No. 20-1402

IN THE SUPREME COURT OF THE UNITED STATES

STEPHEN HAMMONDS

Petitioner,

v.

ROBERT THEAKSTON, M.D. and MATTHEW MARTIN,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

RESPONDENTS' BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

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RESPONSE TO QUESTIONS PRESENTED FOR REVIEW

Supreme Court Rule 14(1)(a) states that the Questions Presented shall be "expressed concisely in relation to the circumstances of the case, without unnecessary detail" and "should not be argumentative or repetitive." Unfortunately, Petitioner Stephen Hammonds has chosen not to abide by this rule, instead framing his "Questions Presented for Review" essentially as a summary of the argument, replete with misstatements of fact. When his claims are examined in light of the actual facts as supported by the evidence, as well as the relevant law, it is clear that there is no basis for the issuance of this writ.

Petitioner's "Questions Presented" contain several misstatements of both fact and law, including as follows:

1. Petitioner's first issue begs the question by assuming (based on misstated facts) that the unconstitutionality of Respondents' conduct was "reasonably obvious." As discussed below, he then adds to this logical fallacy by mischaracterizing both the holding of the United States Court of Appeals for the Eleventh Circuit in this case and the relevant law. When properly analyzed in light of the record as a whole, there is no circuit split in this case.

2. Petitioner's second issue is also based on the same fundamental mischaracterization of the Eleventh Circuit's holding in this case and the relevant law. The court below correctly analyzed the "clearly established" prong of the qualified immunity inquiry as asking "whether preexisting case law – that is, case law predating September 29, 2014 – made it obvious that Dr. Theakston's treatment

of Hammonds's diabetes with only short-acting insulin would be *conscience-shocking*." (Doc. 105-1, Opinion, pg. 12) (emphasis in the original). While it did hold that a single district court case with dissimilar facts could not rise to the level of clearly-established law, it simply did not require an appellate case on all fours as Petitioner asserts.

3. Petitioner's characterization of the district and circuit court as having "summarily" granted qualified immunity is belied by each court's analysis of the facts as revealed by the entire record and the relevant law. It also appears to be based on his fundamental misunderstanding of the appropriate "order of battle" in a qualified immunity case.

Finally, Hammonds never raised any argument or objection to the general principles governing the doctrine of qualified immunity as applied in the Eleventh Circuit prior to the instant Petition. He also never argued that this case could be properly classified as an "obvious clarity" case, as he now claims. Therefore, even if his Questions Presented were not riddled with misstatements of fact and law, they could not be properly brought before this Court in this case.

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STATEMENT OF THE CASE

Hammonds's "Statement of the Case" is riddled with misstatements and critical omissions of fact, including as follows:

A. Hammonds has misstated the relevant facts regarding his underlying condition and his treatment during prior incarcerations.

1. Hammonds states that he had been previously provided with both short- and long-lasting insulin during two prior incarcerations "without incident." (Petition, pg. 5.) This statement is not supported by the record. To the contrary, the records show that Hammonds had initially been allowed to self-administer short- and long-acting insulin until April 2007, when Dr. Theakston disallowed him from doing so after multiple issues, including five hypoglycemic episodes in a single month; Dr. Theakston then prescribed a specific mix of long- and short- acting insulin. (Doc. 82-18, pgs. 7-8; 82-19, pg. 2)

2. Hammonds only received short-acting insulin during his 2013 incarceration, without any ill effects. (Appendix, Doc. 82-3, ps. 2-3; 82-4, pg. 72.)[1] His assertion to the contrary appears to be based on a misreading by counsel of the relevant record. While this record includes Novolin (a long-acting insulin) as one of Hammonds's "stated medication," the plan that was actually implemented was: "3 units insulin sq [subcutaneously]; Regular insulin sliding scale; blood glucose log BID."

3. Hammonds' statement that he was using short- and long-term insulins

[1] Because this misstatements plays such a large role in Hammonds's arguments, the relevant record is attached hereto as an Appendix.

as "prescribed" at the time of his 2014 arrest is misleading. In fact, Hammonds was not regularly seeing a doctor at the time of his incarceration in 2014 and did not have a prescription for the long and short acting insulin he was carrying at the time he was booked into the jail and was self-medicating his diabetic condition. (Doc. 82-45, 9:1-4; Doc. 82-46, 41:2-5, 43:14-44:7.)

4. Hammonds's A1C level was 8.5, which indicates that his diabetes was not well-controlled prior to his incarceration, and that his blood sugar was on average over 250. (Doc. 82-42 ¶ 8.) Similarly, his June 2016 medical records show a glucose level of 247 and an A1C of 7.7; his physician noted that "since [he] is a type I diabetic and somewhat brittle is probably a good place for him." (Doc. 82-47.) Hammonds himself admitted that low blood sugar incidents happened "often throughout [his] life," and that there have been times that he had to go to the hospital to treat them. (Doc. 82-45, 16:11-19.)

5. Further, the medical records establish that Hammonds had a habit of refusing to follow prescribed regimens to his detriment. For example, on October 20, 2014, Hammonds was seen at the Emergency Department of Huntsville Hospital and while the medical staff was attempting to treat him, he "would continuously self-titrate his insulin while in the emergency department. On multiple occasions he was asked to allow (sic) is due and monitor his blood sugar but he was noncompliant." (Doc. 82-27, pg. 25.)

