

FINISHED COPY

AMERICAN DIABETES ASSOCIATION
POLICE/PRISON WEBINAR

NOVEMBER 19, 2014

Services Provided By:
Caption First, Inc.
P.O. Box 3066
Monument, CO 80132
1-877-825-5234
+001-719-482-9835
www.captionfirst.com

This text is being provided in a rough-draft Format. Communication Access Realtime Translation (CART) or captioning are provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings.

>> TARYN EGELANIAN: It is 3:00 p.m. We're going to go ahead and start. I'm just going to give a couple of brief announcements and turn the meeting over.

Just to let you all know, the meeting is being recorded today and all phone lines will be muted but those of the presenters. There will be time for questions, you're welcome to submit the questions in the bottom, lower left-hand portion of the screen via the chat box.

We're happy that you were able to join us today. Now I'm going to turn the program over to Ben Eisenberg to start.

Ben, I can't hear you. Ben, please press star 7.

>> BEN EISENBERG: This is Ben Eisenberg with the American Diabetes Association.

Thank you for coming to the Police, Prisons and Diabetes webinar. This is an emerging issue. We think it is very effecting of lots of people in diabetes in the jail, prison system and we appreciate you coming out.

A little background, American Diabetes Association is a large health organization, but we also have a

wonderful advocacy department and we're the legal advocacy part of the American Diabetes Association. We deal with legal advocacy and employment, education, prisons, places of public accommodation, pretty much everything you can imagine that relates to diabetes discrimination. We have a diabetes hotline, if you call in, we give free legal assistance by phone and we also have help with litigation support, trainings, a whole range of programs. It is a great program for people with diabetes and we appreciate you all for coming out.

I'm Ben Eisenberg, a staff attorney. We also have Sarah Fech from the American Diabetes Association and we also have an attorney, Alan Yatvin and Dr. Kuneil Koliwad.

If Alan and Kuneil Koliwad would like to introduce themselves briefly, that would be wonderful.

>> ALAN YATVIN: I'm Alan. I'm an attorney with Police Misconduct Civil Rights Litigation. I'm a member of the American Diabetes Association legal advocacy subcommittee which I Chaired for three years up until last year. I'm happy to be here. Look forward to having an interesting session and answering some of your questions.

>> BEN EISENBERG: Right.
Dr. Kuneil Koliwad.

>> SUNEIL KOLIWAD: I'm happy to be here.

I'm Kuneil Koliwad. I'm the president of the Bay Area Volunteer Leadership Board for the American Diabetes Association. I'm a faculty member in the Diabetes Center at the University of California, San Francisco where I do basic science research and clinical care, patients with both Type 1 and Type 2 Diabetes. And I have participated locally in a few panel discussions during the last year on issues relevant to legal advocacy, police and prisons, and I'm happy to be involved in this wide-ranging discussion we'll have today.

>> BEN EISENBERG: Dr. Kuneil Koliwad will give -- for those still learning about diabetes, want to know how it relates in this particular context, Kuneil Koliwad has the expertise and will have introduction diabetes, diabetes care, some more issues as well.

>> SUNEIL KOLIWAD: Thank you very much.

Just to give a little bit of the background and set the stage for what we're really talking in terms of diabetes, I think it helps to have a bit of understanding for the biology, physiology that are going

on in the bodies of individuals who have both Type 1 and Type 2.

Let's start with Type 1. It can be characterized simply, it is a condition which results from a misidentification by our immune systems of self-versus non-self, our immune system is to tell what is us and what's foreign, and attack the foreign thing and leave us alone. We're wonderfully evolved to produce that function. Every once in a while the immune system goes array and misidentifies a protein as foreign but it is not. In the case of Type 1 that occurs for insulin, producing cells in the pancreas. These cells are destroyed by our own immune system.

Patients with Type 1 Diabetes needs insulin. They don't have the cells in their body that make it. That insulin is usually administered in the form of a type of insulin that acts over a long period of time throughout the 24-hour daily cycle then other insulins, which act in accordance with the need to handle the sugars that are present in the foods that we eat. That requires multiple injections daily.

Because it is an autoimmune disease and it is not solely the result of the effects chronically of the environment, dietary habits, physical activity, Type 1 Diabetes oftentimes results younger in life and is the most common type of Diabetes that affects children. If a patient with Type 1 Diabetes does not have insulin, they'll ultimately enter a state called diabetic ketoacidosis; if not treated, can be fatal resulting first in coma and then subsequently in death. These patients require insulin and cannot go extended periods of time without having it.

On the other hand, Type 2 Diabetes, this type -- not as much anymore with the growing obesity epidemic -- traditionally occurs in patients who are older, adults, if not people in the second half of their lives. In Type 2 Diabetes the problem is not a problem of a lack of insulin, in fact, the pancreas of patients with Type 2 Diabetes is large compared to the normal and it is cranking out a bunch of insulin. The problem with Type 2 Diabetes is that insulin doesn't work properly because of insulin resistance.

