In the

United States Court of Appeals

for the Seventh Circuit

No. 20-2414

FELITA MCGEE, Independent Administrator of the Estate of Michael Carter, Sr., Deceased, and as next of kin,

Plaintiff-Appellee,

v.

LARRY PARSANO, et al.,

Defendants-Appellants.

Appeal from the United States District Court
for the Central District of Illinois.
No. 16-CV-2221 — **Colin S. Bruce**, *Judge.*

ARGUED JANUARY 21, 2021 — DECIDED DECEMBER 15, 2022

Before SYKES, *Chief Judge*, and MANION and ST. EVE, *Circuit Judges*.

SYKES, *Chief Judge*. Five days after Michael Carter, Sr., was booked into the Macon County Jail, he tragically died of diabetic ketoacidosis—a serious complication of diabetes. In

the hours preceding his death, Carter exhibited symptoms commonly associated with diabetic ketoacidosis: confusion, lethargy, and labored breathing. But he was denied timely medical care because the jail nurse thought he was faking his condition. She assured the corrections officers tasked with transferring Carter out of the medical unit that his vitals were within a normal range. Relying on the nurse's medical judgment, the officers declined to intervene and proceeded to relocate Carter, believing that his failure to follow orders stemmed from deliberate refusal, not medically induced incapacity.

Following Carter's death, Felita McGee, the administrator of his estate, sued the Macon County Sheriff's Department and the medical and corrections staff who attended to him before he died. She filed numerous claims under 42 U.S.C. § 1983, including one against the five corrections officers. This appeal concerns only whether those officers are entitled to qualified immunity. The district judge denied the officers' motions for summary judgment on that issue, finding there to be a material factual dispute over whether they had reason to know that Carter was receiving inadequate medical care and thus had a duty to intervene. *McGee v. Macon Cnty. Sheriff's Dep't*, 473 F. Supp. 3d 818, 839 (C.D. Ill. 2020). We reverse. Established circuit precedent entitles a corrections officer to defer to the judgment of medical professionals. *See, e.g.*, *King v. Kramer*, 680 F.3d 1013 (7th Cir. 2013). Because that is what the officers did here, they are entitled to qualified immunity.

I. Background

As the summary-judgment standard requires, we recount the facts in the light most favorable to McGee as the non-

moving party. After Michael Carter, Sr., was charged with attempted cocaine distribution, a warrant was issued for his arrest. On July 13, 2015, officers arrested Carter and booked him into the Macon County Jail. Carter's intake form indicated that he was diabetic and used insulin. A medical-administration record completed the same day noted that Carter had been prescribed two medications to manage his Type 2 diabetes: Metformin and Glyburide.

Over the next few days, Carter intermittently received Metformin but never Glyburide. Then on July 16 he submitted a sick-call request stating that he felt exhausted and had been vomiting. Nurse Edna Morgan responded to Carter's request and administered Zofran, an anti-nausea medication. The next day a call from Carter's worried mother prompted Nurse Ashley Mattingly to also examine Carter. She observed that he was experiencing tachycardia and low blood pressure, so she moved him into the medical unit for a 23-hour observation.

That evening Dr. Robert Braco briefly examined Carter in the medical unit. Dr. Braco mistakenly believed that Carter had been experiencing only respiratory symptoms. So while he gave Carter two medications to alleviate his coughing and anxiety, he did nothing to address his diabetes.

Carter remained in the medical unit overnight. Early in the morning of July 18, Nurse Jo Bates informed Corporal Randall West that Carter was ready to leave the medical unit and return to general population. West instructed Officer Larry Parsano to relay this news to Carter. But when Parsano arrived at Carter's medical cell shortly after 9 a.m., Carter neither looked at nor responded to him. Parsano soon requested the assistance of other officers.

The disturbing events that followed were captured on the jail's surveillance camera. But because the video lacks audio, our account of the dialogue comes from the parties' summary-judgment filings. A few minutes after Officer Parsano requested assistance, Corporal West arrived at Carter's medical cell and learned that Carter was not responding to orders. He was sitting near the shower, leaning against the wall and the toilet. Though Carter's medical condition at this time is unclear, Nurse Bates remarked that his vital readings were better than her own and that he was "faking" an illness. However, West did not observe Bates check Carter's vitals. She instead used smelling salts to determine whether Carter was "playing possum"—or in her words, "playing like [he was] dead." Carter responded to the smelling salts by slightly moving his head, but he did not follow Corporal West's order to stand.

