

Id., Page ID #374.

The policy re-emphasizes that patients must meet "all inclusion criteria," have at least four years of sentence length remaining and have an APRI score of 1.5 or greater before they will be referred for a liver biopsy. *Id.*, Page ID #375. As such, Defendants' policy relies on a patient's APRI score as the sole gateway to any further testing that could determine the progression of the disease or any

consideration for treatment.[8]

Finally, the policy further indicates that if the patient meets the APRI threshold, but the subsequent biopsy does not return results consistent with the treatment criteria, the patient will not be provided with treatment, but will continue having annual APRI monitoring. *Id*., Page ID #375, 378.

D. Plaintiffs

Plaintiffs Mann, Bragg, and Pastrano are all incarcerated at Grafton Correctional Institution, an ODRC facility. Complaint, R. 6, Page ID #239, 241 ¶¶ 3-5, 8. All Plaintiffs have been diagnosed with chronic HCV. *Id.*, Page ID #241 ¶¶ 3-5. All Plaintiffs have requested treatment for their chronic HCV, and all Plaintiffs have been denied that treatment pursuant to Defendants' HCV treatment policy. *Id.*, Page ID #246 ¶ 45. Further, Plaintiffs have been denied more accurate diagnostic testing, including vibration-controlled transient liver elastography. *See id*., Page ID #244 ¶ 33; *id.*, Page ID #245 ¶ 38; *id.*, Page ID #246 ¶ 42. Plaintiffs have been informed that Defendants' policy is based on the cost of treatment for chronic HCV. *See id*., Page ID #246, ¶ 45. All Plaintiffs have suffered from fatigue, jaundice, pain, and reduced liver function as a result of Defendants' refusal

[8] As discussed, *supra*, according to the AASLD, the APRI score is an ineffective measure for the progression of liver damage and is "not sensitive enough to rule out substantial fibrosis." Complaint Ex. I, R. 6, Page ID #307.

to provide HCV treatment. *Id.* ¶ 44. In addition, all Plaintiffs suffer from ongoing progressive and irreversible liver damage. *Id.*

Mr. Mann was 61 years old at the time of the Complaint. *Id.*, Page ID #244 ¶ 29. He has been incarcerated since 1993. *Id*. Mr. Mann was diagnosed with chronic HCV in 2001. *Id.* More than a decade ago, in 2007, he was treated with Interferon and Ribovirin.[9] *Id.* The treatment was not successful, and Mr. Mann continues to have chronic HCV. *Id.* In 2018, he requested treatment under the current standard of care for chronic HCV. *Id.* ¶¶ 30-31; *see also* Complaint Ex. R, R. 6, Page ID #422. His APRI score is 0.36. *Id*., Page ID #244 ¶ 31. He was denied treatment for his chronic HCV because he did not meet the APRI threshold. *Id*. This denial of treatment was based solely on Defendants' policy. *Id.* ¶ 32; *see also* Complaint Ex. R, R. 6, Page ID #422.

Mr. Bragg was 59 years old at the time of the Complaint. Complaint, R. 6, Page ID #245 ¶ 35. He has been incarcerated since 1989. *Id.* He was diagnosed with chronic HCV in 1999. *Id.* More than a decade ago, in 2007, he was treated with Interferon and Ribovirin. *Id.* The treatment was not successful, and Mr. Bragg continues to have chronic HCV. *Id.* In 2018, Mr. Bragg requested treatment under the current standard of care for chronic HCV. *Id.* ¶ 36-37. His APRI score is 0.5.

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[9] At the time, Interferon and Ribovirin were the only treatments available for chronic HCV. However, the treatment was not usually successful. *See* Complaint Ex. F, R. 6, Page ID #281.

Complaint Ex. S, R. 6, Page ID #423. Like Mr. Mann, Mr. Bragg was denied treatment for his chronic HCV because he did not meet the APRI threshold. Complaint, R. 6, Page ID #245 ¶ 37.The decision to deny treatment was based solely on Defendants' policy. *Id.*; *see also* Complaint Ex. S, R. 6, Page ID #423.

Mr. Pastrano was 48 years old at the time of the Complaint. Complaint, R. 6, Page ID #246 ¶ 42. He has been incarcerated since 2011. *Id.* He was diagnosed with chronic HCV in 2006. *Id.* He has never been provided with treatment for his chronic HCV. *Id.* The extent of the progression of Mr. Pastrano's chronic HCV is not known, because he had not had any routine blood tests for approximately a year at the time the Complaint was filed. *See* Complaint Ex. T, R. 6, Page ID #425. In 2018, he requested treatment under the current standard of care for chronic HCV. *Id.*, Page ID #424; Complaint, R. 6, Page ID #246 ¶ 42. Mr. Pastrano was denied treatment for his chronic HCV, based solely on Defendants' policy. *Id*.

III. Proceedings Below

Plaintiffs Mann, Bragg, and Pastrano filed a *pro se* complaint on December 11, 2018, under 42 U.S.C. § 1983.[10] Complaint, R. 6, Page ID #239-425. Plaintiffs sought declaratory and injunctive relief, as well as compensatory damages, for violations of their Eighth Amendment rights. *Id.*, Page ID #249 ¶¶ A-C. Interested Party State of Ohio filed a Motion to Dismiss on behalf of all Defendants. Motion

[10] Plaintiffs were unrepresented throughout the proceedings in the district court.

to Dismiss, R. 15, Page ID #454. Thereafter, Defendants ODRC, Eddy, Hannah (construed as on behalf of successor-in-interest GCIHCA)[11] and Douglas filed a substantially similar Motion to Dismiss. Motion to Dismiss, R. 20, Page ID #483.

The Magistrate Judge recommended granting in part and denying in part the Motions to Dismiss. *See* R&R, R. 45, Page ID #632. Specifically, the Magistrate Judge rejected Defendants' argument that Plaintiffs had failed to state an Eighth Amendment claim against Defendants Eddy, GCIHCA, and Douglas. *Id.*, Page ID #654. After extensive discussion of relevant caselaw addressing current HCV treatment, the Magistrate Judge determined that Plaintiffs' allegations were sufficient to state a claim under Section 1983. *See id.*, Page ID #641-54. The Magistrate Judge correctly recognized that the law on chronic HCV treatment "has evolved" and as such, "caselaw prior to medical developments in Hepatitis C treatment appears to be out of date with respect to the issue of whether a defendant ought to be aware of facts from which the inference could be drawn that a substantial risk of serious harm exists." *Id.*, Page ID #644, 646. The Magistrate Judge determined that "[r]ecent caselaw, indeed, suggests that the deliberate

[11] Defendant Hannah was later terminated. Substitution of Parties, R. 24, Page ID #502-03. At the time of his termination, his successor in the role had not been named, and he was replaced with Defendant GCIHCA. *Id.* The Magistrate Judge construed the Motions to Dismiss on behalf of Defendant Hannah as an argument regarding the GCIHCA. R&R, R. 45, Page ID #631-32 n.2.

indifference claims of prisoner plaintiffs with Hepatitis C should survive the pleading stage." *Id.*, Page ID #647.