Insulin resistance or the failure of the body to respond to insulin occurs in the context of genetic predisposition, obesity, sedentary lifestyle and potentially other factors that are environmental in nature which there is a lot of research around right

now. It is not immediately fatal, but it does produce long-term health problems, and those include heart disease and stroke, problems with the functionality of one's limbs, particularly the legs, problems with the functionality of the nervous system and eye problems as well as kidney problems.

Because people can live for long periods of time with Type 2 Diabetes, when not properly managed they can ultimately develop morbidities which result from the complicating factors. In addition to insulin, Type 2 Diabetes can be managed with oral medications that help make insulin work better in part. That's not something that's has relevant for patients with Type 1 Diabetes. Although at the end of the line, when the medications that we take orally aren't doing a sufficient job of controlling blood sugars, Type 2 patients like Type 1 patients may require insulin to bolster the pancreas to bring the sugars down. Both may be on similar regiments in those cases.

On the one hand, patients with Diabetes, both types, can feel the effects of hyperglycemia, high blood sugar. You see the complicating factors that can ensue in the setting of exceptionally high blood sugars. In the case of Type 1 Diabetes I mention this can include this entity called DKA which can produce death.

In the graphic that's shown to the right, you can see that there may also be some widespread effects in the setting of this acidosis that makes life difficult for people for sugars that are acutely high.

Then, I mention the complications, but here is a list of those complications. This is where the economic cost of Diabetes comes in to play. These complications are very medically intense to manage. They require medicines of their own to manage. They oftentimes lead to hospitalizations, surgeries, and excessive number of ancillary procedures that have to be done. They themselves can produce death independently of the Diabetes itself. And so Diabetes really when poorly managed over the long-term opens the gateway to a whole host of other disease processes that can make the lives of patients with Type 2 Diabetes particularly very, very cumbersome over the long haul.

On the other side of the spectrum, patients with Diabetes, especially those patients who take insulin, can feel the effects of low blood sugar or hypoglycemia which is usually because of a mismanagement with the insulin that the patients take by injection. That

mismanagement can take the form either of giving insulin in anticipation of eating a meal, but then not eating that meal or they could occur because a person is giving themselves too much insulin or has given themselves insulin and then not engaging in the same expected amount of physical activity during the course of that day subsequently.

Any mismatch between the calorie expenditure, food intake and the amount or nature of the insulin given when the timing is not right produce a reduction in blood sugar, and that lowering of blood sugar is called hypo glycaemia. You see some of the symptoms with the mild low blood sugar, and when it is severe it leads to loss of consciousness and can produce death ultimately if not actually dealt with immediately.

So at the end of the day, what we would like to do is to prevent both hypoglycemic and hyperglycemic episodes to keep the sugars in a normal range throughout the day so that acute symptoms can be prevented and also to keep blood sugar within the normal range over the course of one's life so that the chronic complications I mentioned can be prevented.

For the chronic complications, we use a blood test called the hemoglobin A1C which can be administered from a blood draw and ran in the laboratory. We try to keep that A1C value at less than or equal to 7% as a rough guide of where one needs to be chronically controlling their blood sugars over the long-term.

With respect to acute management, we use the finger stick which patients have at home, on their person all the time when they take insulin and they check their blood sugar with a finger stick using that. They actually read the blood sugar level at any given point in time and determine if they had need to eat something, exercise differently, alter their behavior pattern or take more or less insulin that day. The basics of care also involve a lot of education, awareness, practice around monitoring and altering one's lifestyle particularly around diet so as to prevent high blood sugars and low blood sugars and then, of course, medication management.

I mentioned the oral medications, particularly for Type 2 patients and insulin always for Type 1 patients and sometimes for Type 2 patients as well. This is coupled with a multidisciplinary care regiment which involves physician visits, Diabetes educators, nutritionists and sometimes social workers and other

individuals who can help coordinate all of these multiple aspects of care that are necessary to manage patients with Diabetes properly.

I think just to round out, I'll say that in seeing a lot of patients who are detained for one reason or another, either chronically, acutely in the -- by law enforcement or in the prison system we see that this multidisciplinary nature of care, which is really required essentially to keep blood sugar normal acutely and chronically sometimes fails and the substandard care that results from that can produce very high blood sugar in individuals, very low blood sugar in individuals and those severe acute manifestations, which can, as I said, result in worse-case scenario loss of consciousness or even worse. There are also issues with respect to getting the proper diet day after day when the incarcerated environment. There is also among the care providing staff, both medically allied and those who just manage the population in incarceration, they may suffer from some ignorance or lack of education on Diabetes, and that lack of education can cause there to be problems both in acute and chronic management.

With that, I'll turn it back over to Ben and we'll take the discussion forward.

>> BEN EISENBERG: Wonderful. Yes. We will advance the slides here.

There you go.

To asking questions about Diabetes or Diabetes care in prison. We had a question that was related to the diet of people with Diabetes in prison. Sarah had a great answer to that.