Officer Joshua Page then arrived. Page had been assigned to meal duties the morning of July 18, so he knew Carter was diabetic. He also thought Carter appeared sick, in part because his breathing was labored. But Nurse Bates told Page that Carter was "faking" an illness. According to Officer Page, it was not uncommon for inmates at the jail to fake symptoms of an illness.

The video next shows Corporal West kicking Carter several times with varying degrees of force. He also stood on Carter's hand while twisting his foot back and forth. Believing that Carter was refusing to comply with his orders, West decided to move Carter to "deadlock"—the disciplinary portion of the jail.

Corporal Michael Patton and Officer Terry Collins then joined the group of jail staff, though Patton stood outside

Carter's cell. Patton recalls Nurse Bates telling him that Carter's vitals were within a normal range, so he figured that Carter was likely faking his symptoms. Bates similarly told Officer Collins upon his arrival that she had taken Carter's vitals and that he was fine. But again, the video never shows Bates performing any vital checks. Collins observed that Carter appeared lethargic, like he was drunk. And both Page and Collins noticed red Kool-Aid powder throughout Carter's cell and on his hands and feet.

Around 9:15 a.m. Nurse Bates entered Carter's cell with a pulse oximeter. Because she was unable to secure it to his finger, she left without obtaining a reading. Then Officer Parsano, who had positioned himself behind Carter, applied a pressure-point technique designed to encourage Carter to stand. This proved unsuccessful, so together Parsano and Collins dragged Carter to the door of his cell.

Once the officers had positioned Carter near the door, Nurse Bates spent about two minutes tending to him. Officer Page noticed Carter was cool to the touch, so he asked Bates to check Carter's oxygen levels. The video shows Bates doing so. But beyond that, not much is clear—several officers gathered around Carter, making it difficult to identify from the video which tests she performed. McGee contends that Nurse Bates never checked Carter's blood pressure or other vital signs. Because the video does not clearly contradict her contention and because we must construe the facts in her favor, we adopt this interpretation as our own.

Shortly before 9:25 a.m. the officers lifted Carter into a wheelchair and transported him to deadlock. Officer Brandon Wallar, the corrections officer assigned to deadlock on July 18, noticed that Carter appeared sick; he was inco-

herent and pale. He recommended that Carter be taken back to the medical unit. Officer Page likewise felt that Carter should have remained in the medical unit. But the transporting officers opted to leave Carter in deadlock.

The jail's deadlock unit lacks continuous surveillance, so our description of the remaining events comes solely from the parties' summary-judgment filings. After Carter had been moved to deadlock, Officer Parsano returned to Carter's medical-unit cell to clean and prepare it for another inmate. While cleaning, Parsano found two uneaten trays of food, both marked "D" for diabetic. Figuring that Carter was diabetic—a fact he had not previously known—Parsano told Officer Collins to have Nurse Bates check Carter for low blood sugar. Collins located Bates and told her about the discovery of the untouched trays. When he asked her to check Carter's blood-glucose level, she remarked, "[I]f you want me to, I guess I can."

Officers Collins and Page accompanied Nurse Bates to Carter's deadlock cell and watched her check Carter's vitals and conduct a finger-prick blood-glucose test. Carter's blood-glucose level exceeded the glucometer's maximum reading of 500 milligrams per deciliter. Diabetic ketoacidosis, a process where acid accumulates in the bloodstream, is associated with levels above 300.[1] But neither Collins nor Page understood the reading's significance, and Nurse Bates did not appear alarmed.

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[1] *Diabetic ketoacidosis*, MAYO CLINIC, https://www.mayoclinic.org/diseases-conditions/diabetic-ketoacidosis/symptoms-causes/syc-20371551 (last visited Dec. 15, 2022) (advising an individual to seek emergency care if his blood-sugar level exceeds 300 milligrams per deciliter for more than one test).

Bates then located Corporal West and stated that she wanted to give Carter a shot. West understood this to mean that Bates wanted to administer an insulin injection. So around 10:15 a.m. West escorted Nurse Bates back to Carter's cell and watched her give the injection. Bates told West that Carter's symptoms should improve within about ten minutes and that she would check on him in an hour.

