Legal Rights of Prisoners and Detainees with Diabetes: An Introduction and Guide for Attorneys and Advocates

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Constitutional Provisions

INTRODUCTION

People with diabetes frequently experience problems with medical care while in detention. The consequences of this improper care can be stark: periods of unconsciousness leading to injuries, infections and amputations, vision loss and blindness, hospitalization, brain damage, and even death. Even when no long term physical harm occurs, the fear and uncertainty caused by improper medical care can cause enduring emotional and psychological damage to people with diabetes in detention, and their concerned family and friends.

Unfortunately, no one source has collected together relevant law that may provide protection or compensation for individuals with diabetes in detention. This memorandum seeks to fill that gap by surveying current federal case law regarding the rights and protections afforded prisoners and pretrial detainees with diabetes, and providing suggestions for bringing successful diabetes-related claims. Under federal law, detainees have the strongest protections under the Eighth and Fourteenth Amendments, which prohibit deliberately indifferent medical care. Additional protections against disability discrimination arise from the Americans with Disabilities Act and the Rehabilitation Act. State and local laws may provide additional protections for negligence or medical malpractice, even if the medical treatment does not rise to the level of deliberate indifference. Various state law claims may exist for medical wrongful death, intentional infliction of emotional distress, battery, and negligent hiring, training, or supervision, particularly in the pre-trail detainee context, and should be considered in any active case involving a person in detention. However, a state-by-state survey of relevant law is beyond the scope of this paper.

Despite the rights afforded to detained individuals, relatively few claims are brought by attorneys, as relatively few have developed expertise in litigating these types of cases. Thus, much case law has been based on the complaints of *pro se* plaintiffs in detention. It is not particularly surprising that *pro se* plaintiffs—who often do not have access to computers, research tools or basic legal materials—have had limited success. Nonetheless, courts have upheld suits against prison officials under all of the above laws, including suits based on failure to monitor diabetes, failure to provide for special dietary needs, and failure to provide insulin or other diabetes medication.[1] Prevailing plaintiffs have received substantial settlements or judgments for compensatory and punitive damages, plus attorney's fees and costs, and courts have ordered injunctive relief mandating that pretrial detainees and prisoners receive prompt medical evaluation and treatment.[2] The need for development of the law in this area is substantial, as are the opportunities.

[1] *See, e.g.*, *Rosen v. City of Philadelphia*, No. 2000-764, 2001 U.S. Dist. LEXIS 5371, at *6–7 (E.D. Pa. 2001); *Order and Final Judgment* at 3-9*; Rosen v. City of Philadelphia*, No. 2000-764, (E.D. Pa. 2003) (plaintiffs—consisting of persons with diabetes that had been denied timely and appropriate medical care and diet while in police custody—obtained substantial concessions from the defendant city); *Bailey v. City of Lowell*, No. 1:09-cv-10546-RGS (D. Mass. 2009) ($12,500 settlement for failure to provide diabetes foot care in pretrial detention; officers must receive training on diabetes, hypoglycemia, and hyperglycemia for at least three years from the date of the settlement); Southern Poverty Law Center, *Settlement Benefiting Diabetic Inmates is Model for Nation*, SPLC (Jan. 22nd, 2004), http://www.splcenter.org/get-informed/news/settlement-benefiting-diabetic-inmates-is-model-for-nation (Accessed Dec. 1, 2014).

[2] *Vargas v. City of New York*, 105 A.D.3d 834, 834-835 (N.Y. App. Div. 2d Dep't 2013) (jury judgment of over $17 million set aside as a matter of law for failure to state a claim of negligence and civil rights violations), *motion for leave to appeal granted in* 22 N.Y.3d 858 (N.Y. 2013) ; Adriane Quinlan, *After Diabetic Woman's Arrest, a $125,000 Settlement*, NYTimes Blog (July 18, 2011), http://cityroom.blogs.nytimes.com/2011/07/18/after-diabetic-womans-arrest-a-125000-settlement/?_php=true&_type=blogs&_r=0 (Accessed Dec. 1st, 2014); Joseph A. Slobodzian, *City agrees to settle prisoners' diabetes case*, Philly.com (March 14, 2003), http://articles.philly.com/2003-03-14/news/25472811_1_settlement-american-diabetes-association-city-and-police (Accessed Dec. 1st, 2014) (providing $206,000 to police detainees with diabetes who got sick after being denied care); Huffington Post, *Deborah Braillard Lawsuit: Family Of Deceased Inmate Wins $3.25 Million From Sheriff Joe Arpaio's Department*, (Nov. 21st, 2012), http://www.huffingtonpost.com/2012/11/21/deborah-braillard-lawsuit_n_2171281.html?view=print&comm_ref=false (Accessed Dec. 1st, 2014).

I. THE SCIENCE AND MEDICINE OF DIABETES

Diabetes is a disorder of the endocrine system which affects over 29 million Americans and is characterized by high blood glucose levels resulting from defects in insulin secretion, insulin action or both. The pancreas is responsible for making and secreting insulin, a hormone that is used to regulate the level of glucose in the blood.[3] In diabetes, the pancreas has trouble producing sufficient insulin, limiting the body's ability to regulate glucose and convert it into energy.[4]

Normally, during digestion, the body changes sugars, starches, and other foods into a form of sugar called glucose. The blood then carries this glucose to cells throughout the body. There, with the help of insulin, glucose enters the cells and is changed into quick energy for the cells to use or store for future needs. Even in people without diabetes, blood glucose levels go up and down throughout the day in response to food and the needs of the body. For someone with a functioning endocrine system, however, the body is able to keep blood glucose levels within a normal, healthy range of fluctuations. In diabetes, this process is disrupted because insulin is not present or cannot be used properly. When insulin is absent or ineffective, the glucose in the bloodstream cannot be used by the cells to make energy. Instead, glucose collects in the blood, leading to high glucose levels (hyperglycemia). This is the defining characteristic of untreated diabetes.

[3] *See* Centers for Disease Control & Prevention, National Center for Chronic Disease Prevention and Health Promotion, Division of Diabetes Translation, *National Diabetes Statistics Report* (2014), available at http://www.cdc.gov/diabetes/pubs/statsreport14/national-diabetes-report-web.pdf. (Accessed Dec. 1st, 2014).
[4] For more information *see* American Diabetes Association, *Diagnosis and Classification of Diabetes Mellitus,* 37 Diabetes Care no. 1, Supp. 81-90, (Jan. 2014) available online at http://care.diabetesjournals.org/content/37/Supplement_1/S81.full (Accessed Dec. 1, 2014); American Diabetes Association, *Standards of Medical Care in Diabetes 2014*, 37 Diabetes Care no. 1, Supp. 14-80 (Jan. 2014).

A. Types of Diabetes

There are two main types of diabetes: type 1 diabetes and type 2 diabetes.[5] Both involve changes in blood glucose levels, but there may be dramatic differences in the kinds of care they require. This is particularly important to recognize and apply in the detention context, where people with diabetes are dependent on care from others, and where misdiagnosis and improper treatment are frequent problems.[6]

In type 1 diabetes, the pancreas stops making insulin or makes only a tiny amount.[7] Type 1 develops when the body's immune system destroys beta cells in the pancreas, the only cells in the body that make insulin. Thus, the body is no longer able to produce significant amounts of insulin, and a person with type 1 diabetes must receive insulin from an outside source in order to survive. Insulin is typically administered through injections or use of an insulin pump, a small mechanical device that administers insulin through a tube into a permanent injection site. Failure to administer insulin in a timely manner to a person with type 1 diabetes can lead to diabetic ketoacidosis (DKA), a potentially fatal condition caused by severely elevated blood glucose levels.[8]

[5] A third type of diabetes, gestational diabetes, occurs during pregnancy, and usually ends with the pregnancy. Individuals with gestational diabetes typically manage with very close monitoring of blood glucose, diet, and exercise, and, in some cases, insulin. If they take insulin, they are at risk of hypoglycemia just like people with type 1 and 2 who take insulin. Since gestational diabetes is rare in prison contexts, it is not addressed in this paper.
[6] For detailed information on diabetes care in prison, *see* American Diabetes Association, *Diabetes Management in Correctional Institutions*, 37 Diabetes Care no. 1, Supp. 104-111 (Jan. 2014) available online at http://care.diabetesjournals.org/content/37/Supplement_1/S104 (Accessed Dec. 1st, 2014); *see also* Federal Bureau of Prisons, Management of Diabetes: Federal Bureau of Prisons Clinical Practice Guidelines, (June 2012) available online at http://www.bop.gov/resources/pdfs/diabetes.pdf (Accessed Dec. 1st, 2014).
[7] Type 1 diabetes is sometimes still referred to as "juvenile diabetes" or "insulin-dependent diabetes," these terms should be avoided, as they are ambiguous and no longer favored by the diabetes health care community.
[8] American Diabetes Association, *Hyperglycemic Crises in Diabetes*, 27 Diabetes Care no. 1, Supp. 94-102 (Jan. 2004).

Type 2 diabetes is by far the most common type of diabetes—approximately 95% of people with diabetes have type 2 diabetes.[9] In type 2 diabetes, the body retains the ability to make insulin, but cannot make enough to meet its needs.[10] It is generally believed that in people with type 2 diabetes the body's cells cannot recognize insulin or use it as effectively as in people without diabetes (a condition known as insulin resistance). Generally over time the strain on the pancreas will decrease its ability to produce insulin and will cause blood glucose levels to rise. Some people with type 2, particularly in the early stages of the disease, can control their diabetes solely through diet and exercise. Treatment may then progress to use of oral medications. Finally, as the disease progresses, some people with type 2 diabetes may receive insulin administrations as frequently as a person with type 1 diabetes. However, people with type 2 diabetes, even those who use insulin, have a much lower chance of experiencing deadly diabetic ketoacidosis (DKA) than a person with type 1 diabetes. [11]

B. Hypoglycemia

Insulin and oral medications which lower blood glucose levels are used to treat diabetes. All types of insulin and some oral medications can lower blood glucose levels too much, leading to a potentially dangerous condition known as hypoglycemia (low blood glucose levels).[12] The medical definition of hypoglycemia is a blood sugar reading of 70 mg/dL or below.[13] Symptoms of mild to moderate hypoglycemia include tremors, sweating, lightheadedness, irritability,

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[9] *See National Diabetes Statistics Report*, *supra*, note 4.
[10] Type 2 diabetes is sometimes referred to as "adult-onset diabetes" or "non-insulin dependent diabetes." These terms are also outdated and disfavored.
[11] Guillermo E. Umpierrez et al., *Diabetic Ketoacidosis and Hyperglycemic Hyperosmolar Syndrome*, 15 Diabetes Spectrum no. 1, 28–36 (Jan. 2002), available online at http://spectrum.diabetesjournals.org/content/15/1/28.short (last visited Dec. 1st 2014).
[12] Wendy L. Bennett, et al. *Comparative effectiveness and safety of medications for type 2 diabetes: an update including new drugs and 2-drug combinations*. 154 Annals of Internal Medicine no. 9, 602-613 (May, 2011), available online at http://annals.org/article.aspx?articleid=746950 (Accessed Dec. 1st, 2014).
[13] *See* American Diabetes Association Workgroup on Hypoglycemia, *Defining and Reporting Hypoglycemia in Diabetes*, 28 Diabetes Care no. 5, 1245–49 (May 2005), available online at http://care.diabetesjournals.org/content/28/5/1245.full (Accessed Dec. 1st, 2014).

confusion, and drowsiness. It is easy to mistake the symptoms of hypoglycemia for alcohol or drug intoxication. Hypoglycemia usually can be treated easily and effectively by consuming a ready source of glucose such as fruit juice. If it is not treated promptly, however, hypoglycemia can become severe and potentially life-threatening. Symptoms of severe hypoglycemia include inability to swallow, convulsions or unconsciousness.

Insulin directly lowers the body's blood glucose level, and will lead to hypoglycemia in some situations.[14] Most oral medications do not cause hypoglycemia because they do not act to increase native insulin activity.[15] However, a class of oral drugs (known as sulfonylureas) can lower blood glucose by stimulating the pancreas to produce and release more insulin.[16]

It is important to distinguish between severe hypoglycemia and its milder forms. All people with type 1 diabetes, and some people with type 2 (those who are taking insulin or oral medications which lower blood glucose levels) will experience hypoglycemia.[17] It is simply not possible with current diabetes treatment to regulate blood glucose levels as tightly as people without diabetes do naturally. However, many people with diabetes will rarely, or never, experience severe hypoglycemia or lose consciousness. When blood glucose levels drop,

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[14]Insulin is not the only injected medicine used by people with diabetes. People with type 2 diabetes may use other injectable medications, including Byetta and Victoza. These injected medications may be confused with insulin, but they are not related drugs, and do not normally cause hypoglycemia. *See* Erika Gebel, *A Quick Guide to Incretin-based Medicines*, Diabetes Forecast (Dec. 2009), available online at http://www.diabetesforecast.org/2009/dec/a-quick-guide-to-incretin-based-medicines.html (Accessed Dec. 1st, 2014).