Unfortunately a diet is not usually done well, a lot of carbs and not handled well by the prison system. There can be a grievance request to have a diabetic diet, but they're difficult and sometimes the most difficult to obtain is the food issues. Courts have not been helpful with that.

There was a question, I'm going to send that to Dr. Kuneil Koliwad, a question, can retinopathy be reversed by surgery or --

>> KUNEIL KOLIWAD: The question has to do with reversal in general.

I will say that Diabetes is a continuum, and the diagnosis of having Diabetes is made based on a fasting blood sugar or a hemoglobin A1C level or the blood sugar responds to the consumption of a drink, a sugary beverage, a cola-type beverage with a certain amount of

sugar in it. So we use all of these measures to diagnose Diabetes. Whether you do or do not meet the criteria, you may be on the continuum. Regardless of where you are on the continuum there are things reversible.

By the time people get chronic complications of Diabetes the pancreas function that's left is usually very little. So these are individuals who have had usually poor glucose management, substandard, inadequate -- at least suboptimal glucose management for several years, if not more than 10 years. By that point it is very little pancreatic function left and usually the patients are already on both types of insulin I mentioned at the beginning. They're the ones who develop eye complications, nervous system complications, cardiac and oftentimes stroke complications.

When you're at the point of experiencing those complications we have not found a lot of data that suggests that either diet and lifestyle or more intensively bariatric surgery can reverse those complications.

On the other hand, there is data to strongly suggest that robust lifestyle modification and particularly bariatric surgery can remove the glucose abnormality of Diabetes. The question is now doing so late in the game, if doing so, will reverse the complications if they have already set in and I think the jury is out on that.

>> BEN EISENBERG: I have another question quickly about how long can Type 1 Diabetes go without insulin before they have risk of ketoacidosis.

>> SUNEIL KOLIWAD: A great question.

At the most, 48 hours. If a person is active, burning calories rapidly because they're busy, that could be a much shorter period of time. If they're sick, not eating because they have got a cold, some other virus and their nauseated and not taking insulin in that setting, it can be a very short period of time. Sometimes even less than 24 hours. As a rule of thumb we're talking about a day or two, maybe three at the most.

>> BEN EISENBERG: Great. We'll have more time for questions with regard to the prison context --

>> ALAN YATVIN: Before you do, can I inject something here?

I wanted to -- Dr. Kuneil Koliwad very importantly, on his last slide there, slide 9, was talking about the

differences of someone who's in custody. That's really the key to remember. If you're a person with Diabetes and you feel that your blood sugar is going low, you can go to the refrigerator, get a coke, around the corner to a corner store to get a packet of peanut butter crackers, Sweet Tarts, you're in control. If you have a problem, you call Dr. Kuneil Koliwad's office and talk to a Diabetes educator on his staff with your questions or someone in his clinical staff if you have specific medical problems. You can't do that in prison. None of those things are at your disposal. You don't have access to your insulin, your testing, your diet, sometimes not even water when you're in police or prison custody. That's very much the difference of someone who manages their Diabetes well outside the custodial setting and someone with Diabetes in the custody of the police or in a prison setting.

>> SUNEIL KOLIWAD: A quick follow-up point to that: If you go back to slide 7 in your mind, hypoglycemic and hyperglycemic, a major manifestation of that developing process is confusion. It is listed at the top, even in mild hypoglycemic, when you need your wits about you, your faculties to be intact so that you can do what you need to do to rectify the situation. As someone with Diabetes, not only are you not in control, but now you're not as easily able to communicate your needs to those people around you, and if those people are somewhat ignorant of the needs to begin with, that really sets up a very, very ominous scenario for a bad outcome. I think what Alan brought up is a center point to all of this.

>> BEN EISENBERG: Especially someone with mental illness or other disabilities or if there is confusion, whether they're under the influence of alcohol, that's a big problem.

Let's talk a little bit about the law enforcement context and problems that come up.

Sarah Fech will address that.

>> SARAH FECH: Yes.

Okay. So in the law enforcement and police misconduct context there are several laws that are causes of action in law enforcement cases. The first is 42USC1983, commonly known as 1983.

This is a federal law that makes it illegal for individuals to be deprived of a Constitutional Right by a person acting under color of state law. In this context, the typical Constitutional Rights that come

into play are the 4th Amendment Right to be free from an unreasonable seizure or the 14th Amendment Right to adequate medical care.

An individual acting under color of state law in this context would be an officer making an arrest or detaining it an individual.

So the first of those two was the 4th Amendment, the right of people to be free against securing against unreasonable searches and seizures. Alan, would you mind quickly summarizing Graham? It is an important case here that we get a lot of factors from, and it actually involves an individual with Diabetes.

>> ALAN YATVIN: Yes.

Graham is one of those cases where if you do 4th Amendment use of force litigation you know Graham. Police officers are trained on Graham factors.

I have been at training sessions with police where we have discussed Graham and the Graham factors you see here, but nobody ever remembers the facts of Graham.