The Magistrate Judge also rejected Defendants' argument that Defendants Eddy and GCIHCA must be dismissed because they fall under the doctrine of *respondeat superior*. The Magistrate Judge found that "Plaintiffs' Complaint establishes that Defendants Eddy and GCIHCA at least implicitly authorized, approved, or knowingly acquiesced in providing medical care, or the lack thereof, to Plaintiffs." *Id.*, Page ID #640. However, the Magistrate Judge recommended granting the Motions to Dismiss with respect to ODRC. *Id.*, Page ID #637-38.

Defendants Eddy, GCIHCA, and Douglas objected to the Magistrate Judge's recommendations, Objections to R&R, R. 50, Page ID #668, and Plaintiffs filed a response, Resp. to Objections to R&R, R. 51, Page ID #673. The District Judge thereafter sustained Defendants' objections and granted the Motions to Dismiss in full. Order, R. 52, Page ID #680-81. Plaintiffs subsequently filed a Motion for Relief from Judgment. Motion for Relief, R. 54, Page ID #683-88.

Defendant Chambers-Smith and Defendant Parks separately filed substantially similar Motions to Dismiss, arguing Plaintiffs failed to state a claim under the Eighth Amendment. *See* Motion to Dismiss, R. 35, Page ID #584; Motion to Dismiss, R. 43, Page ID #620. The Magistrate Judge applied the reasoning of the district court's prior determination and recommended granting the

Motions to Dismiss. R&R, R. 56, Page ID #699-701. Plaintiffs objected to the Magistrate's Report and Recommendations. Pls. Obj. to R&R, R. 57, Page ID #703-05. The district court adopted the Report and Recommendations, finding that "Plaintiffs' Hep-C conditions are being monitored and therefore under ongoing care. They are not being ignored. Defendants are not obligated to provide the more aggressive treatment that Plaintiffs have requested." Order, R. 58, Page ID #709. The District Judge further denied Plaintiffs' Motion for Relief from Judgment. *Id.*, Page ID #710.

Finally, the District Judge dismissed the "various unknown doctors, nurses and other health care providers responsible to provide health care for Ohio prisoners" as well as the "various unknown state officers responsible for promulgation of ODRC medical policies" for failure to identify and effect service. *Id*. The court entered final judgment on September 26, 2019. Judgment, R. 59, Page ID #711.

STANDARD OF REVIEW

A "District Court's disposition of the motion to dismiss is based purely on the legal sufficiency of plaintiff's case," therefore, "the proper appellate standard of review for the granting or denial of the motion is *de novo*." *Barrett v. Harrington*, 130 F.3d 246, 251 (6th Cir. 1997) (internal quotation marks omitted).

Further, this Court holds "pleadings filed by a pro se litigant to less stringent standards than formal pleadings drafted by lawyers, and may not uphold the dismissal of such a pleading simply because [we] find[ ] the plaintiff's allegations unlikely." *Thomas v. Eby*, 481 F.3d 434, 437 (6th Cir. 2007) (internal quotation marks and citations omitted) (alteration in original).

Finally, as Plaintiffs brought this action under a civil rights statute, the district court's decision to dismiss it must be "scrutinized with special care." *Moore v. City of Harriman*, 272 F.3d 769, 771 (6th Cir. 2001) (en banc) (internal citation omitted).

SUMMARY OF ARGUMENT

Plaintiffs have been categorically denied medical treatment for chronic HCV, a serious medical need. Chronic HCV is curable disease. But when left untreated, it causes progressive and irreversible liver damage, and can lead to liver cancer and death. Moreover, the current medical standard of care provides for the treatment of all patients with chronic HCV without delay, regardless of the progression of their disease, except for those with short life expectancies.

Plaintiffs' allegations sufficiently state an Eighth Amendment claim. The district court's conclusions to the contrary are based on a misapprehension of Plaintiffs' claims and run afoul of binding Circuit precedent.

First, Plaintiffs sufficiently alleged that Defendants have been deliberately indifferent to their serious medical needs. Defendants know that untreated chronic HCV causes progressive and irreversible liver damage. And they know that the current medical standard of care calls for treating all patients with chronic HCV without delay. Yet despite this knowledge, they have deliberately denied Plaintiffs any treatment for their chronic HCV, in violation of the Eighth Amendment. *See Allah v. Thomas*, 679 F. App'x 216, 220 (3d Cir. 2017) (holding that plaintiff stated an Eighth Amendment claim when he alleged he was denied treatment for chronic HCV). This denial is based not on individualized medical determinations, but on a blanket policy and the cost of treatment, in further contravention of Defendants' constitutional obligations. *See Roe v. Elyea*, 631 F.3d 843, 862 (7th Cir. 2011); *Blackmore v. Kalamazoo Cty.*, 390 F.3d 890, 899 (6th Cir. 2004) (holding that delay of medical treatment "for non-medical reasons . . . creates the constitutional infirmity").

The district court erred in dismissing Plaintiffs' claims. First, the district court dismissed Plaintiffs' claims simply because they "are not being ignored." But this test runs counter to binding precedent from this Court, which provides that a prisoner "is not required to show he was literally ignored" to state an Eighth Amendment violation. *Rouster v. Cty. of Saginaw*, 749 F.3d 437, 448 (6th Cir. 2014) (quoting *LeMarbe v. Wisneski*, 266 F.3d 429, 439 (6th Cir. 2001)). Second,

the district court misapprehended Plaintiffs' claims, arguing their complaints were a mere disagreement with a prescribed course of treatment. But this rationale is inapplicable here: Plaintiffs allege they have been categorically denied any treatment at all. Finally, the district court erroneously suggested that because Plaintiffs are being monitored with blood tests, they are receiving adequate treatment. This again misapprehends Plaintiffs claims and falsely equates "monitoring" with "treatment." *See Postawko v. Missouri Dep't of Corr.*, No. 2:16-CV-04219-NKL, 2017 WL 1968317, at *7 (W.D. Mo. May 11, 2017) ("[A]dopting a monitoring policy instead of treatment and waiting to see just how much the inmate's health may deteriorate is not permissible.").

Second, Plaintiffs have sufficiently alleged claims against Defendants Eddy and GCIHCA in their official capacities, and against Eddy in his individual capacity. The district court erred when it assumed these Defendants were sued in their individual capacities only. It then dismissed Plaintiffs' claims based on the doctrine of *respondeat superior* and that doctrine's inapplicability in Section 1983 actions. In fact, application of this Court's "course of proceedings" test makes clear both Defendants are sued in their official capacities. *Moore*, 272 F.3d at 772-73. As such, the theory of *respondeat superior* simply does not apply.

