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UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

JENNIFER BYRUM, as the personal representative and next of kin of Ricky Lynn Lewis, deceased, *Plaintiff-Appellant*,	No. 25-5830
v.	
KNOX COUNTY, TENNESSEE, *Defendant-Appellee*.	

Appeal from the United States District Court for the Eastern District of Tennessee at Knoxville.
No. 3:24-cv-00239—Thomas A. Varlan, District Judge.

Argued: April 29, 2026

Decided and Filed: October 8, 2026

Before: STRANCH, BLOOMEKATZ, and HERMANDORFER, Circuit Judges.

COUNSEL

ARGUED: Richard E. Collins, COLLINS LAW, Knoxville, Tennessee, for Appellant. Federico A. Flores, KNOX COUNTY LAW DIRECTOR'S OFFICE, Knoxville, Tennessee, for Appellee. **ON BRIEF:** Richard E. Collins, COLLINS LAW, Knoxville, Tennessee, Dan Channing Stanley, Knoxville, Tennessee, for Appellant. Federico A. Flores, David S. Wigler, KNOX COUNTY LAW DIRECTOR'S OFFICE, Knoxville, Tennessee, for Appellee.

BLOOMEKATZ, J., delivered the opinion of the court in which STRANCH, J., concurred, and HERMANDORFER, J., concurred in part. HERMANDORFER, J. (pp. 23–31), delivered a separate opinion concurring in part and dissenting in part.

OPINION

BLOOMEKATZ, Circuit Judge. Jennifer Byrum sued Knox County on behalf of her father, Ricky Lynn Lewis, after he died of a drug overdose while in pretrial detention. Byrum asserts that during the approximately seventeen hours Lewis was in the County's detention facility, it was obvious that he was experiencing a drug-related medical emergency and should have been provided medical care. Yet jail staff placed Lewis in a holding cell for over nine hours and left him virtually unmonitored and untreated—writhing in pain and lying barely conscious on the floor covered in his own feces.

Byrum asserted several theories of liability against the County, all of which the district court rejected at the pleading stage. On appeal, Byrum challenges the district court's dismissal of her municipal liability claims, arguing that her allegations plausibly establish that the County was deliberately indifferent to her father's right to adequate medical care in jail and is at fault for her father's death. We agree with Byrum, but only in part. Byrum's allegations, along with the jail's surveillance video, give rise to a reasonable inference that the County did not adequately train jail staff to recognize and respond to drug-related medical emergencies, such as Lewis's overdose. Because we hold that Byrum stated a plausible claim for failure to train, we reverse as to that claim. But we affirm the district court's dismissal of Byrum's other municipal liability claims.

BACKGROUND

I. Factual History

This case arises on a motion to dismiss, so we recite the facts as alleged in Byrum's complaint and construe all reasonable inferences in her favor. *England v. DENSO Int'l Am. Inc.*, 136 F.4th 632, 634, 636 (6th Cir. 2025).

Early in the morning on May 25, 2023, Lewis called 911 to report a crime. He asked dispatch to help him retrieve his vehicle, which had just been stolen. When dispatch arrived, they observed that Lewis was intoxicated and behaving erratically, wandering in the street and muttering. He admitted to having used methamphetamine. According to the police report documenting the encounter, Lewis "posed a direct potential danger to himself and others." First Am. Compl., R. 10, ¶ 15 (quoting police report). The officers searched Lewis's vehicle and found "drug paraphernalia and a powdery substance 'consistent with Heroin.'" *Id.* (quoting police report).

The officers arrested Lewis for drug possession and took him to the Roger D. Wilson Detention Facility, a jail operated by the Knox County Sheriff's Office. He arrived at the jail around 5:02 a.m. Surveillance footage shows Lewis "unstable on his feet and hunched over with his arms across his stomach" as Sheriff's deputies, correctional officers, and other jail staff processed him into the jail. *Id.* ¶ 16. The Tennessee Corrections Institute establishes "minimum standards for local jails," including "medical screening" during booking, and the jail's written policies reaffirm the minimum standards. *Id.* ¶ 17. But "no initial medical screen was performed to determine whether Lewis could safely be admitted into the Jail." *Id.* ¶ 19. As depicted by the surveillance footage, Lewis was moved "in a wheelchair" because he was unable to walk on his own and, at various points, he was "lying on a bench unconscious." *Id.* ¶ 20.

About two hours after Lewis arrived at the jail, footage shows at least four individuals—whom the complaint identifies as John Doe 1, John Doe 2, Jane Doe 1, and Jane Doe 2—surrounding Lewis. Jane Doe 1, an "apparent[]" member of the jail's medical staff, performed a sternum rub on Lewis to wake him, but "he continued to drift in and out of consciousness" and "his breathing was labored, slow, and shallow." *Id.* ¶¶ 22–23. According to the complaint, "Lewis's medical distress was obvious; he was clearly in the throes of an overdose or acute drug withdrawal." *Id.* ¶ 23. But instead of administering naloxone—a drug commonly used to reverse opioid overdose—Jane Doe 1 and Jane Doe 2 placed "'smelling salt' capsules under Lewis's nose to keep him awake as they attempted to take vital signs." *Id.* ¶ 25. And John Doe 1 joked that Lewis must be "dying of bone cancer." *Id.* ¶ 26.

Then, jail staff locked Lewis in a holding cell for approximately nine hours and did not monitor him. Tennessee Corrections Institute's "minimum standards for adult correctional facilities" establish that "[a]ll inmates shall be personally observed by a facility employee at least once every hour on an irregular schedule. More frequent observation shall be provided for inmates who are intoxicated." *Id.* ¶ 82 (quoting Tenn. Comp. R. & Regs. § 1400-01-.16). The jail's written policies establish that pretrial detainees in holding cells "who have a medical condition, such as withdrawals from drugs or alcohol," should be observed "every 15-30 minutes." *Id.* ¶ 83. None of the staff followed either policy. Byrum alleges that, despite putting Lewis in an observation cell, jail staff "were not adequately trained on the requirements of the minimum standards or their own written policy and procedures." *Id.* ¶ 85. Rather than monitor Lewis, John Doe 1, John Doe 2, Jane Doe 1, Jane Doe 2, and "all other correctional officers and medical personnel interacting with Lewis failed to take any reasonable measure to abate the risks" of his apparent overdose. *Id.* ¶ 29.

About four hours after Lewis was taken to the holding cell, an officer dropped off a bag of food, but Lewis was otherwise left completely unmonitored. The surveillance footage shows him "writhing in pain" for several hours. *Id.* ¶ 30. About five hours in, Lewis "defecate[d] uncontrollably" on himself, and then spent three and a half more hours "convulsing on the ground in his own feces." *Id.* ¶¶ 31–32. Finally, officers entered the cell, put Lewis in a wheelchair, and took him to the shower to clean him off. At that point, John Doe 3 asked Lewis "what he [was] *on*," and Lewis responded, "meth." *Id.* ¶ 33. After the shower, the officers placed him in another holding cell without providing medical attention.

At around 6:06 p.m., the surveillance footage shows Lewis "forcefully hitting his head on the thick glass of the cell door." *Id.* ¶ 35. As a result, John Doe 4, John Doe 5, and John Doe 6 took Lewis to a "padded room" and placed him in a restraint chair. *Id.* ¶ 36. While restrained, he continued to "thrash about," "once again soil[ing] himself." *Id.* ¶¶ 36–37. Around 8:30 p.m., officers took Lewis to the bathroom to clean him off and change his clothes, and then returned him to the cell without providing any medical care.

Around 10:00 p.m., Jane Doe 3 and Jane Doe 4 came to the cell and discovered that Lewis was not breathing. They started chest compressions but did not call 911 until approximately 40 minutes later. Lewis was transported to a medical center where he was placed on life support, and he died early the next morning. According to the autopsy report, Lewis died of "acute methamphetamine, fentanyl, xylazine, and morphine intoxication." *Id.* ¶ 42.