[15] Other classes of diabetes drugs include those that keep the liver from releasing too much glucose (biguanides), slow the digestion of starches (alpha-glucosidase inhibitors), or that make muscle cells more sensitive to insulin (thiazolidinediones). Like sulfonylureas, meglitinides also stimulate insulin release by the pancreas, but do not typically cause hypoglycemia. For more information about oral diabetes medications, *see American Diabetes Association Complete Guide to Diabetes*, 5th ed. Alexandria, VA, American Diabetes Association, 2011 at 169–80.

[16] UK Prospective Diabetes Study Group, *Intensive blood-glucose control with sulphonylureas or insulin compared with conventional treatment and risk of complications in patients with type 2 diabetes (UKPDS 33)*, 352 Lancet issue 9131, 837-853 (Sept. 12th, 1998), available online at http://www.thelancet.com/journals/lancet/article/PIIS0140-6736%2898%2907019-6/fulltext (Accessed Dec. 1st, 2014).

[17] Individuals who are not taking insulin or oral medications known as sulfonylureas (in other words, those who have type 2 diabetes treated with diet and exercise, or with other classes of medications) are not subject to any of the risks of hypoglycemia.

individuals with diabetes first experience milder hypoglycemia, which can then become severe if untreated, leading to loss of consciousness. Most people with diabetes are able to recognize the signs and symptoms of mild hypoglycemia, and will be able to treat the condition to keep it from becoming severe.[18]

C. Hyperglycemia

Hyperglycemia (high blood glucose) can cause a host of symptoms and can also eventually lead to more severe consequences.[19] Hyperglycemia generally begins at 200 mg/dL, but individuals differ in the point at which they begin to show symptoms. The symptoms of mild to moderate hyperglycemia include hunger, thirst and dehydration, headache, nausea, fatigue, blurry vision, frequent urination, and itchy and dry skin. Individuals with hyperglycemia can also have fruity smelling breath, which can be mistaken for the smell of alcohol. In addition to these short-term consequences of acute hyperglycemia, chronic high blood glucose levels can cause a number of very serious long-term complications, such as nerve damage, heart disease, blindness, kidney failure, stroke, and death.[20] Thus, in situations where a person is unable to take medication to address high blood glucose for an extended period of time, their chances of experiencing these health complications rises.

If a person who needs insulin is not able to take that medication for a period ranging from several hours to several days, he or she can experience diabetic ketoacidosis (DKA). Type 1

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[18] Jeffrey Unger, *Uncovering undetected hypoglycemic events*, 5 Diabetes Metabolic Syndrome & Obesity 57-74 (2012), available online at http://pubmedcentralcanada.ca/pmcc/articles/PMC3340111/ (Accessed Dec. 1st. 2014).
[19] *See* Umpierrez et al, *Diabetic Ketoacidosis and Hyperglycemic Hyperosmolar Syndrome*, *supra* note 11.
[20] Christopher J. Schofield, et al., *Diabetes Care Mortality and Hospitalization in Patients After Amputation/ A comparison between patients with and without diabetes*, 29 Diabetes Care no. 10, 2252-2256 (Oct. 2006), available online at http://care.diabetesjournals.org/content/29/10/2252 (Accessed Dec. 1st, 2014); *see also* Donald S. Fong, *Diabetic Retinopathy*, 27 Diabetes Care no. 10 (Oct. 2004).

diabetes has a greatly increased risk of DKA as compared to type 2 diabetes.[21] DKA is a life-threatening and often deadly consequence of a shortage of insulin. The body begins to burn fatty acids for energy since it cannot use the glucose without insulin. The byproduct of breaking down fatty acids are ketone bodies, which render the blood acidic. Diabetic ketoacidosis, if left untreated, will eventually result in death.[22]

D. Summary of Medical Care for Diabetes in Prison

In sum, diabetes is a widespread and serious health condition with two significantly different types, and individual variations in its manifestation and care. Individuals with type 1 diabetes will require regular administration of insulin, and possible emergency care for severe hyperglycemia or DKA. Individuals with type 2 diabetes may require administration of oral medications, or a modified administration of insulin, depending on the progression of their condition. For both types of diabetes, effective care may require regular blood glucose checks to avoid hyperglycemia or hypoglycemia, managing carbohydrate intake to avoid swings in blood glucose levels, and care for secondary complications such as vision problems, nerve pain, kidney failure or heart problems.[23]

[21] People with type 2 diabetes are more likely to develop hyperglycemic hyperosmolar syndrome. The mortality rate for this condition is high. *See* Umpierrez et al, *Diabetic Ketoacidosis and Hyperglycemic Hyperosmolar Syndrome*, *supra*, note 11.
[22] American Diabetes Association, *Hyperglycemic Crises in Diabetes*, 27 Diabetes Care no. 1, Supp. 94-102 (Jan. 2004).
[23] For detailed information on diabetes care in prison, *see Diabetes Management in Correctional Institutions*, *supra*, note 6.

DISCUSSION

I. DELIBERATE INDIFFERENCE TO SERIOUS MEDICAL NEEDS

A. Constitutional Prohibition Against Deliberate Indifference to Serious Medical Needs as Cruel and Unusual Punishment

Most successful federal claims related to medical treatment for people with diabetes in correctional facilities are brought under the United States Constitution. The Eighth Amendment protects people in custody who have been convicted of crimes, and prohibits inflicting "cruel and unusual punishments." U.S. CONST. AMEND. VIII. Although the Constitution does not require comfortable prisons, "neither does it permit inhumane ones." *Farmer v. Brennan*, 511 U.S. 825, 832 (1994). It is settled law that "the treatment a prisoner receives in prison and the conditions under which he is confined are subject to scrutiny under the Eighth Amendment." *Id.* (quotations omitted).

People in pre-conviction detention, including people in jails or holding cells, have similar protects under the Fourteenth Amendment. *See, e.g.*, *City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983) (due process under 14th Amendment protects pre-trial detainees). People subject to arrest are protected by the Fourth Amendment. *See, e.g., Currie v. Chhabra*, 728 F.3d 626 (7th Cir. 2013) (protections under Fourth Amendment for individuals detained by police). The Fourth Amendment applies to individuals have not been charged with a crime, but are still detained by police officers.[24]

Cruel and unusual punishment under the Eighth Amendment includes deliberate indifference to serious medical needs. *See, e.g., Estelle v. Gamble*, 429 U.S. 97, 104 (1976).

[24] For more information on this topic, which is outside the scope of this paper, a companion paper directly addresses law enforcement response and misconduct affecting people with diabetes. *See* Sarah Fech and Greg Murray, American Diabetes Association, *Inappropriate Law Enforcement Response to Individuals with Diabetes: An Analysis of Federal Law* (Sept. 2014).

Deliberate indifference has both an objective and a subjective component. *Hunt v. Uphoff*, 199 F.3d 1220, 1224 (10th Cir. 1999) (citing *Farmer*, 511 U.S. at 834). To satisfy the objective component, the medical need must be "sufficiently serious." *Id.* More specifically, the condition must be "one that has been diagnosed by a physician as mandating treatment or one that is so obvious that even a lay person would easily recognize the necessity for a doctor's attention." *Id.* (quoting *Ramos v. Lamm*, 639 F.2d 559, 575 (10th Cir. 1980)). The subjective component is satisfied when a plaintiff establishes that defendant knew plaintiff faced "a substantial risk of harm and disregarded that risk, 'by failing to take reasonable measure to abate it.'" *Young v. Warren*, 151 Fed. Appx. 664, 666 (10th Cir. 2005) (quoting *Farmer*, 511 U.S. at 847).

1. Objective Component: Diabetes as a Serious Medical Condition

The consensus judicial opinion is that, for constitutional deliberate indifference claims, diabetes is objectively a "serious medical condition." *See, e.g., Ortiz v. City of Chicago*, 656 F.3d 523, 532 (7th Cir. 2011) (identifying diabetes type 1 diabetes as a "serious medical condition" for purposes of a deliberate indifference claim). This is treated as almost a *per se* rule by many courts.[25]

In rare cases, courts make distinctions between the seriousness of different types or manifestations of diabetes. The Third Circuit Court noted that not all insulin-treated people with diabetes require the same level of medical care. *See Rouse v. Plantier*, 182 F.3d 192, 198 (3rd

[25] See also *Williams v. Hartz*, 43 Fed. Appx. 964, 965 (7th Cir. 2002) ("diabetes is a serious medical condition"); *Naphier v. County of Genesee*, No. 11-13754, 2012 U.S. Dist. LEXIS 180845, 22-23 (E.D. Mich. 2012) ("It takes no medical training to understand that when a diabetic is deprived of her insulin, grave consequences follow. That fact might even be relegated to the category of common knowledge"); *Aull v. Osborne*, No. 4:07CV-00016, 2009 U.S. Dist. LEXIS 2914, *16 (W.D. Ky. 2009) ("diabetes unquestionably is a serious medical condition"); *Suggs v. Mobley*, No. 2:05cv00281 JMM-JWC, 2008 U.S. Dist. LEXIS 107339, *7 (E.D. Ark. 2008) ("It is undisputed that diabetes is a serious medical condition, especially the type that requires insulin administration."); *Rollins v. Magnusson*, No. 03-82-B-W, 2004 U.S. Dist. LEXIS 25873, *10 (D. Me. 2004) ("Rollins's [type 2] diabetes is a serious medical condition and he has a constitutional right to receive medical treatment for that condition, including medications such as insulin").

Cir. 1999). The court distinguished between "unstable diabetes"—where blood sugar levels consistently fluctuate—and "'stable' diabetics" whose blood sugar levels remain consistent over time. *Rouse*, 182 F.3d at 198. The court suggested, without extensive analysis, that unstable diabetes would more apparently rise to the level of a serious medical condition. *Id.*

Some courts have questioned whether type 2 diabetes is always a serious medical need. In *Hale v. Burns*, an inmate claimed the prison denied him a special meal for people with diabetes, once, and once failed to administer one dosage of oral medication for type 2 diabetes. *Hale v. Burns*, No. 2:06-CV-136, 2007 U.S. Dist. LEXIS 50033, *7 (E.D.Tenn. 2007). The treating nurse claimed missing one dosage "would not kill him." *Id.* The court acknowledged that diabetes "may" qualify as a serious medical need. *Id.* at *8. However, the court argued that in this particular case, there was no indication that the inmate experienced any symptoms with respect to diabetes, and the plaintiff furnished no details from which to infer that a missed dose of "diabetic medication" or a one-time deprivation of a diabetic diet amounted to a "sufficiently serious medical need." *Id*. at *8 (quoting *Bellamy v. Bradley*, 729 F.2d 416, 419-20 (6th Cir. 1984)).[26]

In sum, most courts assume that diabetes is a serious medical condition, including non-insulin using type 2 diabetes, with little additional evidence required. *See, e.g., Ortiz*, 656 F.3d at 527, 530-32 (accepting plaintiff's medically incorrect assertion that failure to monitor blood glucose and take oral medication for Type 2 diabetes could cause a detainee to "slip into either a hyperglycemic or hypoglycemic state, which could lead to a fatal coma"). Nevertheless, some courts view type 2 diabetes skeptically, especially if the plaintiff in question has presented little

[26] *See also Herrerra v. Mich. Dep't of Corr*., No. 5:10-CV-11215, 2011 U.S. Dist. LEXIS 98576, 50-51 (E.D. Mich. 2011) ("even if plaintiffs alleged sufficient facts to show that their diabetes . . . constituted serious medical needs, the complaint fails to allege that defendants were deliberately indifferent to those needs"); *Smith v. Bree*, No. C 06-00103 JF (PR), 2011 U.S. Dist. LEXIS 34094 (N.D. Cal. 2011) ("although Type 1 diabetes is a serious medical condition … no legal authority holds that this also is the case for non-insulin dependent diabetes").

or no substantive facts about diabetes. *See, e.g.*, *Hale*, 2007 U.S. Dist. LEXIS 50033. Plaintiffs, therefore, should not assume that a court will understand the seriousness of diabetes; instead, they should plead specific facts that clearly show the dangerous consequences of improper diabetes care.[27]

2. Subjective Component: Requisite Knowledge by Prison Officials of Substantial Risk Caused by Diabetes

Deliberate indifference requires an examination of a prison officials' subjective mental state. *Farmer*, 511 U.S. at 842. A prison official who is unaware of a substantial risk of harm might escape liability, even if that risk was obvious and a reasonable prison official should have noticed it. *Id.* The requisite mental state required is similar to that required for criminal recklessness: more than mere negligence, but not requiring a specific purpose to cause substantial harm. *Id.* at 835-36; *Vaughn v. Gray*, 557 F.3d 904, 908 (8th Cir. 2009) (deliberate indifference standard requires a "mental state akin to criminal recklessness: disregarding a known risk to the inmate's health.") In other words, there is no constitutional violation unless a prison official knows about and disregards a substantial risk of serious harm, even if the action in question "constitutes medical malpractice." *Self v. Crum*, 439 F.3d 1227, 1232 (10th Cir. 2006).