ARGUMENT

"A motion to dismiss for failure to state a claim is a test of the plaintiff's cause of action as stated in the complaint, not a challenge to the plaintiff's factual allegations." *Golden v. City of Columbus*, 404 F.3d 950, 958-59 (6th Cir. 2005). As such, a district court may not dismiss a complaint unless "it is clear that the plaintiff can prove no set of facts consistent with the allegations that would entitle him to relief." *Flanory v. Bonn*, 604 F.3d 249, 252-53 (6th Cir. 2010). When conducting that inquiry, a court must accept all well-pleaded factual allegations as true and construe the complaint in the light most favorable to the plaintiff. *Westlake*, 537 F.2d at 858. Further, when parties proceed *pro se*, as the Plaintiffs did before the district court, their pleadings are to be "held to less stringent standards than those prepared by attorneys, and are liberally construed when determining whether they fail to state a claim upon which relief can be granted." *Martin v. Overton*, 391 F.3d 710, 712 (6th Cir. 2004) (citing *Haines v. Kerner*, 404 U.S. 519, 520-21 (1972)).

Here, Plaintiffs have alleged that they have chronic HCV, a serious medical need. Plaintiffs have alleged that Defendants know the failure to treat chronic HCV results in a substantial risk of serious harm due to progressive and irreversible liver damage, yet Defendants have deliberately denied Plaintiffs medical treatment.

Plaintiffs have further alleged that the denial of treatment was based solely on a policy promulgated and implemented by the Defendants. The policy categorically denies consideration for treatment until a patient has advanced liver disease. Defendants' policy, and the subsequent denial of treatment based on that policy, does not meet the medical standard of care for chronic HCV. Further, delay in treatment may render that treatment less effective. Plaintiffs have alleged that Defendants' policy is based solely on the cost of treatment rather than medical need. Finally, Plaintiffs have alleged that they are suffering harm, and a substantial risk of future harm, through progressively decreased liver function, and the risk of developing worsening fibrosis and cirrhosis. Plaintiffs provided detailed information in their complaint, and incorporated by reference copious amounts of additional factual information regarding chronic HCV, the current medical standard of care, and Defendants' policies and procedures.

These allegations are more than sufficient to support Plaintiffs' claims that Defendants' failure to treat their chronic HCV constitutes deliberate indifference to a serious medical need. The district court erred in concluding otherwise.

It further erred when it dismissed Plaintiffs' official-capacity injunctive relief claims against Defendants Eddy and GCIHCA. The district court improperly relied on the doctrine of *respondeat superior* and incorrectly treated those claims as if they were individual capacity claims only.

The district court's dismissal must be reversed. As this Court has held, our legal system "remains committed to guaranteeing that prisoner claims of illegal conduct by their custodians are fairly handled according to law. Ensuring that claims are not thrown out before an adequate opportunity to consider their merit is essential to that guarantee." *Thomas*, 481 F.3d at 442 (quoting *Jones v. Bock*, 549 U.S. 199, 203 (2007)) (internal citation and quotation mark omitted).

I. Plaintiffs Have Sufficiently Alleged That Defendants Are Deliberately Indifferent To Their Serious Medical Needs.

Deliberate indifference to prisoners' serious medical needs violates the Eighth Amendment's proscription against cruel and unusual punishments. *Estelle v. Gamble*, 429 U.S. 97, 104 (1976). This constitutional standard protects against both current harm and the risk of future harm, even when the harm might not occur immediately. *See Helling v. McKinney*, 509 U.S. 25, 33 (1993).

Deliberate indifference has both objective and subjective components: The objective component requires a showing that "the medical need at issue is sufficiently serious." *Alspaugh v. McConnell*, 643 F.3d 162, 169 (6th Cir. 2011) (internal quotation marks and citation omitted). The subjective component requires plaintiffs to show that defendants "have a sufficiently culpable state of mind in denying medical care." *Id.*

A. Chronic HCV Is A Serious Medical Need.

Plaintiffs have sufficiently alleged, and Defendants concede, that chronic

HCV is a serious medical need. *See* Complaint, R. 6, Page ID #242-434 ¶¶ 14-25. *See also* Order, R. 52, Page ID #680 (noting that this allegation is undisputed). Plaintiffs suffer from fatigue, jaundice, pain, and reduced liver function. Complaint, R. 6, Page ID #246 ¶ 44. They are also at risk of progressive and irreversible liver damage as a result of their untreated chronic HCV. *Id*.

Indeed, this Court and courts across the country have repeatedly held that chronic HCV is a serious medical need. *See Owens v. Hutchinson*, 79 F. App'x 159, 161 (6th Cir. 2003) ("[Plaintiff] has adequately alleged that he suffered from an objectively serious medical condition—hepatitis C virus."). *See also Roe*, 631 F.3d at 862 ("HCV infection is a serious medical condition that can lead to irreversible physical damage and even life-threatening situations."); *Stafford v. Carter*, No. 1:17-CV-00289-JMS-MJD, 2018 WL 4361639, at *12 (S.D. Ind. Sept. 13, 2018) (finding chronic HCV to be a serious medical need); *Hoffer v. Jones*, 290 F. Supp. 3d 1292, 1299 (N.D. Fla. 2017) (same); *Abu-Jamal v. Wetzel*, No. 3:16-CV-2000, 2017 WL 34700, at *11 (M.D. Pa. Jan. 3, 2017) (same). The objective component of deliberate indifference is in no serious dispute.

B. Defendants Are Deliberately Indifferent To Plaintiffs' Serious Medical Needs.

Plaintiffs have also sufficiently alleged the subjective component of their Eighth Amendment claim, namely that Defendants acted with deliberate indifference when they denied Plaintiffs treatment for chronic HCV. Defendants

know that untreated, chronic HCV causes significant and irreversible liver damage and that the medical standard of care requires treatment of all patients with chronic HCV without delay, except for those with short life expectancies. Despite this knowledge, Defendants have deliberately chosen to provide no treatment to Plaintiffs. Plaintiffs allege this decision is (1) in contravention of the medical standard of care; (2) based on a blanket policy instead of an individualized medical determination; and (3) based on the cost of treatment rather than a medical rationale.

1. Defendants Knowingly Disregarded A Substantial Risk of Serious Harm To Plaintiffs When They Refused To Treat Plaintiffs' Chronic HCV.

To demonstrate deliberate indifference, a plaintiff must sufficiently allege that a defendant "'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' by failing to take reasonable measures to abate it." *Rhinehart v. Scutt*, 894 F.3d 721, 738 (6th Cir. 2018) (quoting *Comstock v. McCrary*, 273 F.3d 693, 703 (6th Cir. 2001)). Defendants' knowledge can be inferred "if a risk is well-documented and circumstances suggest that the official has been exposed to the information so that he must have known of the risk . . . ." *Id.* at 738. Further, "a factfinder may conclude that a prison official knew of a substantial risk from the

very fact that the risk was obvious." *Rouster*, 749 F.3d at 447 (quoting *Farmer v. Brennan*, 511 U.S. 825, 842 (1994)).

