IN THE UNITED STATES DISTRICT COURT

FOR THE WESTERN DISTRICT OF WISCONSIN

Case Number 14-CV-783-jdp

TIMOTHY TALLEY,

Plaintiff,

v.

MICHAELS DITTMAN, et al.,

Defendants.

AMENDED COMPLAINT UNDER THE CIVIL RIGHTS ACT, 42 § 1983

TIMOTHY TALLEY
PRO SE PLAINTIFF.

Timothy Talley #202836
Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 900
Portage, Wisconsin 53901-0900

AMENDMENT AUTHORITY

The Plaintiff, Timothy Talley, Pro Se, moved for leave to amend the Complaint (Dkt.5), which was granted by the Court on December 10, 2004. (Dkt.6). This Complaint shall be construed as Plaintiff's Amended Complaint under F. R. Civ. P. 15(a)(2).

I. PRESENT PLACE OF COMPLAINT.

Plaintiff Timothy Talley is presently confined at:

Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 900
Portage, Wisconsin 53901-0900

(A) There is a Grievance procedure in place at Columbia Correctional Institution.

(B) Talley used the Grievance procedure as follows:

(1) INMATE COMPLAINT NUMBER CCI-2011-25444:

The Complaint was filed on December 20, 2011.

The Inmate Complaint Investigator recommended that the Complaint be Affirmed on January 24, 2012.

Warden Meisner affirmed the Complaint on February 3, 2012.

Talley appealed the Warden's decision to the Corrections Complaint Examiner on February 7, 2012.

The Corrections Complaint Examiner recommended the Complaint be affirmed on April 26, 2012.

The Secretary's designee affirmed the Complaint on May 3, 2012.

(2) INMATE COMPLAINT NUMBER CCI-2012-2819:

The Complaint was filed on February 6, 2012.

The Inmate Complaint Investigator recommended that the Complaint be affirmed on February 27, 2012.

The Warden designee affirmed the Complaint on March 5, 2012.

Talley appealed the Warden's decision to the Corrections Complaint Examiner on March 15, 2012.

The Corrections Complaint Examiner recommended the Complaint be affirmed on May 2, 2012.

The Secretary's designee affirmed the Complaint on May 8, 2012.

(3) INMATE COMPLAINT NUMBER CCI-2014-11050.

The Complaint was filed on June 6, 2014.

The Inmate Complaint Investigator recommended that the Complaint be dismissed on July 1, 2014.

The Warden's designee dismissed the Complaint on July 8, 2014.

Talley appealed the Warden's decision to the Corrections Complaint Examiner on July 14, 2014.

The Corrections Complaint Examiner recommended the Complaint be dismissed on July 17, 2014.

The Secretary's designee dismissed the Complaint on July 25, 2014.

II. PARTIES.

(A) The Plaintiff is:

Timothy Talley #202836
Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 900
Portage, Wisconsin 53901-0900

(B) The First Defendant is:

Michael Dittman, Warden
Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 950
Portage, Wisconsin 53901-0950

Dittman was, at all times relevant, the Warden of Columbia Correctional Institution. Dittman is being sued in his official capacity and his personal capacity.

(C) The Second Defendant is:

Edward Wall, Secretary DOC
3099 E. Washington Avenue
Post Office Box 7925
Madison, Wisconsin 53707-7925

Wall was, at all times relevant, the Secretary of the Department of Corrections. Wall is being sued in his official and his personal capacity.

(D) The Third Defendant is:

Gary Hamlin, Secretary DOC
3099 E. Washington Avenue
Post Office Box 7925
Madison, Wisconsin 53707-7925

Hamlin was, at all times relevant, the Secretary of the Department of Corrections. Hamlin is being sued in his official capacity and his personal capacity.

(E) The Fourth Defendant is:

Michael Meisner, Warden
Columbia Correctional
2925 Columbia Drive
Post Office Box 950
Portage, Wisconsin 53901-0950

Meisner was, at all times relevant, the Warden of Columbia Correctional Institution. Meinser is being sued in his official capacity and his personal capacity.

(F) The Fifth Defendant is:

Gregory Grams, Warden
Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 950
Portage, Wisconsin 53901-0950

Grams was, at all times relevant, the Warden of Columbia Correctional Institution. Grams is being sued in his official capacity and his personal capacity.

(G) The Sixth Defendant is:

David Melby, Unit Manager
Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 950
Portage, Wisconsin 53901-0950

Melby was, at all times relevant, a Unit Manager at Columbia Correctional Institution. Melby is being sued in his official capacity and his personal capacity.

(H) The Seventh Defendant is:

Dalia Suliene, Doctor
Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 950
Portage, Wisconsin 53901-0950

Suliene was, at all times relevant, a Medical Doctor at Columbia Correctional Institution. Suliene is being sued in

her official capacity and her personal capacity.

(I) The Eighth Defendant is:

Karl Hoffman, Medical Doctor
Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 950
Portage, Wisconsin 53901-0950

Hoffman is, at all times relevant, a Medical Doctor at Columbia Correctional Institution. Hoffman is being sued in his official capacity and his personal capacity.

(J) The Ninth Defendant is:

Karen Anderson, H.S.U. Manager
Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 950
Portage, Wisconsin 53901-0950

Anderson was, at all times relevant, the Health Service Unit Manager at Columbia Correctional Institution and a Registered Nurse. Anderson is being sued in her official capacity and her personal capacity.

(K) The Tenth Defendant is:

Keisha Perrnoud, H.S.U. Manager
Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 950
Portage, Wisconsin 53901-0950

Perrnoud was, at all times relevant, the Health Service Unit Manager at Columbia Correctional Institution and a Registered Nurse. Perrnoud is being sued in her official capacity and her personal capacity.