However, this subjective knowledge may be proved through circumstantial evidence. *Farmer*, 511 U.S. at 842. This evidence can show the risk was so obvious that the prison official must have known about it. *Id.*; *see also Owensby v. City of Cincinnati*, 385 F. Supp. 2d 626, 648 (S.D. Ohio 2004) (holding that "the fact that the official actually drew the required inference may be demonstrated through circumstantial evidence or by showing that the risk was 'obvious'"). In other words, objective evidence of extremely obvious medical needs may prove an official must have known about those needs, even if the official denies medical knowledge of

[27] For detailed information on diabetes care in prison, *see Diabetes Management in Correctional Institutions*, 37 Diabetes Care no. 1, Supp. 104-111, *supra*, note 6.

diabetes and its consequences. *See Jackson v. Fauver*, 334 F. Supp. 2d 697 (D. N.J. 2004) (deliberate indifference may be proved through "objective evidence that a plaintiff had serious need for medical care, and prison officials ignored that evidence.") (quoting *Natale v. Camden Cnty. Corr. Facility*, 318 F.3d 575, 582 (3d Cir. 2003)); *see also Howard v. City of Columbus*, 239 Ga. App. 399, 404 (Ga. Ct. App. 2000) (holding that for the purposes of "deliberate indifference," knowledge does not require a "final diagnosis, correct diagnosis, or a complete medical history when the inmate has not been allowed to see and to be examined by a physician or when medical care has been unreasonably delayed").

For the purposes of proving deliberate indifference, a plaintiff must provide specific evidence on the subjective state of mind of each of the individual officials in question. Failure to do so will almost certainly lead to a dismissed suit. Even if the danger from lack of diabetes care would be blatantly obvious to a *reasonable* person, that is not sufficient. *See, e.g.*, *Self*, 439 F.3d at 1232. However, clearly obvious medication problems, such as unconsciousness, seizures, or infections, may be presented as evidence to show that the officer *must* have known something was seriously wrong with the detainee's health, rebutting any claims they make that they were ignorant of any serious health conditions. *See Natale*, 318 F.3d at 582.

B. Protections Against Deliberate Indifference for Pre-Trial Detainees Under the Fourteenth Amendment at Least as Great as Eighth Amendment

The Eighth Amendment protection against deliberate indifference only applies to post-conviction detainees, such as inmates in prisons; protections for pre-trial detainees under the due process clause of the Fourteenth Amendment are "*at least* as great as the Eighth Amendment protections available to a convicted prisoner." *City of Revere*, 463 U.S. at 244.. It is theoretically possible that protections for pre-trial detainees might be *stronger* than those provided to post-conviction prisoners. *See Gibson v. Cnty. of Washoe, NV.*, 290 F.3d 1175, 1188 n.9 (9th Cir.

2002) ("it is quite possible" that protections under Fourteenth Amendment "in some instances exceed those" under the Eighth Amendment) *accord Hubbard v. Taylor*, 399 F.3d 150, 158-59 (3d Cir. 2005). As a practical matter, though, most courts apply the same standards for deliberate indifference under the Eighth and Fourteenth Amendment. *See, e.g., Upham v. Gallant*, No. 99-2224, 2000 U.S. App. LEXIS 23915 (1st Cir. 2000) (under Fourteenth Amendment claim, "we apply an analysis identical to that applied in Eighth Amendment cases") (citing *Hare v. City of Corinth*, 74 F.3d 633, 643 (5th Cir. 1996).[28]

In practice, then, the standard for deliberate indifference is identical under the Eighth or Fourteenth Amendments. The distinction does have some relevance, though, if only as a pleading requirement, and the careful plaintiff will cite the correct amendment to avoid any unnecessary procedural delay.[29]

C. Procedural Issues Regarding Filing Claims for Constitutional Violations In the Prison Context

1. States, Municipalities, and Government Officials as Defendants

Most prison employees are government officials. Prisoners and pretrial detainees may bring a claim if they can establish that a person acting under the color of state law caused a "deprivation of any rights" afforded by the Constitution or federal law. 42 U.S.C. § 1983. This

[28] *See Caiozzo v. Koreman*, 581 F.3d 63, 71 n.3 (2d Cir. 2009) (string cite of cases applying same standard for both Amendments); *see also Hare*, 135 F.3d at 324 ("the State owes the same duty under the Due Process Clause and the Eighth Amendment to provide both pretrial detainees and convicted inmates with basic human needs, including medical care and protection from harm, during their confinement").

[29] At least one court has rejected a suit by a pretrial detainee who improperly pled his claim under the Eighth Amendment; however, the court granted leave to amend the complaint. *Chavez v. Bd. of County Comm'rs*, 899 F. Supp. 2d 1163, 1186-1187 (D.N.M. 2012) (this decision "may seem to be a technicality" but plaintiffs must provide the Court with "accurate allegations of the correct constitutional right"). In fact, it may be an abuse of discretion for a district court to refuse to grant leave to amendment a complaint, merely because of a mistaken plea under the Eighth Amendment, rather than the Fourteenth Amendment. *See Thomas v. Town of Davie*, 847 F.2d 771, 772-73 (11th Cir. 1988) (trial court abused its discretion by refusing to allow plaintiff to amend mistaken claim under Eighth Amendment); *see also Natale*, 318 F.3d at 581 (failure to plead under Fourteenth Amendment instead of Eighth Amendment "does no lasting damage," and the court made did not require plaintiff to amend complaint).

includes the prohibition of deliberate indifference to serious medical conditions under the Eighth or Fourteenth Amendments. Correctional officials and correctional medical personnel generally work under the color of law when performing their duties. *See, e.g.*, *Rivera v. LaPorte*, 896 F.2d 696 (2d Cir. 1990) (officers of prison working under color of law). For the purposes of 42 U.S.C. § 1983, a "person" includes individual employees, most city or county governments, private corporations, and employees of those corporations working pursuant to corporate policy. *See Monell v. Dep't of Social Services*, 436 U.S. 658, 690-91 (1978); *Correctional Services Corp. v. Malesko*, 534 U.S. 61, 71 n.5 (2001). This includes private contractors hired by the state, at least when performing state functions such as providing healthcare services. *See West v. Atkins*, 487 U.S. 42, 43 (U.S. 1988) (private physician contracted by state to treat inmates working under "color of law"). However, it is important to note that the state itself is not a "person." *Will v. Michigan Dep't of State Police*, 491 U.S. 58, 71 (1989). This means that neither a state, nor state employees acting in their official capacity, may be sued for damages under § 1983, only employees in their individual capacities. *Id.*[30]

Municipal or independent county governments, or their representatives working in their official capacity can only be liable for damages under § 1983 "where the municipality itself causes the constitutional violation at issue" and *respondeat superior* does not apply; therefore, merely employing someone who violates the constitution does not create municipal liability. *City of Canton v. Harris*, 489 U.S. 378, 385 (1989) ("*Respondeat superior* or vicarious liability will not attach under § 1983") (citing *Monell.*, 436 U.S. at 694–95). Instead, the plaintiff must show that the government entity "maintains a policy or custom" that rises to the level of deliberate indifference to serious medical needs, and that the harm suffered was "proximately caused" by

[30] It is possible to sue government agencies and defendants in their official capacities under the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. *See infra.*

the policy or custom. *Hahn v. Walsh*, 762 F.3d 617, 639 (7th Cir. 2014). Under this high standard, only clearly documented and systemically inadequate medical care policies have a possibility of success. *See King v. Kramer*, 680 F.3d 1013, 1021 (7th Cir. 2012) (material question of fact if deliberate indifference where detainee died after being refused medication, and jail policy "eerily" resembled a policy requiring "jail staff to throw away all prescription medications without implementing an appropriate mechanism for providing alternative treatment.")

This is an extremely difficult standard to meet. Because the standard is high, few, if any diabetes-related cases meet this municipal liability standard. *See, e.g.*, *Hahn*, 762 F.3d at 638 (policy of only providing two blood glucose checks and regular insulin administration not deliberately indifferent, even though detainee died after not being provided insulin for 36 hours).[31] Because the standard is so high, erroneously suing an employee in their official capacity alone, instead of specifically sue employees or other agents in their individual capacity, can significantly reduce a plaintiff's possibility of success. This is one of the most common mistakes made by plaintiffs in diabetes-related deliberate indifference claims. *See, e.g.*, *Hahn v. Walsh*, 915 F. Supp. 2d 925 (C.D. Ill. 2013) (erroneously only naming defendants in official rather than individual capacity).[32]

[31] In an early case, *Dewell v. Lawson*, 489 F.2d 877 (10th Cir. 1973), the court found possible municipal liability. The plaintiff had been arrested for public drunkenness, and, since there were no intake procedures for screening inmates with diabetes, he was incarcerated for four days without treatment until he was found in a coma and transferred to a hospital. *Id.* As a result of a lack of insulin, plaintiff suffered a stroke and brain damage. *Id.* The court held that the plaintiff had properly stated a claim for relief, since the failure of the chief of police to establish procedures and to train personnel to protect an incarcerated person from injury by reason of his diabetes condition could possibly amount to cruel and unusual punishment. *Id.* However, supervisorial liability may no longer hold under § 1983, and this case may rest on this requirement. *See T.E. v Grindle*, 599 F3d 583, 588 (7th Cir. 2010) (striking down supervisorial liability under § 1983); *contrast with Al-Kidd v Ashcroft*, 580 F3d 949, 965 (9th Cir. 2009) (upholding liability); *but see Simmons v Navajo County*, 609 F3d 1011, 1020–21 (9th Cir. 2010); *see also Sanchez v Pereira-Castillo*, 590 F3d 31, 49 (1st Cir. 2009) (upholding § 1983 supervisorial liability, but rejecting supervisorial liability under federal *Bivens* actions).

[32] Some courts may be gracious, especially too *pro se* plaintiffs, and read the complaint as if the plaintiff named defendant's in their individual capacity; however, this is at the discretion of the court. *See Davis v. St. Louis County*,

2. Federal Government

Litigation under § 1983 usually does not apply to actions against *federal* government employees. *Settles v. U.S. Parole Comm'n*, 429 F.3d 1098 (2005). Instead, claims for injunctive relief are permitted under 5 U.S.C. § 702, a separate statute. *See Trudeau v. Federal Trade Comm'n*, 456 F.3d 178, 186-87 (D.C. Cir. 2006) (§ 702 waives immunity for all equitable claims against federal agencies or officers in their official capacities.) In limited circumstances, damages claims that do not involve administrative discretion may be brought directly against the United States under the Federal Tort Claims Act. 28 U.S.C. §§ 2671-80. Claims for damages for constitutional violations may be brought against federal officers in their individual—not official—capacities under a court-created right of action pursuant to *Bivens v. Six Unknown Agents of Federal Bureau of Narcotics*, 403 U.S. 388, 397 (1971); s*ee also Carlson v. Green*, 446 U. S. 14, 100 (1980); *Albert v. Yost*, 431 Fed. Appx. 76, 78 (3d Cir. 2011). This *Bivens* action is the "federal analog" to suits brought under § 1983. *Hartman v. Moore*, 547 U.S. 250, 254 n. 2 (2006).[33]

Private contractors of the federal government, however, are not susceptible to *Bivens* actions, and therefore are free from liability for damages for constitutional violations. *Malesko*, 534 U.S. at 70-74. In most circumstances, only state law can provide remedies when the defendants are private federal contractors. *See Minneci v. Pollard*, 132 S. Ct. 617; 181 L. Ed. 2d 606 (2012); *Wilkie v. Robbins*, 551 U.S. 537, 550 (2007) (no Bivens action where alternative, existing processes provide adequate protection).

2015 U.S. Dist. LEXIS 21105 (E.D. Mo. 2015) (only naming defendants in official capacity but reading complaint as if named in individual capacity.)

[33] For pre-trial detainees in federal custody, the Fifth Amendment due process clause applies, not the Fourteenth Amendment. *See Bell v. Wolfish*, 441 U.S. 520, 535 (1979) (the Fifth Amendment does not allow punishment for pre-trial detainees, since conviction under due process of law).

3. Qualified Immunity

Many government officials at a prison will also claim the protection of qualified immunity. The doctrine of qualified immunity protects government officials (but not municipalities themselves) from liability from civil damages as long as their conduct does not "violate clearly established statutory or constitutional rights of which a reasonable person would have known." *Pearson v. Callahan*, 555 U.S. 223 (2009) (quoting *Harlow v. Fitzgerald*, 457 U.S. 800, 818 (1982)). The Supreme Court has emphasized that qualified immunity is an inquiry "in which the result depends very much on the facts of each case." *Brosseau v. Haugen*, 543 U.S. 194, 201 (2004).

An Eighth or Fourteenth Amendment claim implicates a constitutional right, but prison officials will frequently argue that 1) a reasonable person could not have known that the prisoner with diabetes had objectively serious medical need, or 2) that the prison official did not have the subjective mental state of deliberate indifference to the prisoner's needs. *See, e.g.*, *Fogarty v. Gallegos*, 523 F.3d 1147, 1162 (10th Cir. 2008). The first two arguments mirror the two-prong deliberate indifference standard. However, to succeed in a claim against a government official, a plaintiff must address each of these arguments, not only under Eighth Amendment and Fourteenth Amendment jurisprudence, but also under the doctrine of qualified immunity. Finally, to overcome qualified immunity, it must be factually demonstrated that the official had personal involvement in the constitutional violation. *Cf. Egebergh v. Nicholson*, 272 F.3d 925 (7th Cir. 2001) (overturning lower courts grant of qualified immunity where officers had knowledge detainee had diabetes and yet did not provide insulin); *Lemay v. Winchester*, 382 Fed. Appx. 698, 701-02 (10th Cir. 2010) (sufficient facts alleged, for purpose of motion to dismiss, that officials

should not be granted qualified immunity, since they were personally involved with intake and providing care for person with diabetes).