About a half-hour after Carter received his insulin injection, his lawyer arrived at the jail and asked to meet with him. Officer Page went to retrieve Carter from his cell. At that time Page learned from Corporal West that Nurse Bates had given Carter a medication. When Officer Page asked Carter whether he wanted to see his lawyer, Carter nodded in agreement. Because Carter had previously removed his jail uniform, he began trying to dress himself. For the next few minutes, he struggled to put his pants on. He ultimately gave up, and jail staff informed his lawyer that Carter was unable to meet with him.

Around 11:15 a.m. Officer Page and Corporal Ronke Austin—the command officer in charge on July 18—accompanied Nurse Bates back to Carter's cell for another blood-glucose test. His blood-glucose level still exceeded 500 milligrams per deciliter. Austin—who is diabetic—recognized the reading as dangerously high. According to Corporal Austin, Carter looked "like he was in a daze." Austin expressed her concern to Nurse Bates, who then contacted Dr. Braco. After doing so, Bates assured Austin that Dr. Braco would "see [Carter] when he [came] in at three." But because Corporal Austin interjected that Carter would die by then, Bates agreed to send Carter to the hospital by squad car.

Corporal Austin summoned several officers, including Officer Page and Corporal Patton, to locate a wheelchair for Carter. As Page approached Carter's cell, he noticed that Carter was leaning against the wall and had drool running down his chest. While Officer Page ran to obtain the automated external defibrillator, Corporal Patton grabbed Carter's wrist to check his pulse. Unable to find one, the officers delivered a shock with the defibrillator and performed CPR. Carter was pronounced dead upon his arrival at the hospital.

Felita McGee, the administrator of Carter's estate, sued the Macon County Sheriff's Department, Decatur Memorial Hospital, Dr. Braco, Nurse Bates, and five of the corrections officers who encountered Carter on the morning of his death: West, Parsano, Collins, Patton, and Page. Though McGee filed a host of state and constitutional claims, only the § 1983 claim against the corrections officers is relevant to this appeal. McGee alleges that the officers deprived Carter of his Fourteenth Amendment due-process right to adequate medical care as a pretrial detainee. The officers moved for summary judgment on qualified-immunity grounds, but the district judge ruled against them. He concluded that a material factual dispute existed as to whether the officers had reason to know that the medical staff was failing to provide adequate care. The officers appealed.

II. Discussion

The Fourteenth Amendment's Due Process Clause governs McGee's medical-care claim because Carter was arrested on a warrant and remained in custody at the Macon County Jail as a pretrial detainee. *Kingsley v. Hendrickson*, 576 U.S. 389, 400 (2015); *Miranda v. County of Lake*, 900 F.3d

335, 350 (7th Cir. 2018); *Pulera v. Sarzant*, 966 F.3d 540, 549 (7th Cir. 2020) ("Before a finding of probable cause, the Fourth Amendment protects an arrestee; after such a finding, the Fourteenth Amendment protects a pretrial detainee."). So the standard that applies to McGee's claim differs from that which governs the claims of convicted prisoners under the Eighth Amendment. In *Kingsley* the Supreme Court specifically advised courts to heed the important distinctions between the Eighth Amendment's Cruel and Unusual Punishment Clause and the Fourteenth Amendment's Due Process Clause. Under the Due Process Clause, the appropriate standard is "solely an objective one." *Kingsley*, 576 U.S. at 397.

Kingsley involved an excessive-force claim brought by a pretrial detainee, but in *Miranda*, 900 F.3d at 350–52, we extended its logic to a detainee's medical-care claim. Applying *Kingsley*, we concluded that a pretrial detainee must prove only that the defendant's challenged conduct was *objectively* unreasonable; he need not also demonstrate, as the Eighth Amendment requires, that the defendant was *subjectively* aware that his conduct was unreasonable. *Id.* at 352. The objective-reasonableness standard requires that we "focus on the totality of facts and circumstances" in the case and "gauge objectively—without regard to any subjective belief held by the individual—whether the response was reasonable." *McCann v. Ogle County*, 909 F.3d 881, 886 (7th Cir. 2018).