(L) The Eleventh Defendant is:

Meredith Mashak, H.S.U. Manager
Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 950
Portage, Wisconsin 53901-0950

Mashak is, at all times relevant, the Health Service Unit Manager at Columbia Correctional Institution and a Registered Nurse. Mashak is being sued in her official capacity and her personal capacity.

(M) The Twelfth Defendant is:

Kenneth Adler, Medical Director
3099 E. Washington Avenue
Post Office Box 7925
Madison, Wisconsin 53707-7925

Adler is, at all times relevant, the Department of Corrections Medical Director at Central Office. Adler's being sued in his official capacity and his personal capacity.

(N) The Thirteenth Defendant is:

Sergeant Kyburz
Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 950
Portage, Wisconsin 53901-0950

Sergeant Kyburz was, at all times relevant, a Correctional Sergeant employed at Columbia Correctional Institution. Sergeant Kyburz is being sued in her personal capacity.

(O) The Fourteenth Defendant is:

C.O.II Cooper
Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 950
Portage, Wisconsin 53901-0950

C.O.II Cooper was, at all times relevant, a Correctional Officer II employed at Columbia Correctional Institution. C.O.II Cooper is being sued in his personal capacity.

III. PREVIOUS LAWSUITS.

(1) This lawsuit began in State Court, Columbia County Case No. 14-JD-7. On November 17, 2014, the Case was removed to Federal Court and leave to amend the complaint was granted. (Dkt.6).

(2) Another lawsuit involving dispensation of the wrong medication to Plaintiff on two separate occassions was filed in Dane County Case No. 14-CV-3210. Talley has since dismissed the case because he was unable to obtain service on the defendants in a timely manner. The Defendants were: Michael Meisner, CO II Cooper, Sgt. Kyburz, and Edward Wall. The claims in the Dane County lawsuit are now included in this Case.

IV. STATEMENT OF CLAIMS.

(3) As the Secretary of the Department of Corrections, Wall is responsible for the supervision of all Department of Correction Institutions and to implement, modify or stop policies; procedures; executive and administrative directives; and internal management procedures that regulate the conduct and responsibilities of both staff and inmates.

(4) Wall is responsible for monitoring the recurring problems within the Department of Corrections and to implement new policies or modify existing policies to put a stop to the recurring problems or to at least minimize the continuance of a recurring problem.

(5) In the Department of Corrections, there is a continuing policy which results in the denial of medically recommended, required or prescribed medications.

(6) The ¶(5) denial of medication has four components:

(A) Failure to timely refill medications by Health Services Unit Staff;

(B) Failure to timely refill medications by Central Pharmacy;

(C) Failure to prescribe medically recommended or required medications; and

(D) Abrupt discontinuation of prescribed medically recommended or required medications.

(7) In the Department of Corrections, there is a continuing policy which results in the denial of medically recommended, required, or prescribed ambulatory devices; pain management devices; disease management, physical therapy, and prevention of physical degradation regimens; and disability accommodations under the American Disabilities Act.

(8) Most of the issues arising under ¶(7) are addressed by what is now denominated the "Special Needs Committee", which is composed of mainly non-medical personnel.

(9) The Special Needs Committee makes a decision on whether an inmate is to have his Special Medical Needs provided for or denied.

(10) The Special Needs Committee results in medical decisions by mainly untrained, non-medical personnel.

(11) Inmates are denied access to the policies, procedures, and criteria relied upon by the Special Needs Committee.

(12) Inmates are not allowed to meet with the Special Needs Committee to discuss their needs.

(13) The Department of Corrections has a continuing policy that requires Correctional Officers and Correctional Sergeants to issue inmates their "controlled" medications.

(14) The ¶(13) policy has Health Services Employees (who are trained and licensed) dispense several of the Schedule I Narcotics themselves.

(15) The ¶(13) policy is resulting in the untrained, unlicensed, ill-prepared Correctional Officers and Correctional Sergeants dispensing the wrong medications to inmates; dispensing the wrong dosage of medications to inmates; or dispensing the right medications to inmates at the wrong time.

(16) The Department of Corrections receives "hundreds" or maybe even "thousands" of complaints regarding the denials discussed in ¶¶(5-6) each year.

(17) The Department of Corrections receives "hundreds" or maybe even "thousands" of complaints regarding the denials discussed in ¶¶(7-12) each year.

(18) The Department of Corrections receives "hundreds" or maybe even "thousands" of complaints regarding the ¶(13) policy discussed in ¶¶(13-15) each year.

(19) The Department of Corrections generates "hundreds" or maybe even "thousands" of Staff-Written Incident Reports regarding Staff issuing inmates the wrong medication each year.

(20) Despite the documentation generated within the Department of Corrections in ¶¶(16-19), Wall has failed to take appropriate steps to modify the practices, policies and procedures in Department of Corrections that are causing the

majority of these complaints and mistakes so as to reduce the harm to inmates.

(21) Dittman is responsible for overseeing the care and custody of inmates at Columbia Correctional Institution. In doing so, he is made aware that the documents generated in ¶¶(16-19) exist and has therefore gained knowledge of the problems occurring as a result of the facts set forth in ¶¶(5-19).

(22) Despite the knowledge in ¶(21), Dittman has failed to take steps to modify the practices, policies and procedures at Columbia Correctional Institution that are causing the majority of these complaints and mistakes so as to reduce the harm to inmates.