4. Statutes of Limitations

The text of § 1983 does not provide a statute of limitations, and for that reason, federal courts apply the statutes of limitations for the state statute or cause of action that most closely mirrors § 1983. *See, e.g.*, *Deepwells Estates, Inc. v. Inc. Vill. of the Head of the Harbor*, 973 F. Supp. 338, 344 (E.D.N.Y. 1997) (citing *Wilson v. Garcia*, 471 U.S. 261, 268–69 (1985)) (applying New York state statute of limitations for § 1983 claim). Courts have applied state statutes of limitations based on state statutes or causes of action for personal injury, intentional torts, contract claims, state civil rights, suits against government officials, or even catch-all principles when no other statute of limitation applies. Because statutes of limitations vary from state to state, the limitations period applied to § 1983 varies considerably, with limitations ranging from as low as one year to as high as ten years.[34]

5. Prison Litigation Reform Act

Finally, administrative exhaustion is a vital component to all prison civil rights litigation. Any person confined in prison, jail, or a correctional facility *cannot* file suit under § 1983 or any

[34] *See, e.g.*, *Bd. of Regents v. Tomanio*, 446 U.S. 478, 484 n.4 (1980) (applying New York's three-year statute of limitations for actions "to recover upon a liability, penalty or forfeiture created or imposed by statute" to § 1983); *Wolfe v. Horn*, 130 F. Supp. 2d 648, 657 (E.D. Pa. 2001) (applying Pennsylvania's two-year statute of limitations for personal-injury actions to § 1983); *Williams v. D.C.*, 676 F. Supp. 329, 331 (D.D.C. 1987) (applying the District of Columbia's three-year statute of limitations for tort actions seeking recovery for personal injuries to § 1983); *Shorters v. Chicago.*, 617 F. Supp. 661 (N.D. Ill. 1985) (applying Illinois' five-year statute of limitations for "all civil actions not otherwise provided for" to § 1983); *Vanlaarhoven v. Newman*, 564 F. Supp. 145, 150 (D.R.I. 1983) (applying Rhode Island's ten-year statute of limitations for breach of implied warranty to § 1983); *Kline v. N. State Tex. Univ.*, 782 F.2d 1229, 1232 (5th Cir. 1986) ("Although the appropriate statute of limitations is determined by reference to state law, the question of when a federal cause of action accrues is a matter of federal law"); *Hall v. Asher*, 355 F. Supp. 808, 811 n.6 (D. Md. 1973) (applying Maryland's three-year statute of limitations for violations of an article of the Maryland Declaration of Rights to § 1983); *Freeze v. Griffith*, 849 F.2d 172, 175 (5th Cir. 1988) (applying Louisiana's one-year statute of limitations for actions against state officials to § 1983).

other federal law until they first meet the strict requirements of the Prison Litigation Reform Act (PLRA), codified at 42 U.S.C. §§ 1997 *et sec.* The PLRA limits the type of suit a prisoner may bring, and excludes damages claims entirely based on emotional or mental injury. A physical injury most occur, and must be the basis for any mental or emotional damages claims. *See* 42 U.S.C. § 1997e(e).A prisoner must first exhaust all available administrative remedies *before* filing suit. 42 U.S.C. § 1997e(a); *Neal v. Goord,* 267 F.3d 116, 121-23 (2d Cir. 2001). This exhaustion requirement is very strict. There is no exception for urgent medical needs. Proper exhaustion under the PLRA requires compliance with an agency's deadlines and "other critical procedural rules." *Woodford v. Ngo,* 548 U.S. 81, 90-91, (2006); *see also Johnson v. Ford*, 261 Fed. Appx. 752, 755-57 (5th Cir. 2008) (reversing ruling in favor of inmate with diabetes who failed to file grievance within 15 day deadline set by prison system). Proper exhaustion includes using every available appeal, and finishing the process, before bringing suit. *Johnson v. Jones,* 340 F.3d 624, 627-28 (8th Cir. 2003). Unless prison officials bar prisoners from filing grievances, or engage in fraud or coercion, there are very few exceptions to this "proper exhaustion" rule. *See Hemphill v. New York*, 380 F.3d 680, 690 (2d Cir. 2004) (deterrence by officials from filing grievances may avoid exhaustion requirement).

Internal grievance procedures may be long, difficult, and unable to obtain certain kinds of relief. For example, in one county facility, no grievance forms were available to prisoners, and "the method to submit a grievance require[d] a detainee ... to hand deliver it to a social worker [even though] a social worker may infrequently visit a tier, leaving a detainee without any written procedure to grieve." *Pickett v. Dart*, 2014 U.S. Dist. LEXIS 30215, *3 (N.D. Ill. Mar. 2014). In this same case, there was a delay of up to twenty five days between a submitting and receiving a medical grievance, and an additional two month delay before receiving a written

response. *Id.* Nonetheless, failure to file a grievance, and to follow up with a second grievance appeal when necessary, can lead to dismissal of a case under the PLRA. *See Thunderbird v. Or. State Dep't of Corr*., 2011 U.S. Dist. LEXIS 79336 (D. Or. 2011) (prisoner's claim that staff refused administer insulin dismissed for failure to appeal denial of written grievance within 14 days of receiving that denial).

However, the PLRA does not apply to individuals who have been released from custody. *Talamantes v. Leyva*, 575 F.3d 1021 (9th Cir. 2009) (exhaustion requirement not applicable to former prisoners not confined when suit is filed). Therefore a former prisoner or detainee, or their family members, if deceased, may be able to bring a claim for damages after release, even if the PLRA would have barred the suit while in a correctional facility.[35]

D. Specific Types of Claims for Deliberate Indifference to Serious Medical Needs Affecting People with Diabetes

Substantive claims involving diabetes fall into a number of categories. Most diabetes-related claims arise from the quality or type of diabetes care. As discussed below, these claims must walk the fine distinction between purely negligent and actually deliberately indifferent care. Next in frequency, and commonly brought by *pro se* plaintiffs in detention, are requests for changes to quantity or quality of food. These are often the least successful claims. The most successful claims involve outright failure to provide insulin; in fact, courts will often assume deliberate indifference if this failure to provide insulin leads to injury or death. Denial of medication, delay in providing medication, and giving the wrong type of medication have mixed

[35] Additional restrictions under the Prison Litigation Reform Act should be considered. The "three strikes" forbids a prisoner who has filed three frivolous suits from filing any further suits in the future, unless the prisoner is "under imminent danger of serious physical injury." 28 U.S.C. § 1915(g) (2000). Attorney fees are limited, particularly in cases seeking only damages and not injunctive relief. *See Boivin v. Black*, 225 F.3d 36, 40–46 (1st Cir. 2000) (fees are limited to 150% of recovered nominal damages); *Walker v. Bain*, 257 F.3d 660, 667 n.2 (6th Cir. 2001) (§1997e does not apply if non-monetary relief is granted); *but see Johnson v. Daley*, 117 F. Supp. 2d 889 (W.D. Wis. 2000) *reversed on these grounds by Johnson v. Daley*, 339 F.3d 582 (7th Cir. 2003) (en banc) (holding that limit on hourly rates and limit to 150% of damages deny equal protection). Unlike most civil cases, defendants in PLRA cases do not need to furnish a reply unless ordered to do so by the court. 42 U.S.C. § 1997e(g) (2006).

results. Finally, claims related to diabetes complications, such as foot care or nerve pain, are also commonly brought in the detention context.

1. Negligence and Medical Malpractice Does Not Constitute Deliberate Indifference

Deliberate indifference to serious medical needs is conclusively covered under the Eighth Amendment. Courts have made equally clear that deliberate indifference does not include "mere disagreement as to the proper medical treatment." *Jackson v. Fauver*, 334 F. Supp. 2d at 706 (quoting *Spruill v. Gillis*, 372 F.3d 218, 235 (3d Cir. 2004)). Neither does it provide protection against negligence or medical malpractice. *See, e.g.*, *Rouse*, 182 F.3d at 197 (in "the medical context, an inadvertent failure to provide adequate medical care cannot be said to constitute an unnecessary and wanton infliction of pain or to be repugnant to the conscious of mankind.") (quoting *Estelle*, 429 U.S. at 97); *see also Durmer v. O'Carroll*, 991 F.2d 64, 67 (3d Cir. 1993) (holding that "the law is clear that simple medical malpractice is insufficient to present a constitutional violation"). Unintentional ignorance, lack of knowledge, or poor quality care may be actionable under various state laws, but they are generally not enough to rise to the level of deliberate indifference under federal law. Instead, there must be some culpable state of mind. *See Rouse*, 182 F.3d at 197 ("It is well-settled that claims of negligence or medical malpractice, without some more culpable state of mind, do not constitute 'deliberate indifference.'")

For example, the Seventh Circuit held that even repeated acts of negligent conduct are not tantamount to deliberate indifference. *Sellers v. Henman*, 41 F.3d 1100 (7th Cir. 1994). In *Sellers*, the prisoner alleged that he had been denied appropriate medical treatment and that his diet was too low in calories and too high in saturated fat. *Id.* at 1102. The court noted the importance of medical treatment and diet to the health of a person with diabetes; however, the court held that these allegations alone did not prove cruel and unusual punishment. *Id.*

Moreover, negligence is not actionable under the Eighth Amendment. *Id.* The court noted that while many cases have stated that repeated acts of negligence may constitute *evidence* of deliberate indifference, those acts do not constitute an alternative theory of liability. *Id.* at 1103.[36]

However, in *Howard v. City of Columbus*, the state appellate court overturned the defendant's successful motion for summary judgment on a deliberate indifference claim that involved consistent ignorance and incompetence by jail officials. *Howard*, 239 Ga. App. at 400-08. In this case, the intake screening for detainees was performed by deputies with no medical training, and habitually failed to take a medical history for diabetes or hypertension. *Id.* at 400. Over the course of his detention, the lack of proper diet and medication caused Mr. Howard's condition to worsen "to the extent that he appeared visibly sick to a lay person." *Id.* Nonetheless, neither the facility officers nor medical professionals contacted paramedics or provided adequate care, and the detainee died of diabetic ketoacidosis. *Id.* at 401-02. The court held that "[i]gnorance is not bliss; otherwise a premium would be placed upon ignorance in order to escape liability when an illness is not diagnosed." *Id.* at 405. Therefore, the court held that "repeated denial, delay, insufficient or inappropriate medical care constitutes circumstantial evidence of subjective, deliberate indifference." *Id*. Furthermore, the fact that "ten to thirteen inmates […] died from diabetes while in custody between 1980 and 1992," and two more inmates were hospitalized for ketoacidosis the month before the inmate died, was at least "some

[36] *See also Green v. McLaughlin*, 480 Fed. Appx. 44, 48 (2d Cir. 2012) (failure to transfer individual with diabetes to a different facility to receive diabetes care is a disagreement about medical care, not deliberate indifference); *Randall v. Bd. of County Comm'rs*, 184 Fed. Appx. 723 (10th Cir. 2006) (inmate with type 1 diabetes developed renal failure and required emergency medical attention for hypoglycemia more than twelve times; however, no deliberate indifference since he received two blood glucose checks per day, and received medication every day); *Loslee v. Garden*, 420 Fed. Appx. 821 (10th Cir. 2011) (inmate with highly unstable type 1 diabetes experienced frequent episodes of low blood glucose levels, and received three insulin injections daily at the infirmary, with a once-daily blood glucose check; based on this evidence, the Tenth Circuit found that, "[w]ithout question" the defendants had adequately address the plaintiff's needs.)

evidence" of deliberate indifference. *Id.* at 408. Therefore even the Sheriff could be liable for deliberate indifference due to failure to supervise jail staff. *Id.* at 407-08.

Claims regarding medical care are therefore more likely to succeed if the facts show that individuals knew that particular medical care was required, but they failed to provide it. The facts should go beyond showing simple incompetence, ignorance, or negligence. *See Sellers*, 41 F.3d at 1102. Complaints merely alleging removals of insulin pumps, plus medically incompetent administration of insulin (or other diabetes care) will likely not succeed, even if these actions lead to serious medical complications. *See, e.g.*, *Davis v. St. Louis County*, 2015 U.S. Dist. LEXIS 21105, 2-3 (D. Mo. 2015) (removal of insulin pump that lead to hospitalization was not deliberate indifference, since officials attempted to provide insulin through injections; actions were at worst medical malpractice). Instead, a complaint should allege that a prisoner informed a prison official of his need for a particular medicine, failure to provide the medicine could result in severe health consequences, and the official specifically ignored that request. *See, e.g.*, *Flowers v. Bennett*, 123 F. Supp. 2d 595, 601 (N.D. Ala. 2000) ("If, however, the facts are that [the officer] was told that [plaintiff] was a severe diabetic who could go into a coma if she didn't receive insulin, [the officer] was arguably deliberately indifferent.").

2. Failure to Provide Insulin

Many courts have upheld claims of failure to provide insulin as rising to the level of deliberate indifference. Because of the obviousness of the need, and the severity of the risk, failure to provide insulin claims are the strongest and most frequently successful types of diabetes cases in the detention context. *See, e.g.*, *Dewell v. Lawson*, 489 F.2d 877 (10th Cir. 1973) (deliberate indifference to inmate presumed to be drunk in spite of diabetes identification tag, not provided insulin for four days, leading to ketoacidosis and permanent brain damage).

