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 INSTITUTION
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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INTRODUCTION

This case is about Defendants' categorical refusal to treat Plaintiffs' chronic Hepatitis C virus ("HCV") — a serious, progressive disease that when left untreated results in permanent and irreversible liver damage, liver failure, and death. There is only one treatment for chronic HCV: Direct-Acting Antiviral ("DAA") therapy. But that treatment can cure chronic HCV in nearly all cases.

Plaintiffs allege that Defendants denied them DAA therapy in contravention of the medical standard of care. This denial was based on a blanket policy and the cost of treatment rather than on individualized medical determinations. Plaintiffs further allege that Defendants knew that failure to treat chronic HCV results in a substantial risk of serious harm, yet deliberately denied Plaintiffs the *only treatment available*. At this motion to dismiss stage, therefore, Plaintiffs sufficiently alleged an Eighth Amendment violation.

Defendants' entire argument to the contrary relies on a single, specious proposition: that Plaintiffs were, in fact, provided "treatment." Indeed, the foundation for Defendants' house of cards is a speculative version of the facts they prefer — not the facts as clearly alleged in the Complaint. Based on this faulty foundation, Defendants assert that this case is about the adequacy of the care provided, and not about a denial of care. But this case is not one in which Plaintiffs received one type of treatment and seek another. Rather, this case is about

Defendants' categorical denial of the only treatment available for Plaintiffs' chronic HCV. Defendants' alternate reality cannot be credited at this motion to dismiss stage. The house of cards must fall.

Defendants also bring two new legal questions before this Court. Defendants assert qualified immunity for the first time in their response brief. This defense has been waived and, regardless, is without merit. Defendants also assert Plaintiffs' injunctive claims are moot due to Defendants' recent agreement to provide them with DAA therapy. But Defendants cannot escape liability by attempting to moot out Plaintiffs' claims at the eleventh hour. And due to the case's class action posture in the district court, Plaintiffs' injunctive claims are not moot.

ARGUMENT

I. Plaintiffs Sufficiently Alleged That Defendants' Refusal To Treat Their Chronic HCV Constitutes Deliberate Indifference.

A 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). Plaintiffs state an Eighth Amendment claim when they sufficiently allege that, objectively, "the medical need at issue is sufficiently serious" and that, subjectively, defendants had "a sufficiently culpable state of mind in denying medical care." *Alspaugh v. McConnell*, 643 F.3d 162, 169 (6th Cir. 2011) (quoting *Blackmore v. Kalamazoo Cnty*., 390 F.3d 890, 895-96 (6th Cir.2004)).

The objective component of deliberate indifference is not in dispute here, as Defendants repeatedly have conceded. *See* Resp. Br. at 23, 30.[1] *See also* Order, R.52, Page ID#680 (noting objective component was undisputed before the district court).

The subjective component requires allegations that Defendants "subjectively perceived facts from which to infer substantial risk to the prisoner, that [they] did in fact draw the inference, and that [they] then disregarded that risk." *Comstock v. McCrary*, 273 F.3d 693, 703 (6th Cir. 2001) (citing *Farmer v. Brennan*, 511 U.S. 825, 837 (1994)).

Notably, Defendants do not argue that Plaintiffs failed to adequately plead facts demonstrating that Defendants knew each Plaintiff had chronic HCV. Defendants similarly do not argue that Plaintiffs failed to adequately plead that Defendants were aware of the serious risk chronic HCV poses to Plaintiffs' health when left untreated. And Defendants do not argue that Plaintiffs failed to adequately allege that Defendants disregarded that serious risk when they deliberately refused to provide Plaintiffs with DAA treatment — the only treatment available for chronic HCV.

Instead, Defendants assert that their policy of standing by and observing as Plaintiffs' condition progressively deteriorates to the point of permanent and

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[1] Citations to briefing before this Court refer to page numbers assigned by the ECF system.

irreversible liver damage constitutes "treatment" and immunizes them from liability. Neither the facts nor the law supports this assertion. Plaintiffs adequately alleged deliberate indifference because Defendants (1) refused to provide the only treatment available for chronic HCV; (2) based that refusal on a blanket policy in lieu of individualized medical determinations; and (3) based that refusal solely on cost of treatment.

A. Defendants Refused To Provide Plaintiffs The Only Treatment Available For Chronic HCV.

Left untreated, chronic HCV results in progressive and irreversible liver damage, including fibrosis, cirrhosis and death. Complaint, R.6, Page ID#242 ¶ 14; *id.* Page ID#243 ¶15; Complaint Ex. P, R.6, Page ID#408. But the advent of DAA therapy in the last decade rendered chronic HCV a curable disease. Complaint Ex. E, R.6, Page ID#275. Notably, DAA therapy is the *only* treatment available for chronic HCV. *See* Complaint Ex. F, R.6, Page ID#285; Complaint Ex. E, R.6, Page ID#275. The current medical standard of care provides that all patients should be treated with DAA therapy as early in the disease's progression as possible. Complaint Ex. I, R.6, Page ID#300-01. Yet Defendants categorically refused to provide Plaintiffs with this critical medical care, in deliberate indifference to their serious medical needs. Complaint, R.6, Page ID#246 ¶ 45.

Defendants assert that Chronic Care Clinic enrollment constitutes "treatment" for HCV. But this assertion is belied by the facts alleged in the

Complaint. According to the Ohio Department of Rehabilitation and Correction ("ODRC") policy, the Chronic Care Clinic provides periodic "physical assessments," the components of which mirror a typical physical exam. *See* Complaint, Ex. L, R.6, Page ID#380. The policy also provides for periodic lab work, including an APRI blood test, which measures the disease's progression. *Id.* In other words, these assessments simply "monitor" the Plaintiffs' current stage of liver deterioration.

In addition, there are no facts in the Complaint demonstrating that Plaintiffs received these monitoring assessments regularly, or that medical staff executed the assessments appropriately. To the contrary, Plaintiff Pastrano alleges he is not receiving regular assessments. Complaint, R.6, Page ID #246 ¶ 42.