II. Procedural History

Byrum brought this lawsuit against Knox County, various County officials, and eight Jane and John Doe jail staff, raising civil rights claims under 42 U.S.C. § 1983 and state tort claims.[1] As most relevant here, Byrum claimed that by failing to train jail staff and acquiescing to various unconstitutional customs, the County was deliberately indifferent to Lewis's Fourteenth Amendment right to adequate medical care while in pretrial detention. The district court granted the County's motion to dismiss the municipal liability claims and then declined to exercise supplemental jurisdiction over Byrum's state law claims.

Byrum timely filed a notice of appeal, challenging the dismissal of her municipal liability claims.

ANALYSIS

We review the district court's decision to dismiss Byrum's case for failure to state a claim de novo. *Nugent v. Spectrum Juv. Just. Servs.*, 72 F.4th 135, 138 (6th Cir. 2023). In that review, we take all well-pleaded allegations contained in the complaint as true and construe the facts in the light most favorable to Byrum. *Id.* Reading the complaint in that light, Byrum's claims need only be plausible to survive the motion to dismiss. *Martinez v. Wayne County*, 142 F.4th 828, 835 (6th Cir. 2025). To state a plausible claim, Byrum must plead "factual content that allows the court to draw the reasonable inference that the [County] is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). While Byrum's "burden is not high in this posture, it does not disappear either," *Martinez*, 142 F.4th at 836, and where a

[1]Byrum sued the individual defendants in their official and individual capacities. For somewhat confusing reasons not before us, Byrum's individual capacity claims were dismissed without prejudice after she failed to properly serve the individual defendants. D. Ct. Op., R. 46, PageID 311. Byrum limited her appeal to challenging the dismissal of her claims against the County.

complaint pleads conclusory factual allegations that are "merely consistent with a defendant's liability, it stops short of the line between possibility and plausibility of entitlement to relief," *Crawford v. Tilley*, 15 F.4th 752, 762 (6th Cir. 2021) (quoting *Iqbal*, 556 U.S. at 678).

In this appeal, Byrum asks us to review the district court's dismissal of her § 1983 claims that the County violated her father's Fourteenth Amendment right to adequate medical care. Section 1983 imposes liability against "person[s]" who deprive others of federal rights under the color of state law. 42 U.S.C. § 1983. In *Monell v. Department of Social Services*, the Supreme Court held that municipalities are recognized as "persons" for purposes of § 1983. 436 U.S. 658, 701 (1978). But our review over these *Monell* claims proceeds differently than that over claims against individual officers.

We use a "two-pronged inquiry" to evaluate *Monell* claims. *Cash v. Hamilton Cnty. Dep't of Adult Prob.*, 388 F.3d 539, 542 (6th Cir. 2004). *First*, we ask whether a plaintiff "asserted the deprivation of a constitutional right." *Id.* Here, Byrum points to the County's deliberate indifference to Lewis's serious drug-related medical needs, which we have recognized as a deprivation of a constitutional right. *See, e.g.*, *Shadrick v. Hopkins County*, 805 F.3d 724, 736–37 (6th Cir. 2015); *Griffith v. Franklin County*, 975 F.3d 554, 566 (6th Cir. 2020); *Helphenstine v. Lewis County*, 60 F.4th 305, 322–26 (6th Cir. 2023). *Second*, if the plaintiff has identified a constitutional violation, we must consider whether the municipality was "responsible for that deprivation" of rights. *Cash*, 388 F.3d at 542. The County did not challenge whether Lewis suffered a deprivation of a constitutional right in its motion to dismiss. It limited its challenge to the second inquiry—its responsibility for the deprivation. So we confine our analysis to that question as well.

In evaluating whether the County was responsible for Lewis's constitutional deprivation, we do not follow a theory of *respondeat superior*, meaning that a municipality may not be held liable under § 1983 simply because it "employ[ed] a tortfeasor." *Monell*, 436 U.S. at 691. Instead, the County is responsible "only for '[its] *own* illegal acts.'" *Connick v. Thompson*, 563 U.S. 51, 60 (2011) (quoting *Pembaur v. City of Cincinnati*, 475 U.S. 469, 479 (1986)). Therefore, to survive the motion to dismiss her *Monell* claims, Byrum must identify a specific County policy or custom that caused the violation of Lewis's constitutional rights. *Wright v.*

Louisville Metro Gov't, 144 F.4th 817, 827 (6th Cir. 2025). Our court has recognized four independent methods of establishing a municipality's illegal policy or custom: a plaintiff may prove "(1) the existence of an illegal official policy or legislative enactment; (2) that an official with final decision making authority ratified illegal actions; (3) the existence of a policy of inadequate training or supervision; or (4) the existence of a custom of tolerance or acquiescence of federal rights violations." *Burgess v. Fischer*, 735 F.3d 462, 478 (6th Cir. 2013) (citing *Thomas v. City of Chattanooga*, 398 F.3d 426, 429 (6th Cir. 2005)).

Byrum presses several distinct theories of *Monell* liability in her complaint. We first consider Byrum's failure-to-train theory, holding that she sufficiently pled this claim. Next, we address Byrum's remaining theories of liability—which claim that the County maintained policies of inadequate medical screenings, underfunding, and overcrowding—and hold that Byrum failed to plausibly state these claims.

I. Failure to Train

We begin with Byrum's failure-to-train claim. Byrum argues that the County inadequately trained jail staff to address drug-related medical emergencies, such as acute withdrawal and overdoses. Specifically, Byrum pleads that jail staff "lacked the training . . . to adequately screen arrestees for serious medical conditions requiring immediate medical attention" or otherwise treat or seek care for detainees with medical needs stemming from drug use. First Am. Compl., R. 10, ¶ 47. She further alleges that the jail staff were not trained on the jail's own policies regarding screening and monitoring.

At the outset, we emphasize that a "municipality's culpability for a deprivation of rights is at its most tenuous where a claim turns on a failure to train." *Connick*, 563 U.S. at 61. In this context, the court applies "rigorous requirements of culpability and causation." *Arrington-Bey v. City of Bedford Heights*, 858 F.3d 988, 995 (6th Cir. 2017) (quoting *Bd. of Cnty. Comm'rs of Bryan Cnty. v. Brown*, 520 U.S. 397, 415 (1997)). To survive dismissal on her failure-to-train claim, Byrum must plausibly allege that (1) the County's "training program was inadequate for the tasks that [officials] must perform," (2) the "inadequacy was the result of the [County's] deliberate indifference," and (3) the "inadequacy was closely related to or actually caused the

injury." *Jackson v. City of Cleveland*, 925 F.3d 793, 834 (6th Cir. 2019); *see also Helphenstine*, 60 F.4th at 323. We examine each of these elements in turn.

A. Adequacy of the Training Program

Turning to the first element of a failure-to-train claim, Byrum's complaint plausibly establishes that the County's training program did not adequately teach jail staff how to recognize and respond to medical emergencies relating to drug overdoses.

Screening and Initial Care. As alleged in the complaint, jail staff did not medically screen Lewis when he arrived at the jail, in contravention of the jail's policy requiring medical screening during the intake process for all pretrial detainees. Nor did the jail staff provide or call for any medical care upon Lewis's arrival, despite surveillance footage depicting him "unstable on his feet and hunched over," Lewis's previous admission that he had taken drugs, and the officers' discovery of drug paraphernalia and a powdery substance in his vehicle. First Am. Compl., R. 10, ¶ 16. Immediately upon entry, Byrum alleges, Lewis's medical needs were clear, as he had to be transported in a wheelchair because he was so impaired that he could not walk on his own.