Significant damages judgments or settlements have resulted from these cases, *See, e.g.*, *Scinto v. Preston*, 170 Fed. Appx. 834, 835-36 (4th Cir. 2006) (deliberate indifference by police officers for preventing plaintiff from recovering insulin from car and failing to provide it in detention, eventually leading to hospitalization with permanent damage).[37] Even pleadings by *pro se* plaintiffs in detention have had success in surviving summary judgment for denial of insulin cases. *Slay v. Alabama*, 636 F.2d 1045, 1047 (5th Cir. 1981) (genuine question of fact whether failure by prison doctor to provide "needle," presumably an insulin injection, was deliberate indifference).

For example, in *Beatty v. Davidson*, an inmate spent the night calling out vocally for insulin, but was denied any access to medication for twenty four hours. *Beatty v. Davidson*, 713 F. Supp. 2d 167, 175 (W.D.N.Y. 2010). The plaintiff drank from a toilet due to severe thirst. *Id.* Ultimately, a doctor found the plaintiff unresponsive and hypothermic: he was hospitalized for four days due to "diabetic ketoacidosis." *Id.* at 172. Therefore the court denied a motion for summary judgment by the defendant, and found a material question of fact as to whether there was deliberate difference by various correctional officers. *Id.*

In an even more severe case, a detainee allegedly died due to officer's failure to provide insulin. *Egebergh*, 272 F.3d at 925-28. The detainee, Fitzgibbons, was arrested for shoplifting and it was noted during his booking that he needed an evening and morning shot of insulin; his sister brought his insulin to the jail and he was given an evening shot. *Id.* at 927. However, despite the officers' admitted awareness that people with diabetes can be seriously harmed by being denied insulin, the officers denied Fitzgibbons his morning insulin before his bail hearing.

[37] For more cases on police failure to allow access to insulin, *see Garretson v. City of Madison Heights*, 407 F.3d 789, 794 (6th Cir. 2005) (officers who did not provide inmate insulin, leading to hospitalization for ketoacidosis, were deliberately indifferent); *Egebergh v. Nicholson*, 272 F.3d 925 (7th Cir. 2001) (deliberate indifference by police officers for ignoring morning shot of inmate, leading to ketoacidosis and death).

Id. He died later that night due to diabetic ketoacidosis. *Id.* The court overturned a grant of summary judgment with respect to the officer's qualified immunity defense, since the jury could find that the officers were deliberately indifferent to Fitzgibbons' serious medical need for insulin and thus qualified immunity was not appropriate. *Id.* at 928.

Denial of insulin need not lead to ketoacidosis, permanent damage, or death in order to meet the standard of deliberate indifference. For example, in *Johnson v. Ford*, a prisoner with medical passes clearly established his status as person with diabetes was overlooked or ignored by guards when he called to be escorted for insulin injections. *Johnson v. Ford*, No. C-05-2232006, U.S. Dist. LEXIS 30941, *18-19 (S.D. Tex. 2006). The court rejected the defendant's argument that any injuries were *de minimis*. *Id.* The court reasoned that the plaintiff had suffered "pain, fear, confusion, physical discomfort, and anxiety;" furthermore, because of the denial of care, there were no medical records for the period of time in question to document changes in blood glucose levels. *Id.* The prison also "curiously" failed to produce any other medical records. *Id.* Therefore there was a genuine issue of material fact as to whether the officers in question were deliberately indifferent to a serious medical need. *Id.* at *19, *overruled on other grounds* 261 Fed. Appx. 752, 757 (5th Cir. 2008) (failure to file grievance within 15 days amounted to inexcusable failure to exhaust remedies under PLRA).

However, even cases alleging failure to provide insulin can be lost through procedural mistakes or omissions. For example, in *Hahn v. Walsh*, Ms. Hahn had a history of domestic violence, along with severe diabetes care problems, including at least one incident of being involuntarily committed after attempting to kill herself by overdosing on insulin. *Hahn*, 915 F. Supp. 2d at 932. After she allegedly stabbed her husband, and was taken to jail by local police officers, Ms. Hahn stated that she had diabetes and was suicidal, but was otherwise

uncooperative and refused to give more information. *Id.* at 935. She reluctantly had her blood glucose checked, and when it was high, reluctantly agreed to self-administer a large quantity of insulin. *Id.* at 937. Ms. Hahn then repeatedly refused to have her blood glucose re-checked with that machine. *Id.* Since jail policy was to not force medical care without consent, unless there was an emergency medical need, the jail did not administer insulin for more than 36 hours. *Id.* at 939. The next morning, Ms. Hahn was found in medical distress, and died later that day from severe diabetic ketoacidosis. *Id.*

Nonetheless, the district court, and later the Seventh Circuit, upheld the defendant's motion for summary judgment against the plaintiff's deliberate indifference claims. *Hahn*, 915 F. Supp. 2d at 925, *aff'd in part, remanded in part on other grounds* 762 F.3d at 620. The plaintiff failed to properly serve individual medical officials and jail employees in their individual capacity. *Hahn*, 915 F. Supp. 2d at 955, 957. This was most likely an unintended and procedurally fatal error on the part of the plaintiff. [38] The Sheriff could not be liable through *respondeat superior*, or through other vicarious liability—only for personal knowledge and liability—and no evidence showed any personal knowledge of Ms. Hahn's situation. *Id* at 951. The plaintiff did not identify any causal connection between a policy or practice of the jail and the actual harm suffered; therefore, the plaintiff did not meet the standard of municipal liability for deliberate indifference to serious medical needs. *Id.* at 951-54, 957; *see also Hahn*, 762 F.3d at 620 (upholding grant of summary judgment for defendant on deliberate indifference claims

[38] *Cf. Hahn v. Walsh*, 2009 U.S. Dist. LEXIS 120619, 9-11 (C.D. Ill. 2009) (erroneously suing defendant Walsh in official capacity instead of individual capacity, also suing "Un-named Champaign County Correctional Officers, Un-named Jail Nurse"); *Hahn*, 915 F. Supp. 2d at 940 ("Plaintiffs also named Deputy Matthew McCallister, Jenna Thode, Karee Voges, Jeffrey Shumate, Arnold Mathews, Carl Brown and Nurse Susan Swain as Defendants. However, the record shows that these Defendants have not been served in this action. Accordingly, these Defendants are hereby terminated as parties to this action.")

since no individual capacity claims were pled, no causal connection between prison policies and equipment usage and the resulting death by ketoacidosis).[39]

3. Not providing medical care

Failure to provide any medical care at all, even without knowledge that a person has diabetes, can rise to the level of deliberate indifference. For example in *Phillips v. Roane County*, an inmate exhibited life-threatening symptoms such as vomiting, sickness, fainting, unconsciousness, and paleness. *Phillips v. Roane County*, 534 F.3d 531, 541 (6th Cir. 2008). In spite of this, the correctional officers failed to transport the inmate to the hospital for diagnosis. *Id.* She subsequently died of ketoacidosis. *Id.* Even though the plaintiff had not indicated that she had diabetes, the court still found sufficient evidence of deliberate indifference to survive a motion for summary judgment. *Id.* However, if there are no obvious symptoms of diabetes or serious health conditions, failure to provide medical care is not deliberate indifference, even if the patient dies from diabetic ketoacidosis. *See Greer v. Tran*, 124 Fed. Appx. 261 (5th Cir. 2005) (no deliberate indifference where the facility doctor "tested for and ruled out diabetes mellitus […] and there is no indication in the record […] that Tran knew either that James was diabetic or that James experienced any symptoms before falling into a diabetic ketoacidotic coma).

Even if diabetes is undiagnosed, failure to provide care may rise to the level of deliberate indifference if the need is obvious. *See Carswell v. Bay County*, 854 F.2d 454, 455 (11th Cir. 1988). In *Carswell*, the Eleventh Circuit upheld jury verdict finding that defendants were deliberately indifferent to the serious needs of a pretrial detainee with undiagnosed diabetes. *Id.* The plaintiff detainee did not know he had diabetes, and did not mention any medical problems

[39] The Seventh Circuit, however, did remand the case in order to grant the plaintiff leave to amend their Illinois state wrongful death claims to include a required affidavit and report. *Id.* at 635.

at his intake. *Id.* However, the defendant had no medical screening procedure, and soon after detention, the plaintiff had lost a significant amount of weight in a short time, repeatedly requested medical attention, and was eventually hospitalized and diagnosed with diabetes. *Id.* Since the need for medical attention was apparent even to a layperson, the court found that the jury could have found deliberate indifference on the part of the relevant correctional officials. *Id.*

In a similar way, the Second Circuit found that a pretrial detainee provided evidence sufficient to show deliberate indifference where "following his arrest, [plaintiff] was pale, dizzy, perspiring profusely, trembling uncontrollably, hardly able to talk, and repeatedly losing consciousness." *Weyant v. Okst, et al*., 101 F.3d 845, 849-50 (2d Cir. 1996). In addition the officers were informed that Charles had severe diabetes and needed to go to the hospital immediately; however, there was confusion over whether he was in insulin shock (hypoglycemia) or needed an insulin shot (for hyperglycemia). *Id.* Nonetheless, the officers had knowledge of an existing serious medical need, and the defendants "denied Charles medical attention throughout the period of his detention," since they neither provided insulin nor food during the time in which he was detained. *Id.* at 850. The lower court had granted summary judgment for the defendants, since they had made a reasonable medical judgment; the Second Circuit, however, overturned this decision and remanded for further proceedings. *Id.* at 857.

For inmates with type 2 diabetes, failure to provide oral medication may also rise to the level of deliberate indifference. In *Ortiz v. City of Chicago*, *supra*, a pre-trail detainee with type 2 diabetes was not provided with oral medications. *Ortiz*, 656 F.3d at 529. The inmate allegedly cried out continuously for help until her cries became weaker. *Id.* at 527. A fellow inmate yelled on her behalf and was told to "shut the f---up!" *Id.* at 529. The court found that it was unclear whether the problems observed by prison staff were symptomatic of diabetes or other conditions;

instead, the question was whether "the defendant ... should reasonably have known that [plaintiff] needed medical care." *Id.* at 533. Since this was a case of providing "no medical care," and that failure ultimately led to death, allegedly by "diabetic coma," the court denied the defendants motion for summary judgment on the deliberate indifference claims. *Id.* at 538-539.

In a similar way, the prison policy in *Hefner v. McMinn County* permitted officers to withhold medication for type 2 diabetes if the prisoner's condition was not life threatening. *Hefner v. Mcminn County*, No. 1:10-CV-169, 2011 U.S. Dist. LEXIS 111147 (E.D. Tenn. 2011). Since a prisoner with type 2 diabetes was denied oral medication for one day, allegedly causing damage due to high blood glucose, the plaintiff could survive a motion for summary judgment. *Id.*

In addition, in *Anders v. Bucks County*, the court allowed the plaintiff to proceed on deliberate indifference claims based on failure to treat type 2 diabetes. *Anders v. Bucks County*, 2014 U.S. Dist. LEXIS 66352, *22 (D. Pa. 2014). Plaintiff had informed the defendants that she had type 2 diabetes and required monitoring and blood glucose monitoring. *Id.* at *3. Nonetheless, for more than two months, and despite frequent requests from the inmate, the defendants denied the plaintiff any medication and monitoring. *Id*. The day after being examined by a prison doctor, without having blood glucose checked, the plaintiff experienced convulsions, seizures, worsening of vision and ultimately transported to a hospital after she was discovered unresponsive in her cell. *Id.* at *4. The defendants argued that failure to check blood sugar was medical malpractice at worse, not deliberate indifference. *Id.* at *22. The plaintiff however, had alleged that the refusal to treat was deliberate, that claim was sufficient to state a Eighth Amendment violation, and the plaintiff therefore survived the defendant's motion to dismiss. *Id.* at *23.

4. Wrong Type of Medicine or Wrong Diagnosis

Knowingly providing the wrong medication to a prisoner with diabetes—when that medication can negatively impact both diabetes treatment and health generally—can constitute deliberate indifference. *See Bowers v. Milwaukee Co. Jail Med. Staff*, 52 Fed. Appx. 295, 298 (7th Cir. 2002). In *Bowers*, the prisoner, proceeding *pro se*, claimed that he repeatedly alerted medical personnel at the jail that he was being given another prisoner's medications in addition to his own diabetes medications. *Id.* Nonetheless, jail personnel continued to administer medications that can interfere with insulin release. *Id.* Ultimately, the prisoner lost several teeth due to complications he believed were related to diabetes. *Id.* at 297-298. The Seventh Circuit found that that the plaintiff had adequately stated a claim for relief, and overturned the lower courts grant of the defendant's motion to dismiss. *See also Roberson v. Bradshaw*,198 F.3d 645, 646-47 (8th Cir. 1999) (overturning grant of summary judgment since dispute of fact as to whether plaintiff had adverse reaction to medication to type 2 diabetes, and doctors ignored his request to change medications, even though he had visible signs such as dizziness, sweating, and fits of raving and delirium).