Although pretrial detainees have a right under the Fourteenth Amendment to adequate medical care, we have "long recognized" that correctional institutions typically "engage in the division of labor" between medical profes-

sionals and other security and administrative staff. *Miranda*, 900 F.3d at 343. "When detainees are under the care of medical experts, non-medical jail staff may generally trust the professionals to provide appropriate medical attention." *Id.* So "the law encourages non-medical security and administrative personnel at jails and prisons to defer to the professional medical judgments of the physicians and nurses … without fear of liability for doing so." *Berry v. Peterman*, 604 F.3d 435, 440 (7th Cir. 2010). An exception exists only if a jail official "had reason to know that the[] medical staff w[as] failing to treat or inadequately treating an inmate." *Miranda*, 900 F.3d at 343.

But even if that exception applies, the doctrine of qualified immunity may still shield a jail official from damages liability. Rooted in the idea of fair notice, qualified immunity "protects 'all but the plainly incompetent or those who knowingly violate the law.'" *Mullenix v. Luna*, 577 U.S. 7, 12 (2015) (quoting *Malley v. Briggs*, 475 U.S. 335, 341 (1986)). According to the Supreme Court, the doctrine strikes the proper balance between the significant costs of personal suits for damages and the need for a remedy against those who abuse their power. *Harlow v. Fitzgerald*, 457 U.S. 800, 814 (1982). It therefore attaches unless (1) a government official "violated a federal statutory or constitutional right, and (2) the unlawfulness of [his] conduct was clearly established at the time." *District of Columbia v. Wesby*, 138 S. Ct. 577, 589 (2018) (quotation marks omitted).

We review a denial of summary judgment on qualified-immunity grounds de novo and ask "whether viewing the facts in the light most favorable to the plaintiff," the government official is entitled to qualified immunity. *Howell v.*

Smith, 853 F.3d 892, 897 (7th Cir. 2017). Before applying that standard to this case, we must assess a threshold jurisdictional question.

A. Appellate Jurisdiction

McGee argues that we lack jurisdiction to hear the officers' interlocutory appeal. While a pretrial order denying summary judgment usually is not an appealable "final decision" under 28 U.S.C. § 1291, it is well settled that an order denying qualified immunity is immediately appealable under § 1291 and the collateral-order doctrine. *Mitchell v. Forsyth*, 472 U.S. 511, 527–30 (1985). This is so because "[q]ualified immunity is 'an immunity from suit rather than a mere defense to liability.'" *Plumhoff v. Rickard*, 572 U.S. 765, 771–72 (2014) (quoting *Pearson v. Callahan*, 555 U.S. 223, 231 (2009)). Absent an interlocutory appeal, a pretrial order denying qualified immunity is effectively unreviewable: By the time the trial court enters its final order, "the immunity from standing trial will have been irretrievably lost." *Id.* at 772.

In *Johnson v. Jones*, 515 U.S. 304 (1995), the Supreme Court announced a narrow exception to immediate appealability. *Johnson* involved a claim of excessive force under the Fourth Amendment. The plaintiff sued five police officers, alleging that they had beaten him and caused him to suffer several broken ribs. *Id.* at 307. Three officers moved for summary judgment, asserting that the plaintiff lacked evidence that they had participated in the beating. *Id.* But the judge denied their motion because the parties' deposition testimony raised a genuine factual issue over whether the three officers had been involved. *Id.* at 308. Though the officers appealed the judge's order, the Supreme Court held that it was not imme-

diately appealable because it "raised a genuine issue of fact concerning [the officers'] involvement in the alleged beating." *Id.* at 313. A defendant otherwise "entitled to invoke a qualified immunity defense[] may not appeal a district court's summary judgment order insofar as that order determines whether or not the pretrial record sets forth a 'genuine' issue of fact for trial." *Id.* at 319–20.

The Court has since clarified the exceedingly limited scope of *Johnson*'s holding, cabining it to pretrial orders that determine only "a question of 'eviden[tiary] sufficiency,' *i.e.*, which facts a party may, or may not, be able to prove at trial." *Plumhoff*, 572 U.S. at 772 (quoting *Johnson*, 515 U.S. at 313). Such orders do not determine an officer's entitlement to qualified immunity; they are merely "garden-variety summary-judgment ruling[s] about whether the evidentiary record shows a merits-related factual dispute for trial." *Smith v. Finkley*, 10 F.4th 725, 751 (7th Cir. 2021) (Sykes, J., dissenting). They are therefore not "final decisions" under § 1291 and not immediately appealable. But when a case raises a pure question of law—like, for example, whether a defendant's conduct violated clearly established law—we may exercise our appellate jurisdiction. *Plumhoff*, 572 U.S. at 773. Indeed, "deciding legal issues of this sort" is one of our "core responsibilit[ies]." *Id.*