B. Hammonds has misstated the relevant facts regarding his treatment.

6. First, Hammonds has continued to misrepresent Martin's role as

somehow supervising the medical staff despite his lack of certification. The testimony was clear that Martin had no involvement in the supervision of the medical staff as to the course of treatment. In his deposition, Martin testified that as jail administrator that he would be in charge of staffing issues and issues regarding their time, but he made it abundantly clear that he did not become involved in any medical procedure issues. (Doc. 82-6, 57:1-9.) Even though Martin was jail administrator, he did not supervise the medical staff because he did not have any medical background. He allowed the medical staff to set the medical policies, protocols and treatments of the inmates. (Doc. 82-8, ¶ 2.) Put plainly: Martin did not violate Alabama law by practicing medicine without a license.

7. In 2014, inmates with diabetes were treated pursuant to standing orders set by Dr. Robert Theakston, where the inmate is given regular insulin pursuant to a sliding scale and regular blood glucose checks. (Doc. 91-1, 72:3-6; Doc. 82-3, ¶ 3; Doc. 82-5, ¶ 3.)

8. The sliding scale called for the following units of insulin to be given when the blood glucose read certain levels:

Blood Glucose (mg/dl)	**Insulin Dose**
<70	Give snack, Alert on Call Nurse
70-110	0 Units
111-150	0 Units
201-250	2 Units Sub Q
251-300	4 Units Sub Q
301-350	6 Units Sub Q
351-400	8 Units Sub Q
>400	10 units Sub Q

If Glucose Levels exceed 400 or if Display Reads HI, Alert On-Call Nurse.

(Doc. 82-16.)

The practice at the jail was that the corrections staff drew the dosage of insulin and gave the syringe to the inmate to inject. (Doc. 82-5, ¶ 4.)

9. This protocol was used for several years and no inmate had any medical issue as a result of the treatment protocol. (Doc. 82-3, ¶ 8; Doc. 82-5, ¶ 5.)

10. This protocol was adopted because it allowed the jail's medical staff to assess an inmate's insulin needs while he/she was incarcerated. Jail inmates are often mistaken about the type of insulin that they take and their regimen. Like Hammonds, many inmates do not receive regular medical care and may actually be harming themselves by self-medicating. Further, conditions at the jail (including activity level and diet) may be different from what an inmate is used to in the free world. Providing long and short acting insulin without determining the inmate's needs therefore runs the risk of hypoglycemia, which can be a deadly condition. (Doc. 82-3, ¶¶ 3 & 4; Doc. 82-4; Doc. 82-5, ¶ 3.)

11. Hammonds's statement that the experts all agreed that this regimen "did not meet any standard of care" is flatly wrong. According to Defendants' expert, Dr. Bruce Trippe, who is a diabetic specialist, Dr. Theakston's treatment for Hammonds's onset of DKA was appropriate. (Doc. 82-42, ¶ 6) Further, Dr. Trippe noted the peculiar position that Dr. Theakston had as the jail doctor. First, Dr. Theakston's patients are not like those seen by Dr. Trippe, a specialist. Theakston has no prior relationship with them and has no idea if the inmate follows the treatment for his condition. Second, the inmate is in a closed environment with less

activity and a different diet. On this basis, the treatment for an inmate's diabetes is different in the jail than at home. Accordingly, he opined that the monitored sliding scale is adequate and reasonable. (Doc. 82-42, ¶ 4).

12. As noted by the Eleventh Circuit, even Dr. Venters, Hammonds's proffered expert, hedged his testimony on this point. Venters admitted that he had no specialized training in endocrinology. (Doc. 82-43, pgs. 11, 18.) Thus, he testified based on his general experience in corrections medicine merely that he had "almost never seen a patient who is known to be insulin dependent be given only short-acting insulin…" and that it was just his "sense" that it was "no treatment for half the problem." (Doc. 82-43, pg. 28.) Venters also readily admitted that he was not qualified to opine on more in-depth questions about issues such as A1C levels. (Doc. 82-43, pg.29.)[2]

C. Hammonds has misstated facts regarding this incarceration.

13. Jonathan Langley was the registered nurse ("RN") working at the jail in 2014 and recalled Hammonds. He reviewed previous records of Hammonds's incarcerations and noted that in during his brief incarceration in 2013, Hammonds was given regular insulin as directed by the sliding scale and had no medical issues from this treatment. Langley decided to follow this treatment protocol in 2014. (Doc. 82-4, 57:16-23; Doc. 82-5, ¶ 6; Doc. 82-17, pg. 4.)

14. From September 29, 2014 – October 3, 2014, Hammonds's blood sugar levels and insulin dosages were as follows:

[2] It is worth noting that Respondents filed a Motion in Limine to exclude the opinions of Dr. Venters. (Doc. 83) This motion was not ruled upon by the District Court because it granted summary judgment.

NOTE	DATE	TIME 1	FIRST BLOOD SUGAR READING	FIRST INSULIN PROVIDED	TIME 2	SECOND BLOOD SUGAR READING	SECOND INSULIN PROVIDED	TIME 3	LAST BLOOD SUGAR READING	LAST INSULIN PROVIDED
Arrived at 1:10 PM	9/29/2014	-	-	-	-	-	-	8:00 PM?	231 mg/dl	4U R
	9/30/2015	9:15 AM	315 mg/dl	6U R	12:20 PM	333 mg/dl	NONE	8:00 PM?	310 mg/dl	6U R
	10/1/2014	8:45 AM	380 mg/dl	8U R	3:36 PM	334 mg/dl	NONE	8:00 PM?	336 mg/dl	6U R
	10/2/2014	NONE	NONE	NONE	NONE	NONE	NONE	8:00 PM?	248 mg/dl	3U R
	10/3/2014	8:30 AM	252 mg/dl	4U R	NONE	NONE	NONE	8:00 PM?	250 mg/dl	NONE

(Doc. 82-15, pgs. 2 - 3.)