However, providing a different type of insulin, rather than the wrong medication entirely, is not necessarily deliberate indifference. *See Hudson v. Univ. of Tex. Med. Branch*, 441 Fed. Appx. 291, 292 (5th Cir. 2011). In *Hudson*, a defendant provided a different type of insulin than requested by the plaintiff. *Id.* This was not sufficient to find deliberate indifference. *Id*. In a similar manner, the court in *Moody v. Eagleton*, found that a plaintiff who had a reaction to a new insulin regime, and refused to take new type of insulin, had not been treated with deliberate indifference; instead, this was a disagreement about medical care. *Moody v. Eagleton*, No. 9:09-1480-CMC-BM, 2010 U.S. Dist. LEXIS 36256, 23-24 (D.S.C. 2010).

It is possible, however, to allege deliberate indifference for administering the wrong type of insulin, if this leads to harmful consequences. In *Flowers v. Bennett*, the court denied defendants' motion for summary judgment where plaintiff alleged that the prison officials failed to provide her with usable insulin in a timely manner. *Flowers*, 123 F. Supp. 2d at 601. Though many facts were in dispute, for purposes of the motion for summary judgment, the court assumed the following facts—the plaintiff was booked at night, during which she told the officer that she had severe diabetes, had taken an insulin shot at supper, and needed a different type of insulin shot before bed, and another at breakfast. *Id.* Moreover, plaintiff said that if she did not receive the shots, she would probably go into a coma. *Id.* The jail did not have the proper insulin, and no one called a medical professional in order to obtain the proper insulin. *Id.* at 596. Rather the plaintiff was placed on medical watch. *Id.* Consequently, the plaintiff did not receive her insulin and consequently developed DKA. *Id.* at 596-97. The court reasoned that "[i]f someone needs to take different types of insulin, there is certainly a reasonable inference that it would have been prescribed as part of medical treatment," and if the officers were told that the plaintiff "was a severe diabetic who could go into a coma if she didn't receive insulin, [the officer] was arguably deliberately indifferent." *Id.* at 601-02.

In addition, improper diagnosis of symptoms as related to another condition, rather than diabetes, is not necessarily deliberate indifference. In *Knowles v. SCDC*, a prison doctor incorrectly diagnosed a prisoner's symptoms as being based on preexisting Hepatitis C, rather diabetes. *Knowles v. SCDC* , No. 2:09-1921-MBS-RSC, 2010 U.S. Dist. LEXIS 76953, *18-19 (D.S.C. 2010). The court found that this may have been negligence, but not deliberate indifference, especially since the prison attempted to provide some care, even if it was not the best care. *Id*.; *cf. Lentworth v. Potter*, No. 7-03-CV-156-BD, 2006 U.S. Dist. LEXIS 48481 at

*4-5 (N.D. Tex. 2006), *aff'd* 255 Fed.Appx. 903 (5th Cir. 2007), *cert. denied*, 553 U.S. 1059 (2008) (finding no deliberate indifference despite three-year delay in providing insulin to inmate, since the prisoner was not aware he had diabetes, and doctors were merely negligent in failing to diagnose it).

Misdiagnosis as to the type of diabetes is not necessarily deliberate indifference. *See White v. Lee*, 441 Fed. Appx. 484 (9th Cir. 2011)**.** In *White*, prisoner claimed to have Type 1 diabetes, and had been taking insulin for some time before incarceration. *White v. Kasawa*, 2010 U.S. Dist. LEXIS 24871, * 3 (N.D. Cal. 2010). Several physicians claimed he had Type 2 diabetes. *Id.* at 3. After the inmate experienced severe hypoglycemia, they removed him from insulin administration, and placed him on oral medication regimes for nine months. *Id.* at 3-5. He continued to experience hypoglycemia, and was placed on a new regime of oral medications. *Id.* On this regime, he experienced frequent high blood glucose levels (over 250) for over six months, a toe infection, blurred vision, and leg pain. *Id.* The Ninth Circuit upheld the holding of the district court, since "a difference of opinion about the best course of medical treatment does not amount to deliberate indifference." *White*, 441 Fed. Appx. at 484 (citations omitted).

5. Delay in Providing Care

Certain courts have held that delay in providing medical care may violate the Eighth Amendment. *See Hunt*, 199 F.3d at 1224 (citing *Thomas v. Town of Davie*, 847 F.2d 771, 772-73 (11th Cir. 1988) (upholding deliberate indifference claim for delay in obtaining medical care when the victim obviously needed immediate medical attention)). The Tenth Circuit noted that delays that violate the Eighth Amendment frequently involve life-threatening situations in which it is apparent that delay would exacerbate a prisoner's problems. *Id.*; *contrast with Perkins v.*

Schwappach, 399 Fed. Appx. 759, 760 (3d Cir. 2010) (no deliberate indifference by prison guard who required inmate to obtain medical pass before obtaining medicine to treat diabetes).

In addition, in *Naphier v. County of Genesee*, care was delayed because of administrative inefficiency. *Naphier*, No. 11-13754; 2012 U.S. Dist. LEXIS 180845 at *27-28. A booking officer spoke with a detainee for only two minutes, but observed the plaintiff shaking, sweating, and vomiting. *Id.* These were symptoms of diabetes. *Id.* The employee recorded answers about medication and conditions, but did not call for medical care. *Id.* The employee printed out a medical form, and put it on a shelf, where it would be found several hours later. *Id.* The court found that a jury could reasonably conclude that the defendant perceived and disregarded a substantial risk to Naphier's health, and therefore was deliberately indifferent to the plaintiff's serious medical needs. *Id.* at *28.

6. Food and Diet

A large number of claims brought by prisoners regarding diabetes care are for inappropriate diet. *See, e.g.*, *Bettis v. Bickel*, No. 08-7079, 2009 U.S. App. LEXIS 2172 (10th Cir. 2009).[40] Almost all courts agree that the Eighth Amendment does not require a prison to provide a specific diet for people with diabetes, so long as they present a range of choices that

[40] *See also, e.g.*, *Sellers v. Henman*, 41 F.3d 1100, 1102 (7th Cir. 1994) (prisoner's claim regarding appropriate diet constituted a mere difference in medical opinion); *Williams v. Hartz*, 43 Fed. Appx. 964, 965 (7th Cir. 2002) (refusal to provide a special diet did not violate the Eighth Amendment); *Hernandez v. Lewis*, 1991 U.S. App. LEXIS 20887, *2 (9th Cir. 1991) (claim that the prison diet was inadequate was a "mere difference in judgment, which…does not support a claim of deliberate indifference"); *Kaza v. Allen*, 1995 U.S. App. LEXIS 32189, *12 (9th Cir. 1995) (same); *Jackson v. Lucine*, 119 Fed. Appx. 70 (9th Cir. 2004) (plaintiff with diabetes failed to offer evidence that special diet was medically necessary); *Vandiver v. Corr. Med. Servs*., 2009 U.S. App. LEXIS 9702 (6th Cir. 2009); *Falciglia v. Erie County Prison*, 279 Fed. Appx. 138 (3d Cir. 2008); *Randall v. Bd. of County Comm'rs*, 184 Fed. Appx. 723 (10th Cir. 2006); *Franklin v. McCaughtry*, 110 Fed. Appx. 715, 719 (7th Cir. 2004); *Hunt v. Uphoff*, 199 F.3d 1220 (10th Cir. 1999); *Roberson v. Bradshaw*, 198 F.3d 645, 646 (8th Cir. 1999); *Barlow v. Forrest County Sheriff's Dep't*, 2010 U.S. Dist. LEXIS 9795, 18-19 (S.D. Miss. 2010); *Thomas v. Donahue*, 2009 U.S. Dist. LEXIS 40769, *3-4 (E.D. Cal. 2009); *Wilson v. Woodford*, 2009 U.S. Dist. LEXIS 25749 (E.D. Cal. 2009); *Moody v. Bell*, 2009 U.S. Dist. LEXIS 83123, 5-6 (S.D. Ohio 2009); *Dye v. Sheahan*, No. 93 C 6645, 1995 U.S. Dist. LEXIS 3027, *6 (N.D. Ill. 1995); *Taylor v. Anderson*, 868 F. Supp. 1024, 1026 (N.D. Ill. 1994); *Johnson v. Harris*, 479 F.Supp. 333, 335 (S.D.N.Y. 1979).

could meet the dietary needs of a person with diabetes. *See, e.g.*, *LaFlame v. Montgomery County Sheriff's Dep't*, 3 Fed. App'x 346, 347 (6th Cir. 2001) (failure to adjust diet appropriately was a mere difference of opinion over treatment).[41]

For example, the Sixth Circuit denied a prisoner's Eighth Amendment claim related to the prison's failure to provide a special diet for prisoners with diabetes. *Mullins v. Cranston*, Nos. 97-4492/98-3188, 1999 U.S. App. LEXIS 32580 (6th Cir. 1999). The court upheld the lower court's summary judgment ruling for the defendant, primarily because the defendant produced evidence that it offered the plaintiff a class on choosing appropriate foods from the prison food service offerings, and stressed to prisoners that it was up to them to choose foods that met their diabetes-related needs. *Id.* at *4. The court found that the plaintiff's request that a special tray of food be prepared for him was a mere difference of opinion regarding his medical needs. *Id.*

Because complaints about prison food are frequent, courts may be quick to dismiss diet claims. In fact, large numbers of claims by prisoners regarding diet and nutritional needs have even been struck down as frivolous, and barred the plaintiff from filing any further suits in federal court. *See, e.g.*, *Wallen v. Olsen*, 75 Fed. Appx. 289 (2003) (dismissing prisoner's claim of being fed non-diabetic food for two week period as frivolous); *Dobbs v. Canteen Catering Serv.*, NO. 4:07CV190-P-B, 2008 U.S. Dist. LEXIS 32272, *11-12 (N.D. Miss. Apr. 18, 2008) (plaintiff who ate unrestricted meals "to satisfy his appetite" and then complained about denial of

[41] *See also, e.g.*, *Carrion v. Wilkinson*, 309 F. Supp. 2d 1007, 1015 (N.D. Ohio 2004) (denying claim of plaintiff on a self-monitored diet for diabetes, who requested to be placed on a diabetic diet, but was refused the same); *Hoyt v. Rogers*, 2010 U.S. Dist. LEXIS 142070, 11-13 (E.D. Mich. 2010) (plaintiff in "was in control of his dietary destiny); *Vandiver v. Correctional Med. Servs., Inc.*, 2010 U.S. Dist. LEXIS 99339, *2 (W.D. Mich. 2010) (no claim where plaintiff was educated on food choices); *Moody v. Bell*, 2009 U.S. Dist. LEXIS 83123, at *2-3 (S.D. Ohio 2009) (denying claim where plaintiff complained bread and cereal did not comport with his self-monitored diabetic diet).

a “diabetic snack” pack made frivolous claim, and since more than a dozen frivolous had already been filled, plaintiff banned from filing any more complaints in federal court).

However, the outcome may be different if the facility denies access to food to someone experiencing severe hypoglycemia. *See Lolli v.County of Orange*, 351 F.3d 410, 418-21 (9th Cir. Cal. 2003). In the *Lolli* case, a person with type 1 diabetes was arrested for a minor traffic offense. *Id.* When he was placed in his holding cell, he claimed he informed several officers that he had diabetes and needed food. *Id.* However, he was later violently restrained and suffered significant injuries due to behavior which he claimed was related to diabetes. *Id.* at 411-13. The court found that the circumstantial evidence, such as “Lolli's extreme behavior, his obviously sickly appearance and his explicit statements that he needed food because he was a diabetic” all could point to a deliberate indifference to serious medical needs. *Id.* at 421. Lolli even testified that he was on his feet and spoke up to the deputies as soon as they entered the cell, telling them of his deteriorating condition and asking for food, and even after he had been cuffed and was being carried away he continued to do so, pleading "My God, . . . I'm a diabetic, and all I needed was food, all I need is some food." *Id.* In light of these disputed facts, therefore, the court found sufficient evidence to overturn a lower court’s grant of summary judgment, with respect to some of the defendants involved. *Id.* at 422.