Further, these monitoring assessments are not "treatment." These assessments do not slow the progression of the disease. They do not reverse the progression of the disease. And they do not cure the disease. Nor are they intended to. As such, it strains credulity to consider a periodic physical exam and occasional bloodwork "treatment" for a progressive and deadly disease. *See Postawko v. Missouri Dep't of Corr.*, No. 2:16-cv-04219, 2017 WL 1968317, at *8 (W.D. Mo. May 11, 2017) (holding defendants' "monitoring policy…prolongs the suffering of those…with chronic HCV and allows the progression of the disease to accelerate."). On a motion to dismiss, Defendants' characterization of these

monitoring assessments cannot be credited. *See Westlake v. Lucas*, 537 F.2d 857, 858 (6th Cir. 1976) (holding that court must accept all well-pleaded factual allegations as true and construe complaint in the light most favorable to the plaintiff on a motion to dismiss).

Defendants also inaccurately suggest that there are other forms of treatment for chronic HCV, and that Plaintiffs either received or had access to this treatment. *See, e.g.*, Resp. Br. at 16, 34, 49. But these statements misconstrue the allegations in the Complaint. No treatment, other than DAA therapy, exists for chronic HCV. *See* Complaint Ex. F, R.6, Page ID#285; Complaint Ex. E, R.6, Page ID#275.

The treatments Defendants refer to are not for chronic HCV, but for other independent conditions, such as portal hypertension, that arise from untreated HCV. *See, e.g.*, Complaint Ex. I, R.6, Page ID#301 (AASLD Guidelines referring to portal hypertension as a clinical manifestation of advanced liver disease). And Defendants rely on pure speculation when they suggest that Plaintiffs may be treated for these other conditions. There is nothing in the Complaint that suggests Plaintiffs have received the treatment described by Defendants. And even if they had, treatment for independent conditions does not constitute treatment for the chronic HCV. Again, Defendants' speculation cannot be credited on a motion to dismiss. *See Westlake*, 537 F.2d at 858.

Finally, Defendants repeatedly contend, without support, that a different, lower standard of care applies to Plaintiffs simply because they are incarcerated. Resp. Br. at 25, 37, 54. But that is not the law. The Eighth Amendment is grounded in the "evolving standards of decency," *Estelle v. Gamble*, 429 U.S. 97, 102 (1976), and requires Defendants to provide adequate medical care based on prevailing professional standards. *See, e.g.*, *Comstock*, 273 F.3d at 709 (relying on the standard of care described by plaintiffs' experts to find plaintiff stated a constitutional claim); *Nunes v. Mass. Dep't of Corr.*, 766 F.3d 136, 142 (1st Cir. 2014) ("[A] prisoner must show that the medical care provided is not adequate, as measured against prudent professional standards.") (internal quotation marks omitted); *Roe v. Eleya*, 631 F.3d 843, 857 (7th Cir. 2011) (holding that doctors display deliberate indifference if decisions are a "substantial departure" from "accepted professional judgment, practice, or standards").

In addition, federal courts have recognized, and applied, the standard of care for HCV treatment set forth by Plaintiffs here. *See, e.g.*, *Hoffer v. Jones*, 290 F. Supp. 3d 1292, 1296 (N.D. Fla. 2017) ("[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 v. Carter*, No. 1:17-CV-00289, 2018 WL 4361639, at *13 (S.D. Ind. Sept. 13, 2018) ("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."); *Abu-Jamal v. Wetzel*, No. 3:16-cv-2000, 2017 WL 34700, at *15 (M.D. Pa. Jan. 3, 2017) (holding the "standard of care for treating" chronic HCV "is to administer DAA medications").

B. Defendants Relied On A Blanket Policy In Lieu of Individualized Medical Determinations.

Plaintiffs allege that Defendants' refusal to provide Plaintiffs DAA therapy was based solely on the reflexive application of a blanket policy, without any consideration of their individual medical needs. Complaint, R.6, Page ID#246 ¶ 45. Under Defendants' policy, patients will not even be considered for treatment until they have developed severe fibrosis or cirrhosis. *See* Complaint Ex. L, R.6, Page ID#375; Complaint Ex. K, R.6, Page ID#361. However, DAA treatment is most effective when provided early in the progression of the disease. Complaint Ex. I, R.6, Page ID#301. As such, this denial of care based on a blanket policy disregards a substantial risk of serious harm and constitutes deliberate indifference.

Defendants suggest that the Constitution does not require individualized medical determinations, but provide no support for that proposition. Resp. Br. at 56. To the contrary, courts routinely hold that reliance on blanket policies, in lieu of exercising medical judgment, constitutes deliberate indifference. *See, e.g.*, *Colwell v. Bannister*, 763 F.3d 1060, 1063 (9th Cir. 2014) (holding that the "blanket, categorical denial of medically indicated [treatment] solely on the basis

of an administrative policy…is the paradigm of deliberate indifference"); *Roe*, 631 F.3d at 860-63 (holding that there is a "basic legal obligation to provide care adequate to a particular inmate's medical circumstances" and doctor implementing a "blanket" policy was deliberately indifferent); *De'Lonta v. Angelone*, 330 F.3d 630, 635 (4th Cir. 2003) (holding plaintiff stated a claim where "refusal" to provide treatment was "based solely on the Policy rather than on a medical judgment concerning De'lonta's specific circumstances."). *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). Defendants' attempt to distinguish these decisions is unavailing, as the plain language in each opinion broadly rejects the application of blanket policies and requires individualized medical determinations. *See id.*

Defendants also suggest that certain language in ODRC's policy indicates Defendants made individualized medical determinations. Resp. Br. at 18. To be sure, the policy states that it is "not intended to be a substitute for professional judgment by the attending physician." Complaint Ex. L, R.6, Page ID#370. Yet Defendants later concede that each Plaintiff was denied HCV treatment not based on Defendants' professional judgment, but solely because "none qualified for it under the Department's treatment protocol." Resp. Br. at 19. And Defendants'

assertions that individualized determinations *may* be made in *some* cases cannot be credited on a motion to dismiss. *See Westlake*, 537 F.2d at 858.