About two hours after Lewis first arrived at the facility, an "apparent[]" member of the jail's medical staff performed a sternum rub on Lewis, to wake him from unconsciousness, while three other individuals surrounded Lewis. Even after the sternum rub, Lewis continued to go in and out of consciousness and his breathing was "labored, slow, and shallow." *Id.* ¶ 23. A member of the jail staff also used smelling salts to revive Lewis long enough to take his vitals, but no one administered naloxone—a medication commonly used to reverse opioid overdose—or otherwise provided medical care.

During this initial period, Byrum alleges that at least four individuals (John Doe 1, John Doe 2, Jane Doe 1, and Jane Doe 2) interacted with Lewis enough to observe the severity of his medical needs. But none provided care beyond briefly bringing him to consciousness, only for him to fall back out of it. Nor did these members of the jail staff screen Lewis for a serious medical need, provide instructions to jail staff for Lewis's care and monitoring, or return to check on him over the next hours when he was locked in the holding cell.

These allegations pertaining to Lewis's initial intake and screening process give rise to a reasonable inference that, despite the jail's screening policy, jail staff lacked adequate training on medical screening protocols. Byrum pleads that even within the first couple of hours, it was "obvious" that Lewis was in "medical distress," but jail personnel did not provide proper care. *Id.* ¶ 23. Given that not one of the multiple individuals who interacted with Lewis during this initial period recognized the medical emergency, let alone responded to it by providing appropriate treatment, we can reasonably infer at this pleading stage that the staff were not trained on the jail's screening policy, nor were they trained on how to identify the medical signs of overdose or administer care when a detainee was experiencing that type of medical emergency. *See Helphenstine*, 60 F.4th at 324–25.

Monitoring and Seeking Medical Assistance. Beyond screening, Byrum pleads that during the nine hours jail staff locked Lewis in the holding cell, all Jane and John Does, as well as "all other correctional officers and medical personnel interacting with Lewis[,] failed to take any reasonable measures" to provide or seek medical care and failed to regularly monitor him. First Am. Compl., R. 10, ¶ 29. According to jail policy, staff are required to monitor and observe detainees in holding cells who have a medical condition every 15–30 minutes. The complaint alleges, however, that while Lewis was in the holding cell, no one monitored or observed him for hours at a time, in violation of even the minimum policy that requires jail staff to observe all detainees, on average, every hour.

No one observed Lewis until four hours in, when an officer dropped off a bag of food at the door. During this period, Lewis was "writhing in pain" for several hours. *Id.* ¶ 30. An hour later, Lewis "defecate[d] uncontrollably" on himself. *Id.* ¶ 31. He spent three and a half more hours "convulsing on the ground in his own feces," as depicted below. *Id.* ¶ 32.

Even after finding him in that state, jail staff did not call for outside medical care or otherwise provide treatment. *See Hehrer v. County of Clinton*, 161 F.4th 955, 965 (6th Cir. 2025). Nor did they commit to frequent monitoring. Instead, jail staff simply put Lewis in a wheelchair, showered him off, and placed him back in the holding cell.

These allegations give rise to the inference that jail staff were not adequately trained on the observation policies or how to otherwise identify and handle drug-related medical emergencies in the jail. Jail staff in this case did not even have to guess the cause of Lewis's condition: he admitted to using drugs when the police arrested him for heroin possession and repeated that he was on "meth" to a staff member who evidently knew he was intoxicated and asked what he was "on." Still, not one of the staff members who interacted with Lewis earlier in the day regularly monitored Lewis while he was locked in the holding cell or otherwise provided medical care for the acute drug reaction he was obviously experiencing.

Further, Byrum alleges that later in the evening, at least three new individuals moved Lewis to a restraint chair after he was found "forcefully hitting his head" on the holding cell door, a behavior that is consistent with the symptoms of overdose. First Am. Compl., R. 10, ¶¶ 35–36. In the padded room he was taken to, Lewis defecated on himself again. Jail staff took him to the bathroom to clean him off, but—again—no one provided or called for any medical care.

Several hours later, jail staff discovered Lewis was not breathing. Jail staff administered chest compressions, but no one called 911 for another 40 minutes. Multiple staff members knew he was not breathing; it was not as if there was only one employee who had to choose between chest compressions and calling 911, which delayed making the call. Instead, even in this dire scenario, no one immediately called for medical care.

In *Helphenstine v. Lewis County*, we viewed the total failure to respond to a medical emergency, by multiple individuals, as creating a material question of fact as to whether those individuals were adequately trained—even where the "record [was] mixed on whether the jailers ever received any training or instruction regarding withdrawal or medical emergencies." 60 F.4th at 324. Reviewing the summary judgment record, we recognized that at least one individual testified that she had "received training on what constituted an alcohol-withdrawal-related medical emergency" and most employees "agreed that an inmate experiencing a medical emergency should be sent to the hospital." *Id.* But, we explained, the record also contained testimony from deputy jailers that they "had not received any training regarding withdrawal or how to identify medical emergencies," and at least one individual testified that there was no specific training on how to determine whether an inmate's symptoms "indicated that their withdrawal was about to be fatal." *Id.* Other county defendants also testified that they "had never seen" the jail's written policies recognizing withdrawal as a medical emergency. *Id.* On that record, we held, the staff had not been adequately trained by the jail.

Critically, in *Helphenstine* we relied on the jail employees' failure to respond to the emergency to support an inference of inadequate training. We acknowledged that employees might have received some training on how to identify withdrawal-related medical emergencies "in the abstract." *Id.* But we concluded that the employees' inability "to do so when one presented itself" would allow "a reasonable jury [to] conclude that their training, to the extent they were trained, was insufficient." *Id.* So too here. Based on Byrum's allegations that not one individual screened or monitored Lewis despite his obvious symptoms and the jail's own policies, we can plausibly infer that to the extent the jail staff were trained on the jail's policies, that training was "insufficient." *See id.*

The dissent suggests that *Helphenstine* is "far afield" from this case because the "affirmative evidence" (i.e., "employee testimony") about the training program created the material question of fact. Dissent at 28. And it further says that Byrum's failure to plead these types of specific facts regarding the content and extent of the training program is fatal to all three prongs of her failure-to-train claim. But, as the dissent also recognizes, *Helphenstine* was at summary judgment, while this case is at the pleading stage, subject to the motion to dismiss standard. At this juncture, our task is to consider whether Byrum alleged sufficient facts to permit a reasonable inference that the training was inadequate. And while our substantive reasoning in *Helphenstine* is instructive as to what factual allegations can suffice to state a plausible *Monell* claim, the type of evidence produced at summary judgment should not confuse what a plaintiff is required to allege at the pleading stage. *See* Dissent at 25 (citing *City of Canton v. Harris*, 489 U.S. 378, 390–91 (1989) (post-trial) and *Jackson*, 925 F.3d at 834 (summary judgment)).

Byrum's specific factual allegations regarding the total failure of the jail staff to identify and respond to Lewis's obvious drug-related medical emergency and to follow the jail's own policies permit the reasonable inference that the County's training was inadequate. This is not a situation where the failure to recognize and respond to Lewis's needs was consistent with "an otherwise sound program" that was "negligently administered," nor a scenario where "adequately trained officers" made the "occasional[] . . . mistake[]." Dissent at 29 (quoting *City of Canton*, 489 U.S. at 391). As alleged, this was a comprehensive failure to provide medical treatment and follow clear jail policies to screen and monitor detainees with medical needs by every single member of the jail staff. The combined force of the factual allegations contained in the complaint plausibly establish that the staff was not adequately trained on how to identify and respond to drug-related medical emergencies, and to follow the jail's own screening and monitoring protocols. This reasoning is not novel—it is rooted in the ordinary standards for assessing the sufficiency of a complaint on a Rule 12(b)(6) motion to dismiss.