The facts: Graham itself arose in the context of someone with Diabetes. Graham felt the onset of hypoglycemia and asked a friend to drive him to a nearby convenience store to purchase orange juice. The friend agreed. Graham entered the store but saw there was a line ahead of him at the checkout line and he turned around and hurried out of the store and asked Barry to drive him to a nearby friend's house instead.

Conner -- the case is Graham versus Conner -- Conner was the police officer. He was a Charlotte, North Carolina officer. He saw Graham hastily enter and leave the store and he thought maybe there was a robbery going on, the place was being cased for a robbery. He followed Barry's car, the friend's car for about a mile and a half, and then he pulled the car over. The driver told the police officer that Graham was suffering from reaction to his insulin related to his Diabetes. The officer ordered them out of the car and told them to wait while he checked back with other officers to see what was going on at the convenient store.

At this point Graham got out of the car and he was confused. He ran around it twice, he sat down on the curb. He briefly passed out. A number of other police officers arrived on the scene and they rolled him over on the sidewalk, cuffed his hands behind his back, ignoring his friend's please to get him sugar. One of the officers -- this is what Dr. Kuneil Koliwad was talking about, about officers who don't really know

anything about Type 1 and Type 2 Diabetes and the differences -- said I have seen a lot of people with sugar Diabetes and never acted like this, ain't nothing wrong with the MF but drunk, lock the SOB up.

The officers then lifted Graham up from behind, carried him over, placed him face down on the hood and he began to regain consciousness and asked the officers to check his wallet and he was told to shut-up and slammed down on the hood of the car.

They grabbed him, threw him head first into a police car. While he was waiting in the police car a friend of his whose house they were going to brought orange juice up to the car, the officers wouldn't let him have it.

Finally when they learned nothing had happened at the convenient store they realized there was something wrong, figured out that he did indeed have Diabetes. Of course, at that point Graham had a broken foot, cuts on his wrist, a bruised forehead and an injured shoulder and ringing in his ear that continued until the time of court.

So this is -- this is the key use of force case and it all arose in the context of someone having a hypoglycemic emergency.

>> SARAH FECH: So the Graham factors that Alan and I discussed briefly that we get from the case are to assess the reasonableness of the use of force in each particular incident. That's a weighing test. You'll weigh the severity of the crime that's suspected, or that's occurred. What is the suspect doing that may or may not pose a threat to himself or to others or to the officers? Whether that person is actively resisting arrest or attempting to evade arrest. Those are the factors we get from Graham to assess reasonableness.

Then we also assess the level of intrusion, weighing the government interest against the level of intrusion into the individual. The amount of force being used weighed against, you know, whether there are less intrusive methods available and also the emotional case.

And in Cleveland, we have a case of number 2, which is an individual that had been handcuffed, put in a police vehicle and there was a dispute about whether he had spit at the officer or whether he was just speaking and there was some sort of spital that came from his mouth. The officer rather than shutting the door punched him in a face. There was an opportunity for a less intrusive method that was not used. That's another set of weighing factors there.

Alan, would you mind speaking briefly about some kind of important commonalities, trends in successful cases that we have seen?

>> ALAN YATVIN: Commonalities, when we become lawyers we stop being able to communicate in simple English.

Basically one of the sorts of things you'll see in cases that you'll be able to prevail, one, of course, notice.

In the Graham case I was talking about, Mr. Graham's friend Barry, the driver, he was telling the officer he has Diabetes, he's experiencing low blood sugar and he needs sugar. The notice doesn't get much better than that. There is certainly cases where you will see that kind of notice. Other types of notice may be a medical alert tag, seizures occurring, medical personnel on the scene or relatives informing the police that the person is experiencing a medical crisis of some sort even if they don't specifically say Diabetes.

The other factor in a case where you're likely to have success is that the person is not posing a threat to himself or others. That if somehow the behavior is dangerous, like someone driving and weaving on a crowded highway, the officers' conduct is more luckily to be forgiven than if they're staggering around, not hurting anyone, behaving strangely but not aggressively, speaking incoherently, unresponsive or even unconscious.

As I said in the vehicle context, if the person is pulled over and experiencing problems from their Diabetes, any use of force by police is less likely to be justified than if they are in a situation where they're driving or attempting to enter a vehicle or attempting to continue to drive.

>> SARAH FECH: Okay. Then the next type of 1983 case here that's common is under the 14th Amendment, a denial of medical care. Ben will talk more about that in the detainment, post-conviction setting, but medical care could be needed during arrest, pretrial detainment.

You know, there are two standards here: The first is an arrestee standard, that's an individual who has not yet had a judicial determination of probable cause. They were arrested not pursuant to a warrant, and have not yet had a hearing. This is a -- usually it is a brief window of time, but not insignificant. I should say that it is only explicitly recognized as a separate standard in the 6th, 7th, 10th Circuits, because it is much easier to meet. I would highly recommend that anyone in a different circuit urge the court to adopt

this standard.