In addition, food-related claims may succeed if there are no options for food which will allow a person to manage diabetes, and this lack of food leads to serious medical complications. The key case is *Johnson v. Harris*, where the court granted a prisoners claim for damages and injunctive relief where prison officials refused to provide proper meals even after the plaintiff had a leg amputated because of gangrene and high blood glucose levels. 479 F. Supp. 333, 335-36 (S.D.N.Y. 1979). The court reasoned that prison officials deliberately ignored a serious risk to

health by intentionally providing the prisoner with the choice of eating the wrong foods, or not eating at all. *Id.*; *accord Dye v. Sheahan*, No. 93 C 6645, 1995 U.S. Dist. LEXIS 3027, *6 (N.D. 1995) ("courts have recognized that denying a diabetic prisoner a special diet may violate the Eighth Amendment because certain foods are extremely dangerous to diabetics' health" (citing *Johnson v. Harris*, 479 F. Supp. at 336-37)).[42]

This precedent may be outdated, though. Although many courts cite to *Johnson*, few, if any, have upheld a dietary claim past a motion for summary judgment. *See, e.g.*, *Taylor v. Anderson*, 868 F. Supp. 1024, 1026 (N.D. Ill. 1994) (denying motion to dismiss claim of prisoner with diabetes alleging that a prison official failed to provide him with his prescribed diabetes diet even though the official was aware of his condition), *but summary judgment granted* No. 94 C 1618, 1995 U.S. Dist. LEXIS 15577, 10-13 (N.D. Ill. 1995) (finding plaintiff with diabetes could eat most of same foods as general population, "albeit in smaller portions," and no evidence of serious injury suffered because of diet). This may be the result of improvements in diabetes care over the past thirty years that have permitted people with diabetes to have more flexible dietary control, making it difficult to claim that denial of a special diet will implicate a serious medical need.[43] Although courts, in theory, hold that a prisoner with diabetes may have a claim based on a failure to provide a proper diet, only the most egregious fact patterns—involving intentional

[42] Some modern district courts have allowed cases to survive a motion to dismiss, but all have been struck down in a motion for summary judgment. *See, e.g., Allen v. Aramark Corp*., 2010 U.S. Dist. LEXIS 52471 (W.D. Ky. 2010) (plaintiff with diabetes who did not received diabetes diet trays survived motion to dismiss, but failed to overcome summary judgment); *Copelton v. Corr. Corp. of Am*., 2010 U.S. Dist. LEXIS 126424 21 -23 (D. Mont. 2010) (denying motion to dismiss and allow motion for preliminary injunction to survive, but granting summary judgment against inmate since facts showed he regularly purchased candy bars and voluntarily selected non-diabetic meal trays); see also *Rivera v. Dyett*, 1994 U.S. Dist. LEXIS 3732 (S.D.N.Y. 1994) (claim survived motion to dismiss but struck down in motion for summary judgment where diabetic plaintiff failed to introduce evidence that injury, including two amputations, were caused by lack of a specific diabetic diet), *aff'd* 43 F.3d 1457 (2d Cir. 1994).

[43] The American Diabetes Association, for example, does not suggest a particular diet for people with diabetes, but rather advises consistent adherence to general dietary guidelines. *See*, *supra note* 4, American Diabetes Association, *Standards of Medical Care in Diabetes 2014*.

changes in diet, with animus, and resulting in severe physical damage—would likely succeed past a motion for summary judgment.

7. Diabetes Complications and Inadequate Foot Care

Diabetes may cause complications such as neuropathy, which affects nerve function in extremities. These complications can create claims in the detention context. For example, in *Ruffin v. Deperio,* the plaintiff, a state prisoner with diabetes alleged that improper medical care led to the amputation of his foot from gangrene related to diabetes. *Ruffin v. Deperio,* 97 F. Supp. 2d 346 (W.D.N.Y. 2000). In *Ruffin*, a table fell on the plaintiff's foot, resulting in pain and swelling. *Id.* at 351. Sometime thereafter, the plaintiff's toe was amputated, and later his leg below the knee. *Id.* at 349. Defendants argued that only the initial pain and swelling had to be an objectively serious medical injury to fall within the Eighth Amendment, and that the plaintiffs could not "bootstrap" the later amputations. *Id.* at 351. The court rejected this argument in two ways. First, the court held that the Eighth Amendment does not limit serious injuries to fractures and dislocations, but "instead permits injury to focus on level of pain and degeneration." *Id.* at 351 (citations omitted). Second, the court held that the foot amputation was:

> "extremely relevant" to the objective analysis because "[a] reasonable layperson could certainly conclude, in light of plaintiff's extensive medical history and the well-documented concerns about injuries to diabetics, particularly injuries to their extremities, that a table falling on plaintiff's foot would result in potentially more severe injuries to him than it would an otherwise healthy individual."

Id. at 352.

With regard to the subjective "deliberate indifference" analysis, the defendants argued that because plaintiff received medical care, and was eventually referred to an outside specialist, the defendants were not deliberately indifferent. *Id* at 353. The court found, however, that "a reasonable jury could conclude that defendants' 'treatment' of plaintiff consisted of little more

than documenting his worsening condition." *Id.* Ultimately, the court held that the plaintiff had shown "that the defendants' actions displayed a sufficient degree of apathy to his serious medical needs so as to survive summary judgment." *Id.*

The court rejected defendants' characterization of plaintiff's allegations as mere negligence or disagreement over treatment. *Id.* at 354. The court noted that the plaintiff did not complain that he requested a specific type of treatment and was refused. *Id.* Rather, plaintiff argued that it was deliberate indifference for defendant to fail to act on his "repeated complaints of pain, swelling, difficulty in walking, inability to sleep due to foot pain, and blackening of toes," all of which were "obvious symptoms of serious medical problems in a diabetic," especially in light of his very high blood glucose levels. *Id*; *see also Brownlow v. Trim*, No. 2:10-CV-524, 2011 U.S. Dist. LEXIS 85041 (S.D. Ohio 2011) (summary judgment on deliberate indifference claims denied where plaintiff with neuropathy had broken foot, forced to walk in improper cast, denied access to diabetes medication and diabetic diet); *see also Milton v. Turner*, 445 Fed. Appx. 159, 163 (11th Cir. 2011) (surviving summary judgment for deliberate indifference claim where inmate with type 2 diabetes had infected foot, denied work boots, and forced to work even requested medical care and visibly in pain).

II. AMERICANS WITH DISABILITIES ACT AND REHABILITATION ACT PROHIBITIONS AGAINST DISCRIMINATORY TREATMENT

A. Title II of the Americans with Disabilities Act

The Supreme Court has held that Title II of the Americans with Disabilities Act (ADA) applies to state prisons. *See Pennsylvania Dep't of Corrections v. Yeskey*, 524 U.S. 206 (1998).[44]

[44] Title III of the ADA, which covers public accommodations operated by private entities, has not been applied in any significant way in the context of prisoners' rights.

However, as will be discussed, the application of the ADA to prison medical care has been limited.

Title II of the ADA provides that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity." 42 U.S.C. § 12132. There are four elements in a Title II ADA claim against a state or municipal prison or jail, *see Thompson v. Davis*, 295 F.3d 890, 895 (9th Cir. 2002):

> (1) the prisoner or detainee meets one of the statute's three definitions of disability; (2) the prisoner or detainee is "qualified to participate in or receive the benefit of" the particular program or activity of the prison or jail; (3) the prisoner or detainee was excluded from participation in or denied the benefits of the prison or jail's services, programs, or activities, or was otherwise discriminated against; and (4) the exclusion, denial of benefits, or discrimination was based on disability.

The Supreme Court has held that, in the context of Title II of the ADA, the deliberate refusal of prison officials to accommodate disability-related needs, including "fundamentals" such as "medical care," constituted exclusion from participation in, or the denial of benefits, programs, and services of the prison system. *United States v. Georgia*, 546 U.S. 151, 157 (2006). Failure to provide medical care may therefore violate Title II of the ADA .

B. The Rehabilitation Act

In a similar way, the Rehabilitation Act also protects prisoners and detainees with disabilities in correctional facilities. *See Fitzgerald v. Corr. Corp. of Am.*, 403 F.3d 1134, 1144 (10th Cir. 2005). However, unlike the Americans with Disabilities Act, the Rehabilitation Act only applies to correctional facilities that are operated by the federal government, that receive federal funds, or are enlisted as federal contractors. *Id.*[45] For example, state prisons that receive

[45] The Rehabilitation Act does not define "financial assistance." *Shepherd v. U.S. Olympic Comm.*, 94 F. Supp. 2d 1136, 1146 (D. Colo. 2000). Circuit Courts may differ as to their approach. By way of example, the Tenth Circuit

federal funds are included under § 504 of the Rehabilitation Act, as are private prisons providing services for the federal government. Aside from that one difference, the requirements of the Rehabilitation Act and the ADA are substantially the same. *See, e.g.*, *Gorman v. Bartch*, 152 F.3d 907, 912 (8th Cir. 1998) (quoting *Allison v. Dep't of Corr*., 94 F.3d 494, 497 (8th Cir. 1996)) ("The ADA has no federal funding requirement, but it is otherwise similar in substance to the Rehabilitation Act, and 'cases interpreting either are applicable and interchangeable.'").[46] Since the requirements of the ADA give "at least as much protection" as the Rehabilitation Act, *Bragdon v. Abbott*, 524 U.S. 624, 630 (1998), most plaintiffs should plead under both the ADA and the Rehabilitation Act if possible. However, if a defendant does not receive federal funds and is not a federal government contractor or agency, then the Rehabilitation Act is inapplicable, and the suit must proceed under the ADA. In a similar manner, federal agencies are not bound by the ADA, and may only be liable to suit under the Rehabilitation Act. Since the statutes are substantially the same, they will be treated as such for the remainder of this paper.

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has defined "financial assistance" as a government subsidy, and "[t]he test to determine whether a government transfer of money to an entity is a subsidy is whether Congress or the federal agency administering the program intended to subsidize the entity." *Id.* at 1146. Only recipients with discretion to receive federal aid are required to comply with § 504; mere beneficiaries with no such discretion are not similarly bound. *See United States Dep't of Transp. v. Paralyzed Veterans of America*, 477 U.S. 597, 605–06 (1986) ("Congress imposes the obligations of § 504 upon those who are in a position to accept or reject those obligations as a part of the decision whether or not to 'receive' federal funds.")

[46] However, depending on the jurisdiction, there may be some minor substantive differences. Some Circuit Courts hold that the ADA requires but-for causation, and does not allow for mixed-motive discrimination claims. *See Lewis v. Humboldt Acquis. Corp*., 681 F.3d 312, 317-22 (6th Cir. 2012) (en banc) (holding that but-for causation is required to establish liability under the ADA and that Title VII's mixed-motive remedies are not available to ADA plaintiffs); *Serwatka v. Rockwell Automation, Inc.*, 591 F.3d 957, 961-64 (7th Cir. 2010) (same); *Palmquist v. Shinseki*, 689 F.3d 66, 74-75 (1st Cir. 2012) (no mixed motive claims under ADA, discrimination need not be "sole" reason causing action). In contrast, other circuits have held that the requirements for causation and the applicability of mixed-motive claims are the same under both the ADA and Rehabilitation Act. *See Baird v. Rose*, 192 F.3d 462, 470 (4th Cir. 1999) (allowing mixed motive claims under ADA); *Buchanan v. City of San Antonio*, 85 F.3d 196, 200 (5th Cir. 1996) (same); *Pedigo v. P.A.M. Transport, Inc*., 60 F.3d 1300, 1301 (8th Cir. 1995) (same); *Head v. Glacier Northwest, Inc*., 413 F.3d 1053, 1063-65 (9th Cir. 2005) (not requiring but-for causation under ADA); *McNely v. Ocala Star-Banner Corp*., 99 F.3d 1068, 1073-77 (11th Cir. 1996) (same). In short, depending on the Circuit Court, discrimination based on mixed motives may be more difficult to make under the ADA, and the standard of causation may be stricter under the Rehabilitation Act.

C. Procedural Aspects of Rehabilitation Act and Americans with Disabilities Act Claims

Under both the Americans with Disabilities Act and the Rehabilitation Act, defendants, including prison officers and medical personnel, may not be sued in their individual capacities. The ADA only permits suits against prison staff working in their official capacity, and not the individual officers working for that entity. *See Vinson v. Thomas*, 288 F.3d 1145, 1156 (9th Cir. 2002) ("plaintiff cannot sue state officials in their individual capacities to vindicate rights created by Title II of the ADA or section 504 of the Rehabilitation Act") *cert. denied*, 537 U.S. 1104 (2003); *Walker v. Snyder*, 213 F.3d 344, 346 (7th Cir. 2000) (same), *cert. denied*, 531 U.S. 1190, (2001); *Alsbrook v. City of Maumelle*, 184 F.3d 999, 1005 n. 8 (8th Cir. 1999) (en banc) (same).

Claims for injunctive relief are never barred by sovereign immunity. *See, e.g., State Employees Bargaining Agent Coalition v. Rowland*, 494 F.3d 71, 95 (2d Cir. 2007) (citing *Ex parte Young*, 209 U.S. 123 (1908)).[47] However, some state entities may claim Eleventh Amendment sovereign immunity against claims for *damages* arising from ADA or Rehabilitation Act claims. For Rehabilitation Act claims, courts have held that when state entities receive federal funds, they have waived their sovereign immunity from damage suits. *See, e.g.*, *Degrafinreid v. Ricks*, 417 F. Supp. 2d 403, 414 (S.D.N.Y. 2006) (continued acceptance of federal funds after *Bd. of Trustees of Univ. of Alabama v. Garrett*, 531 U.S. 356 (2001) is a knowing relinquishment of immunity).[48] Damages claims against a state under the ADA are more complicated. First, if the violation would also actually violate constitutional prohibitions,

[47] For the purposes of pleading, it is important to make claims specifically against a state official, in their official capacity, and not the state itself, since the later pleading may run afoul with sovereign immunity, even in the injunctive context.