(23) Meisner was responsible for overseeing the care and custody of inmates at Columbia Correctional Institution. In doing so, he is made aware that the documents generated in ¶¶(16-19) exist and has therefore gained knowledge of the problems occurring as a result of the facts set forth in ¶¶(5-19).

(24) Despite the knowledge in ¶(21), Meisner failed to take steps to modify the practices, policies and procedures at Columbia Correctional Institution that are causing the majority of these complaints and mistakes so as to reduce the harm to inmates.

(25) Grams was responsible for overseeing the care and custody of inmates at Columbia Correctional Institution. In doing so, he is made aware that the documents generated in ¶¶(16-19) exist and has therefore gained knowledge of the problems occurring as a result of the facts set forth in ¶¶(5-19).

(26) Despite the knowledge in ¶(21), Grams failed to take steps to modify the practices, policies and procedures at Columbia Correctional Institution that are causing the majority of these complaints and mistakes so as to reduce the harm to inmates.

(27) As the Secretary of the Department of Corrections, Hamlin was responsible for the supervision of all Department of Correction Institutions and to implement, modify or stop policies; procedures; executive and administrative directives; and internal management procedures that regulate the conduct and responsibilities of both staff and inmates.

(28) Despite the documentation generated within the Department of Corrections in ¶¶(16-19), Hamlin failed to take appropriate steps to modify the practices, policies and procedures in Department of Corrections that are causing the majority of these complaints and mistakes so as to reduce the harm to inmates.

(29) By failing to take appropriate steps in ¶20, Hamlin was deliberately indifferent to the needs of inmates and demonstrated a wanton disregard to the overall health and welfare of inmates under his custody and control.

(30) By failing to take appropriate steps in ¶22, Dittman is deliberately indifferent to the needs of inmates and demonstrated a wanton disregard to the overall health and welfare of inmates under his custody and control.

(31) By failing to take appropriate steps in ¶28, Hamlin was deliberately indifferent to the needs of inmates and to

the needs of inmates and demonstrated a wanton disregard to the overall health and welfare of inmates under his custody and control.

(32) By failing to take appropriate steps in ¶24, Meisner was deliberately indifferent to the needs of inmates and demonstrated a wanton disregard to the overall health and welfare of inmates under his custody and control.

(33) By failing to take appropriate steps in ¶26, Grams was deliberately indifferent to the needs of inmates and demonstrated a wanton disregard to the overall health and welfare of inmates under his custody and control.

(34) Melby was responsible for the operation of the Special Management Units, Units 6 and 7, at Columbia Correctional Institution.

(35) Unit 6 is a general population Unit where either mentally challenged inmates or physically disabled inmates are housed.

(36) Unit 6 is totally handicap accessible with safety grab rails and secure seats in the showers for those unable to stand.

(37) Unit 7 is a general population Unit for mentally challenged inmates and also houses some segregation inmates.

(38) Melby also was responsible for the operation of the two Segregation Units; DSI and DSII.

(39) In the Segregation Units, any time inmates leave their cell, they are handcuffed behind their backs. This includes going to showers, visits, hearings, recreation, and HSU/PSU

interviews.

(40) Suliene was the primary Doctor at Columbia Correctional Institution and her responsibilities included diagnosing inmates; treating inmates; referring inmates to specialists; and prescribing medications to inmates for treatment of illnesses or for pain management.

(41) Suliene was also responsible for followup care to insure that her orders and prescriptions were being followed and to implement the recommendations and prescriptions of the specialists who treated inmates who she referred to the specialists.

(42) Hoffman is the primary Doctor at Columbia Correctional Institution and his responsibilities include diagnosing inmates; treating inmates; referring inmates to specialists; and prescribing medications to inmates for treatment of illnesses or for pain management.

(43) Hoffman is responsible for followup care to insure that his orders and prescriptions are being followed and to implement the recommendations and prescriptions of the specialists who treated inmates who he referred to the specialists.

(44) Anderson was the Health Unit Services Manager at Columbia Correctional Institution and her responsibilities included overseeing the Health Services Unit at Columbia Correctional Institution; developing policies, procedures, and checks and balances to insure that inmates are receiving proper care; medications are ordered from Central Pharmacy on time;

medications are being received from Central Pharmacy on time; medications are being refilled and provided to inmates on time; and that inmates are not being provided the wrong medication, the wrong dose of a medication, or receiving the right medication at the wrong time.

(45) Perrnoud was the Health Unit Services Manager at Columbia Correctional Institution and her responsibilities included overseeing the Health Services Unit at Columbia Correctional Institution; developing policies, procedures, and checks and balances to insure that inmates are receiving proper care; medications are ordered from Central Pharmacy on time; medications are being received from Central Pharmacy on time; medications are being refilled and provided to inmates on time; and that inmates are not being provided the wrong medication, the wrong dose of a medication, or receiving the right medication at the wrong time.

(46) Mashak is the Health Unit Services Manager at Columbia Correctional Institution and her responsibilities include overseeing the Health Services Unit at Columbia Correctional Institution; developing policies, procedures, and checks and balances to insure that inmates are receiving proper care; medications are ordered from Central Pharmacy on time; medications are being received from Central Pharmacy on time; medications are being refilled and provided to inmates on time; and that inmates are not being provided the wrong medication, the wrong dose of a medication, or receiving the right medication at the wrong time.

(47) Adler is the Department of Corrections Medical Director and Supervisor of Physicians as well as the Chairman of the Madison Central Office Medication and Treatment Oversight Committee. In this capacity, he oversees all D.O.C. Health Service Units in the State and the doctors and nurses employed thereat. As Chairman of the Medication & Treatment Committee, he heads the Committee responsible for approving or disaproving all Schedule I drugs for inmate use; their duration and dosage; and approving or disapproving all Class I, II, III and IV medical treatment requests for specialists or specialized treatment or diagnosis. Adler is responsible for all DOC HSU Policies and Procedures throughout the State.