To be sure, discovery might reveal additional details of the County's training policies, like the evidence available at summary judgment in *Helphenstine*. That discovery could support or harm Byrum's claim. But here, the mere fact that Byrum has not yet had the opportunity to

access that information, which is likely within the County's sole possession, does not stand as an obstacle that defeats her claim at the pleading stage. Nor does it undermine the specific facts Byrum pled from which we can reasonably infer that her failure-to-train theory is plausible. *See New Albany Tractor, Inc. v. Louisville Tractor, Inc.*, 650 F.3d 1046, 1051 (6th Cir. 2011) (explaining "plaintiff must allege specific facts" to state a claim "even if those facts are only within the head or hands of the defendants"). If, to establish a failure-to-train claim, Byrum were required to plead the specific details of what was contained in the County's training manual, or what the County specifically told employees during each training session—as the dissent seems to suggest she might—it is hard to imagine how any such claim could survive. Such a rule would be at odds with the distinctions between the standard at the pleading stage and that at the post-discovery summary judgment stage. If that were indeed the rule, it would seem to incentivize plaintiffs to plead that *no* training was provided at all, as to escape the requirement of pleading specific details of the training program before that information was known. And it would also seem to make failure-to-train claims greatly dependent on the transparency of correctional institutions and local governments—and in turn to incentivize those entities to be less transparent.

If we do not require specific details of training sessions in the complaint, the dissent suggests that our analysis "risks converting allegations about individuals' bad acts or negligence into failsafe failure-to-train claims against municipalities." Dissent at 24. But our holding is not so broad. It is based on the totality of the factual allegations here; not just that a few employees failed to respond to Lewis's emergency. As the dissent itself points out, we recently affirmed the dismissals of failure-to-train claims where a few individuals allegedly failed to adequately respond or otherwise carry out their constitutional responsibilities. But in those cases, there was a dearth of surrounding allegations that plausibly pointed to a failure to train, rather than just the mistakes of a few individuals. Our holding today does not conflict with those prior results.

In *Linden v. City of Southfield*, which the dissent emphasizes, first responders inaccurately ceased resuscitative efforts on a woman before obtaining permission to stop their attempts and then pronounced her dead even though "numerous medical indicators" showed signs of life. 75 F.4th 597, 600 (6th Cir. 2023). There, we explained that the plaintiff

"marshal[ed] no facts to support th[e] bare conclusion" that a municipality had failed to provide its first responders with training on when to "take patients to the hospital in emergencies and obtain permission before ceasing resuscitative efforts." *Id.* at 605–06. Unlike here, however, that was a scenario where the first responders—individuals with specialized education and expertise—were performing duties consistent with the education and expertise they would be expected to have. Considering that the first responders would be presumed to have this preparation, the simple fact that they made an inaccurate call, without more, did not indicate that it was the municipality's failure to provide specialized training, rather than their negligence, that caused the error. Here, by contrast, one would not necessarily expect that jail staff would have the same education and expertise. So that the jail staff were inadequately trained is a much more reasonable inference to draw. What's more, in *Linden*, "numerous laypersons recognized signs that [the decedent] was still alive," which the court emphasized "suggest[ed] that . . . special training" would not have saved her life. *Id.* at 606. If training would not have saved the decedent's life, then her death did nothing to imply a lack of training. But here, as explained above, that at least ten jail staff did nothing as Lewis suffered a medical emergency does suggest that those staff were inadequately trained.

In *Wright v. Louisville Metro Government*, the other case cited by the dissent, the plaintiffs similarly pled conclusory allegations that the municipality "failed to adequately train their officers regarding the process to obtain a Search Warrant and its subsequent execution," after the execution of a warrant allegedly violated their Fourth Amendment rights. 144 F.4th at 827. Unlike here, the plaintiffs in *Wright* identified no specific policy that the officers were insufficiently trained on, nor pled specific facts from which it could be inferred that it was the training program that caused the claimed constitutional error. In other words, the plaintiffs offered no reason to think the alleged constitutional defects resulted from anything other than isolated misconduct or negligence. By contrast, in this case, Byrum alleges that the jail had policies in place that required staff to screen for potential medical issues and observe detainees experiencing medical emergencies, yet no one—across seventeen hours and despite Lewis's obvious medical needs—complied with those protocols, suggesting that jail staff were inadequately trained on them. So neither *Linden* nor *Wright* involved facts as extreme as those here, where at least ten people failed to respond to an obvious emergent situation for which they

should have been prepared. The variation in the outcomes of our cases therefore underscores the essential point: the plausibility of the inference regarding inadequate training depends heavily on the facts, as alleged, in each specific case.

The specific facts Byrum alleges here, starting with the moment Lewis entered the jail through to the 911 call, plausibly demonstrate that the County failed to adequately train its staff on how to handle drug-related medical emergencies. Indeed, throughout the approximately seventeen hours that Lewis was at the facility, at least ten individuals interacted with Lewis. Despite having policies in place, not even one individual properly medically screened Lewis, regularly monitored him, or otherwise sought or provided medical care—even as he defecated uncontrollably on himself, laid in his own feces, and banged his head into his cell door. This is not a case where a single employee (or even a few) failed to follow protocol or best practices. Instead, there is "enough factual matter" alleged in the complaint to give rise to a reasonable inference that jail staff were not adequately trained to recognize and respond when detainees were in the throes of a drug-related medical emergency. *See Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 556 (2007).

B. Deliberate Indifference

Byrum has also sufficiently pled the deliberate indifference element of her failure-to-train claim. Deliberate indifference is "a stringent standard of fault," *Bryan Cnty.*, 520 U.S. at 410, requiring a plaintiff to prove that the municipality "disregarded a known or obvious consequence" of its actions, *Connick*, 563 U.S. at 61.[2] There are two ways to satisfy the deliberate indifference standard for *Monell* claims. Under the first, Byrum must show a "pattern of similar constitutional violations by untrained employees." *Id.* at 62. From a pattern of violations, we could infer that the County was on notice of the need for training to protect

[2]We note that our en banc court recently revised the standard for deliberate indifference claims for pretrial detainees under the Fourteenth Amendment. *Poynter ex rel. Fernandez v. Shirley*, __ F.4th __, 2026 WL 2641092 (6th Cir. Sep. 8, 2026). This case was briefed and argued before our en banc court decided *Poynter*. While we previously required "recklessness" for the subjective component of deliberate indifference claims for pretrial detainees under the Fourteenth Amendment, *Brawner v. Scott County*, 14 F.4th 585, 596 (6th Cir. 2021), we now require knowledge for the subjective prong of deliberate indifference, *see Poynter*, 2026 WL 2641092, at *2, *6. Here, we apply the more stringent standard, as articulated in *Poynter*. Under that standard, Byrum's claim survives the pleading stage, so *Poynter* does not affect the outcome in this case.

incarcerated persons' constitutional rights but shirked its responsibility to provide that training. *Id.* Byrum has not identified prior instances of unconstitutional conduct, so we do not consider this theory.[3]

Even absent a pattern of violations, in limited circumstances, a single violation of federal rights can create a plausible inference of deliberate indifference. *See Bryan Cnty.*, 520 U.S. at 409. Byrum pursues this single-violation path. But to sustain a claim under this theory, Byrum must show that the County "'failed to train its employees to handle recurring situations presenting an obvious potential' for a constitutional violation." *Shadrick*, 805 F.3d at 739 (quoting *Bryan Cnty.*, 520 U.S. at 407). In this context, obviousness has two components: it "must be obvious that the failure to train will lead to certain conduct, *and* it must be obvious (*i.e.*, clearly established) that the conduct will violate constitutional rights." *Arrington-Bey*, 858 F.3d at 995. Only if the need for training "is so obvious" and the training's inadequacy is "so likely to result in the violation of constitutional rights" can we reasonably say the County was "deliberately indifferent to the need." *City of Canton*, 489 U.S. at 390. As alleged, we can infer that the County was aware of, but disregarded, the "substantial risk of serious harm" that would result from inadequately training jail staff on how to identify and respond to drug-related medical emergencies. *Farmer v. Brennan*, 511 U.S. 825, 837, 839 (1994). This case, therefore, presents one of the "narrow" circumstances from which we may infer deliberate indifference based on a single incident. *Bryan Cnty.*, 520 U.S. at 409.