Still, "[t]he line between a non-appealable factual dispute and an appealable abstract legal question is not always clear." *Smith*, 10 F.4th at 735. "[A] great number of orders denying qualified immunity at the pretrial stage are linked closely to the merits of the plaintiff's claim." *Id.* (quoting *Jones v. Clark*, 630 F.3d 677, 679 (7th Cir. 2011)). Our task then is to decide whether the judge's ruling centers on pure

questions of historical fact—"questions of who did what, when or where, how or why." *Id.* at 747 (quoting *U.S. Bank N.A. v. Vill. at Lakeridge, LLC*, 138 S. Ct. 960, 966 (2018)). A ruling identifying such a merits-related factual dispute cannot be immediately appealed, even if "entered in a 'qualified immunity' case." *Johnson*, 515 U.S. at 313. But if the judge's order instead applies the familiar qualified-immunity inquiry to undisputed historical evidence, nothing impedes us from exercising our jurisdiction on interlocutory appeal. Quite the opposite in fact; we are obligated to do so.

Plumhoff illustrates this jurisdictional principle. At issue in *Plumhoff* was whether police officers used excessive force during a high-speed car chase. The officers had fired multiple shots at the fleeing car, which caused the car to crash and ultimately killed both the driver and passenger. 572 U.S. at 770. The officers moved for summary judgment on qualified-immunity grounds, but the judge denied their motion. *Id.* After reviewing the available video evidence, he concluded that the officers had violated clearly established Fourth Amendment law. *Estate of Allen v. City of West Memphis*, No. 05-2489, 2011 WL 197426, at *1 (W.D. Tenn. Jan. 20, 2011). The Sixth Circuit affirmed. 509 F. App'x 388 (6th Cir. 2012).

The Supreme Court reversed on the merits, though it first addressed the issue of appellate jurisdiction. It held that the narrow exception articulated in *Johnson* did not foreclose immediate appellate review of the judge's summary-judgment ruling. *Plumhoff*, 572 U.S. at 773. The petitioners did "not claim that other officers were responsible for [the] shooting." *Id.* "[R]ather, they contend[ed] that their conduct did not violate the Fourth Amendment and, in any event,

did not violate clearly established law." *Id.* They had "raise[d] legal issues … quite different from any purely factual issues that the trial court might confront if the case were tried." *Id.* So the Sixth Circuit had "properly exercised jurisdiction." *Id.*

On the question of our appellate jurisdiction, this case is indistinguishable from *Plumhoff*. Like in *Plumhoff*, we have a video that captured much of the corrections officers' relevant conduct. Additionally, the parties do not dispute the pertinent historical facts. They agree that Carter was seriously ill the morning of July 18 (and we now know this was due to diabetic ketoacidosis). They also agree that Nurse Bates assured the officers that Carter's vitals were fine and that he was "faking" his symptoms. But McGee and the officers part ways over whether the officers reasonably deferred to Bates's medical judgment: While McGee contends that the officers should have intervened to ensure that Carter received adequate treatment, the officers argue that they were legally entitled to defer to Bates, and even if not, no clearly established law required that they override her judgment.

Underlying this dispute are two purely legal issues. The first is whether the officers violated Carter's right to due process by deferring to the medical staff. The answer to this question turns on the objective reasonableness of the officers' conduct. Assuming for present purposes that the officers acted unreasonably, we then ask whether qualified immunity nonetheless protects them because their mistake in judgment was a reasonable one. With the video evidence and the agreed-upon historical facts, we have all we need to answer those questions.

Nor did the district judge identify a factual dispute on which our answers to these questions might turn. On the question of the officers' entitlement to qualified immunity, he held that "[it] was sufficiently clear that failing to take any action in light of a serious medical need was unconstitutional at the time of Carter's death." *McGee*, 473 F. Supp. 3d at 840. In sum, the judge addressed and decided the core qualified-immunity question we confront here. For this reason his order is subject to immediate appellate review; our jurisdiction is secure.