Here, Plaintiffs have sufficiently and plausibly alleged that Defendants are aware of the substantial risk of harm posed by a failure to treat chronic HCV, yet have refused to provide treatment despite that knowledge. The progressive nature of chronic HCV is well-documented and commonly known in the medical and corrections communities. *See, e.g.*, Complaint Ex. E, R. 6, Page ID #273; Complaint Ex. N, R. 6, Page ID #393; Complaint Ex. K, R. 6, Page ID #332-33 (New York Department of Corrections guidelines discussing the progression of chronic HCV). *See also Gordon v. Schilling*, 937 F.3d 348, 360 (4th Cir. 2019) ("[Defendant] is the Chief Physician for a state prison system, and by virtue of that role, it is entirely reasonable to presume that he is familiar with the risks presented by untreated HCV."). And Plaintiffs have alleged that Defendants themselves distribute information about chronic HCV, the progressive nature of the disease, and the risks that come from a failure to treat it. *See* Complaint, R. 6, Page ID #244 ¶ 28; *see also* Complaint Ex. N, R. 6, Page ID #389; Complaint Ex. O, R. 6, Page ID #397.

Similarly, it is widely known and well established that the current standard of care provides for treatment of all patients with HCV without delay, regardless of the progression of the disease. *See* Complaint, R. 6, Page ID #243 ¶ 24; Complaint

Ex. I, R. 6, Page ID #300. Federal courts have recognized as much. *See*, *e.g.*, *Hoffer*, 290 F. Supp. 3d at 1296 ("[T]he present-day standard of care is to treat chronic-HCV patients with DAAs as long as there are no contraindications or exceptional circumstances. It is inappropriate to only treat those with advanced levels of fibrosis."); *Stafford*, 2018 WL 4361639, at *13 ("It is undisputed that treatment with DAA medication represents the medical standard of care for treatment of chronic HCV, regardless of the level of fibrosis or APRI score."). And the "most recent update to [the AASLD's] guidance includes a section addressing HCV testing and treatment in correctional settings, and it recommends that individuals in prison receive treatment according to the AASLD Guidance." *Id.* at 9 (granting summary judgment to plaintiffs and holding that defendants' use of a policy delaying treatment until patients met certain APRI scores violated the Eighth Amendment). Defendants certainly would have been exposed to this information as medical professionals and officials in charge of developing policies and procedures for the treatment of HCV. *See Rhinehart*, 894 F.3d at 738.

Further, federal courts have held that plaintiffs sufficiently plead deliberate indifference and state an Eighth Amendment claim when they have been categorically delayed or denied treatment for chronic HCV, in contravention of the

current standard of care.[12] *See, e.g.*, *Allah*, 679 F. App'x at 220 (holding that plaintiff plausibly alleged an Eighth Amendment violation when he alleged he "did not receive *any* treatment for his Hepatitis C condition") (emphasis in original); *Lovelace v. Clarke*, No. 2:19-CV-75, 2019 WL 3728265, at *4 (E.D. Va. Aug. 7, 2019) (collecting cases and holding that plaintiff sufficiently stated an Eighth Amendment claim when he was simply "monitored" but "received no 'treatment'" in contravention of the accepted standard of care and based solely on non-medical considerations); *Postawko*, 2017 WL 1968317, at *7 (holding that plaintiffs plausibly alleged an Eighth Amendment violation when they alleged defendants

[12] This Court has not had the opportunity to consider the delay or denial of chronic HCV treatment in light of the dramatic medical advances of the past decade, and the changed standard of care, discussed *supra*. In two unpublished opinions, this Court previously determined that *pro se* prisoner plaintiffs alleging denial of treatment for chronic HCV failed to state an Eighth Amendment claim. *See Hix v. Tennessee Dep't of Corr.*, 196 F. App'x 350, 357 (6th Cir. 2006); *Edmonds v. Robbins*, 67 F. App'x 872, 873 (6th Cir. 2003). Both opinions turned on a now outdated standard of care, and therefore have no applicability here. The Eighth Amendment draws its meaning from the "evolving standards of decency that mark the progress of a maturing society." *Estelle*, 429 U.S. at 102. It is, of course, in the nature of medical science to evolve over time. And Eighth Amendment standards evolve with it. *Id.* Medical advances and the current standard of care, therefore, must be considered when determining what level of care is reasonable, and what constitutes cruel and unusual punishment. *Cf. Edwards v. Alabama Dep't of Corr.*, 81 F. Supp. 2d 1242, 1250 (M.D. Ala. 2000) ("While a failure to provide certain [HIV] treatments might not have risen to the level of deliberate indifference in 1990, that same level of care might now amount to an eighth-amendment violation[.]").

relied solely on APRI scores and delayed DAA treatment until the disease had progressed, in contravention of the applicable medical standard of care).[13]

For example, in *Postawko*, the court determined that plaintiffs had stated an Eighth Amendment claim when:

> Defendants know that the applicable standard of care calls for treating *all* patients suffering from chronic HCV with those DAA drugs, regardless of their cirrhosis/fibrosis progression or APRI score, and that a delay in treatment with DAA drugs increases the risks of HCV progression as well as decreases the benefits of DAA treatment. However, despite this awareness, Defendants follow a policy or custom that categorically denies DAA drug treatment to inmates with chronic HCV.

2017 WL 1968317, at *6 (emphasis in original).

Similarly, here, Plaintiffs have sufficiently alleged that Defendants know the medical standard of care is to treat all patients with chronic HCV, regardless of the progression of the disease; that Defendants know that a delay in treatment presents a substantial risk of serious harm to the Plaintiffs and decreases the effectiveness of

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[13] *See also Gordon*, 937 F.3d at 359 ("[I]t is inconsistent with the Eighth Amendment for a prison official to withhold treatment from an inmate who suffers from a serious, chronic disease until the inmate's condition significantly deteriorates."); *Stafford*, 2018 WL 4361639, at *20 (concluding defendants' failure to treat plaintiffs with chronic HCV violates the Eighth Amendment and granting plaintiffs summary judgment); *Abu-Jamal*, 2017 WL 34700, at *18 (granting preliminary injunction and holding that plaintiff sufficiently established deliberate indifference when plaintiff demonstrated that "Defendants have deliberately denied providing treatment" with the knowledge that "the standard of care is to administer DAA medications regardless of the disease's stage[,]" that plaintiff would suffer harm, and that treatment would be less effective if delayed).

treatment; and that despite this awareness, Defendants have deliberately chosen not to treat Plaintiffs' chronic HCV. As such, Plaintiffs have sufficiently stated an Eighth Amendment claim.

2. Defendants' Reliance On A Blanket Policy, In Lieu Of Individualized Medical Determinations, Constitutes Deliberate Indifference.

Plaintiffs allege that Defendants' categorical denial of treatment is based solely on a blanket policy applied in lieu of individualized medical determinations. Complaint, R. 6, Page ID #246 ¶ 45. For example, in response to Mr. Mann's request for treatment, he was told that there are "very specific guidelines and policies regarding the treatment of Hepatitis C. The medical team will review this as needed, and follow the appropriate guidelines." Complaint Ex. R, R. 6, Page ID #422. Mr. Mann was further informed that "medical staff have followed the appropriate guidelines set forth in 68-MED-01, 68-MED-14, and Medical Protocol C-5. There will be no further action concerning [your request for treatment] at this time." *Id.*

Similarly, in response to his request for HCV treatment, Mr. Bragg was informed that ODRC "has a protocol (Medical Protocol C5) in place for said treatment. Your APRI score currently is 0.5, in order to receive treatment your APRI score must be at least 1.5." Complaint Ex. S, R. 6, Page ID #423. Finally, in denying Mr. Pastrano's request for treatment, staff informed him that there "are

specific guidelines for Hepatitis C treatment. You can refer to protocol A-6 for these guidelines." Complaint Ex. T, R. 6, Page ID #424.