Indeed, Plaintiffs allege that this "professional judgment" was not exercised. Instead, Defendants denied Plaintiffs' treatment based solely on a reflexive application of the policy's requirements. *See* Complaint Ex. R, R.6, Page ID#422 (denying Mr. Mann treatment because "medical staff have followed the appropriate guidelines set forth in [ODRC policies]"); Complaint Ex. S, R.6, Page ID#423 (denying Mr. Bragg treatment because ODRC "has a protocol (Medical Protocol C5) in place for said treatment"); Complaint Ex. T, R.6, Page ID#424 (denying Mr. Pastrano treatment because there "are specific guidelines for Hepatitis C treatment").[2]

C. Defendants Based Their Policy On Treatment Cost In Lieu of Individualized Medical Determinations.

Finally, Plaintiffs sufficiently alleged that Defendants' policy is based not on any medical judgment but solely on the cost of treatment, in deliberate indifference to their serious medical needs. *See* Complaint, R.6, Page ID#246 ¶ 45.

Defendants assert, without support, that the pleadings "contradict" Plaintiffs' allegations. Resp. Br. at 59-60. But that is not so. The Complaint plausibly alleges that Plaintiffs were denied treatment solely on the basis of the policy, and that the

[2] Defendants' sudden reversal and decision to treat each Plaintiff, Resp. Br. at 22-23, similarly suggests that no medical judgment was applied when previously denying them treatment.

policy itself was designed solely around costs. *See* Complaint, R.6, Page ID#246 ¶ 45. And, again, Defendants' suggestion that they may have considered factors other than cost when developing the policy cannot be credited at this motion to dismiss stage. *See Westlake*, 537 F.2d at 858.[3]

Further, it is settled law that the delay or denial of medical treatment based on non-medical reasons, such as cost, constitutes deliberate indifference. *See, e.g.*, *Blackmore*, 390 F.3d at 899 (holding that prison officials who "delay medical treatment" for serious medical conditions "for non-medical reasons" violate the Constitution); *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).

II. Plaintiffs Sufficiently Alleged That Defendants' Refusal To Provide HCV Treatment Constitutes A Denial Of Care.

This Court at times "distinguish[es] between cases where the complaint alleges a complete denial of medical care and those cases where the claim is that a prisoner received inadequate medical treatment." *Alspaugh*, 643 F.3d at 169

[33] Similarly, Defendants' suggestion, without support, that the policy is premised on the "prospects of successful treatment" should be disregarded. Resp. Br. at 59. Nothing in the policy supports that proposition. And the medical community is clear that treatment is most successful when provided early in the disease's progression — not after the patient has developed advanced liver disease, as required by Defendants' policy. *See* Complaint Ex. I, R.6, Page ID#301.

(citation omitted). This distinction is grounded in the Court's reluctance "to second guess medical judgments." *Id.*

A clear-eyed review of Plaintiffs' allegations demonstrates that this case falls squarely into the "denial of care" category. Defendants' assertions to the contrary rely on a misapprehension of Plaintiffs' claims and a misapplication of the relevant legal standards. First, as described above, there is *only one* treatment for chronic HCV — DAA therapy. Denial of DAA therapy constitutes a denial of the only treatment available. And Defendants did not exercise any "medical judgment" when denying Plaintiffs treatment but instead reflexively applied a blanket policy and relied on cost considerations. Defendants' alternate facts cannot be credited at this motion to dismiss stage. *Westlake*, 537 F.2d at 858. Second, in the alternative, even under the "inadequate care" framework, Plaintiffs sufficiently stated a constitutional claim.

A. Defendants' Refusal To Provide DAA Therapy Constitutes A "Complete Denial" Of Care.

1. Defendants' refusal to provide Plaintiffs with DAA therapy — the only treatment available for chronic HCV — constitutes a denial of care. This Court applies the "denial of care" category when a patient received little or no treatment to address a serious condition meaningfully. For example, this Court applied the "denial of care" framework when a plaintiff had a stomach ulcer and was treated with only an antacid. *See Westlake*, 537 F.2d at 860.

In contrast, this Court applies the "adequate care" category when a patient has received extensive and ongoing care, and the court is being asked to reconsider a doctor's medical judgment. *See Alspaugh*, 643 F.3d at 169 (applying "adequate care" category when plaintiff received "extensive" treatment for injuries, including surgery); *Rhinehart v. Scutt*, 894 F.3d 721, 750-51 (6th Cir. 2018) (applying "adequate care" category when plaintiff received "ongoing" treatment, including medications and surgery).

Here, each Plaintiff requested the only treatment available for HCV, and each was denied, solely because each did not meet the arbitrary criteria set forth in Defendants' policy. *See* Complaint, R.6, Page ID#246 ¶ 45. Further, Plaintiffs were denied even *consideration* for any treatment until the disease caused significant and irreversible liver damage. *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).

Defendants suggest that periodic monitoring assessments should be considered ongoing "treatment" and therefore remove Plaintiffs' allegations from the denial of care framework. Resp. Br. at 50-51. As discussed above, that contention is in conflict with the allegations in the Complaint and cannot be credited at this motion to dismiss stage. *See supra* section I(A).

Further, Defendants' proffered caselaw does little to bolster their argument. *Cook* was not about HCV at all, and the decision does not stand for the proposition that "monitoring" equals "treatment." *See Cook v. Corizon Health, Inc.*, No. 19-1660, slip. op. at 5 (6th Cir. Feb. 18, 2020) (unpublished). Rather, the Court upheld summary judgment for defendants in a brief decision based on evidence that the plaintiff received ongoing treatment including a series of different medications intended to improve his gastrointestinal condition. *See id. See also Cook v. Corizon Health, Inc.*, No. 2:18-CV-25, 2019 WL 3043906, at *14-16. (W.D. Mich. Apr. 25, 2019), report and recommendation adopted, No. 2:18-CV-25, 2019 WL 2223252 (W.D. Mich. May 23, 2019) (providing additional factual information including diagnosis for hepatitis B, not HCV). Here, Plaintiffs have not received *any* treatment intended to improve their condition. As such, *Cook* is inapplicable on the law and the facts.