15. On October 3, 2014, jail administrator Matthew Martin received a call from a 911 operator that a call had been made to E-911 regarding an inmate that was purportedly experiencing a medical emergency. Martin checked with staff and learned that a Code Blue had not been called. He also learned that the inmate purportedly experiencing the medical emergency was Hammonds. Martin checked on Hammonds and found him with other inmates. Martin asked Hammonds if he was experiencing a medical crisis. Hammonds stated that he was not. Martin asked why

a call was made to 911 stating that he was experiencing a medical emergency. Hammonds responded that his mother must have been worried. (Doc. 82-6, 99:5-100:2; Doc. 82-8, ¶ 3)

16. Martin called the telephone number that called 911 and spoke with Hammonds's mother. Martin told her that she could not call 911 except for an emergency. He also told her that misusing 911 could lead to a person with a true emergency, like a child who could not breathe because of asthma, not being able to receive needed medical attention, and that it was a crime. (Doc. 82-6, 99:5-100:2; Doc. 82-8, ¶ 4; Doc. 82-46, 33:2-12.)

17. Hammonds's mother, Carla Hammonds, testified that Martin was at first angry when he called but that he calmed down when he learned that he was speaking with Hammonds's mother. She testified that Martin told her that he checked on Hammonds and found him to be fine and receiving medical care from the medical staff. (Doc. 82-46, 24:11-25:8, 32:12-37:22.)

18. On October 3, 2014, Hammonds placed commissary orders that included the following: barbeque potato chips, trail mix, nutty bar, chicken ramen noodle soups, beef ramen noodle soups, white cheddar popcorn, tuna pouches, Sprite, and Mountain Dew. (Doc. 82-22, pgs. 2-3.) This order establishes that Hammonds's testimony that he did not have access to the kiosk (Doc. 82-45, 44:7-13.) is untrue.

19. Hammonds was seen on security camera eating moon pies and other sugary snacks. (Doc. 82-15, pg. 11.) While Hammonds has attempted to imply nefarious intent because these videos were not preserved, the record establishes that

Martin simply did not see a reason to preserve them at the time because he was not aware that they depicted a significant incident. (Doc. 82-6, 114:17-115:1) This suit was not filed until almost the very last minute, and no preservation letter was ever sent.

20. On October 4, 2014, Hammonds was transferred from the Male Dorm to maximum security to restrict his commissary access. (Doc. 82-20; Doc. 82-15, pg. 4.)

21. Hammonds had access to kiosks to communicate with corrections and medical staff in every place that he was housed. (Doc. 82-21; Doc. 82-5 ¶¶ 8-9.) These kiosks are the same kiosks that are used to order commissary items, and they may be accessed via fingerprint. (Doc. 82-5, ¶¶ 8-9.)

22. At approximately 8:49 a.m. on October 4, 2014, Hammonds's blood sugar was 444 mg/dl and he was administered 10 units of R insulin. At approximately 8:00 p.m., Hammonds's blood sugar was 543 mg/dl and he was administered 10 units of R insulin. (Doc. 82-15, pgs. 2-3.)

23. Dr. Theakston was never informed of Hammonds's blood glucose levels from September 29, 2014 – October 4, 2014. (Doc. 91-1, 69: 19-70: 22, 105: 22; Doc. 82-3, ¶ 11.)

24. Dr. Theakston was not aware that Hammonds was in the DeKalb County Corrections Center until October 5, 2014. (Doc. 82-3, ¶ 11.)

25. On October 4, 2014, Hammonds complained of chest pains and an EKG test was performed. The results were reviewed by Jonathan Langley at that time.

(Doc. 82-15, pgs. 4-5.)

26. On October 5, 2014, the booking officer reported to paramedic Chris Black that Hammonds's blood glucose level registered as "High," which meant that it was over 400. Black moved Hammonds to the medical unit and gave him 10 units of insulin per Langley's instructions. Hammonds's blood glucose level was checked four hours later, and the test still read "High." Black consulted with Dr. Theakston who ordered intravenous ("IV") fluids and another 10 units of insulin to be delivered through the IV. When this treatment was unsuccessful, Dr. Theakston ordered Hammonds to be transported to the emergency room. (Doc. 91-1, 104:17-105:10, 109:1-110:4; Doc. 82-3, ¶ 13; Doc. 82-10, ¶ 5; Doc. 82-15, pgs. 6-7.)

27. Hammonds was hospitalized at DeKalb County Regional Medical Center from October 5, 2014 – October 8, 2014 and was treated for hyperglycemia and DKA. He was treated with "aggressive fluid resuscitation" and IV insulin until the DKA was resolved. (Doc. 82-23, pg. 3.)

28. While at the hospital, Hammonds told Officer Mike Traylor that he deliberately ate sugary snacks to run his blood glucose up because he did not like the insulin he was receiving. (Doc. 82-11, ¶ 3; Doc. 82-15, pg. 11.)

29. Hammonds did not have his basal or long duration insulin for five days prior to his blood sugar spike. Because of the lapse of this time, Dr. Trippe opined that that the discontinuation of the basal insulin was not the only cause of Hammonds's hyperglycemia and other factors contributed to it. (Doc. 82-42, ¶ 9). Other factors contributing to the onset of the condition certainly would be eating

sugary snacks to sabotage the treatment protocol.