(48) Under current Department of Correction and Columbia Correctional Institution policies, Sergeant Kyburz was responsible for dispensing inmate controlled medications during her shifts on a housing unit.

(49) Under current Department of Correction and Columbia Correctional Institution policies, C.O.II Cooper was responsible for dispensing inmate controlled medications during his shifts on a housing unit.

(50) When dispensing inmate controlled medications at Columbia Correctional Institution, a correctional officer or sergeant is to follow the following procedure: (1) verify the inmate's name; (2) Verify which medications the inmate is to receive at that time; (3) Verify that the medications being dispensed actually belong to that inmate and are to be dispensed at that time; (4) Verify the dosage of each medication to be

dispensed; (5) Dispense the medication; (6) Insure the inmate fully consumes the medication; and (7) Logs the medication actually issued into a special Medication Log Book.

(51) The Department of Corrections does not have a policy requiring nurses or other trained medical professionals to dispense all controlled prescription medication to inmates under its custody and control.

(52) Columbia Correctional Institution does not have a policy requiring nurses or other trained medical professionals to dispense all controlled prescription medication to inmates under its custody and control.

(53) The Department of Corrections allows correctional officers and sergeants to dispense prescription, controlled medication to inmates.

(54) Columbia Correctional Institution allows correctional officers and sergeants to dispense prescription, controlled medication to inmates.

(55) The Department of Corrections does not require correctional officers or sergeants to be licensed or otherwise certified to dispense prescription, controlled medication to inmates.

(56) C.C.I. does not require correctional officers or sergeants to be licensed or otherwise certified to dispense prescription, controlled medication to inmates.

(57) Kyburz is not a trained medical professional.

(58) Kyburz is not licensed or certified to dispense prescription, controlled medication to inmates.

(59) Cooper is not a trained medical professional.

(60) Cooper is not licensed or certified to dispense prescription, controlled medication to inmates.

(61) On December 16, 2011, Cooper was working in Unit 4 at Columbia Correctional Institution during the H.S. [Hours of sleep](Bedtime) medication dispensation for controlled medications.

(62) During the H.S. medication dispensation for controlled medication on Unit 4, Cooper was passing out the controlled medications to inmates.

(63) During the H.S. medication dispensation for controlled medications on Unit 4, Correctional Officer Benninger was observing, supervising, and training Cooper while Cooper physically issued controlled medications to inmates.

(64) At approximately 2035 on December 16, 2011, Cooper gave Talley three 50 milligram Tramadol tablets.

(65) At approximately 2035 on December 16, 2011, following D.O.C. policies, Talley took the three tablets placed into his hand by Cooper.

(66) At approximately 2035 on December 16, 2011, Talley was to be taking three tablets of medication in total.

(67) At approximately 2035 on December 16, 2011, Talley was to be taking two 50 milligram Tramadol tablets according to Talley's doctor-ordered prescription.

(68) At approximately 2035 on December 16, 2011, Talley was to be taking one Noritrypline (sic) tablet according to Talley's doctor-ordered prescription.

(69) Once Talley took the three Tramadol tablets, Benninger asked Cooper: "What did you do?"

(70) Benninger then stated to Cooper: "You've got to pay attention and read the med cards."

(71) Talley then asked Benninger: "What did he do?"

(72) Benninger then informed Talley: "He gave you too many Tramadol."

(73) Benninger then instructed Talley to return to his cell, which Talley did.

(74) Incident Report 24569 verifies Talley was given the wrong dose of Tramadol on December 16, 2011 at approximately 2030. (The I.R. mistakenly states HU9 instead of HU4).

(75) On December 16, 2011 at approximately 2100, Talley began to experience an upset stomach.

(76) On December 16, 2011, approximately 2100, Talley began to experience numbness in his head.

(77) On December 16, 2011, at approximately 2100, Talley began to sweat.

(78) On December 16, 2011, at approximately 2100, Talley began to feel his heart racing.

(79) On December 16, 2011 at approximately 2107, Talley became very sick and threw up violently to the point of dry heaving.

(80) After throwing up, Talley felt severely overheated.

(81) After throwing up, Talley began to have heart palpitations.

(82) After throwing up, Talley felt like he was going to

pass out.

(83) After throwing up, Talley had an itching sensation over his entire body.

(84) After throwing up, Talley had a severe headache that felt like a migraine and was debilitating.

(85) While suffering the symptoms in ¶¶79-84, Talley was extremely concerned that he was overdosing.

(86) On December 16, 2011, at approximately 2110, Benninger performed a count round of Talley's tier.

(87) When Benninger was at Talley's door, Talley informed Benninger of the symptoms in ¶¶79-84.

(88) Talley then told Benninger that he wished to see H.S.U.

(89) Benninger informed Talley that H.S.U. had already been notified.

(90) Benninger informed Talley that an Incident Report (24569) had been written.

(91) Benninger informed Talley that he would contact H.S.U. again and inform them of the symptoms Talley had described.

(92) On December 16, 2011, at approximately 2125, Benninger informed Talley that it wasn't anything serious.

(93) Benninger then informed Talley that the medication was only slightly stronger than tylenol.

(94) Benninger instructed Talley to drink plenty of fluids.

(95) Benninger informed Talley that he would not be seen by H.S.U.

(96) After Benninger left, Talley vomited again.

(97) At approximately 2152, Talley vomited for the last

time.