B. Qualified Immunity

With the jurisdictional dilemma resolved, we return to qualified immunity. We begin and end with step two of the qualified-immunity inquiry: whether the unlawfulness of the officers' conduct was clearly established at the time of Carter's death. We choose this path in light of the Supreme Court's instruction that "lower courts 'should think hard, and then think hard again,' before addressing both qualified immunity and the merits of an underlying constitutional claim." *Wesby*, 138 S. Ct. at 589 n.7 (quoting *Camreta v. Greene*, 563 U.S. 692, 707 (2011)). For a right to be clearly established, "existing precedent must … place[] the statutory or constitutional question beyond debate." *Ashcroft v. al-Kidd*, 563 U.S. 731, 741 (2011). Put differently, every reasonable officer must have understood that deferring to the judgment of medical staff in these circumstances was unlawful. *Id.* Here, our caselaw points decidedly in one direction, but it does so in *favor* of the officers' reasonableness. We therefore hold that the corrections officers are entitled to qualified immunity.

To support her contrary position, McGee mostly relies on cherry-picked legal propositions about an inmate's constitutional entitlement to adequate medical care. *See, e.g.*, *Farmer v. Brennan*, 511 U.S. 825, 832 (1994) ("[P]rison officials must ensure that inmates receive adequate food, clothing, shelter, and medical care … ."); *Estelle v. Gamble*, 429 U.S. 97, 104–05 (1976) (classifying the intentional denial or delay of access to medical care as deliberate indifference). Yet the Supreme Court has "'repeatedly told courts … not to define clearly established law at a high level of generality' since doing so avoids the crucial question whether the official acted reasonably in the particular circumstances that he or she faced." *Plumhoff*, 572 U.S. at 779 (alteration in original) (citation omitted) (quoting *Al-Kidd*, 563 U.S. at 742). So we narrow our focus to cases that specifically address the situation we confront here: whether a corrections officer may rely on a nurse's judgment that an inmate is faking symptoms of an illness.

McGee responds that the "law has always been sufficiently clear" that the corrections officers' conduct was unconstitutional. But at the time of Carter's death—and still now—our caselaw has said precisely the opposite. *King* involved an almost identical set of facts, and we held that the district judge correctly granted summary judgment in the officers' favor. In *King* the jail medical staff inexplicably decided to wean an inmate off his anxiety medication. 680 F.3d at 1015. Abrupt withdrawal from that medication is associated with symptoms of agitation, tremors, hallucinations, and seizures. *Id.* at 1016. Those are exactly the symptoms the inmate experienced. The morning of his death, two corrections officers found him "convulsing on the floor, screaming and foaming at the mouth." *Id.* But the on-call

nurse accused the inmate of faking his seizure and told him to "quit acting like a child and get up." *Id.* at 1017. After the inmate began convulsing again an hour later, the nurse moved him to a padded cell, and from there she did nothing more. That evening he died. *Id.*

The judge granted summary judgment in the officers' favor and held that their deference to the nurse was not unlawful. We affirmed. "The officers were not responsible for administering medical care" to the inmate. *Id.* at 1018. Instead "they were 'entitled to defer to the judgment of jail health professionals.'" *Id.* (quoting *Berry*, 604 F.3d at 440). The officers had properly notified the nursing staff when the inmate was experiencing seizures. *Id.* But they "were not trained to assess whether an inmate [was] genuinely experiencing seizures, and so they lacked the capacity to judge whether [the nurse] made an inappropriate diagnosis." *Id.*

King controls our decision here. Simply put, it dictates that corrections officers are not constitutionally obligated to override the judgment of medical professionals unless they have reason to know that an inmate is receiving inadequate treatment. This remains true even when an inmate is in obvious distress and even when the medical staff has misdiagnosed an inmate—or worse, accused him of faking a very real illness. Our cases since *King* have affirmed these principles. *See, e.g.*, *Miranda*, 900 F.3d at 343 (affirming the dismissal of claims against corrections officers who were assured that the medical staff was monitoring an inmate who died from a hunger strike); *Estate of Perry v. Wenzel*, 872 F.3d 439, 450, 459 (7th Cir. 2017) (affirming summary judgment for corrections officers who stood next to an inmate who died

"writh[ing] around" in a bloody spit mask while the observing nurses did nothing).

Importantly, *King* was decided at step one of the qualified-immunity inquiry. In other words, it affirmatively established that a corrections officer may trust jail medical professionals to provide inmates with appropriate medical care. There is accordingly no legal basis for McGee's contention that at the time of Carter's death, the law was clearly established in her favor.