Edmonds similarly falls short. That decision did not equate "monitoring" with "treatment" and it turned on a now-outdated standard of care for chronic HCV. *Edmonds v. Robbins*, 67 F. App'x 872, 873 (6th Cir. 2003). Cases like *Edmonds*, which apply an outdated standard of care, are inapplicable when determining whether Plaintiffs sufficiently alleged a constitutional violation today. *See Postawko*, 2017 WL 1968317, at *9 (distinguishing and declining to apply *Edmonds* and similar cases "because they were decided prior to the approval of

DAA drugs for HCV treatment when the only HCV treatments available were far less effective, as well as when the medical standard of care was different from the one applicable today.”).[4]

The remaining cases cited by Defendants similarly fail to provide guidance to this Court. Each case was litigated by pro se plaintiffs; was based on little, if any, evidence regarding the current standard of care for chronic HCV; and was resolved on the merits of plaintiffs’ claims at the summary judgment stage in conclusory, unpublished opinions. *See, e.g.*, *Dawson v. Archambeau*, 763 F. App’x 667, 673 (10th Cir. 2019) (noting pro se plaintiff put forth no evidence other than a verified complaint and a variety of statements in summary judgment briefing); *Black v. Alabama Dep’t of Corr.*, 578 F. App’x 794, 796 n.2 (11th Cir. 2014) (noting pro se plaintiff’s evidence was not sworn and therefore not considered); *Roy v. Lawson*, 739 F. App’x 266, 267 (5th Cir. 2018) (noting pro se plaintiff did not submit “any medical evidence” supporting his argument).[5] *See also Garner v.*

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[4] Further, in *Edmonds*, the plaintiff’s treatment decisions were based on an individualized medical determination, rather than a blanket policy. The Court found that plaintiff’s physician determined that his condition did not warrant medication under then-prevailing standards of care, and that his medical opinion was supported by physicians at a local hospital. *Edmonds*, 67 F. App’x at 872-73. By contrast, as discussed *supra*, no individualized medical determinations have been made in this case.

[5] Defendants’ district court cases are also unavailing. *See Williams v. Catoe*, No. 6:17CV627, 2018 WL 9825178, at *8 (E.D. Tex. Aug. 6, 2018) (dismissing on screening pro se complaint that failed to allege facts about the current standard of care); *Buchanon v. Mohr*, No. 2:16-CV-279, 2016 WL 4702573, at *3 (S.D. Ohio

Kennedy, 713 F.3d 237, 244 (5th Cir. 2013) (holding prior Fifth Circuit cases cited by prison officials "not controlling here," because in "both cases, the plaintiffs were pro se and there is no indication that they countered [the prison's] evidence").

By contrast, those courts that have considered, in reasoned decisions, the failure to treat chronic HCV and the current standard of care held that plaintiffs who were simply "monitored," rather than provided with DAA treatment, stated a constitutional claim based on a denial of care. *See, e.g.*, *Allah v. Thomas*, 679 F. App'x 216, 220 (3d Cir. 2017) (holding that plaintiff stated a constitutional claim when 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 with HCV stated a claim when he was "monitored" but "received no 'treatment'"); *Postawko*, 2017 WL 1968317, at *9 (holding that plaintiffs stated a claim because "Plaintiffs do not allege a mere dispute about which HCV medication they receive, but instead, they allege that they do not receive any HCV medication."); *see also Abu-Jamal*, 2017 WL 34700, at *18 ("This is not a mere disagreement with the course of care… Defendants have deliberately denied providing treatment to inmates with [HCV] and chosen a course of monitoring instead.").

Sept. 8, 2016), report and recommendation adopted, No. 2:16-CV-279, 2016 WL 5661697 (S.D. Ohio Sept. 30, 2016) (upholding motion to dismiss in pro se case and relying on an outdated policy, or a misunderstanding of a policy, that suggested treatment took four years to complete).

Defendants suggest this Court should ignore the abundance of cases addressing the modern standard of care for HCV treatment because two of those cases acknowledged that monitoring is "less efficacious" than treatment. Resp. Br. at 53 (citing *Postawko*, 2017 WL 1968317, at *7; *Abu-Jamal*, 2017 WL 34700, at *14). Defendants suggest this reasoning is "faulty." *Id.* In fact, this rationale is supported by binding precedent from this Court, which provides that the Eighth Amendment is violated when a defendant knowingly proceeds with a "less efficacious" treatment route. *See Darrah*, 865 F.3d at 373 (holding a reasonable jury could find deliberate indifference when defendant prescribed medication known to be "less efficacious" for treating plaintiff's condition); *see also McCarthy v. Place*, 313 F. App'x 810, 816 (6th Cir. 2008) (holding that doctor was deliberately indifferent when he provided plaintiff a "less efficacious treatment route").

2. The distinction between a "denial of care" and "inadequate care" is grounded in the Court's reluctance to "second guess medical judgments."*Alspaugh*, 643 F.3d at 169. Decisions that involve medical judgment, and therefore fall into the second category, include those that "weigh[] the potential health benefits that the procedure could provide against the potential side effects" or choose between equally valid forms of treatment. *See Rhinehart*, 894 F.3d at 744, 751; *see also Richmond v. Huq*, 885 F.3d 928, 943 (6th Cir. 2018) ("Officials do not act with

deliberate indifference when they choose one medically reasonable form of treatment over another.") (internal quotation marks and alteration omitted).

Here, no medical judgments were made. Defendants did not weigh the benefits of DAA therapy over any potential side effects. And they did not choose between two equally valid forms of treatment, despite Defendants' suggestions to the contrary. Instead, Defendants were presented with providing no treatment, or providing the only treatment available for chronic HCV, and they chose to provide no treatment. In doing so, they did not exercise any medical judgment but rather relied entirely on a blanket policy with strict inclusion and exclusion criteria, and did not consider the Plaintiffs' individual medical needs. Complaint, R.6, Page ID#246 ¶ 45.

Further, Defendants failed to exercise any medical judgment when they designed a policy solely around treatment cost. Complaint, R.6, Page ID#244 ¶ 31; #246 ¶ 45. Indeed, the strict criteria set in the policy guarantee that ODRC will have to treat few prisoners with chronic HCV, thus ensuring minimal expenditures.

B. Even Under The "Inadequate Care" Framework, Plaintiffs Sufficiently Alleged Deliberate Indifference.

In the alternative, even under the "inadequate care" framework, Plaintiffs sufficiently alleged a constitutional violation. A defendant may provide care that is so "woefully inadequate as to amount to no treatment at all." *Alspaugh*, 643 F.3d at

169 (internal quotation marks omitted). For example, a doctor who failed to confirm that his staff had implemented a treatment plan, and where his staff had provided pain medication and antibiotics but failed to change a wound dressing six times during a 16-day confinement, was found deliberately indifferent under this test. *Richmond*, 885 F.3d at 939-40. Here, not only have Defendants failed to implement treatment, they have not authorized treatment at all.