(98) Talley was unable to sleep for 24 hours after receiving the Tramadol.

(99) Talley was sick to his stomach for almost 24 hours after receiving the Tramadol.

(100) Talley was unable to eat anything for over 24 hours after receiving the Tramadol.

(101) Tramadol is an opiate agonist.

(102) Tramadol is a restricted drug that must be approved by Central Office before it can be prescribed and given to an inmate.

(103) Tramadol is in the same category as oxycontin.

(104) Tramadol is in the same category as morphine.

(105) Tramadol is in the same category as mscontin.

(106) Tramadol is in the same category as vicodin.

(107) Tramadol is in the same category as percocet.

(108) Tramadol can be extremely dangerous if abused.

(109) Tramadol overdoses can cause death.

(110) In late January, 2012, Talley saw the prison doctor in H.S.U. to follow up on a University of Wisconsin Hospital and Clinics off-site appointment.

(111) The prison doctor told me that she was adding a new medication to my regimen.

(112) On February 3, 2012, at approximately 1655, Kyburz was dispensing the P.M. controlled medication on HU4.

(113) At approximetely 1655, Kyburz gave Talley two 50 milligram Tramadol tablets.

(114) Talley then asked Kyburz if his new medication had been delivered to the unit.

(115) Kyburz then provided Talley with two additional tablets out of a different "blister pack".

(116) The second set of tablets were two additional 50 milligram Tramadol tablets.

(117) Kyburz also provided Talley with two additional tablets out of a third "blister pack".

(118) The third set of two tablets were not Talley's medication.

(119) It is unknown what these final two tablets were.

(120) In accordance with D.O.C. Policies and Procedures, Talley took the dispensed medication and demonstrated that he had fully swallowed the medication.

(121) Talley then retrieved writing supplies so he could write down the names of the new medications.

(122) When Kyburz attempted to look up the new medications in the medication log book, there was no record of any new controlled medication.

(123) After dispensing the medication and checking the medication log book, Kyburz realized that she had provided Talley with the wrong medication.

(124) Kyburz acknowledged that she gave Talley four 50 milligram Tramadol tablets instead of two, in Incident Report #27222.

(125) Kyburz apologized profusely to Talley for giving him medication not prescribed to him.

(126) Kyburz called H.S.U. and reported her mistake.

(127) Kyburz informed Talley that he would not be seen by Health Services Unit.

(128) Health Services Unit never did a blood draw to determine what the other medication Talley had been provided by Kyburz.

(129) On February 3, 20102, at approximately 1715, Talley began to experience light-headedness and dizziness.

(130) On February 3, 2012, at approximately 1715, Talley began to experience trouble breathing.

(131) On February 3, 2012, at approximately 1715, Talley began to experience dry mouth.

(132) On February 3, 2012, at approximately 1715, Talley began to experience shaking.

(133) On February 3, 2012, at approximately 1715, Talley began to experience headache.

(134) On February 3, 2012, at approximatley 1715, Talley began to experience sweating.

(135) On February 3, 2012, at approximately 1715, Talley began to experience itching.

(136) On February 3, 2012, at approxiamtely 1715, Talley began to experience nausea and upset stomach.

(137) Talley was still suffering some of these symptoms (¶¶129-136) thirty-six hours later.

(138) Ten days later, Talley still had hives and rashes on his body from the medications he had been provided on February 3, 2012 at approximately 1655.

(139) On February 3, 2012 at approximately 1720, Talley began violently vomiting.

(140) Talley felt like he was going to die.

(141) On February 3, 2012, Kyburz was informed by Talley that Talley was going to file a formal grievance against Kyburz for dispensing the wrong medication.

(142) On February 3, 2012, Kyburz wrote Conduct Report Number 1957055 for lying and misuse of medication.

(143) On February 2, 2012, H.S.U. provided Talley with a Health Services Request informing Talley that the doctor had prescribed new/additional medication.

(144) On February 17, 2012, Talley was found not guilty of all charges on Conduct Report Number 1957055.

(145) On March 1, 2012, Security Director Janel Nickel provided Talley with a memo stating that Talley was given the wrong and improper dose of medication.

(146) Kyburz was aware at the time she wrote the Conduct Report that Talley intended to file a formal grievance against her.

(147) Kyburz was aware at the time she wrote the Conduct Report that D.O.C. Policy prevents an inmate from filing a formal grievance under D.O.C. 310, Wisconsin Administrative Code when the incident complained about is the subject of a pending conduct report.

(148) Kyburz wrote the conduct report to attempt to prevent Talley from successfully filing a formal grievance against her.

(149) Kyburz wrote the conduct report in retaliation for

Talley informing her that he was going to write a formal grievance against her.

(150) State and Federal laws restrict the dispensing of controlled medications to licensed, certified, and trained medical professionals (doctors, nurses, pharmacists, etc.) and make it a crime for individuals not so authorized to distribute or otherwise dispense such controlled medications.

(151) Prior to November of 2012, Talley was receiving 100 milligram of Tramadol four times daily. (400 mg. daily total).

(152) Prior to November of 2012, Talley was receiving 800 mg. Ibuprofen 3 times daily. (2400 mg. daily total).

(153) Prior to November of 2012, Talley was receiving 1000 mg MAPAP 4 times daily. (4000 mg. daily total).

(154) Prior to November of 2012, Talley was prescribed a "Tens" Unit which supplies electronic pulses to the skin to help alleviate back pain.

(155) In November of 2012, Talley was taken to University of Wisconsin Hospital in Madison, Wisconsin, for spinal surgery.