30. The hospital treated Hammonds by placing him on a sliding scale with coverage of regular insulin. (Doc. 82-23, pg. 35; Doc. 82-12, 25:14-19)

31. Hammonds's glucose levels while at the hospital from October 5, 2014 – October 8, 2014, were as follows:

Note	DATE	TIME	BLOOD SUGAR READING
	10/5/2014	14:05	689
283 Gluhome	10/5/2014	16:35	623
	10/5/2014	17:50	542
	10/5/2014	20:04	413
	10/5/2014	21:47	317
	10/5/2014	23:48	252
	10/6/2014	0:58	211
	10/6/2014	2:10	296
281 Gluhome	10/6/2014	3:12	280
	10/6/2014	4:06	330
	10/6/2014	5:29	272
	10/6/2014	7:40	293
	10/6/2014	9:29	236
	10/6/2014	11:46	233
	10/6/2014	13:49	217
	10/6/2014	14:39	234
	10/6/2014	15:36	201
	10/6/2014	17:53	208
	10/6/2014	19:58	210
	10/6/2014	22:20	231
181 Gluhome	10/7/2014	2:39	203
	10/7/2014	4:00	174
	10/7/2014	5:40	140
	10/7/2014	10:36	261
	10/7/2014	12:03	253
	10/7/2014	15:06	222
	10/7/2014	15:30	214

	10/7/2014	19:00	176
	10/7/2014	21:21	209
	10/8/2014	0:52	229
	10/8/2014	4:33	392
	10/8/2014	8:39	409
	10/8/2014	10:50	327
	10/8/2014	16:50	176
	10/16/2014	12:41	220

(Doc. 82-23, pgs. 7-17.)

32. In the discharge summary of October 8, 2014, Hammonds's treating physician, Dr. Carmelo Mendiola noted,

> Patient was admitted with DKA, hydrated, IV insulin given, potassium was eventually replaced and his sugars and DKA resolved. He was noted to have some abnormal cardiac rhythm, and Dr. Al Halaseh saw him, and said there is nothing to do…. At this time, patient has been eating good for the last 12 48 p.m. (sic) sugars are up and down, and I feel that he can be discharged to jail, and for him to check his blood sugars before breakfast, before lunch, before supper in 3 hr after supper, and his medications can be adjusted accordingly. He will be discharged with NovoLog 70 30, 30 units subcu right before breakfast in her (sic) before supper, and a sliding scale regular insulin.

(Doc. 82-23, pg. 3.)

33. Hammonds returned to the jail on October 8, 2014 and was "ambulatory and in no acute distress." (Doc. 82-15, pg. 10.)

34. Hammonds's medications were adjusted per the discharge instructions. His blood sugars were checked three times daily, sliding scale covered by regular insulin three times daily, and 70/30 NovoLog insulin, 30 units, given before breakfast and before supper. (Doc. 82-14, pg. 40.)

35. Again, Hammonds has mischaracterized the treatment he received in the jail after his release. There is no specific sliding scale, including the one suggested in Hammonds's hospital discharge instructions. The scale varies from hospital to

hospital and from doctor to doctor. Essentially, everyone has their own sliding scale protocol. (Doc. 82-12, 25:1-19).

36. On October 10, 2014, Sara Slaton discovered uneaten trays of meals and uneaten brown bags of diabetic snacks in Hammonds's cell. (Doc. 82-15, pg. 11.)

37. Hammonds's blood sugar levels and insulin dosages from October 8, 2014, to his discharge from jail on October 16, 2014, were as follows:

NOTE	**DATE**	**TIME 1**	**FIRST BLOOD SUGAR READING**	**FIRST INSULIN PROVIDED**	**TIME 2**	**SECOND BLOOD SUGAR READING**	**SECOND INSULIN PROVIDED**	**TIME 3**	**LAST BLOOD SUGAR READING**	**LAST INSULIN PROVIDED**
Returned to Jail - after 8:30 PM	10/8/2014	HOSPITAL	HOSPITAL	HOSPITAL	HOSPITAL	HOSPITAL	HOSPITAL	NONE	379 mg/dl	8U R
	10/9/2014	9:30 AM	485 mg/dl	30U 70/30	10:56 AM	423 mg/dl	10U R	8:00 PM?	159 mg/dl	30U 70/30 - 2U R
	10/10/2014	4:42 AM	243 mg/dl	30U 70/30 - 3U R	11:33 AM	90 mg/dl	NONE	8:00 PM?	249 mg/dl	30U 70/30 - 3U R
	10/11/2014	4:53 AM	287 mg/dl	30U 70/30 - 4U R	NO TIME	165 mg/dl	2U R	8:00 PM?	294 mg/dl	NONE

	10/12/2014	4:02 AM	408 mg/dl	30U 70/30 - 10U R	None	NONE	NONE	8:00 PM?	294 mg/dl	30U 70/30 - 4U R
	10/13/2014	4:28 AM	201 mg/dl	30U 70/30 - 3U R	11:10 AM	172 mg/dl	2U R	8:00 PM?	289 mg/dl	30U 70/30 - 4U R
	10/14/2014	4:31 AM	279 mg/dl	30U 70/30 - 4U R	11:13 AM	217 mg/dl	2U R	8:00 PM?	259 mg/dl	30U 70/30 - 4U R
	10/15/2014	4:20 AM	288 mg/dl	30U 70/30 - 4U R	11:07 AM	237 mg/dl	3U R	8:00 PM?	410 mg/dl	30U 70/30 - 10U R
	10/16/2014	4:35 AM	309 mg/dl	30U 70/30 - 6U R	NONE	481 mg/dl	NONE	RELEASED	RELEASED	RELEASED

(Doc. 82-15, pgs. 2-3.)