Defendants suggest that Plaintiffs received "some" care, in the form of periodic physical exams and blood tests, and therefore Defendants were not deliberately indifferent. Resp. Br. at 34-35. At base, Defendants ask this Court to immunize the prison doctor who, presented with a patient bleeding profusely from a neck laceration, does nothing but observes, and occasionally measures the pints of blood flowing from the patient's neck. Defendants would have this court find those measurements constitute "treatment" and that the Constitution requires nothing more. They argue there is no obligation to actually provide available, life-saving care; that simply watching a patient slowly deteriorate and die is sufficient. But that is not, and never has been, the law.

Indeed, it is "insufficient for a doctor caring for inmates to simply provide *some* treatment for the inmates' medical needs[.]" *Richmond*, 885 F.3d at 940 (emphasis added). Rather, to avoid deliberate indifference, Defendants must provide medical care "without consciously exposing the patient to an excessive

risk of serious harm." *Id.* (citation omitted). *See also Comstock*, 273 F.3d at 707 n.5 ("Defendants' position is, apparently, that if a prison doctor offers some treatment, no matter how insignificant, he cannot be found deliberately indifferent. This is not the law[.]").

Here, Defendants have consciously exposed Plaintiffs to an excessive risk of serious harm. Plaintiffs have alleged that Defendants are aware that the standard of care provides for treating *all* patients with DAA therapy, regardless of disease progression; that Defendants know that delayed treatment results in progressive and irreversible liver damage; and that Defendants know that DAA therapy is most effective when provided early in the disease's progression. Yet Defendants have consciously disregarded these excessive risks to the Plaintiffs' health by deliberately choosing not to provide them with DAA therapy — the only treatment available for chronic HCV.

Defendants' cases are not to the contrary. Both arise on a summary judgment posture, with merits decisions based on limited to no evidence put forth by pro se plaintiffs. *See Roy*, 739 F. App'x at 266 (basing decision solely on pro se plaintiff's medical records); *Black*, 578 F. App'x 794, 796 n.2 (declining to consider pro se plaintiff's unsworn evidence). Neither court had the opportunity to consider the standard of care, or that DAA therapy is the only treatment available. *See Garner*, 713 F.3d at 244 (holding prior cases cited by prison officials "not controlling

here," because in "both cases, the plaintiffs were pro se and there is no indication that they countered [the prison's] evidence"). Further, in *Roy*, the plaintiff complained that defendants deviated from the applicable treatment policy, which may indicate defendants made an individualized medical determination regarding this plaintiff's particular medical needs. *See Roy*, 739 F. App'x at 267. And in *Black*, the decision largely turned on the fact that the plaintiff failed to prove any "negative health consequences" as a result of untreated HCV. *Black*, 578 F. App'x at 796.

In contrast to these cases, here, Plaintiffs alleged detailed information about DAA treatment, the standard of care, and the detrimental effects of delaying and denying DAA treatment. They alleged that Defendants failed to exercise any medical judgment when denying them care. And, as noted previously, those courts that have considered the denial of HCV treatment in reasoned decisions, taking into consideration the current standard of care, held that plaintiffs who were denied DAA therapy stated a constitutional claim. *See, e.g.*, *Allah*, 679 F. App'x at 220; *Lovelace*, 2019 WL 3728265, at *4; *Postawko*, 2017 WL 1968317, at *7; *see also Gordon v. Schilling*, 937 F.3d 348, 359 (4th Cir. 2019) ("[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 provide HCV treatment violates the Eighth Amendment and granting plaintiffs summary judgment).

III. Plaintiffs Sufficiently Alleged Claims Against Defendants Eddy And The GCIHCA.

Plaintiffs have valid claims against Defendant Andrew Eddy in his individual capacity, as well as for injunctive relief in his supervisory capacity. They have also articulated claims against the Grafton Correctional Institution Health Care Administrator ("GCIHCA") in a supervisory capacity for injunctive relief.

Little substantive dispute remains here. Defendants concede that the district court was wrong to dismiss Plaintiffs' claims against Defendant Eddy on the basis that those claims rest on *respondeat superior*. Resp. Br. at 45. Plaintiffs agree. Eddy's alleged role in promulgating and implementing the offending policies, upon which his signature appears, is sufficient to support direct claims against him in both his official and individual capacities. *See* Complaint, R.6, Page ID#247 ¶ 48; *id.* Ex. L, R.6, Page ID#370; *id.* Ex. M, R.6, Page ID#381. Moreover, his knowledge and acquiescence to his subordinates' routine failures to provide medical treatment gives rise to a claim for supervisory liability. He need not have "physically put his hands on" Plaintiffs or "even physically been present" at the

time; the causal connection between his knowing acquiescence and Plaintiffs' injuries is enough. *Peatross v. City of Memphis*, 818 F.3d 233, 242 (6th Cir. 2016).

Defendants also do not contest that where Plaintiffs have alleged official-capacity claims for injunctive relief against both Eddy and the GCIHCA, *respondeat superior* cannot apply conceptually, as the action is "equivalent to a suit against the entity on whose behalf [the employees] act." *Knott v. Sullivan*, 418 F.3d 561, 574-75 (6th Cir. 2005) (internal citation omitted). Defendants are wrong, however, in attempting to limit the GCIHCA's role to that of passive supervisor. Collectively with Eddy, the GCIHCA is alleged to be "directly and proximately responsible" for denial of HCV treatment to Plaintiffs, including by direct involvement in denying their requests for treatment. *See* Complaint, R.6, Page ID#247 ¶¶ 48, 51; Complaint Ex. S, R.6, Page ID#423 (GCIHCA denying treatment request). Again, the combination of direct action and knowing acquiescence suffices to state a claim. *Peatross*, 818 F.3d at 241-42.

IV. Defendants' Qualified Immunity Defense Fails On Both Procedural And Substantive Grounds.

Defendants assert qualified immunity on appeal, for the first time in this case. Resp. Br. at 40. That defense has been waived. As Defendants concede, they "failed below to seek dismissal based on qualified immunity." Resp. Br. at 42. No exception to the waiver rule is warranted. In the alternative, the defense must be

rejected: Defendants violated clearly established law when they denied medical treatment for Plaintiffs' serious medical needs.