[48] Cases with very old facts may need to produce additional proof that the state was aware of its requirements under Section 504, and voluntarily continued to receive federal funds. *See, e.g., Shariff v. Coombe*, 655 F. Supp. 2d 274, 306–07 (S.D.N.Y. 2009) ("Regardless of whether New York knowingly waived its sovereign immunity on February 21, 2001 or September 25, 2001, it is clear that New York had *not* knowingly waived its immunity at the time Plaintiffs filed their Fourth Amended Complaint on October 15, 1998. Accordingly, Plaintiffs' claims for monetary relief under § 504 are barred by the Eleventh Amendment and are, thus, DISMISSED").

such as deliberate indifference under the Eighth Amendment, then sovereign immunity is abrogated, and the claim may proceed. *Goonewardena v. New York*, 475 F. Supp. 2d 310, 323 (S.D.N.Y. 2007). Second, if no such constitutional violations exist, then courts must examine whether Congress had the authority under § 5 of the Fourteenth Amendment to abrogate immunity under the Americans with Disabilities Act. *Id.* The result of this analysis is not well settled, and is conducted on a case-by-case basis. *Id.* at 326 (asking whether abrogation under Title II is a congruent and proportional response to the history of discrimination against the people with disabilities in the context of access to public education); *see also Mary Jo C. v. N.Y. State & Local Ret. Sys*., No. 11-2215, 2013 U.S. App. LEXIS 2013, 55-57 (2d Cir. 2013) (declining to address the constitutionality of Title II of the ADA's abrogation of sovereign immunity).

D. Making Americans with Disabilities Act and Rehabilitation Act Claims

First, the plaintiff must demonstrate that he or she is a qualified individual with a disability. The ADA defines "disability," as "a physical or mental impairment that substantially limits one or more major life activities of such individual; a record of such an impairment; or being regarded as having such an impairment." 42. U.S.C. § 12102(1)(A)–(C). For cases with facts taking place before January, 2009, plaintiffs must prove that diabetes substantially limits a major life activity, and ameliorative effects of medication such as insulin must be taken into account. *See Caldwell v. Quarterman*, No. 3:04-CV-2166-L, 2007 U.S. Dist. LEXIS 91347 (N.D. Tex. 2007) (inmate with "emerging' diabetes" who was treated with insulin, and suffered from "fainting spells" which required revival with orange juice, did not "establish a disability as defined by the ADA.") This is a difficult standard to overcome.

However, the ADA Amendments Act of 2008, Pub. L. No. 110-325, 122 Stat. 3553 (2008) clarified that the definition of disability included "the operation of a major bodily function, including but not limited to, functions of the immune system … endocrine, and reproductive functions," and the ameliorative effects of medication cannot be taken into account. 42 U.S.C. § 12102(2)(B); *see also* 29 C.F.R. § 1630.2(i)(1)(i)–(ii). Since January 1st, 2009, therefore, a plaintiff must only present proof that he or she has diabetes, and that diabetes substantially affects the function of the endocrine system; this threshold issue about substantial impairment of major life activity "should not demand extensive analysis." 29 C.F.R. § 1630.2(j)(1)(iii) (2011).[49]

Next, the plaintiff must demonstrate that he or she was qualified to access benefits or services of the facility, and these benefits or services were in fact denied. This is primarily a factual question. *See, e.g.*, *Frederick v. Cal. Dep't of Corr. & Rehab*., No. C 08-2222 MMC (PR), 2012 U.S. Dist. LEXIS 47860 (N.D. Cal. 2012) (triable issue of fact whether the plaintiff was qualified to access benefits and services of correctional program under Title II of the ADA).

Finally, and most importantly, the denial of benefits or services must be discrimination based on disability, not medical treatment decisions. *Fitzgerald*, 403 F.3d at 1144 (plaintiff in detention must prove that medical treatment benefits were denied "solely by reason of disability.") Claims of disability discrimination in the prison context typically fall into three categories: 1) Substandard medical care, 2) Denial of medical care as retaliation or punishment, or 3) Denial of participation in programs and activities.

[49] For more information on proving that diabetes is a disability under both pre- and post-2009 versions of the statute, *see* Brian Dimmick, American Diabetes Ass'n, *Demonstrating Coverage under the ADA Amendments Act of 2008 for People with Diabetes* (Jan. 2015).

1. Denial of Medical Care or Provision of Substandard Medical Care under Americans with Disabilities Act

Courts consistently agree that negligent medical care alone is not a form of disability discrimination. See, e.g., *Burger v. Bloomberg*, 418 F.3d 882, 883 (8th Cir. 2005) (standard of medical care provided to inmate for his diabetes could not be basis for ADA reasonable accommodation action).[50] Courts frequently construe claims brought by prisoners and detainees under the ADA and Rehabilitation Act as claims regarding the plaintiff's medical needs and not discrimination on the basis of disability. *See, e.g.*, *Fitzgerald*, 403 F.3d at 1143. Rather, the courts have generally held that claims regarding poor medical care or treatment are cognizable under the Eighth or Fourteenth Amendment, *not* the ADA or Rehabilitation Act. *See, e.g.*, *Carrion v. Wilkinson*, 309 F. Supp.2d 1007, 1016 (N.D. Ohio 2004) (denial of diabetic diet "not the type of claim that the ADA [was] intended to cover" but cognizable under Eighth Amendment). Instead, to state a claim under the ADA, the plaintiff must show that the defendant denied medical care, or provide substandard care, intentionally, and *because* of the plaintiff's disability. *See Kiman v. N.H. Dep't of Corr.*, 451 F.3d 274 (1st Cir. 2006) (negligent medical care is not discrimination under ADA, which instead requires discriminatory motive).

However, extremely unreasonable medical decisions may be evidence of discrimination because of disability:

> For example, a plaintiff may argue that her physician's decision was so unreasonable – in the sense of being arbitrary and capricious – as to imply that it was pretext for some discriminatory motive, such as animus, fear, or apathetic attitudes. Or, instead of arguing pretext, a plaintiff may argue that her physician's decision was discriminatory on its face, because it rested on stereotypes of the disabled rather than an individualized inquiry into the patient's condition – and hence was unreasonable in that sense.

[50] *Accord Walls v. Texas Dep't of Crim. Justice*, 270 Fed. Appx. 358, 359 (5th Cir. 2008); *Iseley v. Beard*, 200 Fed. Appx. 137, 142 (3d Cir. 2006); *Marlor v. Madison County*, 50 Fed. Appx. 872, 873 (9th Cir. 2002); *Bryant v. Madigan*, 84 F.3d 246, 249 (7th Cir. 1996); *Owens v. O'Dea*, 1998 U.S. App. Lexis 10761 (6th Cir. 1998).

Kiman, 451 F.3d at 284-285 (internal quotation marks and citations omitted); see also *Hughes v. Colorado Dep't of Corr.*, 594 F. Supp. 2d 1226, 1241-42 (D. Colo. 2009) (adopting reasoning of *Kiman*).

Since most prison complaints regarding diabetes discrimination are actually based on receiving poor or negligent medical care, most ADA or Rehabilitation Act claims fail. However, in *Tidwell v. Stringer*, a pretrial detainee alleged violations of ADA Title II and the Rehabilitation Act based on the local sheriff department's failure to administer medication for diabetes. *Tidwell v. Stringer*, 2014 U.S. Dist. LEXIS 76169, *1-3 (S.D. Ala. 2014). The magistrate denied the Defendant's motion to dismiss, since ADA Title II and the Rehabilitation Act do not, as a matter of law, preclude a prisoner from alleging a violation of those statutes based on deliberate indifference to a serious medical condition or failure to provide adequate. *Id.* at *10-12. A parallel § 1983 claim could therefore proceed under the Fourteenth or Eighth Amendment, as well, as long as the constitutional deliberate indifference claims were not based on an alleged deprivation of the plaintiff's rights created by the Rehabilitation Act and the ADA. *Id.* at *11; s*ee also Payne v. State,* No. CV-09-1195-PHX-NVW, 2010 U.S. Dist. LEXIS 40865, *12-13 (D. Ariz. 2010) (an inmate with diabetes had been given inconsistent insulin injections, suffered severe hypoglycemia, and been denied a special diabetes diet for many years; the court struck plaintiff's claims, but gave leave to amendment his ADA Title II claims to present factual allegations that "indicate an outright and deliberate denial or refusal of access to medical care for a qualifying disability")

In at least one case, a magistrate judge for a district court found denial of diabetes medication to be a violation of the ADA. In *Montez v. Owens*, the prisoner had to wait three weeks before his oral medication for diabetes was made available to him. *Montez v. Owens* ,

Civil Action No. 92-N-870, 2007 U.S. Dist. LEXIS 36218, *11-12 (D. Colo. 2007). The magistrate judge noted that there are no claims for "substandard medical treatment" under the ADA or Section 504. *Id.* at *12. Instead, these claims are cognizable under the Eight Amendment. *Id.* Nonetheless, the judge reasoned that to "deny a diabetic needed medication is to treat that individual differently," since non-diabetics do not need oral medications or insulin to stay alive. Therefore, the judge found that "running out of [oral diabetes] medicine is unconscionable and a violation of the ADA and Rehabilitation Act." The claimant was given $350 in damages for his "fear" that he would not receive oral medication. *Id.*at *13.

2. Discriminatory denial of medical care or services due to animus or intention to punish

Other successful claims relate to denial of care based on implications of animus. In *Coker v. Dallas County Jail*, a plaintiff with diabetes and other conditions brought claims under the ADA and Rehabilitation Act regarding the prison's decision to remove his wheelchair. *Coker v. Dallas County Jail* No. 3:05-CV-005-M (BH), 2009 U.S. Dist. LEXIS 62978 (N.D. Tex. 2009). The deprivation of the wheelchair had been classified as "medical grievances" and sent to "medical staff," and since the prison was responsible for medical decisions, the prison was responsible for confiscating the wheelchair. *Id.* The court held there was a genuine question of material fact whether this action "subjected him to more punishment than non-disabled prisoners." *Id.* Furthermore, denial may have been unnecessary to prevent possession of contraband, and therefore may have been conducted with the intent to punish the inmate. *Id.; compare with Garcia v. Miller*, No. 99-0009, 1999 U.S. App. LEXIS 32429 (2d Cir. 1999) (reversing summary judgment on ADA and Section 504 claim made by inmate with diabetes and blindness who claimed he was punished more than other inmates for skipping meals).

3. Denial of Participation in Programs and Activities Under Americans With Disabilities Act

A final category of claims involves unequal treatment for people with disabilities. Unlike the medical care cases, these claims resolve around disparate treatment of people with diabetes attempting to take advantage of prison work programs, education opportunities, or skills development. For example, in *Frederick v. Cal. Dep't of Corr. & Rehab*., the court found a triable issue of fact whether the plaintiff was entitled to money damages under Title II of the ADA. 2012 U.S. Dist. LEXIS 47860 (N.D. Cal. 2012). In this case, the California Correctional Training Facility did not allow individuals with insulin treated diabetes who had unstable medical histories to perform skilled work functions. *Id.* at *8. Even after multiple rounds of administrative review, and in spite of repeated clearances by doctors, the prison refused to consider evidence that the inmate did not use insulin. *Id.* *8-9. Therefore the court held that the correctional facility may have improperly denied the inmate participation in its programs and activities because of disability. *Id.; contrast with In re M.S.*, 2009 Cal. App. LEXIS 924 (Cal. App. 1st Dist. 2009) (Superior Court judge did not violate ADA by placing youth with type 1 diabetes into more restrictive correction setting because no adequate medical care was available at other facilities, after many facilities were individually evaluated).

E. Summary of ADA and Rehabilitation Act Disability Discrimination Law

In summary, the ADA and the Rehabilitation Act permit claims based on discriminatory denial of medical treatment. *See Kiman*, 451 F.3d at 284. Courts, however, are often hostile to these claims and view medical care complaints as being outside the scope of the ADA. *See, e.g.*, *Burger*, 418 F.3d at 884. More frequently, successful ADA claims focus on denial of access to programs such as boot camps or work releases. *See, e.g. Frederick*, 2012 U.S. Dist. LEXIS

47860. The strongest ADA or Rehabilitation Act claims point to the specific prison programs or services that an inmate could not access due to their diabetes. Preferably, an ADA claim would state a claim for denial of services based on animus against a person with diabetes. Since the majority of claims by prisoners with diabetes relate to inadequate medical care, rather than unequal provision of services, most diabetes case law has developed under the Eighth and Fourteenth Amendments.

CONCLUSION

A variety of claims are cognizable under the deliberate indifference constitutional standard, the Americans with Disabilities Act, and the Rehabilitation Act. There are many procedural and substantive barriers to bringing successful claims, in spite of strong underlying legal protections. A progressively more experienced group of attorneys is vital to expanding the practical reach of the existing laws on the books. Since the needs of people with diabetes in detention are significant and wide-ranging, there are many opportunities for growth and development of the law in this area.

For additional information about the law related to diabetes care, the American Diabetes Association has a Legal Advocate Program. Legal Advocates (licensed attorneys with expertise in diabetes discrimination matters) are available to assist individuals with diabetes in diabetes discrimination cases, including correctional facility issues. Updated additional resources are available at www.diabetes.org/policetraining.

Attorneys, health care professionals, and other professional advocates should call 1-800-DIABETES and ask to speak directly with a Legal Advocate or write to LegalAdvocate@diabetes.org.

Individuals, family members, and friends concerned about treatment in correctional facilities should call 1-800-DIABETES and will be provided with short intake form which can be submitted by email, fax, or mail. Service is available in Spanish. For more information on our Legal Advocate Program, see www.diabetes.org/gethelp.

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