Essentially it is an objectively unreasonable standard. You know, was the treatment or the failure to provide treatment objectively unreasonable? The factors considered are whether the defendant had notice? The seriousness of the medical need, which with the person who uses insulin, it will always be a serious medical need. The scope of the request of treatment in terms of time, expense, invasiveness, and whether there is police interests that could be relevant to providing that care. This test, this objective, unreasonable test was laid out by the 7th Circuit.

All our pretrial detainments, the standard is deliberate and different, it is a hard standard to meet. The Constitution deprivation has to be sufficiently serious demonstrating incarceration under conditions that pose a substantial risk of serious harm. This is fairly easy to meet in the Diabetes context especially when you talk about denying insulin. That's sufficiently serious.

The prison official has to have a culpable state of mind, that's difficult to demonstrate.

So denials of medical care for individuals with disabilities most often include refusing access to food, water, use of the restroom. When a person has high blood sugar, they need to use the rest room frequently. Refusing to provide medication such as insulin, allowing someone to check their blood sugar -- it involves the use of a needle, which is obviously a concern in an incarceration context. Even exposure to very high heat that can be an aggravating factor for individuals with disabilities -- with Diabetes, excuse me.

Okay. Alan, would you mind taking over for this slide?

>> ALAN YATVIN: You know, I know I'm down for this slide. We have really covered it.

Shumate versus Cleveland is a case where the plaintiff was found by officers staggering around in a parking lot. He told the officers that he had Diabetes and he needed sugar. The ambulance were called to the scene. They were there. They offered to check the plaintiff's blood glucose but the officers would not allow them to do so. Instead, they ran a warrant check, found out that he had several traffic warrants for his arrest and they took him to the station before -- instead of allowing the ambulance crew to immediately treat him.

In that case, the successful elements were as we have discussed earlier: The plaintiff communicated, he told the police what his problem was and what he needed. He had Diabetes and needed sugar, not something too complicated.

Also that he was exposed to a possibility of severely adverse consequences from the denial of medical care. Which was there! They were standing right there. It wasn't like they had to take him anywhere or do anything. This was the most egregious of scenarios.

The causation part of these cases, the best chances of success are usually to identify a link between the injury and a specific policy of the department if you're seeking to get municipal liability. For example, no medical screening of police cell rooms, no guidelines or procedures for providing persons arrested with medication, to have access to that medication, procedures to provide food and water, no training of parole officers or cell room officers to recognize and respond to the needs of persons with Diabetes. These municipal liability cases can be proven through official written policies, through customs or practices that have the force of policies so as to demonstrate that they're the actual policy of the department.

For example, you have someone who is in police custody and you have a policy of the police department that says whenever anyone comes into a police district or precinct station with medication they're to be questioned about that medication and transported somewhere where a medical provider can make decisions about their receiving that medication. That's the written policy, that's a good one probably. If it turns out that the reality is that no one is ever allowed access to their medication and no one is ever transferred in a timely fashion to somewhere where a medical decision maker can determine whether they should have the medication then the real policy of the police department is actually the practice, not the written policy.

Talk about this all day, these are cases that basically you don't get to do discovery to prove the policy unless you can prove the policy. Twombly and Iqbal.

Some courts have been very strong in requiring detailed pleading -- basically federal notice pleading is out the window on claims, if not literally, practically. And the result is that you need to have

information on your departments to know what they're doing or what they're not doing so that you can make enough of a threshold showing to get past emotion for dismissal. It depends on the courts.

Recently I filed a case involving a man who was shot by police who were attempting to take him into custody on a mental health commitment. They completely bobbled it and I included in that a municipal liability claim. It was clear that they had no training and no procedures for what to do with people who were being taken to custody on civil, mental health commitments. The defendants last week filed a motion to dismiss, last Thursday. We had a rule 16 conference yesterday and the judge before I had answered said this is fact dependent, I'm denying it. Every court is different. Definitely the bar has been raised on municipal liability claims.

>> SARAH FECH: I'm going to move forward.

This slide is about sort of procedural consideration which I won't go into much detail with. They're not too terribly exciting. Things of statutes of limitation, immunity concerns, I have actually written a guide for practitioners on this law enforcement issue and it goes into these issues in much greater details. I can send that out to anyone that's interested.

You know, in particular, there is no statute of limitations in section 1983. You will just apply the most analogous statute of limitations, personal injury statute of limitations, that's pretty common.

Alan, do you want to talk about remedies under 1983 very, very quickly?

>> ALAN YATVIN: You know, the usual compensatory damages are similar to other personal injury or Civil Rights case.

Punitive damages are available to the individual -- to the individual officer -- but not available as to the municipality. Relief may be available although there may be standing hurdles under the Gates standard which is just because they put a guy in a chokehold once doesn't mean that he will be in one again. Because these are cases brought under the Civil Rights act, fees may be available to the prevailing party.

You want me to go into Rosen at all here, Sarah?

>> SARAH FECH: There will be time for that later.