A. Defendants Failed To Assert Qualified Immunity Before The District Court And Therefore Waived It.

Arguments not made before the district court are generally waived on appeal. *Scottsdale Ins. Co. v. Flowers*, 513 F.3d 546, 552 (6th Cir. 2008). This is true even when "both parties briefed *this* court on the issue[.]" *Armstrong v. City of Melvindale*, 432 F.3d 695, 699-700 (6th Cir. 2006) (emphasis in original). And though the Court has at times acknowledged its "discretion" to entertain novel questions on appeal in "exceptional" circumstances, it has "rarely exercised such discretion." *Scottsdale Ins. Co.*, 513 F.3d at 552 (collecting cases). Instead, the inquiry is "generally focused on whether the issue was properly raised before the district court." *Id.* at 553.[6]

Here, Defendants and interested party State of Ohio submitted no fewer than seven briefs supporting dismissal below, yet failed to raise qualified immunity once. Resp. Br. at 42. This Court has declined to consider qualified immunity on appeal even when defendants have done far more to avoid waiver than the Defendants here. For example, waiver has applied where, despite raising qualified

[6] Even in *Harris v. Klare*, cited by Defendants for the proposition that waiver is not absolute, the Court did not grant a waiver. 902 F.3d 630, 635-36 (6th Cir. 2018). Instead, it found that the argument below was sufficient to provide notice of the issue. *Id.*

immunity in their answer and responsive pleadings, defendants failed to brief it in subsequent stages. *Brown v. Crowley*, 312 F.3d 782, 787-88 (6th Cir. 2002) (applying waiver to "encourage future defendants to properly raise this defense at the district court level"). *See also Summe v. Kenton Cty. Clerk's Office*, 604 F.3d 257, 269-70 (6th Cir. 2010) (declining to consider qualified immunity on appeal when defendant raised it in his answer but failed to brief it).

B. The Right To Medical Treatment For A Serious Medical Need Is Clearly Established.

In the alternative, Defendants' qualified immunity defense fails on the merits. When considering qualified immunity, courts must determine (1) whether the plaintiff has alleged a constitutional violation, and (2) whether the constitutional right was "clearly established." *Stoudemire v. Mich. Dep't of Corr.*, 705 F.3d 560, 567 (6th Cir. 2013) (citing *Pearson v. Callahan*, 555 U.S. 223, 232 (2009)).

1. Plaintiffs have sufficiently alleged that Defendants were deliberately indifferent to their serious medical needs when they denied treatment for Plaintiffs' chronic HCV. *See* Pls. Br. at 32-43; *supra* Section I, II.

2. To demonstrate that a right is clearly established, the "contours of the right must be sufficiently clear that a reasonable official would understand what he is doing violates that right." *Stoudemire*, 705 F.3d at 568 (internal quotation marks and citation omitted). But "[t]his does not mean that an official action is protected

by qualified immunity unless the very action in question has previously been held unlawful." *Id.* (internal quotation marks omitted). "Rather, it means that in light of pre-existing law the unlawfulness must be apparent." *Id.* (internal quotation marks omitted).

Decisions of the Supreme Court, this Court, and other circuits can inform whether a right is clearly established. *See Ciminillo v. Streicher*, 434 F.3d 461, 468 (6th Cir. 2006). At times, this Court has relied solely on out-of-circuit persuasive authority to determine a right is clearly established for qualified immunity purposes. *See, e.g.*, *Stoudemire*, 705 F.3d at 575 (relying on a single case from the 10th Circuit to determine right was clearly established).

This Court provides plaintiffs with "two paths" for demonstrating a constitutional right is clearly established: (1) "where the violation was sufficiently obvious under the general standards of constitutional care that the plaintiff need not show a body of materially similar case law," and (2) "where the violation is shown by the failure to adhere to a particularized body of precedent that squarely governs the case here." *Id.* at 568 (internal quotation marks and citations omitted).

This Court typically follows the first path in Eighth Amendment cases.[7] For example, the Court denied qualified immunity for officers' failure to provide

[7] This Court's second "path" appears to lend itself primarily to Fourth Amendment excessive force, search, and seizure cases, where officers are often "forced to make split-second judgments." *City & Cty. of San Francisco, Calif. v. Sheehan*, 135 S.

appropriate medical care to a prisoner with severe burns because "[t]he proposition that deliberate indifference to a prisoner's serious medical needs can amount to a constitutional violation has been well-settled since *Estelle* in 1976." *Richmond*, 885 F.3d at 947 (internal quotation marks omitted). *See, e.g.*, *Bays v. Montmorency Cty.*, 874 F.3d 264, 269 (6th Cir. 2017) ("The Supreme Court has long recognized that inmates have the right to reasonable medical care under the Eighth and Fourteenth Amendment."); *Darrah*, 865 F.3d at 374 (same).

Similarly, the Court denied qualified immunity to a corrections officer who subjected a prisoner to a "rough ride" during transport. *Scott v. Becher*, 736 F. App'x 130, 134 (6th Cir. 2018) (also denying qualified immunity to nurse who provided only ibuprofen to treat a serious back injury). The Court denied qualified immunity in "light of the obviousness of the constitutional violation," holding that even though many courts "have not addressed the specific reckless use of a vehicle to harm an inmate, there is a clear consensus among the circuits that the Eighth

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Ct. 1765, 1775 (2015). Indeed, specificity in prior precedent is "especially important in the Fourth Amendment context, where the Court has recognized that it is sometimes difficult for an officer to determine how the relevant legal doctrine…will apply to the factual situation the officer confronts." *City of Escondido, Cal. v. Emmons*, 139 S. Ct. 500, 503 (2019) (citation omitted). But Fourth Amendment cases are materially different from institutional medical care cases, including this one. Here, Defendants were not required to make split-second decisions, but deliberately created and maintained an HCV treatment policy that they knew did not meet the medical standard of care. They then considered and denied Plaintiffs' requests for medical care, based not on individualized medical judgments, but on this policy.

Amendment protects against the malicious and sadistic infliction of pain and suffering in a diverse range of factual scenarios." *Scott*, 736 F. App'x at 133-34 (internal quotation marks and alterations omitted).