38. Martin arranged for Hammonds's release on an OR bond because he felt that Hammonds was dishonest in regard to diabetes. Martin had received reports that Hammonds would fake giving insulin shots and was not compliant in his treatment. (Doc. 82-6, 84: 3-10; 86: 21-87:15) Once again, Counsel has made misstatements as to the circumstances of his released based on an apparent misunderstanding of the applicable record. Multiple bonds were set in the warrants leading to Plaintiff's arrest; after his initial appearance, a single bond was set on 10/3/14 at $3000. (Doc. 82-14, pgs. 14, 18, 31, 32.) It was reinstated and set as ROR (release on own recognizance) by Order on 10/16/14. (Doc. 82-14, pg. 13.) The 10/3 form was then updated to reflect that no sureties were necessary after the ROR Order.

39. Hammonds has grossly misstated his condition upon release, including his weight loss, and the events that occurred after his release. After his release from

the jail on October 16, 2014, Hammonds did dramatically call for an ambulance to take him to the emergency department where he complained of "numbness in face and lips" …which was subsequently diagnosed as a sinus infection. He also apparently had some constipation. His blood sugar level was 220. Hammonds was not admitted into the hospital and was discharged from the emergency department. (Doc. 82-24, pgs. 6-8.)

40. On October 20, 2014, Hammonds was brought by his family to the emergency department of Huntsville Hospital at 4:14 p.m. with the complaint of altered mental status. Hammonds also complained of facial numbness, numbness in his arms and legs, and constipation. Hammonds admitted that he had taken Klonopin at approximately noon before he arrived at the hospital and had taken Valium, Xanax, and muscle relaxers in the four-day period after his release from jail, none of which had been prescribed to him. Hammonds also reported that he had taken 60 units of insulin but that his blood glucose was still elevated. Hammonds's blood glucose levels while he was at Huntsville Hospital ranged from 262 – 309. When Hammonds was discharged at 11:26 p.m., he was noted to have a "steady gait." He was diagnosed with uncontrolled Type I Diabetes. (Doc. 82-26, pgs. 3, 16, 20; Doc. 82-27, pgs. 22, 29, 30, and 40.)

41. On November 3, 2014, Hammonds began seeing Dr. James Austin D.O. On July 12, 2016, Dr. Austin wrote a letter (presumably for Hammonds to receive disability benefits) and stated, "In October 2014, Mr. Hammonds was in a diabetic

coma, which subsequently caused severe diabetic neuropathy." (Doc. 82-25, pg. 23.)[3]

42. Hammonds's medical records from his first visit to Austin's office on November 3, 2014, reflect that he had a "**chronic** complaint of diabetic neuropathy." (Doc. 82-25, pg. 9) (emphasis added). Dr. Robert Jones, one of Defendants' experts, has flagged this notation as evidence that the neuropathy arose prior to the DKA suffered by Hammonds in October 2014. (Doc. 82-30, pgs. 11-12; Doc. 82-31, 144:7-9.)

43. Hammonds was never in a coma when he was hospitalized in October 2014. (Doc. 82-12, 14:1-3.)

44. Neuropathy is not caused by a single incident but is caused by years of effects of high blood glucose levels on nerves; there can be multiple contributing factors. (Doc. 82-32; Doc. 82-33, 144:7-9; Doc. 82-42.) "It is highly medically improbable that a single episode of diabetic ketoacidosis is the only and proximate cause of his polyneuropathy especially given years of his poor control which is documented." (Doc. 82-30, pg. 13.)

45. Hammonds has complained of back pain and has had a head injury. A degenerative back condition and a head injury can also exacerbate neuropathy. (Doc. 82-25, pg. 12; Doc. 82-29, pgs. 4, 9; Doc. 82-32; Doc. 82-42, ¶ 11.)

[3] This letter is egregious because it is more than another example of Hammonds's exaggerations - it was presumably used to obtain disability.

REASONS WHY THE WRIT SHOULD NOT ISSUE

I. IN ADDITION TO MISSTATING THE RELEVANT FACTS, HAMMONDS HAS MISSTATED AND/OR MISUNDERSTOOD THE APPLICABLE LAW OF THE DOCTRINE OF QUALIFIED IMMUNITY.

Hammonds has framed this case as presenting a circuit split on the proper application of the doctrine of qualified immunity. Although he admits that, with one claimed exception, the United States Court of Appeals for the Eleventh Circuit generally laid out the basic principles of law on the clearly established prong of the qualified immunity analysis correctly in its opinion, he nevertheless insists that its decision somehow betrays a secret rule that it will only deny qualified immunity when there is a case that is on all fours with the situation *sub judice*. This assertion is without merit.

Hammonds first attempts to fault both the appellate court and the district court for granting summary judgment in this case on the "clearly established" prong of qualified immunity without definitively resolving the underlying substantive constitutional violation, even feigning outrage that the court below referred to such an "order of battle" as a mere "suggestion." (Petition, pg. 23.) *Pearson v. Callahan*, 555 U.S. 223, 129 S.Ct. 808, 172 L.Ed.3d 565 (2009), easily disposes of this argument. The *Pearson* Court held that "[t]he judges of the district courts and the courts of appeals should be permitted to exercise their sound discretion in deciding which of the two prongs of the qualified immunity analysis should be addressed first in light of the circumstances in the particular case at hand." 555 U.S. at 236, 129 S.Ct. at

818.[4] Importantly, Hammonds has never argued that *Pearson* was wrongly decided, nor has he argued that the courts below abused their discretion in this case. He has instead chosen to simply ignore its existence. As discussed *infra*, this argument is not the only example of Hammonds taking the tack of simply ignoring the existence of inconvenient truths in this case.