Quickly, on Americans with Disabilities Act -- title 2, the title that comes into play here -- title 2 of the ADA applies to arrests, and, of course, public entities are required to make reasonable modifications to their

policies, practices, procedures to avoid discrimination.

Individuals with Diabetes almost always qualify for protection under the ADA especially following the ADA's triple passage in '98 because the bodily function, it is substantially limited. Some individuals who have Type 2 only control their Diabetes with diet and exercise may not apply for coverage under the ADA, but definitely if you use insulin should be able to find easy coverage in the regs and in several cases.

There are two theories under the ADA: One is wrongful arrest theory that officers have misperceived the lawful effects of your disability as unlawful misconduct and the reasonable accommodation theory, that officers fail to accommodate you during the arrest or pretrial detention.

The statute of limitations is identical to section 504 which requires that courts adopt the most analogous state statute of limitations. Damages are very similar to 1983, but the punitive damages are not available under the ADA.

Then just very briefly under Section 504 of the Rehabilitation Act: Section 504 you know, the ADA incorporates standards from 504, numerous courts have held jurisprudence assessing either to be applicable to both. Most relevant distinction is that the entity receive federal financial assistance. And similar considerations here, if an entity elects to receive federal funding then they are not immune from monetary damages.

That concludes our section on law enforcement.

Ben, would you like to take it over?

>> BEN EISENBERG: Thank you, Sarah.

That's a great area of law. There is a lot of ability to get damages in those kinds of cases if you get the case right. I think you explained very well how that works in the pre-detention setting or detention under arrest.

I'm going to talk about after arrest, when you're put in detention in jail or after conviction, when you're put into detention in a prison or other kind of facility.

You can see here actually the person here on the image, a gentleman who went in to a detention facility, had Diabetes, had terrible Diabetes care, continuously asking and pleading for care in the detention facility, never got it. Unfortunately his foot got infected. He had neuropathy. The infection was not treated and he

had amputated toes in the failure to treat in that case. It is a new story. Unfortunately I get letters every day from people in jails complaining about the Diabetes care in that area. There is a lot of need around the country.

I'll get into the basics of the legal issues.

Sarah talked about the standard under the 4th Amendment. There is also standards under the 8th Amendment and 14th Amendment.

8th Amendment, prohibition of cruel and unusual punishment including deliberate indifference, we talked about that a bit. That's for post-conviction. If you're in prison.

14th Amendment, that's if you're in jail or anything pre-conviction detention. You haven't been convicted of any crime but you're waiting. You don't have the bail, not able to pay bail, that's in the 14th Amendment, it incorporates the 8th Amendment. The standards are the same in practice. Courts tend to read them the same. Some courts have implied that the 14th Amendment, may give greater protections that you have not been convicted yet, you will get greater protection. In practice it is hard to tell if anyone applies a higher standard, but it is their own paper. We want to argue it gives more protections.

So when you get into the prison context, the detention context, that's in the middle of 1986, middle of 1990s, that's to stem the tide of prison litigation, litigation reform, frivolous litigation. It made it improve the difficulty of being able to file a suit if you're in detention, you have to finish all of the internal grievance processes, you have to file a grievance, have the process denied, appeal the process, have that denied, and if there is another level, go through that, then you can file in court. Again, whether prisoner is doing this, representing a person in detention, this all has to be completed with the internal grievance process. It does not apply if you're no longer in custody, if you are out of custody. If you represent someone out of custody and they suffered treatment while in custody, this doesn't apply. If the person is still in custody, it is extremely important to exhaust every single grievance procedure imaginable. Sometimes the deadlines are extremely tight, may be a 10-day response for appeal, 15-day response for appeal. Often the procedure is not listed. It is important to keep track of what those are and exhaust them. There is

very limited exceptions. Almost always you have to exhaust someone that's completely incapacitated or a prison official deliberately tries to lie to someone saying they can't file.

The cruel and unusual punishment includes deliberate indifference to serious medical need, the objective serious medical need, Diabetes counts, Type 2 and Type 1. There is hemming and hawing about Type 2 Diabetes by some of the lower district courts saying that Type 2 may possibly not qualify in all cases but a court has never said that it is not a serious medical need.

The subjective, Diabetes counts. The subjective -- it is the state of mind of prison official. This is when it is important. It means that there has to be a state of mind that the prison official that's indifferent. That means that you can't have negligence, should have known. That means that it is higher than general medical malpractice standards often. It is not just a normal torque standard, has to be higher than that. There has to be some kind of action in the person's mind that gives indication of deliberate indifference.

Medical care: What medical care should be provided, somewhat reasonable, disagreements on diet or food, very, very difficult. For example we have from the 3rd Circuit -- they didn't have a Diabetes specific diet, but there was no evidence that the prison officials knew that it wasn't working for people with Diabetes. Pure incompetence is allowed unless the incompetence would give objective evidence of deliberate indifference. Incompetence and negligence, but not deliberate indifference.