Defendants would have this Court take the opposite approach here. In Defendants' view, in order to survive qualified immunity, Plaintiffs would need to show that denial of the exact same treatment, at the exact same stage, for the exact same disease has previously been ruled unconstitutional. *See* Resp. Brief at 31. But "it defeats the purpose of § 1983 to define the right too narrowly (as the right to be free of needless assaults by left-handed police officers during Tuesday siestas)." *Hagans v. Franklin Cty. Sheriff's Office*, 695 F.3d 505, 509 (6th Cir. 2012). *See Hope v. Pelzer*, 536 U.S. 730, 739 (2002) (holding, in Eighth Amendment prison case, that "officials can still be on notice that their conduct violates established law even in novel factual circumstances").

To apply Defendants' approach would be to disregard the nature of medicine and the constitutional right to medical care — that is, a science that evolves over time with a corresponding right grounded in "evolving standards" of care. It cannot be the law that every medication or treatment, no matter how well-established, must be the focal point of appellate litigation at least once before its use can be "clearly established" as a constitutional requirement.

Even if considering the second path, it is clearly established by a "clear consensus" of caselaw that Plaintiffs have a constitutional right to treatment for chronic HCV. *See, e.g.*, *Abu-Jamal v. Kerestes*, 779 F. App'x 893, 900 (3d Cir. 2019) (denying qualified immunity to officials who failed to provide HCV treatment, as "it was clearly established that denying particular treatment to an inmate who indisputably warranted that treatment for nonmedical reasons would violate the Eighth Amendment"); *Roe*, 631 F.3d at 860 (same, holding "we have no difficulty in concluding that the right to adequate medical care…was clearly established at all times during the relevant actions in this case."). *Cf. Darrah*, 865 F.3d at 374 ("[I]t was 'clearly established' in 2011…that neglecting to provide a prisoner with needed medication, choosing to prescribe an arguably less efficacious treatment method, and continuing on a treatment path that was clearly ineffective could constitute a constitutional violation.").

Defendants' cited cases are not to the contrary. *Cook v. Corizon Health* is not a case about HCV treatment at all, but rather gastrointestinal ailments and diagnosis with hepatitis B. *Cook.*, No. 19-1660, slip. op. at 1; *see also Cook*, 2019 WL 3043906, at *14-16 (discussing facts in more detail). And *Hix* and *Edmonds* do not stand for the proposition that there is no constitutional right to chronic HCV treatment. Neither case challenged the application of a blanket policy. Rather, both examined the individual treatment decisions made for each plaintiff and

determined, based on a now-outdated standard of care, that the plaintiffs had not established more than a difference in opinion. *See Hix v. Tennessee Dep't of Corr.*, 196 F. App'x 350, 356–57 (6th Cir. 2006); *Edmonds*, 67 F. App'x at 873 .

It is also clearly established that denial of treatment based on a blanket policy rather than individualized medical determinations violates the Eighth Amendment. *See, e.g.*, *Roe*, 631 F.3d at 860 ("This basic legal obligation to provide care adequate to a particular inmate's medical circumstances should have been clear to reasonable physicians with the responsibility for creating inmate healthcare policy[.]"); *Colwell*, 763 F.3d at 1063 ("[B]lanket, categorical denial of medically indicated [treatment] solely on the basis of an administrative policy…is the paradigm of deliberate indifference.").

And finally, it is clearly established that denial of medical care based on non-medical reasons, such as cost, is a constitutional violation. *See, e.g.*, *Blackmore*, 390 F.3d at 899 (holding that prison officials who "delay medical treatment of that condition for non-medical reasons" are deliberately indifferent); *Darrah*, 865 F.3d at 372-73 (holding that reliance on cost when providing less effective medical care could constitute deliberate indifference); *Roe*, 631 F.3d at 863 ("[T]he Constitution is violated when [administrative convenience and cost] are considered *to the exclusion of reasonable medical judgment* about inmate health.") (emphasis in original); *Allah*, 679 F. App'x at 220 (same).

V. Plaintiffs' Claims For Injunctive Relief Are Not Moot.

Plaintiffs brought this case pro se as a putative class action. They sought declaratory and injunctive relief, as well as damages, for a class of Ohio prisoners who have been diagnosed with HCV and have either been unsuccessfully treated with obsolete medications and refused DAA therapy, or refused treatment entirely. *See* Complaint, R.6, Page ID#249; Mot for Class Cert, R.5, Page ID#234. Plaintiffs challenged Defendants' denial of treatment to them individually, as well as Defendants' deficient policy governing the provision of treatment for all ODRC patients with HCV. Complaint, R.6, Page ID#246 ¶ 45.

Plaintiffs filed a Motion for Class Certification simultaneously with their Complaint. *See* Mot for Class Cert, Page ID #233-37. The magistrate judge recommended that the class certification motion be denied without prejudice given Defendants' pending motions to dismiss, but recommended that Plaintiffs re-file it upon resolution of the other motions. *See* R&R, R.45, Page ID#632. The district court subsequently adopted this recommendation. Order, R.52, Page ID#680-81.

After the district court granted Defendants' motions to dismiss, Plaintiffs appealed that decision to this Court. Plaintiffs, now proceeding with counsel, filed their opening brief on January 22, 2020. Two days later, on January 24, Defendants informed each Plaintiff that he would soon be provided with HCV treatment. According to Defendants' brief, each Plaintiff was formally approved for treatment

between February 12 and February 25. *See* Resp. Br. at 22. Treatment commenced for each Plaintiff by March 6. *See* Resp. Br. at 23.

Defendants assert that the provision of treatment moots Plaintiffs' request for injunctive relief. Resp. Br. at 23.[8] But this is not so. It is settled law that a "defendant's voluntary cessation of allegedly unlawful conduct ordinarily does not suffice to moot a case." *Friends of the Earth, Inc. v. Laidlaw Environmental Services, Inc.*, 528 U.S. 167, 174 (2000). Further, the mootness doctrine is "flexible" when class actions are involved. *Wilson v. Gordon*, 822 F.3d 934, 942 (6th Cir. 2016) (quoting *U.S. Parole Comm'n v. Geraghty*, 445 U.S. 388, 400 (1980)). And this Court has recognized exceptions to the general rule that dismissal of injunctive claims may be required when a named plaintiff's individual claim becomes moot before class certification. *See Unan v. Lyon*, 853 F.3d 279, 285 (6th Cir. 2017). In particular, the "picking off" and the "inherently transitory" exceptions apply here.