(156) The Spinal Fusion Surgery was to be a relatively short surgical procedure like a small bone chip was to be taken from his hip and placed between Talley's L-4 and L-5 Vertebrae to alleviate his constant, debilitating back pain.

(157) During surgery, it was discovered that Talley's spinal problems were worse than expected.

(158) In addition to the L-4 and L-5 fusion, Talley had to have his S-1 also fused together.

(159) It took surgeons 9 hours to achieve the fusion

required.

(160) The surgeons inserted two Titanium Rods 7" long, six additional pins, and an unknown number of screws holding everything together.

(161) After the surgery, Talley received a document entitled "Discharge Med Orders" which included a "Current Discharge Medication List."

(162) The 11/19/02 Discharge Med Orders covered a 30 day period, until Talley's followup visit at U.W. Hopsital.

(163) The current discharge medication list included:

(A) Diazepam (Valium) 5 mg.: 1 tab orally every 12 hours as needed;

(B) Gabapentin (Neurontin) 300 mg: 2 caps orally 3 X daily;

(C) Morphine 30 mg 12 HR E.R.: 1 tab orally 2 X daily;

(D) Oxycodone 5 mg: 1-2 tabs orally every 4 hours as needed;

(E) Clonazepam (Klonopin) 2 mg: 1 tab orally 2 X daily for 10 days, and then take 1 tab orally 2 X daily as needed for 10 days, then stop.

(164) The current discharge medication list was prescribed by Doctor Brooks at U.W. Hospital; however, Dr. Suliene abruptly stopped these medications after 11 days.

(165) Doctor Meyer, a C.C.I. Psychiatrist and Medical Doctor was informed of the stoppage of medication by Dr. Suliene when he talked to Talley.

(166) Doctor Meyer told Talley that he could die from such

an abrupt stoppage of these medications.

(167) Doctor Meyer then talked to the H.S.U. Manager and Doctor Suliene to get Talley's pain medication reinstated.

(168) The H.S.U. Manager and Doctor Suliene refused to continue Talley's prescribed pain medications.

(169) At the time that his medications were stopped, Talley was wheelchair-bound and suffering extreme pain from his damaged spine and recent surgery.

(170) Because Dr. Suliene and the H.S.U. Manager discontinued and refused to continue Talley's medications, Talley suffered severe withdrawal symptoms.

(171) Because Talley was not provided his medications as prescribed by Doctor Brooks, Talley was left in severe pain from his recent surgery and his spine damage.

(172) For the next 14 months, from November of 2012 to February of 2013, Talley was provided only low-level (non-opiate) nerve damage pain medications.

(173) During this 14 month period, Talley became more physically disabled and was unable to walk from one end of his cell to get his food or use the bathroom.

(174) Talley was reduced to crawling on the floor to get his food, use the bathroom, and move around the cell because putting pressure on his spine caused Talley to collapse in pain.

(175) Talley's attempts to be ambulatory and move around resulted in numerous falls:

(A) Talley fell down the stairs on the Unit;

(B) Talley fell and separated his shoulder;

(C) Talley fell and hit his head on the toilet; and

(D) Several other falls and injuries.

(176) These falls that occurred were preventable, had Talley not been denied a cane, walker and wheelchair by Dr. Suliene, the H.S.U. Manager, and the Special Needs Committee at Columbia Correctional Institution.

(177) Talley was taken to Divine Savior Hospital in Portage, Wisconsin, on numerous occasions because of the falls and injuries sustained by Talley.

(178) Divine Savior Hospital would treat Talley's injuries and prescribe pain medication for Talley.

(179) Dr. Suliene and the H.S.U. Manager would not follow Divine Savior's Medication Prescriptions for Talley and refused to give Talley the prescribed medications.

(180) The denial of pain medications prescribed by Divine Savior Hospital resulted in continued extreme pain to Talley that reasonably should have been treated and minimized.

(181) On most trips to Divine Savior Hospital by Ambulance, Talley was strapped down on a hard, flat board to insure Talley did not incur any further spinal injuries during transport.

(182) Talley has been unable to shower because he was housed in a housing unit without grab bars and a stationary seat and the shower stalls have a high front lip and are not handicap accessible.

(183) Despite the need for Handicap Showers, the C.C.I. Special Needs Committee refused to authorize Talley's placement on Unit 6 where Handicap Showers are available.

(184) Despite the need for Handicap showers, Melby refused to place Talley in Unit 6 where handicap showers were available.

(185) Despite Talley's inability to safely utilize the unit stairs, the C.C.I. Special Needs Committee refused to place Talley on Unit 6 which is set-up for disabilities such as Talley's.

(186) Despite Talley's inability to safely utilize the unit stairs, Melby refused to place Talley on Unit 6 which is set-up to accommodate disabilities such as Talley's.

(187) Despite Talley's demonstrated need for ambulatory devices such as a cane, walker, or wheelchair, Melby refuses to allow Talley to utilize these devices.

(188) Because of the extreme, debilitating pain, Talley is suffering on a continuous basis, Talley has attempted to "end the pain" through numerous suicide attempts.

(189) As "treatment" for his multiple suicide attempts, Talley was given 300 days in the prison disciplinary units.

(190) C.C.I. officials found that Talley suffered from mental illness because of the multiple suicide attempts.

(191) C.C.I. officials did not treat Talley for his mental illness through Psychiatric Therapy.

(192) Doctor Suliene continued to refuse to treat Talley's pain despite Talley continuing to express complaints of extreme pain.

(193) Suliene then retired in 2013, and two part-time doctors hired to "fill in" until such time as a full-time doctor was hired to replace Suliene.