As such, Defendants' policy, and the application of that policy, results in a set of blanket inclusion and exclusion requirements being applied to Plaintiffs without any consideration of their individual medical needs. Under Defendants' policy, to even be considered for treatment, a patient must have an APRI score of at least 1.5. *See* Complaint Ex. L, R. 6, Page ID #375. Defendants have made clear that under no circumstances will Plaintiffs even be considered for curative treatment unless and until their APRI scores pass the policy's threshold. *See* Complaint, R. 6, Page ID #244 ¶ 31; *id.*, Page ID #245 ¶ 37; *id.*, Page ID #246 ¶ 42. *See also* Complaint Exs. R-T, Page ID #422-24. Defendants have also made clear that this determination is based solely on Defendants' policy, and is not based on individualized medical judgments regarding Plaintiffs' individual medical needs. *Id. See also* Complaint Ex. I, R. 6, Page ID #303 (AASLD discussing coinfections and other coexistent medical conditions that may put individual patients at additional risk for accelerated fibrosis progression).

Further, an APRI score of 1.5 or higher indicates the patient has already developed severe fibrosis or cirrhosis—in other words, advanced liver disease. Complaint Ex. K, R. 6, Page ID #361. And DAA treatment is more effective when provided earlier in the progression of the disease, according to the AASLD.

Complaint Ex. I, R. 6, Page ID #301. The wholesale denial of curative treatment, based solely on Defendants' policy, disregards this serious risk of harm to the Plaintiffs.

Reliance on blanket policies, like the one at issue here, in the absence of individual medical determinations, constitutes deliberate indifference. Indeed, Plaintiffs adequately state an Eighth Amendment claim when treatment is denied "based solely on the Policy rather than on a medical judgment concerning [the plaintiff's] specific circumstances." *De'Lonta v. Angelone*, 330 F.3d 630, 635 (4th Cir. 2003). *See also Colwell v. Bannister*, 763 F.3d 1060, 1063 (9th Cir. 2014) (holding that the "blanket, categorical denial of medically indicated surgery solely on the basis of an administrative policy . . . is the paradigm of deliberate indifference"); *Roe*, 631 F.3d at 861-63 (upholding verdict for plaintiff finding that doctor who implemented policy basing HCV treatment on sentence length rather than a patient's individual condition was deliberately indifferent); *Cf. French v. Daviess Cty., Ky.*, 376 F. App'x 519, 523 (6th Cir. 2010) (suggesting that if a prison were to implement a blanket policy, rather than making treatment decisions "based on a reasoned, individualized medical determination[,]" a constitutional violation may be found).

3. Defendants' Refusal To Provide HCV Treatment Based On The Cost Of Treatment Constitutes Deliberate Indifference.

Plaintiffs further allege that Defendants' policy of denying treatment for

chronic HCV is based not on medical rationale but on the cost of treatment. Complaint, R. 6, Page ID #246 ¶ 45. Defendants admit as much in their briefing before the district court. *See, e.g.*, Motion to Dismiss, R. 35, Page ID #589 ("While these newer drugs may have a higher success rate with fewer side effects, they are also inordinately expensive. Cost . . . remain[s] of concern.").

The delay or denial of medical treatment based on non-medical reasons, such as the cost of treatment, constitutes deliberate indifference. *See Blackmore*, 390 F.3d at 899 ("When prison officials are aware of a prisoner's obvious and serious need for medical treatment and delay medical treatment of that condition for non-medical reasons, their conduct in causing the delay creates the constitutional infirmity.").

Indeed, courts routinely reject cost as an excuse for denying necessary medical care. *See, e.g.*, *Darrah v. Krisher*, 865 F.3d 361, 372-73 (6th Cir. 2017) (holding that reliance on cost when providing less effective medical care could constitute deliberate indifference); *Allah*, 679 F. App'x at 220 (holding that withholding HCV treatment from prisoner "*solely* because it was cost-prohibitive" is deliberate indifference) (emphasis in original); *Roe*, 631 F.3d at 863 (While "administrative convenience and cost may be, in appropriate circumstances, *permissible factors* for correctional systems to consider in making treatment

decisions, the Constitution is violated when they are considered to the *exclusion of reasonable medical judgment* about inmate health.") (emphasis in original).

In *Darrah*, this Court held that a reasonable jury could find that defendants were deliberately indifferent when they denied plaintiff effective medical care due to the cost of the required medication. 865 F.3d at 372-73. There, this Court noted that there was no "medical reason" for providing the plaintiff with a less effective, but more cost efficient, treatment. *Id.* at 372. And while "prisons have legitimate reasons to be concerned with the cost of medical treatment for inmates," the Court held that defendants' reliance on this non-medical rationale when providing a "less efficacious" treatment option could support a finding of deliberate indifference. *Id.* at 372-73.

Here, DAA treatment is not only the most effective treatment for chronic HCV, it is the only treatment for chronic HCV. Plaintiffs allege that Defendants, like the defendants in *Darrah*, have knowingly denied medical treatment due to the cost of that treatment. Further, like in *Darrah*, there is no "medical reason" to justify the denial of treatment. *See id.* at 372. This denial, therefore, constitutes deliberate indifference. *See id.* at 373.[14]

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[14] Defendants' complaints about logistical challenges are a smokescreen. *See, e.g.*, Motion to Dismiss, R. 35, Page ID #589-90 (arguing provision of DAA treatment would require additional training, an "efficient patient education model," and a "database" to prioritize patients). Their real concern, as revealed in their briefing

C. The District Court Applied An Incorrect Legal Standard And Misapprehended Plaintiffs' Allegations When It Dismissed Plaintiffs' Eighth Amendment Claims.

The district court dismissed Plaintiffs' claims primarily because Plaintiffs "are not being ignored." Order, R. 58, Page ID #709. *See also* Order, R. 52, Page ID #680 (dismissing claims because Plaintiffs "have failed to allege that Defendants have ignored their condition"). In doing so, the district court applied an incorrect legal standard.

It is established law that "[a] prisoner is not required to show that he was literally ignored by the staff to prove an Eighth Amendment violation, only that his serious medical needs were consciously disregarded." *Rouster*, 749 F.3d at 448 (quoting *LeMarbe*, 266 F.3d at 439) (internal quotation marks omitted). The district court's requirement that Plaintiffs must allege that staff literally ignored their condition stands in direct opposition to this binding circuit precedent.

The district court further argued that Plaintiffs simply disagreed with the course of treatment prescribed by Defendants. Order, R. 52, Page ID #680. To be sure, this Court "distinguish[es] between cases where the complaint alleges a complete denial of medical care and those cases where the claim is that a prisoner

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below, is the non-medical issue of cost. *Id.* (arguing that DAA drugs "are also inordinately expensive."). But regardless, any logistical challenges are similarly "non-medical reasons" for refusing care, and as such fail to excuse the denial of medically necessary treatment. *See Blackmore*, 390 F.3d at 899.

received inadequate medical treatment." *Alspaugh*, 643 F.3d at 169 (quoting *Westlake*, 537 F.2d at 860 n.5).