Make clear to say that state tort laws, state medical malpractice law depending on the state may apply and it is important to check those. The damages still may be available under those and the standard may be less. What is sufficient for deliberate indifference, denying access to insulin for example, Type 1 Diabetes, court after court have said if you don't given insulin to someone who you know has Type 1 Diabetes or reasonably can tell they had Type 1 Diabetes that's deliberate indifference.

As we talked about earlier, 24 hours without insulin, you can be in extreme trouble. I have seen people two hours, three hours, six hours without insulin, if they haven't had one early enough or have variable in the system. Some cases have shown that had requiring

someone with neuropathy to work through pain when they have said they have severe pain and they don't care and punish them by making them work. That can be deliberate indifference.

For example, we have from 7th Circuit, we know that the defendant deliberately withheld it. They withheld the dietary combinations. They knew that they had it happen, then you get judgment.

So we can talk a bit about strongest cases here. Alan, I believe you wanted to talk a bit about -- you helped out with some of these cases, what are the strongest kind of cases related to deliberate indifference?

Can I get you on the line?

>> ALAN YATVIN: Am I there?

>> BEN EISENBERG: Yes.

>> ALAN YATVIN: This is an example of the twisted world in which we lawyers live sometimes.

The better case is the one with the greater injury, that it is harder to persuade a court and a jury if someone is suffering neuropathy incrementally over a long-term as a result of inconsistency in their insulin regiment or not having access to appropriate testing and diet over a long-term than there is if there is severe harm as a result of outrageous conduct. That's perhaps true in most police Civil Rights cases, but in the medical, Diabetes context in particular, the more outrageous the conduct, the more the significant the injury is, it is more debatable to prevail, have a successful result.

The slide, you know, makes a good point. Some states have very good Civil Rights or discrimination statutes that allow you to bring cases under state law to the point where you may not even bring a federal claim because the state law is more favorable. I'm in Pennsylvania, we do not. So invariably these cases are brought in federal court under one of the Civil Rights Acts that we have been discussing.

Ben mentioned the Prison Litigation Reform Act. If you're not familiar with it, you should read it just to it be amazed at how thoroughly Congress has gone out of their way to gut the rights of prisoners to bring suits. Even if a prisoner has a meritorious suit it can be thrown out through failure to exhaust, even if at the end of the day a prisoner prevails, the fees in an inmate case are capped, the hourly rate is capped at I think 150% of the criminal justice act fee for court appointed

criminal attorneys, and a certain percentage of the fee claim comes out of the plaintiff's claim. There is many ways this has been designed to turn attorneys away from the cases and many case, they have been successful in doing just that. There are a lot fewer attorneys doing it as the need has become greater and greater.

>> BEN EISENBERG: That's why we really want to impress the importance of these issues for people in detention from a humanitarian perspective, from this perspective, passionate about the issues.

We know that when you're in detention the legal environment is difficult, if not impossible, but difficult. So we're here to support anyone who's willing to take on the cases, willing to give background support, litigation resources, whatever we can. People are getting really messed up in this detention, people are dying, getting severe injuries. And if the law is not very good, we need people passionate about doing what's right.

>> ALAN YATVIN: In the area of Diabetes: Unfortunately, Diabetes is a growth industry these days. Type 2 Diabetes -- and I'm sure that Dr. Kuneil Koliwad could give us frightening statistics -- it is increasing. That means more people in jail, in both short-term county prison settings and in long-term settings, and even in a few days' worth of in a police custody situations are increasing. The availability of lawyers to represent them in these cases is going down.

>> BEN EISENBERG: Absolutely.

>> SUNEIL KOLIWAD: Just to add to what Alan said, it is the case that overall problems of Diabetes and underlying obesities, Type 2 Diabetes is going up nationwide. It is going up particularly in a striking and noticeable way in socioeconomic groups and also in minority groups that are -- that have higher prevalence in terms of being incarcerated.

The problem is amplified, not only is Diabetes going up overall, but specifically in those groups that are likely to face the circumstances that we have been talking about today. There is a high likelihood that people in that environment will have Diabetes.

>> BEN EISENBERG: Disproportionately affected.

I will touch on what Sarah touched on with the American with Disabilities Act, Section 504.

Essentially it is court medical care. It is not covered and very, very rare circumstances, instead there is usually a work program for example, someone able to

go on a work program, but they say you have Diabetes, you're not fit for duty, when in fact you're fit for duty and sometimes they say anyone with Diabetes cannot be on an outside work program. That's discrimination and not deliberate indifference. That's usually what the claims come through.

There can be some medical care claims because those are unusual if they're an anonymous fear or empathy. Discriminatory animus, examples there.

I have a memo also that's unfinished and unpublished but will be available soon on these issues for prison care. If you want the information, I would be glad to send it to you in the draft form.

Finally, there is a case study from Alan on how to be able to take some of these cases in the prison context.

And we'll answer questions and finish up the webinar.

>> ALAN YATVIN: In the late 90s I handled several cases in Philadelphia involving individuals with Diabetes who were not getting access to appropriate medical care, their medicine or diet or liquids while in police custody. I settled them.