(194) The two doctors who replaced Suliene temporarily were Doctor Heinzl and Doctor Martin.

(195) Dr. Heinzl and Dr. Martin diagnosed Talley as suffering from Sacroiliitis Post Lysectomy Syndrome as a result of the L-4, L-5 and S-1 Spinal Fusion Procedure.

(196) They referred Talley to the Comprehensive Pain Management Clinic (C.P.M.C.) in Appleton, Wisconsin.

(197) C.P.M.C. confirmed the doctor's diagnosis and recommended that Talley undergo a procedure called Spinal Cord Stimulator Surgery to alleviate the pain.

(198) This procedure has been approved but has not been performed.

(199) Dr. Heinzl and Dr. Martin obtained permission from Doctor Adler and the oversight Committee to prescribe and dispense long-term opiate pain medciations to help control Talley's cronic, extreme pain.

(200) Once the approval was received, C.C.I. H.S.U. Staff failed to inform the Doctor that the approval was received and Talley could start his pain-management regimen.

(201) After a substantial delay, Talley discovered the approval and brought it to the Doctor's attention.

(202) Doctor Heinzl then prescribed Methadone: 5 mg. two times daily for 7 days.

(203) Doctor Heinzl prescribed Methadone: 10 mg. at A.M. Meds and 10 mg at P.M. Meds for 4 weeks, starting after the ¶(202) prescription was completed.

(204) Doctor Heinzl then prescribed Methadone: 10 mg. at

A.M. Meds and 15 mg. at P.M. Meds for 4 weeks starting after the ¶(203) prescription was completed.

(205) Doctor Heinzl then prescribed Methadone: 15 mg. at A.M. Meds and 15 mg. at P.M. Meds for 4 weeks starting after the ¶(204) prescription was completed.

(206) Dr. Heinzl then prescribed Methadone: 15 mg. at A.M. Meds and 20 mg. at P.M. Meds, indefinitely.

(207) By following Doctor Heinzl's prescriptions, Talley was able to reduce his pain to fairly tolerable levels, however, full therapeutic target levels were never reached.

(208) Doctor Heinzl was replaced by Doctor Hoffman.

(209) Hoffman saw Talley for the first time and informed Talley that, "The first thing we need to do is get you off this medication [Methadone]. I don't like these drugs. They are very bad drugs."

(210) Talley asked Hoffman if he was aware how bad Talley's pain situation was. Dr. Hoffman told Talley that he did not know the extent of Talley's condition because he hadn't read Talley's file yet.

(211) Hoffman then ordered Talley's Methadone reduced to 12.5 mg. 2 X daily without reading Talley's file.

(212) Hoffman informed Talley that his Methadone would be reduced slowly until the Methadone was completely stopped.

(213) Hoffman eventually stopped Talley's Methadone prescription despite the radical increase in Talley's pain.

(214) As the Methadone doses were decreased by Hoffman, Talley began to suffer more and more intense pain.

(215) Talley began to feel weakness in his legs and became unsteady standing again as the Methadone levels continued being lowered.

(216) Despite Talley's continued complaints of increased pain, Hoffman continued decreasing Talley's Methadone prescription until it was terminated.

(217) According to Dr. Adler and the Madison oversight committee and Dr. Heinzl's prescriptions, Talley's Methadone levels were to be increased, not decreased.

(218) Since the Methadone prescription has been terminated, Talley is no longer able to fully function in the prison setting.

(219) Prison officials, including Dittman and Melby, are aware that Talley is the incarcerated, retired gang leader of the Chicago based Simon City Royals and that there are gang-members at C.C.I. that will harm Talley according to prison gangland rules if the opportunity presents itself.

(220) Despite this knowledge, and Talley's diminished capacity to defend himself because of the debilitating pain and resulting reduction in physical movement, Dittman and Melby have moved Talley back into general prison population.

(221) The Cronic Pain Management Clinic doctor informed Talley that one single wrongly placed hit or blow to his lower spine could easily result in Talley being permanently paralysed from the waist down.

(222) Talley asserts that he is a wounded man with obvious physical disability which healthy inmates (who pray on weakness like wolves) take as weakness and vulnerability to be exploited.

(223) Placement of Talley in Unit 6 would minimize his safety issues because he would be housed with other inmates who are physically disabled.

(224) Placement of Talley in Unit 6 would allow Talley to utilize the handicap equipped showers.

(225) Despite the risks to Talley in general population and the benefit of housing Talley in Unit 6, Dittman, Melby, and the Special Needs Committee refuse to place Talley in Unit 6.

(226) Kyburz wrote Conduct Report #1957055 in retaliation for Talley informing her that he was going to file a Complaint on her for giving him the wrong medications.

(227) Kyburz believed that Talley's Complaint would not be addressed because of the Conduct Report, preventing Talley from exhausting his administrative remedies and suing her.

(228) At the Conduct Report Hearing, Talley was found not guilty of all charges because Kyburz issued the wrong medication.

(229) Talley filed a Notice of Claim with the Attorney General's Office as to all claims herein on 04/11/12.

V. LEGAL CLAIMS.

(230) Each legal claim incorporates and reasserts paragraphs (1) through (229), Supra.

(231) Defendants Wall, Hamlin, and Adler were deliberately indifferent in failing to change the Department of Corrections policies discussed herein while knowing that the current policies were resulting in harm to inmates; resulting in Talley being harmed as set forth herein.

(232) Defendants Grams, Dittman, Meisner, Wall, Hamlin, Adler, Melby, Perrnoud, Anderson, and Mashak were deliberately indifferent in failing to change the Columbia Correctional Institution policies discussed herein while knowing that the current policies were resulting in harm to inmates; resulting in Talley being harmed as set forth herein.