But the district court's suggestion misapprehends Plaintiffs' claims. Plaintiffs do not allege they have been provided with one treatment regimen and prefer another. Rather, Plaintiffs allege that they have been categorically denied any treatment at all. *See* Complaint, R. 6, Page ID #244 ¶ 32; *id.*, Page ID #245 ¶ 37; *id.*, Page ID #246 ¶ 42. In fact, Plaintiffs allege they have been categorically denied even *consideration* for treatment. *See id. See also* Complaint Ex. L, R. 6, Page ID #374-75 (policy requiring patients to meet all inclusion criteria and no exclusion criteria to be considered for treatment). Contrary to the district court's statement that the policy "establish[es] the course of treatment for Plaintiffs[,]" Order, R. 58, Page ID #709, the policy bars even *consideration* for any treatment until the disease has progressed and caused significant and irreversible liver damage.

As discussed previously, per Defendants' policy, to even be considered for treatment, a patient must have an APRI score of at least 1.5. *See* Complaint Ex. L, R. 6, Page ID #375. Defendants refuse to even consider treating Plaintiffs because their APRI scores do not meet this threshold.[15] Complaint, R. 6, Page ID #244 ¶

[15] Notably, even if Plaintiffs met this initial threshold, they would still not necessarily be provided with treatment. Once that threshold is met, Plaintiffs would

31; *id.*, Page ID #245 ¶ 37; *id.*, Page ID #246 ¶ 42. But an APRI score of 1.5 or higher generally indicates the patient has already developed severe fibrosis or cirrhosis. Complaint Ex. K, R. 6, Page ID #361. Further, DAA treatment, which can cure chronic HCV, is more effective when provided earlier in the progression of the disease, according to the AASLD. Complaint Ex. I, R. 6, Page ID #301.

In addition, Defendants' reliance solely on the APRI score to consider treatment results in the additional risk that Plaintiffs will be denied treatment even when their HCV has caused irreversible fibrosis or cirrhosis. The APRI score is known to be an ineffective and often inaccurate measure for the progression of the disease. *Id.*, Page ID #307. Courts around the country have recognized as much. *See, e.g.*, *Stafford*, 2018 WL 4361639, at *17 (discussing defendants' use of the APRI score and finding that "the undisputed medical evidence establishes that the test used by IDOC to estimate the degree of liver fibrosis is not a good predictor at earlier stages of infection . . ."); *Chimenti v. Wetzel*, No. CV 15-3333, 2018 WL 3388305, at *12 (E.D. Pa. July 12, 2018) (discussing defendants' use of the APRI score and finding there is "evidence that the DOC's reliance on an inaccurate method of testing for fibrosis could result in the DOC's failing to treat many

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be eligible to receive a liver biopsy, to measure further the extent of liver damage. If that biopsy did not indicate the presence of liver fibrosis consistent with at least stage 3 fibrosis—indicating advanced liver disease—per Defendants' policy, they would "not be treated." Complaint Ex. L, R. 6, Page ID #375.

individuals who suffer from advanced fibrosis and cirrhosis"). By contrast, the "most efficient approach to fibrosis assessment is to combine direct biomarkers and vibration-controlled transient liver elastography." Complaint Ex. I, R. 6, Page ID #307. But Plaintiffs have been denied this more accurate diagnostic testing. *See* Complaint, R. 6, Page ID #244 ¶ 33; *id.*, Page ID #245 ¶ 38; *id.*, Page ID #246 ¶ 42.

In contrast to the ruling of the district court, a plaintiff "states a proper cause of action when he alleges that prison authorities have denied reasonable requests for medical treatment in the face of an obvious need for such attention where the inmate is thereby exposed to undue suffering or the threat of tangible residual injury." *Westlake*, 537 F.2d at 860. As such, Plaintiffs have sufficiently stated a cause of action: Plaintiffs have alleged that Defendants have denied them any treatment for their chronic HCV; Defendants know that, left untreated, chronic HCV leads to progressive and irreversible liver damage; and the failure to treat puts Plaintiffs at a risk of further developing fibrosis and cirrhosis. *See id. See also Boretti v. Wiscomb*, 930 F.2d 1150, 1154 (6th Cir. 1991) (holding that plaintiff adequately stated a claim of deliberate indifference to serious medical needs when staff "allegedly refused" to provide needed medical treatment). The district court erred in holding otherwise.

Finally, the district court suggested Plaintiffs failed to state a claim because "generally . . . they are being monitored and treated." Order, R. 52, Page ID #680. *See also* Order, R. 58, Page ID #709 ("Plaintiffs' Hep-C conditions are being monitored and therefore under ongoing care."). Again, however, the district court misapprehends Plaintiffs' claims and the law.

First, as discussed above, Plaintiffs allege they have been categorically denied any treatment for their chronic HCV. And Mr. Pastrano alleges he is not even being monitored with regular blood tests. Complaint, R. 6, Page ID #246 ¶ 42. Further, "monitoring" does not equal "treatment" or "ongoing care." Indeed, Defendants' own policy distinguishes between a course of treatment and monitoring. *Compare* Complaint Ex. L, R. 6, Page ID #138 (describing treatment regimen) *with* Complaint Ex. L, R. 6, Page ID #139 (describing monitoring regimen).

Federal courts similarly have recognized this distinction and held that simply monitoring a patient's chronic HCV, rather than providing curative treatment, can constitute deliberate indifference and state an Eighth Amendment claim. In *Lovelace*, the court held that the plaintiff sufficiently alleged an Eighth Amendment claim in part because although the defendant "'monitored' Plaintiff's Hepatitis C over time, Plaintiff received no 'treatment' even after the standard of care changed in 2016 . . . ." 2019 WL 3728265, at *4. *See also Postawko*, 2017

WL 1968317, at *7 (concluding that "adopting a monitoring policy instead of treatment and waiting to see just how much the inmate's health may deteriorate is not permissible."). Similarly, in *Abu-Jamal*, the court granted plaintiff's motion for a preliminary injunction requiring defendants to treat his chronic HCV immediately. The court held, "Simply put, Defendants, pursuant to DOC policy, deliberately chose a course of monitoring over treatment for non-medical reasons and are allowing Plaintiff's condition to worsen while his liver function and his health continues to deteriorate." *Abu-Jamal*, 2017 WL 34700, at *14.

II. Plaintiffs Have Sufficiently Alleged Claims Against The Supervisory Defendants.

In dismissing Plaintiffs' claims against Defendants Eddy and GCIHCA (jointly with Eddy, the "Supervisory Defendants"), the district court relied on the doctrine of *respondeat superior*—and specifically, that doctrine's inapplicability in Section 1983 claims as a basis for liability. *See* Order, R. 52, Page ID #679. Though never expressly stated, the court's analysis presupposed that the Supervisory Defendants had been sued in their individual capacities only, rather than their official capacities. Had it been the latter, the concept of *respondeat superior* would be irrelevant. *See Knott v. Sullivan*, 418 F.3d 561, 574-75 (6th Cir. 2005) (explaining that official-capacity claim is "equivalent to a suit against the entity on whose behalf [the employees] act") (internal citations omitted; alterations in original).