This initial error betrays Hammonds's fundamental misunderstanding of the doctrine of qualified immunity and of the separate roles played by the court and the jury in such cases. It is also the tainted wellspring from which the rest of his argument flows. His insistence that the underlying constitutional question must be resolved first leads him to the conclusion that it should have been resolved in his favor under the summary judgment standard, thus establishing deliberate indifference. He then argues that this presumption of deliberate indifference necessarily negates the defense of qualified immunity. Before the court below, Hammonds argued that case law clearly established that deliberate indifference is unconstitutional, but now argues that deliberate indifference is an obvious violation. Putting aside the issue of waiver for the moment, his new argument still suffers from the same sort of analytical error as the old, to wit: as held by the Eleventh Circuit, it defines the right at issue far too broadly. "As this Court explained decades ago, the clearly established law must be 'particularized' to the facts of the case." *White v.*

[4] In *Santamorena v. Ga. Military Coll.*, 147 F.3d 1337, 1343 (11th Cir. 1998), which was cited by the court below, the Eleventh Circuit stated that "if the Supreme Court intended to impose an absolute requirement on lower courts always to address the merits of constitutional issues…we believe the Supreme Court would have said so more directly." Only a few years later, this Court issued such a direct statement in *Saucier v. Katz*, 533 U.S. 194, 121 S.Ct. 2151, 150 L.Ed. 2d 272 (2001). *Pearson* then explicitly overruled *Saucier*.

Pauly, 137 S.Ct. 548, 552, 196 L.3d.2d 463 (2017) (quoting *Anderson v. Creighton*, 483 U.S. 635, 640, 107 S.Ct. 3034, 97 L.Ed.2d 523 (1987)). "Otherwise, 'plaintiffs would be able to convert the rule of qualified immunity into a rule of virtually unqualified liability simply by alleging violation of extremely abstract rights'" – i.e., the right to be free of deliberate indifference to a serious medical need. *Id.* (quoting *Anderson*, 483 U.S. at 639, 107 S.Ct. 3034).

It is worth noting that Hammonds's argument fails even under its own terms because, as discussed *supra*, it is based on misstatements of fact and/or mischaracterizations of the record, two of which are particularly significant: First, Hammonds continues to incorrectly state that he was treated with both short and long-acting insulin in 2013 based on nothing more than an apparent error by counsel in reading the medical record. Second, he keeps insisting that all the experts agree that the treatment was a "gross deviation from any standard of care," when they plainly did not. As pointed out by the Eleventh Circuit, even Hammonds's own expert, Dr. Venters, hedged his testimony on this point, stating that he had "*almost* never seen" an insulin-dependent patient treated with only short-acting insulin and that he just had a "sense" that short-acting insulin alone was inadequate. In contrast, Dr. Trippe, an endocrinologist, opined that the initial use of a sliding scale protocol was reasonable given the challenges of treating patients like Hammonds, with self-managed, poorly controlled diabetes, in the unique environment of a jail. Even in the absence of qualified immunity – e.g., if this case involved an entity rather than individual defendants – Hammonds still could not meet his burden of putting forth

substantial evidence of a constitutional violation simply by refusing to reckon with a large chunk of the record. *See, e.g.*, *Scott v. Harris*, 550 U.S. 372, 380, 127 S.Ct. 1769, 1776, 167 L.Ed.2d 686 (2007) (holding that summary judgment must be based on the record as a whole and that the plaintiff's version of events should not be credited when it is blatantly contradicted by the record); *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 586-87, 106 S.Ct.1348, 1356, 89 L.Ed.2d 538 (1986) (record at summary judgment must be "taken as a whole")

The Eleventh Circuit correctly held that the relevant question for a court conducting a qualified immunity analysis is not, as Hammonds suggests, whether deliberate indifference is unconstitutional, but whether a reasonable official in Dr. Theakston and Matt Martin's position would understand that their individual conduct rose to the level of deliberate indifference in the first place. Hammonds has never squarely addressed this question, instead arguing that the "clearly established" prong of the qualified immunity analysis should be essentially eliminated, so that summary judgment would turn on the existence of a genuine issue of material fact on the underlying question of deliberate indifference. None of the cases cited by Hammonds as supposed evidence of a circuit split support this argument. His citation of *Natale v. Camden County Correctional Facility*, 318 F.3d 575 (3rd Cir. 2003), is particularly revealing of his fundamental misunderstanding of the question. *Natale* was not at all concerned with qualified immunity; instead, that court held that an entity was not entitled to summary judgment when there was evidence that it had implemented a policy for non-medical reasons that resulted in inmates' immediate

medical needs being ignored, and that this policy had caused the plaintiff to be denied any insulin whatsoever for twenty-one hours. *Id.* at 582-83.