Still, McGee attempts to distinguish *King* and its progeny. She contends that both Carter's medical distress and the inadequacy of Nurse Bates's medical treatment was, or should have been, obvious to the corrections officers. But the obviousness of Carter's deteriorating health—McGee's first point—has minimal relevance under our caselaw. Instead, the appropriate inquiry for a medical-care claim is whether the officers "ha[d] a reason to believe (or actual knowledge)" that the medical staff was "mistreating (or not treating)" an inmate. *King*, 680 F.3d at 1018 (quotation marks omitted). To the extent the obviousness of Carter's condition has any relevance, we have found that corrections officers are entitled to defer to the medical staff in circumstances far more obvious than these. For example, in *King* the inmate experienced severe shaking and foaming at the mouth. Carter's symptoms—lethargy, incoherence, and labored breathing—were more subtle.

We thus constrain our analysis to McGee's second point: whether Nurse Bates provided Carter with obviously inadequate medical treatment. And we do so with the qualified-immunity standard in mind. Under that standard the key question is whether Bates's treatment was so obviously

inadequate that *every* reasonable officer would have known that he could not rely on her medical judgment.

The evidence pertinent to that question is undisputed. In the days preceding his death, Carter experienced a variety of symptoms, including nausea, exhaustion, tachycardia, low blood pressure, and labored breathing. On July 17 he was moved to the medical unit for a 23-hour observation. The following morning Nurse Bates requested that Carter be moved from the medical unit back to general population. Five corrections officers ultimately participated in the transfer because Carter was not responsive to their orders. At least two of those officers, Page and Collins, noticed that Carter appeared sick; he was exhibiting symptoms of lethargy and labored breathing. Officer Page also knew that Carter was diabetic.

Nurse Bates assured the officers that Carter was fine. She told some that Carter was "faking" his symptoms (and this was not an uncommon occurrence at the jail); she told others that his vitals were normal (although it is possible that she never checked them). Several officers observed Bates use smelling salts, and Carter reacted by moving his head. The officers thus proceeded with Carter's transfer, though Corporal West decided to move Carter to the disciplinary unit because of his apparent refusal to cooperate. Both Officers Page and Wallar thought that Carter should have stayed in the medical unit. Wallar specifically thought Carter seemed incoherent and sick.

Following the transfer, Officer Parsano realized that Carter had left several meals uneaten; these meals were marked "D" for diabetic. This discovery eventually prompted Nurse Bates to check Carter's blood-glucose level.

Though his level was dangerously high, the reading meant nothing to Officers Collins and Page. Bates herself did not appear alarmed, but she did administer an insulin shot. After doing so, she informed West that Carter's symptoms should soon improve. An hour later, however, Carter's blood-glucose level had not dropped, so Corporal Austin insisted that Carter be transported to the hospital. By then, it was too late. Tragically, Carter died.

In hindsight we know that Carter was experiencing symptoms of diabetic ketoacidosis. But like in *King*, the lay corrections officers lacked the requisite medical training to either identify or treat Carter's medical condition. Similarly, they "lacked the capacity to judge whether [Nurse Bates] made an inappropriate diagnosis." *King*, 680 F.3d at 1018. And they later observed Bates attempt to treat what appeared to be a diabetic-related illness. In short, McGee has presented no evidence, other than her own sheer speculation, that the officers knew or had reason to know that Nurse Bates was providing inadequate care.

McGee emphasizes that at least two officers—Page and Wallar—thought that Carter appeared sick and disagreed with the decision to move him out of the medical unit. But recognizing that someone is sick is not the same as knowing that he is receiving inadequate care from a trained medical professional. Additionally, McGee's evidence is insufficient to clear the qualified-immunity hurdle. To prevail, McGee must show that every reasonable officer would have understood that relying on Nurse Bates's medical judgment was unlawful. Simply put, she has not done so.

To reiterate, this case concerns only whether the five corrections officers who transported Carter from the medical

unit to the disciplinary unit are entitled to qualified immunity. Under our caselaw, corrections officers may reasonably rely on the judgment of jail health professionals, and the qualified-immunity doctrine protects officers from reasonable mistakes when they do so. Accordingly, the corrections officers here are entitled to qualified immunity. We REVERSE the judgment of the district court and REMAND with instructions to enter judgment in the officers' favor.