1. The "picking off" exception was "developed to prevent defendants from strategically avoiding litigation by settling or buying off individual named

[8] Defendants also note, in passing, that their HCV treatment policy has since been "altered" since Plaintiffs' Complaint. Resp. Br. at 15. But the updated policy is not in the record, and there is no indication that any alterations have cured the policy's problems. To the contrary, Defendants suggest that "much" of the prior policy "remains true under the new protocol." *Id.* Whether or not these alterations have remedied the constitutional infirmities identified by Plaintiffs is a factual question to be determined by the district court on remand.

plaintiffs in a way that would be contrary to sound judicial administration." *Id.* (internal quotation marks omitted). It is recognized both when a class certification motion has been denied and when it is still pending, as "the defendant is on notice that the named plaintiff wishes to proceed as a class, and the concern that the defendant therefore might strategically seek to avoid that possibility exists." *Wilson*, 822 F.3d at 947. Here, Defendants have been on notice since this case commenced that Plaintiffs wished to proceed as a class, and it was clear that Plaintiffs would have another opportunity to move for class certification following this appeal. Defendants' abrupt decision to provide Plaintiffs HCV treatment, two days after the opening brief in this appeal, indicates they are "strategically seek[ing] to avoid" a class action from proceeding. *See id.*

This Court looks to two factors when determining if the "picking off" exception applies: the timing of the relief provided to the plaintiffs and the method of relief. *See Unan,* 853. F.3d at 286; *Wilson*, 822 F.3d at 950-51. The timing here is "suspect." *Unan*, 853 F.3d at 286. In *Unan*, the named plaintiffs' individual claims were not resolved until after the lawsuit and motion for class certification were filed, despite the defendant being on notice of systemic concerns nearly five months earlier. *Id.* Similarly here, the Plaintiffs were not approved for treatment until after a lawsuit and motion for class certification were filed, and after Plaintiffs obtained counsel and the opening brief was filed in this appeal. This is

despite the fact that Plaintiffs first sought treatment in mid-2018, and at the time put Defendants on notice of the systemic problems with Defendants' HCV policy. Complaint, R.6, Page ID#244 ¶¶ 30-31; Page ID#245 ¶ 36-37; Complaint Ex. T, R.6, Page ID#424. *See also Wilson*, 822 F.3d at 950. Indeed, "[t]he exact timing of when these claims were mooted supports a finding that defendant[s were] strategically seeking to avoid litigation by selectively resolving the claims" of the Plaintiffs. *Unan*, 853 F.3d at 286.

The method of the relief here is also suspect. In *Unan* and *Wilson*, the Court applied the picking off exception because defendants could not demonstrate that plaintiffs' claims were mooted through "an established, standardized procedure." *Unan*, 853 F.3d at 286. Rather, the defendants "created a new ad hoc process and mooted the individual named plaintiffs' claims on a cases by case basis[.]" *Id.* (citing *Wilson*, 822 F.3d at 951). Here, Plaintiffs challenge the blanket policy that categorically denies patients even consideration for HCV treatment until serious and irreversible liver damage has occurred. Complaint, R.6, Page ID#246 ¶ 45. Defendants' sudden reversal appears to be not the result of systemic reform to that policy, but rather the result of an "ad hoc process" designed to moot the Plaintiffs' injunctive claims on a case-by-case basis. *See Unan*, 853 F.3d at 286; *Wilson*, 822 F.3d at 950. The "picking off" exception therefore applies here.

2. The "inherently transitory" exception applies if (1) the injury is "so transitory that it would likely evade review by becoming moot before the district court can rule on class certification[;]" and (2) it is clear that "other class members are suffering the same injury." *Unan*, 853 F.3d at 287 (quoting *Wilson*, 822 F.3d at 945). Courts have "focused on uncertainty about how long a claim will remain live, and the defendant's ability to quickly render a claim moot, in holding that this exception applies." *Wilson*, 822 F.3d at 946. And, notably, to meet the "inherently transitory" exception, courts do not require that the named plaintiffs demonstrate they will personally be subject to the same practice again. *See id.* at 944. Rather, courts require only that other class members may suffer the same injury. *Id.* at 945.

Here, like in *Unan* and *Wilson*, because Plaintiffs' ability to access medical care for their chronic HCV rests entirely on Defendants' discretionary action, there was no way of knowing how long their claims for injunctive relief would remain live. *See Unan*, 853 F.3d at 287 ("Where a state may quickly and unilaterally grant relief to an individual once litigation begins, we have found that a claim may be transitory[.]"). Further, the problem being challenged is systemic — in this case, a deficient policy applicable to all patients with HCV — and therefore other putative class members still subject to the policy continue to "suffer the same injury." *Wilson*, 822 F.3d at 945 (holding "inherently transitory" exception applied where the defendant could moot plaintiffs' claims before the district court could rule on

class certification). The "inherently transitory" exception therefore applies to this case as well.[9] Indeed, "refusal to consider a class-wide remedy merely because individual class members no longer need relief would mean that no remedy could ever be provided for continuing abuses." *Id.* at 951 (quoting *Blankenship v. Sec'y of HEW*, 587 F.2d 329, 333 (6th Cir. 1978)).

CONCLUSION

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

[9] Should this Court determine there is insufficient evidence to make a ruling on the question of mootness—given the timing of Defendants' actions, and the parties' inability to present evidence and brief this issue before the district court—the Court should remand on the question of mootness to allow the district court to "have the opportunity to make an evidentiary finding in the first instance." *Wilson*, 822 F.3d at 951.

Dated: May 22, 2020

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

1. The Court granted Plaintiffs-Appellants' motion for leave to file an oversized brief on May 21, 2020, allowing a maximum length of 8,500 words. *See* Order, ECF No. 29-1; Motion, ECF No. 28. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B), as amended by the Court's May 21 Order, because it contains 8,467 words, excluding the parts of the document exempted by Fed. R. App. P. 32(f) and 6th Cir. R. 32(b)(1).

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: May 22, 2020

<u>/s/ Jennifer Wedekind</u>
Jennifer Wedekind

CERTIFICATE OF SERVICE

I hereby certify that on May 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
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