UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF WISCONSIN

GAIL STOCKTON, Individually, and as Special Administrator of the ESTATE OF MICHAEL MADDEN, deceased,

Civil Action No. 2:18-cv-758

Plaintiffs,

v.

MILWAUKEE COUNTY, a municipal corporation, DAVID A. CLARKE, JR., RICHARD R. SCHMIDT, BRIAN PIASECKI, ARMOR CORRECTIONAL HEALTH SERVICES, INC., a foreign corporation, and MERCY MAHAGA,

Defendants.

COMPLAINT AND JURY DEMAND

Gail Stockton, Individually, and as Special Administrator of the Estate of Michael Madden, deceased, by their attorneys, Cannon & Dunphy, S.C., state and allege as follows:

I.

Introduction

1. This is a civil rights survival and wrongful death action brought under 42 U.S.C. § 1983 which raises supplemental state-law claims concerning the Defendants' deliberate indifference and negligence in relation to the prolonged and obvious need for emergency medical treatment for 29-year-old Michael Madden while he was in custody at the Milwaukee County Jail ("the County Jail").

2. Mr. Madden was confined at the County Jail from September 29, 2016, until he died on October 28, 2016. On the day he was detained and in the days that followed, Mr. Madden repeatedly told facility medical staff and the medical staff was aware that he had a congenital heart defect, that he was an intravenous drug user, and that he had used intravenous drugs the day he was detained. Medical staff knew that Mr. Madden's history put him at high risk for developing an infection in his heart, and over the course of his detention, Mr. Madden had obvious signs of infective endocarditis—a serious, but treatable, heart infection and medical emergency. Due to Defendants' actions and inactions, however, he did not receive the treatment required for his illness and his condition deteriorated.

3. During his entire confinement, Mr. Madden suffered from increasing pain and discomfort as his heart infection progressed.

4. In the early morning hours of October 28, Mr. Madden began crying out for help, was obviously experiencing a serious medical crisis, and was in need of care, but one of the responders, a correctional officer, failed and refused to provide care for Mr. Madden. Instead, the officer cursed at Mr. Madden, threw him into a chair and ordered him to sit there, forced him up to his feet when he was clearly unable to stand on his own, and allowed Mr. Madden to drop, fall, and strike his head multiple times.

5. When Mr. Madden was finally taken to the medical clinic for further evaluation and treatment on October 28, his condition was far too grave for effective treatment, and he died there.

6. The Plaintiffs now seek damages for the substantial pain and suffering and loss of society and companionship caused by the Defendants' conduct.

II.

Jurisdiction & Venue

7. This Court has jurisdiction over the subject matter of this Complaint under 42 U.S.C. § 1983 and 28 U.S.C. §§ 1331, 1343(a)(3), 1343(a)(4), and 1367(a).

8. Venue is proper in this Court pursuant to 28 U.S.C. § 1391.

III.

Parties

9. Michael Madden, born April 16, 1987, was a resident of the City of Franklin, Milwaukee County, State of Wisconsin, at all times relevant to this Complaint. He died at the age of 29 on October 28, 2016, in the County Jail.

10. Plaintiff Gail Stockton is Mr. Madden's mother. On December 22, 2016, the Milwaukee County Probate Court appointed her as the Special Administrator of the Estate of Michael Madden. She brings this action in her capacity as Special Administrator and for her benefit as Mr. Madden's lineal heir.

11. Defendant Milwaukee County is a municipal entity in the State of Wisconsin with a principal place of business in the City of Milwaukee. Milwaukee County manages and oversees the County Jail. Acting through the Milwaukee County Sheriff's Office, the County is responsible for training, supervising, and disciplining jail employees; adopting, implementing, and enforcing jail policies and practices; and ensuring that jail conditions and the treatment of detainees complies with the United States Constitution and other federal, state, and local laws. Milwaukee County is liable for the jail policies, practices, and customs that caused the harm alleged below, and under Wis. Stat. § 895.46(1)(a), Milwaukee County is

required to pay or indemnify all judgments, including for compensatory and punitive damages, attorney's fees, and costs that may be awarded against its officials and employees.

12. Defendant David A. Clarke, Jr. was at all times relevant Milwaukee County Sheriff with an office located at the Milwaukee County Sheriff's Department. Under Wis. Stat. § 302.336(2), Sheriff Clarke was legally responsible for the confinement, maintenance, and medical care of all persons confined in the County Jail. He was responsible for training, supervising, and disciplining jail employees; adopting, implementing, and enforcing jail policies and practices; and ensuring that jail conditions and the treatment of detainees complied with the United States Constitution and other federal, state, and local laws, as well as written jail policies. At all times relevant, he had personal knowledge of the policy, practice, and widespread custom of the provision of inadequate medical care at the County Jail. He was acting under color of state law and within the scope of his employment at all times relevant.