That presumption was wrong. Plaintiffs have sufficiently pleaded official-capacity claims against both Defendant Eddy and Defendant GCIHCA. In addition, as to Eddy, Plaintiffs have more than sufficiently alleged direct involvement, knowledge, and implicit acquiescence to unlawful action, so as to state a valid individual-capacity claim.

A. Plaintiffs Sufficiently Pleaded Claims Against Both Supervisory Defendants In Their Official Capacities.

Where a Section 1983 complaint does not expressly specify, this Court—like "the vast majority of our sister circuits"—applies a "course of proceedings" test to determine whether claims against a government employee are in the employee's official or personal capacity. *Moore*, 272 F.3d at 772-73.[16] *See also Kentucky v. Graham*, 473 U.S. 159, 167 n.14 (1985) (the "'course of proceedings' . . . will indicate the nature of the liability sought to be imposed"). Under that test, courts are to consider factors such as "the nature of the plaintiff's claims, requests for compensatory or punitive damages, and the nature of any defenses[.]" *Moore*, 272 F.3d at 772 n.1. The test "also considers whether subsequent pleadings put the defendant on notice of the capacity in which he or she is sued[,]" particularly

[16] The alternative approach, rejected in *Moore*, was to assume official capacity—not individual capacity, as the district court did here—unless expressly stated otherwise. *See Moore*, 272 F.3d at 773.

where the litigation is still in an early stage, such as a dismissal upon a Rule 12(b)(6) motion. *Id.*

The complaint here exhibits numerous features of an official-capacity action. The Supervisory Defendants' official titles are listed along with their names, consistent with an official capacity lawsuit. *See* Complaint, R. 6, Page ID #239-40; *Moore*, 272 F.3d at 773 (omitting titles, unlike here, gave notice of individual capacity claims). Defendant Eddy is named for his role in "the promulgation, interpretation and application of all ODRC Policies and Procedures related to providing medical care to Ohio prisoners[.]" Complaint, R. 6, Page ID #241 ¶ 7; *see also id.*, Page ID #247 ¶ 48 (citing his "direct role in interpreting and applying" policies and protocols). Among the relief sought is a declaration that ODRC's "Policies and Protocols" related to treatment for HCV deny necessary medical care, a feature of official-capacity claims. *Id.*, Page ID #249 ¶ A. *See Graham*, 473 U.S. at 166 (holding that the governmental entity's "policy or custom" must have played a part in the violation for an official-capacity claim).

In their motion to dismiss briefing,[17] Plaintiffs confirmed that they seek to challenge "not just the doctor" at the institution, but also "the promulgation, interpretation and application of the policies themselves," in language mirroring

[17] A Rule 12(b)(6) motion is typically a "relatively early stage of litigation" for purposes of putting a defendant on notice as to capacity. *Moore*, 272 F.3d at 772 n.1.

their complaint allegations. *See* Pls. Opp. to Motion to Dismiss, R. 25, Page ID #511. *See also id.*, Page ID #510-11 ("Plaintiffs submit that . . . they have stated a claim for individual official capacity liability for these defendants, and that they did not, as erroneously claimed by the defendants, only allege supervisory claims."). Defendant Eddy is alleged to have direct responsibility for his "role[] in promulgating the suspect policies[,]" and both Supervisory Defendants are named for their roles in applying those policies, by "overruling the primary care physicians who recommend or prescribe treatment for Ohio and GCI prisoners[.]" *Id.*, Page ID #510. Indeed, Plaintiffs describe as the "primary allegation set forth in this case" that the "policies, as written . . . are deliberately indifferent to the serious medical needs" of prisoners. *Id.*, Page ID #511. Such an allegation is, again, a defining characteristic of an official-capacity claim. *See Graham*, 473 U.S. at 166.[18]

Also tellingly, when Defendant David Hannah vacated the position of GCIHCA, Plaintiffs filed a Notice of Substitution pursuant to Federal Rule of Civil Procedure 25(d), expressly stating that Hannah had been sued in his official capacity only. Notice of Substitution, R. 24, Page ID #502. His unnamed successor

[18] The claims against the other Defendants similarly meet the "course of proceedings" test for official capacity claims. *See Moore*, 272 F.3d at 772-73.

was substituted by title, again indicating an official-capacity claim. *Id.*, Page ID #502-03.

At the motion to dismiss stage—and this appeal—all reasonable inferences must be drawn in Plaintiffs' favor. *Taxpayers United*, 994 F.2d at 296. Layered atop that presumption, if any doubt lingers after examination of the course of proceedings, the matter is to be resolved in Plaintiffs' favor as *pro se* plaintiffs. *Lindsay v. Bogle*, 92 F. App'x 165, 169 (6th Cir. 2004) (applying this principle to determine the capacity in which defendant was sued); *Martin*, 391 F.3d at 712. Both the course of proceedings and the principles of pleading weigh in favor of construing the Supervisory Defendants as defendants in their official capacities—and as to Eddy, as discussed below, in his individual capacity as well.

Defendants have not disputed the sufficiency of Plaintiffs' allegations as official-capacity claims, nor can they. As discussed above, Plaintiffs have stated claims for violation of their Eighth Amendment rights, arising from Defendants' policies. The Complaint ties those policies directly to the Supervisory Defendants' actions in their official capacities, including Dr. Eddy's role in promulgating, interpreting, and enforcing them; and the GCIHCA for implementing them. *See supra*. Accordingly, neither of the Supervisory Defendants should have been dismissed.

B. Plaintiffs Have Also Alleged Sufficient Direct Involvement To State A Claim Against Andrew Eddy In His Personal Capacity.

It is true, as the district court observed, that a plaintiff must allege and prove "personal involvement" by a supervisor for individual liability to attach. *E.g.*, *Grinter v. Knight*, 532 F.3d 567, 575 (6th Cir. 2008). That involvement must be more than mere "failure to supervise, control or train the offending individual," *e.g.*, *Shehee v. Luttrell*, 199 F.3d 295, 300 (6th Cir. 1999), but it need not be explicit, direct contact with the plaintiff. Where a plaintiff alleges that a supervisory official "at least implicitly authorized, approved, or knowingly acquiesced in the unconstitutional conduct," personal liability may be incurred under Section 1983. *Id.* (quoting *Hays v. Jefferson Cty., Ky.*, 668 F.2d 869, 874 (6th Cir. 1982)).