Consider the first component of "obviousness"—the need for training. The need to train jail staff on how to screen and handle drug-related medical overdoses is "patently obvious." *Connick*, 563 U.S. at 64. Given the opioid epidemic and the prevalence of drug addiction, drug-related medical emergencies are not a hidden danger. And, as detailed in the complaint, drug-related emergencies in jails are far too common. As to Knox County specifically, Sheriff Tom Spangler publicly recognized that "the opioid epidemic, including detoxing and overdosing, was getting worse" in the jail in which Lewis was held. First Am. Compl., R. 10, ¶ 56.

[3]At least one other plaintiff brought municipal liability claims against Knox County after her husband died of acute overdose approximately twenty-four hours after he was booked into the same detention facility as Lewis. *Davis v. Knox County*, No. 24-cv-00180, 2025 WL 2648264 (E.D. Tenn. Sep. 15, 2025). But since that incident is not alleged in the complaint, we do not consider it here.

Additionally, Byrum alleges that it was "a common and known hazard that arrestees were being transported to the Jail with sufficiently serious medical needs resulting from acute drug withdrawal or overdose." *Id.* ¶ 52. These allegations support the inference that the County was "aware of the risk" that detainees experiencing overdose or withdrawal would enter the facility, requiring medical care. *Farmer*, 511 U.S. at 829.

Given the County's knowledge that detainees experiencing overdose or withdrawal would enter the facility, we can also infer that the County knew the staff needed to be trained on screening and monitoring protocols to adequately identify and respond to the drug-related medical needs of detainees. Without this specific training, jail staff are unlikely to know how to medically screen, observe, and care for detainees in the throes of overdose or other drug-related emergencies. *See Connick*, 563 U.S. at 64. And that means detainees will die, like Lewis did here. At this early stage of the proceedings, we can infer deliberate indifference from the County's failure to adequately train its jail staff on how to identify and respond to drug-related medical emergencies, in the face of the substantial and obvious risk that serious harm would result.

Consider next the second component of obviousness—the constitutional consequences. It is also obvious that, without training jail staff on how to identify, monitor, and respond to drug-related medical emergencies, they are likely to violate detainees' constitutional rights. Under the Due Process Clause of the Fourteenth Amendment, we have recognized that pretrial detainees have a constitutional right to receive adequate medical care. *See, e.g.*, *Helphenstine*, 60 F.4th at 315, 322–26; *Andrew v. Wayne County*, 957 F.3d 714, 721 (6th Cir. 2020). As we just explained, it is obvious that a failure to adequately train could lead to the jail staff's inability to recognize and respond to drug-related medical emergencies. And from such failures to recognize and respond to medical emergencies, it follows that violations of pretrial detainees' constitutional rights to adequate medical care could predictably result as well. Lewis's death was not caused by a "random and unauthorized act" by a single negligent employee. *Albright v. Oliver*, 510 U.S. 266, 285 (1994) (Kennedy, J., concurring in the judgment). Rather, at the pleading stage, we can infer from Byrum's allegations—including that no member of the jail

staff provided medical care to Lewis during the seventeen hours he was in the jail—that the County's failure to train amounted to deliberate indifference.

C. Causation

Byrum has also satisfied the third element of a failure-to-train claim, causation. A plaintiff must show that a municipality's inadequate training "actually caused" the violation of their constitutional rights. *Connick*, 563 U.S. at 59. At the pleading stage, where we have concluded that inadequate training could predictably result in constitutional injury, that conclusion also supports an "inference" of actual causation. *Bryan Cnty.*, 520 U.S. at 410. That is because it is plausible "that the municipality's indifference led directly to the very consequence that was so predictable." *Id*.

Had there been adequate training on how to identify and respond to drug-related medical emergencies, perhaps at least one staff member would have recognized that Lewis required medical care. Yet, despite Lewis's admission that he was on drugs, and his obvious symptoms of an acute drug reaction that presented immediately upon entry to the jail, no one screened or consistently monitored Lewis throughout the day. Even to the extent that there were brief attempts to wake Lewis from unconsciousness with temporary aids (e.g., the sternum rub and smelling salts), no one administered proven or common treatments for overdose (e.g., naloxone). Nor did anyone continue to monitor Lewis as he went in and out of consciousness or provide a more lasting medical intervention. And, moreover, even after jail staff found Lewis unconscious and began chest compressions, they did not call 911 until approximately 40 minutes later—which again delayed care. Had even one person recognized that Lewis was experiencing an overdose, they may have provided or otherwise sought out medical care that could have saved his life. *See, e.g.*, *Helphenstine*, 60 F.4th at 326. Accordingly, we agree with Byrum that her failure-to-train claim against the County may proceed past the pleading stage.[4]

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[4]The dissent penalizes Byrum for recognizing "multiple inferences for the jail staff's failure" because she at one point alleges that "whether due to inadequate training, lack of supervision, or sheer indifference," jail staff "failed to take any reasonable measure to abate the risks." Dissent at 26 (quoting First. Am. Compl., R. 10, ¶ 29). But Byrum is entitled to plead in the alternative, so we do not view this single sentence as foreclosing a reasonable inference about causation at this stage.

II. Remaining Theories

Although we conclude that Byrum's failure-to-train claim survives the pleading stage, her remaining theories of municipal liability fall short. We address each in turn.

A. Failure to Medically Screen

As a separate basis for establishing *Monell* liability, Byrum claims that the County has a custom of not screening detainees for serious medical needs when they enter the facility. Byrum pleads that, instead of screening, the County "plac[es] intoxicated inmates in holding cells to essentially 'sleep it off.'" First Am. Compl., R. 10, ¶ 57. This theory of liability is distinct from Byrum's training claim because, rather than failing to train staff on an acceptable screening protocol, Byrum is alleging that the County maintained a custom of leaving intoxicated detainees to sleep it off and thus not screening detainees during the intake process at all.

Because Byrum's theory is premised on the County's inaction, we ask whether the alleged practice amounts to a custom of tolerance or acquiescence to the violation of constitutional rights. Byrum must allege (1) the "existence of a clear and persistent pattern" of unconstitutional conduct; (2) "notice or constructive notice" by the County; (3) the County's "tacit approval" of the illegal conduct, "such that [its] deliberate indifference in [its] failure to act can be said to amount to an official policy of inaction"; and (4) that the County's policy was the "moving force" or actual cause of the constitutional deprivation. *Doe v. Claiborne County*, 103 F.3d 495, 508 (6th Cir. 1996); *Wallace v. Coffee County*, 852 F. App'x 871, 876 (6th Cir. 2021).

Byrum does not plausibly allege the existence of a clear and persistent pattern of providing inadequate medical screening, which alone is dispositive of this claim. A plaintiff "cannot rely solely on a single instance" of unconstitutional conduct to show a persistent pattern—meaning that allegations pertaining solely to Lewis, without more, cannot satisfy this element of the claim. *Winkler v. Madison County*, 893 F.3d 877, 902 (6th Cir. 2018) (quoting *Gregory v. City of Louisville*, 444 F.3d 725, 763 (6th Cir. 2006) (Siler, J., concurring in part and dissenting in part)). Though Byrum alleges that the County has an "established custom" of letting "intoxicated inmates" sleep it off, which delays "medical screening of inmates with serious medical needs," First Am. Compl., R. 10, ¶ 57, she does not provide any specific factual

allegations regarding the treatment of other detainees. Thus, besides Byrum's general references to other "inmates," the complaint is devoid of allegations that establish a pattern of similar incidents occurring at the facility.