(233) Defendants Kyburz and Cooper were deliberately indifferent in dispensing controlled medications to inmates while knowing they were not properly licensed, certified, trained and authorized under State and Federal law to do so; and in failing to follow the fully established, if sufficient, current policies regarding the dispensation of controlled medication to inmates; resulting in providing Talley the wrong medications and causing Talley to be harmed as set forth herein.

(234) Defendants Melby, Perrnoud, Anderson, Mashak, Suliene, and Hoffman were deliberately indifferent to Talley's medical needs in denying Talley access to handicap showers and facilities despite the American Disabilities Act and knowledge that Talley required these facilities; resulting in Talley being harmed as set herein.

(235) Defendants Adler, Suliene, Hoffman, Perrnoud, Anderson and Mashak were deliberately indifferent to Talley's pain and suffering when they knowingly refused Talley necessary pain medications while knowingly causing Talley increased, unreasonable pain and loss of mobility, as set forth herein.

(236) Defendants Melby, Perrnoud, Anderson, Mashak, Suliene and Hoffman were deliberately indifferent to Talley's medical

needs in denying Talley use of ambulatory devices such as braces, crutches, cane, walker and wheelchair while knowing that Talley's mobility was decreased substantially, contrary to the American Disabilities Act; causing Talley harm as set forth herein.

(237) Defendants Dittman, Meisner, Grams and Melby were deliberately indifferent to Talley's personal safety, resulting in pain and suffering, emotional distress, mental anguish, anxiety and personal harm as set forth herein.

(238) Defendants Kyburz and Cooper were negligent when they dispensed the wrong medication to Talley, resulting in harm to Talley as set forth herein.

(239) Defendant Kyburz retaliated against Talley to prevent Talley from filing a Complaint and eventually a lawsuit against her.

(240) Talley sought Court review under Wisconsin John Doe Statute, § 968.26, Wis. Stats. Since Defendants have moved this Case to Federal Court voluntarily, the Federal Court must now determine whether the Defendants in this Case have violated § 940.29, Wis. Statutes under either Subsection (1) or (2); Committed misconduct in public office; Violated the State or Federal controlled substances acts; Violated the American Disabilities Act; Violated the criminal counterpart to 28 § 1983; or violated any other criminal provision of State or Federal law.

VI. RELIEF SOUGHT.

(241) Talley seeks final orders on his John Doe review and the issue of criminal charges, as appropriate against each

Defendant.

(242) Talley seeks Declatory Relief, including Mandamus and Prohibition under State Law and Injunctive Relief under Federal Law forcing the Defendants who are sued in their official capacities to modify their policies and procedures such that the harm to inmates as demonstrated herein are minimized to a reasonable degree and such that the policies and procedures are brought into compliance with State and Federal Law.

(243) Talley seeks a State Negligence claim against Defendants' Kyburz and Cooper for the negligent dispensation of wrong medications in the amount of $75,000.00 as to each defendant for Compensatory Damages.

(244) Talley seeks damages in the amount of $100,000.00 as to each Defendant identified in ¶(231) for the deliberate indifference and harm therein.

(245) Talley seeks damages in the amount of $100,000.00 as to each defendant identified in ¶(233) for the deliberate indifference and harm therein.

(246) Talley seeks damages in the amount of $100,000.00 as to each Defendant identified in ¶(234) for the deliberate indifference and harm therein.

(247) Talley seeks damages in the amount of $1,000,000.00 as to each Defendant identified in ¶(235) for the deliberate indifference and harm therein.

(248) Talley seeks damages in the amount of $1,000,000.00 as to each Defendant in ¶(235) for the deliberate indifference and harm therein.

(249) Talley seeks damages in the amount of $100,000.00 as to each Defendant in ¶(237) for the deliberate indifference and harm therein.

(250) Talley seeks damages in the amount of $100,000.00 as to each Defendant in ¶(238) for the negligence and harm therein.

(251) Talley seeks damages in the amount of $100,000.00 as to each Defendant for the violation of § 940.29(1) or (2), Wis. Stats.

(252) Talley seeks damages in the amount of $100,000.00 as to Defendant Kyburz for retaliation against Talley.

(253) Talley seeks Punitive Damages of $1,000,000.00 as to each Defendant over and above the Compensatory Damages set forth in ¶(241) to ¶(252).

(254) Talley seeks a jury trial as to all claims subject to a jury's verdict.

(255) Talley seeks temporary and permanent injunctions requiring Defendants and their successors to treat and continue to treat Talley's pain as prescribed by the C.P.M.C. in Appleton.

(256) Talley seeks recovery of all of his costs in this action.

(257) Talley seeks any and all other relief the Court finds just and proper.

CONCLUSION

The foregoing Complaint is true and correct to the best of my knowledge under penalty of perjury pursuant to 28 § 1746.

Dated this 29 day of January, 2015.

Timothy Talley

TIMOTHY TALLEY
PRO SE PLAINTIFF.

Timothy Talley #202836
Columbia Correctional Institution
2925 Columbia Drive
Post Office Box 900
Portage, Wisconsin 53901-0900

CERTIFICATION OF MAILING

I, hereby certify that on January 29, 2015, I deposited an envelope containing this document into the Columbia Correctional Institution Mailbox correctly addressed to the Clerk of Court for the Western District with proper arrangement for the affixing of first-class postage thereto.

Dated this 29 day of January, 2015.

Timothy Talley

TIMOTHY TALLEY
PRO SE PLAINTIFF.

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