There is nothing surprising or scandalous about the fact that different courts have arrived at different results when presented with different facts, and it is certainly not evidence of a circuit split. Indeed, *Waldrop v. Wexford Health Services, Inc.*, 646 Fed. Appx. 486 (7th Cir. 2016), refutes Hammonds's attempt to argue that other circuits have uniformly held that any deviation in an inmate's preferred treatment of diabetes is basically a per se violation of clearly established constitutional rights. The *Waldrop* court affirmed summary judgment both as to a nurse who had denied the plaintiff, also a type 1 diabetic, insulin when she was not sure of his blood sugar because he refused to submit to a test AND to a doctor who lowered his insulin dosage, which decision it characterized as a matter of "medical judgment about proper diabetes management." 646 Fed. Appx. 490. It did, however, reverse summary judgment to a doctor who had completely denied the plaintiff insulin and substituted Glipizide, a medication that encourages insulin production and is therefore inappropriate for Type 1 diabetics. *Id.* at 491; *cf. Scinto v. Stansberry*, 841 F.3d 219, 227-28 (4th Cir. 2016) (denying qualified immunity in the face of alleged repeated refusals by doctor to follow the insulin regime he had personally prescribed because he was annoyed by the plaintiff's attitude).

This case is not one in which all insulin was withheld, like one of the *Waldrop* defendants, or where non-medical factors, or even personal fits of pique, were allowed to drive medical decisions, as in *Scinto*. Far from being deliberately indifferent, Dr.

Theakston made an affirmative decision to adopt a certain treatment protocol in an effort to respond to specific problems he had seen in the past with inmates like Hammonds. Importantly, this case was ***not*** brought under a policy and procedure theory, assumedly because Hammonds knew he could not meet that evidentiary burden. The question before the Eleventh Circuit Court of Appeals was whether it was clearly established that this decision was unconstitutional, which that court resolved by correctly applying well-established principles of qualified immunity.

It is currently fashionable in certain circles to decry the doctrine of qualified immunity and call for it to either be eliminated outright or severely restricted. The instant Petition harkens to this sentiment by framing the decision in this case as evidence of the Eleventh Circuit as adopting a "remarkably restrictive approach" that "permits government officials to avoid accountability for patently unconstitutional behavior so long as there is no published precedent recognizing that the exact conduct under identical circumstances violates the Constitution." (Pet., pg. 31.) But while Hammonds is, in a sense, seeking a significant restatement of the doctrine of qualified immunity, he has done so under the guise of applying the law as he erroneously believes it currently stands, i.e., his refusal to acknowledge the existence of *Pearson*. As such, the instant Petition does not meet the standards for granting certiorari as stated in Supreme Court Rule 10. There is neither a circuit split, nor an issue of first impression, nor an important issue of law that has been decided in a manner that is contrary to one of this Court's decision. Hammonds's argument to the contrary is based on misstatements of the facts and a misunderstanding of the law. Respondents

therefore respectfully submit that the Petition for Writ of Certiorari is due to be denied.

II. THE PETITION INCORRECTLY TREATS DR. THEAKSTON AND ADMINISTRATOR MARTIN AS INTERCHANGEABLE AND IDENTICAL AND IGNORES THE BASIS FOR THE COURT'S GRANT OF SUMMARY JUDGMENT TO MARTIN.

The Eleventh Circuit properly separately analyzed the claim against Administrator Martin in Part C of its Opinion, holding that he, as a non-medical official, could not be held liable for failing to disregard and override Dr. Theakston's medical judgment pursuant to well-established Circuit precedent, including *Keith v. DeKalb County*, 749 F.3d 1034 (11th Cir. 2014). This holding is consistent with the principle that the qualified immunity analysis must be conducted as to each individual official. *See, e.g.*, *White*, 137 S.Ct. at 550 (holding that qualified immunity analysis requires the situation be examined in light of the facts that were actually knowable to the officer). It appears that Hammonds has chosen to continue his pattern of ignoring inconvenient aspects of this case by pretending throughout the Petition that Dr. Theakston and Martin are interchangeable and identical. His failure to address the primary grounds relied on by the Eleventh Circuit is fatal to his attempt to seek certiorari as to the judgment against Martin. Supreme Court Rule 14.1(a); *Yee v. City of Escondido, Cal.*, 503 U.S. 519, 535-46, 112 S.Ct. 1522, 1532-33, 118 L.Ed.2d 153 (1992).

CONCLUSION

Respondents Dr. Robert Theakston and Administrator Matthew Martin hereby respectfully request that this Court deny the Petition for Writ of Certiorari because it fails to meet the standards for review set out by Supreme Court Rule 10.

Respectfully submitted this the 7th day of June, 2021.

s/Jamie Helen Kidd Frawley
Jamie Helen Kidd Frawley
Counsel of Record

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CERTIFICATE OF SERVICE

I hereby certify that on this the 7th day of June, 2021, I electronically filed the foregoing with the Clerk of the Court and, pursuant to the agreement of the Parties, served a copy of the same on Counsel for Petitioners via electronic mail by consent of the Parties:

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s/Jamie Helen Kidd Frawley
OF COUNSEL

APPENDIX A

Declaration of Dr. Robert Theakston

Dated December 27, 2018

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ALABAMA
MIDDLE DIVISION

STEPHEN HAMMONDS,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**CASE NO.: 4:16-cv-01558-KOB**
	)	
DEKALB COUNTY, AL, et al.,	)	
	)	
Defendants.	)	

DECLARATION OF DR. ROBERT THEAKSTON
PURSUANT TO 28 U.S.C. § 1746

STATE OF ALABAMA)

COUNTY OF DEKALB)

1. My name is Dr. Robert Theakston. I am over the age of 19 and am competent to make this Declaration.

2. I am a licensed physician and received my M.D. from American University of the Caribbean in 1990. I currently own and operate a family medical practice in Ft. Payne called Northside Medical, Inc. I have been associated with the DeKalb County Sheriff's Office as a deputy and as its medical officer since 2005.