Byrum seems to suggest that she does not need to identify other specific instances of unconstitutional conduct because a Tennessee state report proves the County's failure "to address the opioid epidemic." *Id.* ¶ 59. Byrum says the report "found that the Jail, whose staff are ill-equipped in training, licensing, or other needs to address th[e] opioid issue, was acting like a substitute for proper medical treatment." *Id.* Even considering the report, however, Byrum puts forth no factual allegations regarding the County's prior failures to provide adequate medical screening pursuant to its "sleep it off" policy, nor does she make any attempt to connect Lewis's experience in detention to a broader pattern that could prove a municipal custom under such a policy. Because Byrum's specific factual allegations pertain solely to Lewis's medical care, she has not plausibly alleged the existence of a persistent pattern, requiring dismissal of this claim.

B. Overcrowding

Byrum also claims a municipal custom of overcrowding in the jail. She pleads the jail was "overcrowded, putting a strain on officers and staff, as well as supplies, to adequately recognize and treat serious medical conditions, including detoxing inmates." *Id.* ¶ 73. Because this theory, too, is premised on the County's acquiescence in "allowing" the jail to become overcrowded, *id.* ¶ 74, Byrum was likewise required to allege a pattern of unconstitutional conduct; notice or constructive notice; the County's tacit approval of the conduct; and that its policy caused the constitutional injury, *Doe*, 103 F.3d at 508. But neither overcrowding nor understaffing—even if "deliberate"—is "itself a constitutional violation." *Caraway v. CoreCivic of Tenn., LLC*, 98 F.4th 679, 685 (6th Cir. 2024) (citing *Agramonte v. Shartle*, 491 F. App'x 557, 560 (6th Cir. 2012)). Thus, as Byrum's complaint does not sufficiently allege a causal link between the "policy" of overcrowding and the deprivation of Lewis's constitutional right to receive medical care, the claim cannot survive dismissal. *See, e.g.*, *Agramonte*, 491 F. App'x at 560 (dismissing a claim where the alleged overcrowding did not result in "unconstitutional denial of such basic needs as food, shelter, or sanitation").

Rather, the complaint states in a conclusory manner that the policy of overcrowding "put[] a strain on officers and staff" and was "the moving force" behind Lewis's constitutional injury. First Am. Compl., R. 10, ¶¶ 73, 76. Byrum provides no specific factual allegations regarding the overcrowding in the facility at the time of Lewis's detention, nor does she explain how that overcrowding resulted in the County depriving Lewis of medical care on the day he died. Since the complaint does not plausibly allege causation, the overcrowding theory also fails.

C. Underfunding

To the extent Byrum pleads a municipal policy of underfunding the jail as a distinct theory of liability, this *Monell* claim likewise fails. When proceeding under a theory of liability predicated on the municipality's own action, the action itself can establish liability if it is "found to be unconstitutional." *Bryan Cnty.*, 520 U.S. at 406. And, determining that the County's action "violates federal law will also determine that the municipal action was the moving force behind the injury of which the plaintiff complains." *Id.* at 405.

But Byrum has not established that the County's funding decisions were illegal. Rather, she pleads that the County's funds "should have been spent to protect the weakest and most vulnerable of Knox County's citizens," including by funding "monitored detox withdrawal management" care and "additional trained medical staff at the jail." First Am. Compl., R. 10, ¶ 63. Further, she complains that the County "made plans to freeze certain tax rates for certain citizens[] [and] provide tax incentives to corporations," which "eliminat[ed] approximately $1 billion dollars from the budget." *Id.* As a result, she says, the County "continue[d] to fail in [its] responsibilities to address these foreseeable dangers at the Jail, namely by not providing the funding to hire or attract additional officers and staff." *Id.* ¶ 58. Absent allegations of an unlawful policy or practice, however, the merits of the County's policy choices are not ours to review. Byrum points to no authority plausibly establishing that discretionary budget choices constitute unlawful action, nor does she plead any specific factual allegations from which unlawful conduct may be inferred. Byrum's underfunding theory, therefore, does not state a plausible claim.

CONCLUSION

For the foregoing reasons, we reverse as to Byrum's failure-to-train claim and affirm as to her remaining municipal liability claims.

CONCURRENCE / DISSENT

HERMANDORFER, Circuit Judge, concurring in part and dissenting in part. Something went terribly wrong the day Jennifer Byrum's father, Ricky Lewis, entered the Roger D. Wilson Detention Facility. Byrum alleges that Lewis arrived in a state of drug-related medical distress but was never properly screened. Over the next seventeen hours, Lewis's condition deteriorated. Yet jail staff failed to monitor him regularly or provide medical care—some, it's alleged, even seemed to poke fun of Lewis's distress. Lewis died the next day from an acute drug overdose.

Those allegations, if proven, might well show the kind of serious failures by individual jail staff sufficient to sustain individual-capacity claims. But due to a series of "confusing" litigation moves, Byrum has stopped pursuing all of her individual-capacity claims. Maj. Op. 5 n.1. Her only remaining claims allege that Knox County is liable under a *Monell* theory. To prevail on those municipal-liability claims, though, Byrum needs to show more than unconstitutional conduct by Knox County employees. She must connect any unconstitutional actions by jail staff to a policy or custom maintained by the County itself.

The majority concludes that three of Byrum's claims—based upon a failure to medically screen, overcrowding, and underfunding—do not satisfy *Monell*'s requirements. I agree and thus concur in those portions of the majority's opinion.

But unlike the majority, I also would affirm the dismissal of Byrum's failure-to-train claim against the County. The complaint says nothing about the County's training program beyond the conclusory assertion that the training was inadequate. Our caselaw directs dismissal of threadbare failure-to-train claims that "do[] not contain any factual allegations about the content or extent of training that" individual staff "received." *Linden v. City of Southfield*, 75 F.4th 597, 606 (6th Cir. 2023). That rule—properly applied by the district court—reflects that failure-to-train claims are the "most tenuous" basis for holding a municipality liable. *Connick v. Thompson*, 563 U.S. 51, 61 (2011). Courts therefore must apply "rigorous requirements of

culpability and causation" in the failure-to-train context. *Bd. of Cnty. Comm'rs of Bryan Cnty. v. Brown*, 520 U.S. 397, 405 (1997).

Yet here, in what appears to be first-of-its-kind reasoning, the majority deems a failure-to-train claim adequately pled when nothing particular about training is pled at all. The majority's logic seems to suggest that if enough municipal staff respond inadequately to a situation of medical distress, courts can always plausibly infer a failure-to-train claim at the motion-to-dismiss stage. That approach risks converting allegations about individuals' bad acts or negligence into failsafe failure-to-train claims against municipalities—even though the Supreme Court has "consistently refused to hold municipalities liable under a theory of *respondeat superior*." *Id.* at 403. Nor does the theory even work on its own terms here, where Byrum proffers reasons other than poor training that could have caused the jail staff's faulty response.

Rather than chart a new path to plausibility in the failure-to-train context, I would follow our rule from prior cases: Plausible failure-to-train claims require factual allegations about training. I therefore respectfully dissent from the majority's decision to allow Byrum's failure-to-train claim to proceed.

* * *

The majority opinion recites the rules that govern pleading generally and failure-to-train claims specifically. But its application of those rules to Byrum's complaint falters at each turn.