This Court recently clarified these principles in a police shooting case. *See Peatross v. City of Memphis*, 818 F.3d 233 (6th Cir. 2016). In addition to suing the officers who fired the fatal shots, the plaintiff estate brought individual-capacity claims against the Director of the Memphis Police Department, alleging that he was involved in creating and enforcing department policies; "personally condoned, encouraged, approved, or at least implicitly authorized" the officers' conduct; created a "custom and pattern . . . of exonerating" officers who used excessive force; and "rubber stamped" officer misconduct. *Id.* at 238-39. Critically, there was no allegation that the Director was directly involved in the shooting itself or the

events immediately leading to it. The Court nonetheless found that the plaintiff had alleged a valid claim for supervisory liability, explaining:

> We have long held that supervisory liability requires some "active unconstitutional behavior" on the part of the supervisor. However, "active" behavior does not mean "active" in the sense that the supervisor must have physically put his hands on the injured party or even physically been present at the time of the constitutional violation. . . . [W]here an official's execution of his or her job function causes injury to the plaintiff, the official may be liable under the supervisory-liability theory.

Id. at 241-42 (internal citations omitted). Relying on the language of Section 1983—which provides for liability of, *inter alia*, one who "causes [a person] to be subjected" to a deprivation of constitutional rights—the Court explained that the plaintiff had plausibly alleged a causal connection between the decedent's death and the Director's knowledge of, and acquiescence in, his subordinates' conduct through the execution of his job function. *Id.*at 242.

Several Defendants in this action have been sued in their individual capacities; Plaintiffs' demand for compensatory damages is conclusive of that point. *See* Complaint, R. 6, Page ID #249 ¶ C; *Moore*, 272 F.3d at 772 n.1. Their claim against Defendant Eddy, the Director of the ODRC Collegial Review Committee, is one such individual capacity claim. The pertinent allegations mirror those in *Peatross*—Eddy is alleged not only to have "a direct role in interpreting and applying ODRC Medical Policies and Protocols," but to be "directly and proximately responsible for the denial of adequate and timely readily available

prescribed health care for Ohio prisoners, including treatment for HCV[.]" Complaint, R. 6, Page ID #247 ¶ 48. Indeed, his personal signature appears on the policies at issue. Complaint Ex. L, R. 6, Page ID #370; Complaint Ex. M, R. 6, Page ID #381. Through the execution of his job function, he is alleged to have exhibited a "pattern of denying necessary medical care . . . deliberately, purposefully and with the intent to deprive prisoners of necessary health care[.]" Complaint, R. 6, Page ID #247 ¶ 48. Alongside his co-defendants, he is allegedly "aware of the prevalence and seriousness of HCV infections among the prisoners in [his] collective charge," *id.*, Page ID #244 ¶ 28, but "refuse[s] to provide adequate and necessary medical care" under color of ODRC policy. *Id.*, Page ID #244 ¶ 32 (as to Mann). *See also id.*, Page ID # 245 ¶ 37 (Bragg), *id.*, Page ID #246 ¶ 42 (Pastrano).

The district court erred in characterizing these allegations as tantamount to *respondeat superior*, *see* Order, R. 52, Page ID #679, and further erred in attempting to distinguish this case from *Love v. Franklin Cty., Ky.*, 376 F. Supp. 3d 740 (E.D. Ky. 2019). In *Love*, the defendant official was allegedly aware that the plaintiff, a pretrial detainee, was pregnant and in labor, but failed to intervene. *See* 376 F. Supp. 3d at 748. Nothing in *Love*—and certainly nothing in *Peatross*, which expressly holds the contrary—stands for the proposition that the supervisory defendant must personally commit the instant unconstitutional act. *See id.*at 748-

49; *Peatross*, 818 F.3d at 241-42. The fact that Eddy's "execution of [his] job functions causes injury to the plaintiff" is enough. *Peatross*, 818 F.3d at 242.

Moreover, the district court is wrong that "[t]here have been no allegations by Plaintiffs . . . that Plaintiffs were suffering from any urgent medical condition that was ignored or not being treated." Order, R. 52, Page ID #679. Plaintiffs are suffering from an inarguably serious medical condition—they, and those similarly situated, are at risk of severe and permanent liver damage as a result of untreated chronic HCV. They have alleged that Defendant Eddy knew of the prevalence of chronic HCV among the incarcerated population, but nonetheless promulgated and implemented a constitutionally defective policy. *See supra*. Further, they allege that he knew that treating physicians were routinely denying necessary treatment under the unlawful policies, but acquiesced in that practice. As in *Peatross*, that is enough for a supervisory-liability claim, especially with inferences properly drawn in Plaintiffs' favor on a motion to dismiss. *See Taxpayers United*, 994 F.2d at 296 (holding that inferences must be drawn in favor of plaintiff at 12(b)(6) stage); *Lindsay*, 92 F. App'x at 169 (holding that pleadings are to be construed in *pro se* plaintiff's favor as to capacity in which defendant is sued).

CONCLUSION

For the reasons set forth above, this Court should reverse the district court's decisions and remand for further proceedings on the merits.

Dated: January 22, 2020

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because, excluding the parts of the document exempted by Fed. R. App. P. 32(f) and 6th Cir. R. 32(b)(1), it contains 11,333 words.

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface with 14-point Times New Roman font.

Dated: January 22, 2020

/s/ Jennifer Wedekind
Jennifer Wedekind

CERTIFICATE OF SERVICE

I hereby certify that on January 22, 2020, I electronically filed this brief with the Clerk of Court for the United States Court of Appeals for the Sixth Circuit, causing notice of such filing to be served upon all parties registered on the CM/ECF system.

/s/ Jennifer Wedekind
Jennifer Wedekind

ADDENDUM

Plaintiffs-Appellants designate the following district court documents as relevant to this matter:

Record Entry	Description of Document	Page ID #
6	Complaint and Exhibits	239-425
15	Motion to Dismiss by Interested Party, the State of Ohio	454-467
20	Motion to Dismiss by Defendants Douglas, Eddy, Hannah, and ODRC	483-495
24	Notice of Substitution of Parties	502-503
25	Plaintiffs' Opposition to Defendants' Motions to Dismiss	505-514
26	Defendants' Reply in Support of Motions to Dismiss	516-528
33	Plaintiffs' Sur-Reply in Opposition to Motions to Dismiss	572-577
35	Motion to Dismiss by Defendant Chambers-Smith	584-593
38	Plaintiffs' Opposition to Chambers-Smith Motion to Dismiss	598-608
43	Motion to Dismiss by Defendant Parks	620-629
45	Report and Recommendation re Motions to Dismiss by State of Ohio, ODRC, Eddy, Hannah and Douglas	631-655
46	Plaintiffs' Opposition to Parks Motion to Dismiss	656-660
47	Defendants' Reply in Support of Chambers-Smith Motion to Dismiss	662-663
49	Defendants' Reply in Support of Parks Motion to Dismiss	666-667
50	Defendants' Objections to Report and Recommendation	668-672
51	Plaintiffs' Response to Defendants' Objections	673-676
52	Order re Motions to Dismiss by State of Ohio, ODRC, Eddy, Hannah and Douglas	678-681
53	Judgment re State of Ohio, ODRC, Eddy, Hannah and Douglas	682
56	Report and Recommendation re Motions to Dismiss	696-702

	by Chambers-Smith and Parks	
57	Plaintiffs' Objections to Report and Recommendation	703-707
58	Order re Motions to Dismiss by Chambers-Smith and Parks	708-710
59	Judgment re Chambers-Smith and Parks	711
60	Notice of Appeal	712-713