3. In 2014, the jail's medical staff had standing orders to place diabetic inmates on regular insulin with sliding scale coverage and blood sugar checks at least twice a day. This protocol was established because jail inmates are often mistaken about the type of insulin that they should take and their regimen of care.

Often, as in the case of Mr. Hammonds, the inmate is not under a doctor's care and does not have instructions from a doctor as to the proper dosage and treatment for his/her diabetic condition. In turn, the inmate may self-medicate and may be do more harm to himself. Consequently, if the medical staff is to give long and short term acting insulin, without determining the inmate's actual needs, there is a risk of hypoglycemic episodes, which can be fatal.

4. A jail does not present the same conditions that the inmate is used to while not incarcerated. The inmate's diet is different, and the inmate is not as physically active. Consequently, the inmate's blood sugar regimen typically differs while incarcerated. By placing the inmate on sliding scale coverage using regular insulin, the inmate's insulin can be adjusted as needed.

5. An apparent misconception in this case is that there are different physiologic effects from different types of insulin, which is incorrect. Insulin is insulin, whether it is long or short acting. The only difference is the time period in which the insulin remains active in the body.

6. Since the initiation of this lawsuit, I have reviewed the records of Stephen Hammonds' previous incarcerations. I noted that, in 2007, Hammonds suffered five episodes of hypoglycemia. As a result, I informed Hammonds as well as the jail and medical staff that Hammonds had lost the privilege to administer his own insulin. In 2013, Hammonds was incarcerated and was placed on sliding scale

coverage using regular insulin. The records from this incarceration do not indicate that Hammonds experienced any medical issues.

7. Under the existing jail regimen, the jail staff conducts the blood sugar tests, and depending on its reading, draws the dosage of insulin needed as reflected on the sliding scale. The syringe is then given to the inmate who gives himself the injection.

8. This diabetic treatment protocol or regimen has been established for years. With the exception of the allegations raised in this case, no medical issues arose in the treatment given. The sliding scale protocol has consistently worked.

9. My only contact with the Plaintiff on the occasion that is at issue in this case was on October 5, 2014. I did not see the Plaintiff personally on that day. Rather, on that day, I was notified by Chris Black, who is a paramedic at the jail, that Hammonds' blood sugar levels were dangerously high. Jonathan Langley, who was the nurse at the jail, directed that Hammonds be moved to the infirmary.

10. I gave a verbal order that Hammonds be given insulin and IV hydration, which is the standard treatment for hyperglycemia and possible DKA. Hammonds' blood sugar levels did not drop, and within a very short time I ordered Hammonds to be transported to the emergency room. Transporting Hammonds to the hospital to the emergency room was the very best treatment option for Hammonds. I do not specifically recall seeing him.

11. I was never contacted regarding Hammonds' blood sugar levels prior to October 5, 2014, and I was not contacted about his blood sugar levels after his release from the hospital.

12. Upon his return to the jail from the hospital on October 8, 2014, Hammonds was placed on 70/30 mix of long acting and short acting insulin as directed by the sliding scale. It should be noted that Hammonds' blood sugar levels remained elevated even after Hammonds returned from the hospital.

13. Hammonds' blood sugar levels were always high while he was in the jail in 2014. In reviewing the applicable blood sugar check chart, his blood sugar levels were in the 200s and 300s. The only time that the blood sugar levels were abnormally high was on October 4 and 5, 2014, and I gave him the appropriate treatment, and when it was not working, I ordered him to the hospital. That is, I treated Hammonds diligently and promptly hospitalized Hammonds when his blood sugar spiked. I was never deliberately indifferent to Hammonds' care or condition, but acted very quickly to get Hammonds to the hospital.

14. I declare under penalty of perjury that the foregoing is true and correct. I further declare that I am competent to make this declaration, and that the above statements were made by drawing from my personal knowledge.

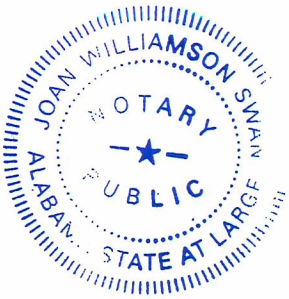
Executed on this the 27th day of December, 2018.

SIGNATURE _____

PRINT NAME Robert W. Theakston, M.D.

SWORN TO AND SUBSCRIBED before me this 27th day of December, 2018.

_____
NOTARY PUBLIC
My Commission Expires: 2-2-22



APPENDIX B

Excerpt of DeKalb County Sheriff's Office Medical Records- Nurses Notes

Dated September 4, 2013

DeKalb County Sheriff's Office
Medical Records

Nurse Notes

09/04/2013

Re: Hammonds, Stephen Austin
Inmate # 437

DOB
SS#: [redacted]

Allergies: NKDA

Supplemental Notes:
12 hour hold for DV

Stated medication: Novolin 18 units mornings, Regular Insulin 10 units mornings, Regular Insulin 10 units hs

Accucheck: 233 mg/dl

Reagent UA: Glucose 1,000 mg /dl, Ketone - Trace All other values WNL

PLAN
3 units insulin sq
Regular insulin sliding scale
Blood glucose log BID

John Smith
on 09/04/2013 at 10:28 PM

Allen Kay

Reviewed:
Robert Theakston
09/12/2013 at 05:48 PM