All agree that Byrum must plausibly allege three elements to state a failure-to-train claim: (1) the municipality's "training program was inadequate for the tasks that officers must perform," (2) "the inadequacy was the result of the [municipality's] deliberate indifference," and (3) "the inadequacy was closely related to or actually caused the injury." *Jackson v. City of Cleveland*, 925 F.3d 793, 834 (6th Cir. 2019) (citation omitted).

The operative complaint goes 0-for-3. And its failures flow from a common deficiency: The complaint says nothing about the training program the County maintained beyond the

conclusory allegation that any training was inadequate. That silence forecloses Byrum's ability to plausibly plead the elements of a failure-to-train claim.

Adequacy of the training program. The foundational element of a failure-to-train claim is the "adequacy of the training program" itself. *City of Canton v. Harris*, 489 U.S. 378, 390 (1989). Adequacy is measured "in relation to the tasks the particular officers must perform." *Id.* And assessing it by definition requires evaluating the "content" and "extent" of the training provided. *Linden*, 75 F.4th at 606. It is not enough to focus on ideal training practices in the abstract, or to allege only "that an injury or accident could have been avoided if an officer had had better or more training." *City of Canton*, 489 U.S. at 391. Plaintiffs must plead sufficient facts to "condemn the adequacy" of the municipality's approach, tethering their claims to some "identified deficiency in a training program." *Id.* Without "factual allegations indicating what the training policies were," courts cannot assess whether that program was indeed "inadequate." *Wright v. Louisville Metro Gov't*, 144 F.4th 817, 827 (6th Cir. 2025) (citation omitted); *Jackson*, 925 F.3d at 834 (citation omitted).

Yet Byrum's amended complaint not only lacks any adequacy allegations—it pleads no training-related facts at all. It says nothing about the County's training on medical screening, monitoring impaired detainees, recognizing overdose or withdrawal symptoms, or providing medical care. Instead, it outlines state- and jail-level policies that required staff to screen and monitor Lewis, then recounts the staff's failure to adhere to those policies. The complaint then jumps from those staff failures to the conclusion that "the Jail officers and staff were not adequately trained on the requirements of the minimum standards or their own written policy and procedures." Am. Compl., R.10, ¶ 85.

The majority deems that approach sufficient to plausibly plead a failure-to-train claim. Boiled down, the majority's logic about the pleaded facts proceeds as follows. One, Lewis's "medical needs were clear." Maj. Op. 8. Two, Lewis was not medically screened nor received proper "care and monitoring," even though "multiple individuals" at the jail "interacted with Lewis enough to observe the severity of his medical needs." *Id.* at 8-9. Third, given staff's failure to "recognize[]" or "respond[]" to Lewis's "medical emergency," we can infer that the staff was not properly trained on the jail's screening policy or on how to identify and administer

care for an overdose. *Id.* at 9. The majority's inferential chain—proceeding from medical problem, to staff's failure to properly address the problem, to a presumption that "jail staff were not adequately trained"—recurs throughout its plausibility analysis. *Id.* at 10; *see id.* at 10-12.

The problem is that Byrum's complaint says nothing about the County's training—and thus contains no allegations to support leaping from individual staff's inadequate response to Lewis to the conclusion that the "County's training program" was inadequate. *Id*. at 8. On top of that, Byrum recognizes that multiple inferences for the jail staff's failure are available: She alleges that "whether due to inadequate training, lack of supervision, or sheer indifference," the individuals who interacted with Lewis "failed to take any reasonable measure to abate the risks" he faced. Am. Compl., R.10, ¶ 29. Further, some jail staff did attempt to provide basic medical care and screening to Lewis. Those officials' failure to properly diagnose Lewis might well sound in negligence rather than inadequate training. Other behavior by certain jail staff—like comments making light of Lewis's distress—points toward misconduct or indifference rather than training failures on the County's part. But Byrum's now-abandoned individual-capacity claims, not *Monell* claims, were the way to pursue that kind of individual misbehavior.

The majority's outcome—allowing Byrum's training claim to proceed without allegations about training—does not square with our prior cases. *Linden* provides a ready example. There, four emergency medical personnel responded to a call that Timesha Beauchamp was unresponsive. *Linden*, 75 F.4th at 600. The first responders allegedly attempted to resuscitate Beauchamp but eventually stopped and declared her deceased. *Id.* Even when "numerous medical indicators"—like "electrical activity" on her cardiac monitor and her "perceptible" "breathing and pulse"—"showed that Beauchamp was not dead," the first responders "stuck to their conclusion that Beauchamp was dead." *Id.* Beauchamp—who was still alive—was then placed in a body bag and transported to a funeral home, where she later awoke. *Id.* at 601. Weeks later, she succumbed to the incident. *Id.* Her estate then sued the first responders and the City of Southfield, Michigan. *Id.*

If the majority's inference rule applied, a failure-to-train claim should have proceeded. After all, several different first responders failed to recognize the "obvious signs of life Beauchamp displayed." *Id.* at 606. But when the case reached this Court, we affirmed the

dismissal of the estate's failure-to-train claim against the city. *Id.* We explained that the complaint "marshals no facts to support" the "bare conclusion" that the "City provided the First Responders with inadequate training." *Id.* So despite the clear failures by the first responders, we did not infer inadequate training by the city. *Id.* Rather, we concluded that the complaint failed to state a claim because it "d[id] not contain any factual allegations about the content or extent of training the First Responders received." *Id.* That discussion reflects not a bespoke rule for "first responders" and others with "specialized education and expertise," Maj. Op. 14, but the application of standard pleading rules to failure-to-train claims more generally. And if no "factual allegations about the content or extent of training" meant no failure-to-train claim in *Linden*, Byrum's identical pleading defect should produce the same result. 75 F.4th at 606.

Linden isn't the only case on point. In *Wright*, this Court confronted another failure-to-train claim arising from officers' executing a nighttime search of the wrong house based upon an improper warrant. 144 F.4th 817. The *Wright* plaintiffs did not plead anything specific about Louisville Metro's training. Instead, they advanced the same inference argument the majority now accepts: The failure to train officers, they argued, was "apparent from the facts alleged in the Complaint" when the allegations were "[t]aken as a whole." Principal Br. for Appellants 49, *id.* (6th Cir. Jan. 17, 2025). We disagreed that the complaint contained "plausible allegations" to support a failure-to-train claim and affirmed dismissal. *Wright*, 144 F.4th at 827. Our reasoning was clear: "When stripped of the legal conclusions, the Complaint contains no factual allegations indicating what the training policies were,[1] why they were inadequate, how the city was deliberately indifferent, or how the failures related to the Wrights' injuries." *Id.* (quoting *Wright v. Louisville Metro Gov't*, 2022 WL 178591, at *4 (W.D. Ky. Jan. 19, 2022)).

In short, the need to allege "specific details" about training is not a new suggestion. *Cf.* Maj. Op. 13. It is instead the floor our caselaw sets for plausibly pleading a failure-to-train claim.

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[1]The majority seeks to distinguish *Wright* by noting that here, unlike there, Byrum has "identified" the specific screening policy "that the officers were insufficiently trained on." Maj. Op. 14. With respect, that conflates two separate issues—whether the jail had a policy about screening (allegations we have), and what the "training polic[y]" was for informing staff about the screening protocol (allegations we don't have). *Wright*, 144 F.4th at 827 (citation omitted).

Helphenstine v. Lewis County, 60 F.4th 305 (6th Cir. 2023), on which the majority relies, does not alter that conclusion. *Helphenstine*'s consideration of the failure-to-train theory arose at summary judgment. And the summary-judgment record contained affirmative evidence—there, employee testimony—regarding the content of the training program. *Id.* at 324. Specifically, several employees "testified that they had not received any training regarding withdrawal or how to identify medical emergencies." *Id.* It was that evidence in *Helphenstine*—not a connect-the-dot inference from poor conduct back to training—that drove the failure-to-train analysis. *Helphenstine*'s conclusion in short arose from a posture and record far afield from ours. So it does not excuse a pleading-stage plaintiff from including "factual allegations about the content or extent of training" to support a failure-to-train claim. *Linden*, 75 F.4th at 606.