The second, third I settled, the police department said they would review their policies. The problem was, that these people were being held at police districts, stations outlying around the city, rather than the main unit in the police headquarters. The result was that they had holding room officers who didn't really know what they were doing and people were ending up in the hospital because of this. When we settled the second, third case, the city said we will review our policy and training and address as part of the informal discussions of the settlement.

A year later, Steve Rosen comes in my office. Mr. Rosen runs an establishment that didn't have a liquor license. In Philadelphia you can give away beer as long as you're not charging or making the cover charge a condition of receiving the free beer.

The way they set it up was you pay the cover charge and were give a glass to drink free beer, should have been the other way around. You should have gotten the glass and the free beer before you paid the cover charge. They went to arrest his doorman. He said hey, you know, I'm responsible, arrest me.

This 50 some-year-old Jewish-cancer survivor with Type 1 Diabetes was taken into police custody with his insulin pump and testing supplies. At first he was given no access to food. When his pump ran dry he was

given no access to insulin, and eventually he ended up in the emergency room not once but twice during the time he was in police custody.

Well, we filed a suit and we saw relief. We filed it as a class action. As a result of media attention, people came out of the woodwork and it turned out after we did some discovery that there are upwards of 200 people a month with Diabetes who are taken into police custody in Philadelphia. There was really no consistent way in which they were assured of getting access to medication and appropriate diet.

Ultimately we settled the case with the agreement with the City of Philadelphia -- I'm sorry -- let me backtrack.

Because we were seeking perspective relief, we brought -- we asked the ADA to join the litigation, and the American Diabetes Association entered as an institutional plaintiff for the purposes of the injunctive relief.

We settled the case, and as part of the settlement the ADA and Philadelphia Police Department collaborated in producing a training video showing officers about scenarios that occur on the street and within the station house involving persons with Diabetes and how to properly react.

That video was shown to every police officer in Philadelphia, used as part of their training and, in fact, the ADA has been actively distributing it around the country and there are hundreds of police departments, major to minor, to homeland security, which use that video as part of their training and it is as a result of this case brought in Philadelphia over this liquor code violation with Mr. Rosen in the hospital twice. This case was dismissed.

>> BEN EISENBERG: That's a great example of attorney partnership with the American Diabetes Association.

Recognizing the time is ending here, are there any questions?

While you consider that, we want to put in some information about our advocacy attorney network. Sarah was going to share some information on that.

If you have any questions, submit them through chat and we'll try to answer them if anyone is still around for the next five minutes. We'll go over a few minutes and close up the webinar.

>> SARAH FECH: I'm in the middle of answering a question from a presenter. I'll just finish that

quickly over voice.

It is whether an insulin pump establishes an individual as an ADA regulated person with Diabetes, but I guess eligible for ADA protection would be a better way of thinking about that. It is in -- in effect the answer is yes. If you use insulin you're allegeable for ADA protection. The standard, the legal standard is whether the endocrine system is substantially limited, and if you're using insulin, that means that your system is not able to produce insulin on its own and that's a substantial limitation on your daily life.

So just -- you know, we have an attorney network of individuals who take cases for us who are involved in filing a lawsuit in approaching an entity and maybe asking for some kind of informal settlement opportunities, and we would be delighted if any of you would be interested in joining our network either to help in the law enforcement prison, police context or any other context, employment, education cases, et cetera.

We have lots, lots of resources to enable attorneys to take the cases. We don't as the association represent individuals, but we have a team of attorneys here who can help you with finding expert witnesses, with doing case research. With working on strategy, with writing briefs, really anything you need from us, we can work with you to provide -- to enable you to take cases on behalf of individuals with Diabetes and are delighted to serve and assist you.

We have to, of course, put in a plug for Novo Nordisk who we would not be able to do legal advocacy without. They support us with a generous grant every year.

We have -- if anyone has sort of a burning question, wants to submit it, I haven't seen any -- I have one.

What is the best source for finding more information on making a 504 claim under a theory of inadequate medical care?

Well, you would probably be more well served to do a 1983 claim, but the guys that I have published about talks a lot about inadequate medical care in both the law enforcement context and Ben touches much more on inadequate medical care in the detention context. Those are comprehensive guides. My paper is about 100 pages. That is my recommendation for your first source.

If you have more specific questions, you're always welcome to e-mail us at legaladvocate@Diabetes.org. We can hop on the phone with you to troubleshoot a case

you're taking or to provide assistance that is helpful to you.

Ben?

>> BEN EISENBERG: We really are glad to help. We really appreciate you all taking the time for this webinar.

I believe we're done with the content.

Thank you all for coming.

Feel free to follow-up either by phone or e-mail. We'll be glad to follow it all up with you. You'll get the slides soon.

Thank you for attending. I hope to see you all soon.

This text is being provided in a rough-draft Format. Communication Access Realtime Translation (CART) or captioning are provided in order to facilitate communication accessibility and may not be a totally verbatim record of the proceedings.