The majority objects that requiring such plaintiffs to plead "specific[s]" could make pursuing cases harder. Maj. Op. 13. But that simply reflects the reality that the "demanding" failure-to-train standard is "notoriously difficult" to meet. *Gambrel v. Knox County*, 25 F.4th 391, 408 (6th Cir. 2022); *Allen v. Hays*, 65 F.4th 736, 749 (5th Cir. 2023). And we "must" apply that standard "to ensure that" the County "is not held liable solely for the actions of its employee[s]." *Brown*, 520 U.S. at 405.

Stepping back, the majority's objection could be (and has been) made against the baseline rule requiring "enough factual matter" to render legal claims plausible. *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 556 (2007); *cf. id.* at 575 (Stevens, J., dissenting) ("Under the relaxed pleading standards of the Federal Rules, the idea was not to keep litigants out of court but rather to keep them in."). Yet those settled pleading standards and our precedents direct our outcome, any policy concerns notwithstanding.

Against our caselaw, the majority disclaims that its holding is "broad" or creates any conflict. Maj. Op. at 13.[2] Rather, the majority continues, its approach captures some case-specific difference between the "plausibility of the inference" arising from Byrum's allegations, on one hand, and the other complaints that have failed, on the other. *Id.* at 15. But that difference-in-degree approach risks converting every failure-to-train suit into a line-drawing

[2]Of course, to the extent there is conflict, "it is the earlier case[s] that control[]." *Dupont Dow Elastomers, LLC v. NLRB*, 296 F.3d 495, 506 (6th Cir. 2002).

exercise lacking easy answers. What is a "total failure" of municipal staff, *id*. at 11, 12, as opposed to an "inaccurate call" or "the mistakes of a few individuals"? *Id.* at 13, 14. And if total failure means doing nothing, then why don't the attempts by some jail staff here to provide medical care count? Is inadequate action by two or three jail staff enough? Does the answer depend on how many total jail staff are employed? On how many interact with the prisoner? Or on the length of a prisoner's jail stay? The majority may view the answers in this case as easy. But I fear courts will be left guessing about how to apply its failure-to-train formulation in cases to come.

Whatever the intended scope of the majority's holding, I fail to see its legal footing. Shortcomings by municipal staff, standing alone, have never been enough to plausibly plead a claim for inadequate training. That is because even widespread failures are consistent with other explanations: "an otherwise sound program" may be "negligently administered," and "adequately trained officers occasionally make mistakes; the fact that they do says little about the training program or the legal basis for holding the city liable." *City of Canton*, 489 U.S. at 391. After all, "vicarious liability will not attach under § 1983." *Id.* at 385. And when failures by staff "are merely consistent with" a deficient training program, a complaint "stops short of the line between possibility and plausibility." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citation omitted).

To be sure, a plaintiff need not produce specific evidence at the pleading stage. But she must allege enough specific facts about a municipality's training to permit a reasonable inference that the training program was inadequate. Byrum's amended complaint supplies none.

Deliberate indifference. The absence of training-specific allegations also forecloses Byrum's ability to plausibly plead deliberate indifference to inadequate training. As our en banc Court has recently explained, "not every risk or injury experienced by a detainee amounts to punishment for due-process purposes." *Poynter ex rel Fernandez v. Shirley*, ___ F.4th ____, 2026 WL 2641092, at *7 (6th Cir. Sep. 8, 2026) (en banc). Rather, a claimant must demonstrate "an *intent* to punish by the jailer." *Id.* (citation omitted). Given the "gatekeeping role" subjective knowledge plays, "an official's failure to alleviate a significant risk that he should

have perceived but did not cannot be condemned as the infliction of punishment." *Id.* (cleaned up) (quoting *Farmer v. Brennan*, 511 U.S. 825, 838 (1994)).

The majority seeks to surmount that subjective-knowledge hurdle using a single-incident theory of deliberate indifference. That pathway is available only "in a narrow range of circumstances" where the municipality fails "to equip law enforcement officers with specific tools to handle recurring situations" presenting an "obvious potential" for constitutional violations. *Brown*, 520 U.S. at 409. The need for more or different training than the municipality offers must be "so obvious, and the inadequacy so likely to result in the violation of constitutional rights," that municipal policymakers "can reasonably be said to have been deliberately indifferent." *City of Canton*, 489 U.S. at 390.

Those deliberate-indifference rules build from a necessary premise missing here: That something about a municipality's "failure to adequately train" has indeed been pled. Maj. Op. 17-18. Without allegations describing the training a municipality provided (or failed to provide), a court cannot reasonably infer that the municipality knew officers lacked a "specific tool[]" needed to address recurring risks to constitutional rights, *Brown*, 520 U.S. at 409, that there was a "particular glaring omission in a training regimen," *id.* at 410, or that the training's "inadequacy" was "so obvious" that the municipality's failure to correct it amounted to deliberate indifference, *City of Canton*, 489 U.S. at 390. Put simply, Byrum cannot plausibly plead that the County "knowingly" maintained a faulty training regime without plausibly pleading that there were faults to know about. *Poynter ex rel Fernandez*, ___ F.4th at ____, 2026 WL 2641092, at *12 (citation omitted).

Byrum and the majority shift focus to more general allegations. They point to the ongoing opioid epidemic, the sheriff's public comments about the risk of drug overdoses, and the prevalence of drug addiction. From there, they conclude that the need to train staff on medical screening and handling drug-related medical crises is obvious. They then note the potential consequences of inadequate training, including detainee deaths.

That discussion may show that the County was aware of a general risk that in turn created a need for training on certain topics. But such abstract knowledge about the risk of drug-related

incidents says nothing about the County's training program, let alone establish that the program suffered from a specific constitutional deficiency. *City of Canton*, 489 U.S. at 390; *see also Winkler v. Madison County*, 893 F.3d 877, 903 (6th Cir. 2018) (plaintiff failed to "explain how the quality of the medical training provided put the County on notice of the likelihood that jail personnel would respond inadequately to an inmate's medical emergency"). The majority opinion's statement that it can "infer deliberate indifference from the County's failure to adequately train its jail staff" thus assumes facts—inadequate training—lacking plausible support in Byrum's amended complaint. Maj. Op. 17-18. I would not so lightly "permit[] an inference of punitive intent" on the County's part from a complaint that lacks any "factual content" connected to the County. *Poynter ex rel Fernandez*, ___ F.4th at ____, 2026 WL 2641092, at *15; *Iqbal*, 556 U.S. at 678.

Causation. Byrum fares no better on the causation element. Pleading causation requires plausibly alleging that the deficient training "actually caused" the constitutional violation. *City of Canton*, 489 U.S. at 391. The training shortfall must be "the 'moving force' behind the injury alleged." *Brown*, 520 U.S. at 404. So the complaint must allege facts permitting an inference that the constitutional injury would "have been avoided had the employee been trained under a program that was not deficient in the identified respect." *City of Canton*, 489 U.S. at 391. But without any allegations about the County's training program, we don't know what, if any, deficiency existed. That means we cannot infer that a particular training deficiency caused the alleged injury. That is especially true here, where Byrum's complaint alleges that other factors—including "sheer indifference"—might have caused Lewis's death. Am. Compl., R.10, ¶ 29. In short, there is no basis to conclude that a shortfall in the training program—rather than individual negligence or willful deviation from existing policy and training—caused the harm.

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The amended complaint's silence on the County's training program means Byrum has not satisfied the rigorous requirements of pleading a plausible failure-to-train claim. I therefore would affirm the district court's dismissal order in its entirety.