13. Defendant Richard R. Schmidt was at all times relevant the senior commander and a jail inspector at the County Jail and served in that capacity as an employee of Milwaukee County. By law, custom, and/or delegation, he had policy making authority over the jail and was responsible for ensuring that the policies and practices of the County Jail complied with federal and state requirements for the treatment of detainees. At all times relevant, he had personal knowledge of the policy, practice, and widespread custom of the provision of inadequate medical care at the County Jail. He was acting under color of state law and within the scope of his employment at all times relevant.

14. Defendant Brian Piasecki was at all times relevant a correctional officer for the County Jail and served in that capacity as an employee of Milwaukee County. In that role, he was responsible for the health and welfare of those confined in the jail, including Mr. Madden. He was acting under color of state law and within the scope of his employment at all times relevant.

15. Pursuant to Wis. Stat. § 893.80, a Notice of Injury and Claim was presented to Milwaukee County, Sheriff Clarke, Jail Inspector Schmidt, and Correctional Officer Piasecki on January 27, 2017. No action was taken, and the claim is therefore deemed denied.

16. Defendant Armor Correctional Health Services, Inc. ("Armor") is a for-profit correctional healthcare corporation incorporated under the laws of the State of Florida and doing business in the State of Wisconsin. Armor is considered a "person" for purposes of 42 U.S.C. § 1983 and acted under color of state law to provide medical care and services to detainees at the County Jail. Armor was responsible for adopting, implementing, and enforcing policies and practices pertaining to medical care for the County Jail. Armor also was responsible for ensuring that the care provided at the County Jail met minimum constitutional and other legal standards and requirements.

17. Defendant Mercy Mahaga was at all times relevant employed as a nurse practitioner for Armor and assigned by it to provide medical services to detainees at the County Jail. In that role, she was responsible for the health and welfare of those confined in the jail, including Mr. Madden. She was acting under color of state law and within the scope of her employment at all times relevant.

IV.

Factual Allegations

A. The Contract for Medical Services and Emergency Medical Care Between Milwaukee County and Armor

18. On January 1, 2016, Armor renewed a contract with Milwaukee County that granted Armor the exclusive right to provide reasonably necessary medical services and coordinate emergency or specialized medical care through local hospitals to detainees and inmates at the County Jail and the Milwaukee County House of Correction for a term of one year.

19. The contract provided that Milwaukee County would pay Armor base compensation of $15,764,334 for the medical services and emergency medical care that Armor provided.

20. As part of the contract, Armor agreed to cover all costs, up to a limit, for detainees who required outside medical services, including hospitalization and specialized treatment for serious illnesses and medical emergencies.

21. As part of the contract, Armor agreed to cover all costs for diagnostic testing.

22. Under the contract, Armor retained authority to determine whether detainees should receive diagnostic testing or be sent for outside medical services, including hospitalization and specialized treatment for serious illnesses and medical emergencies.

23. Under the contract, any expenditure of funds for diagnostic testing or for an inmate to be transferred to outside medical services for serious illnesses, specialized treatment, or medical emergencies would reduce Armor's profit.

B. Infective Endocarditis: A Medical Emergency

24. Infective endocarditis is a serious medical condition involving the growth of bacteria on the heart valves and potential development of infection in the heart muscle.

25. Individuals with existing heart defects are more susceptible to heart infections, like infective endocarditis, and infective endocarditis is a well-known complication of intravenous drug use because needles often serve as a vector for infection.

26. Due to the high population of intravenous drug users in the prison environment, reasonably trained staff members must be aware of the signs and symptoms of infective endocarditis.

27. Common signs of infective endocarditis include fever, a new or changed heart murmur, flu-like symptoms, fatigue or weakness, rapid heart rate, weight loss, and chest pain.

28. When such symptoms are present on examination, generally accepted medical standards of care call for immediate evaluation by a medical doctor and diagnostic testing, including a chest x-ray, basic laboratory testing of blood, urine specimens, and an echocardiogram.

29. If diagnostic testing shows evidence of infective endocarditis, the condition may be successfully treated with antibiotics or, if necessary, surgery to remove the infected heart valve.

30. Persons who receive such care for infective endocarditis can be expected to make a complete recovery.

31. If treatment is delayed, however, the condition will ultimately result in organ failure and death.

C. The Failure to Properly Diagnose and Treat
Mr. Madden's Medical Emergency Due to Infective Endocarditis

32. On September 29, 2016, Mr. Madden was arrested by the Franklin Police Department for possessing heroin and obstructing justice during a traffic stop. At the time, he appeared to be coming down from heroin and was experiencing withdrawals.

33. Mr. Madden was transported to the Franklin Police Department for booking, and he made suicidal comments there about killing himself because "he couldn't go through withdrawals again." He was in a panic and continually stated things like, "You know I'm going to have to kill myself."

34. Because of the suicidal comments, Mr. Madden was initially transported to the Milwaukee County Mental Health Complex from the Franklin Police Department and, after being medically cleared a short time later, was transferred to the County Jail. During a psychiatric evaluation and intake screenings at the Health Complex and County Jail, Mr. Madden reported that he was addicted to heroin, that he had been using heroin for about a year, that he had been recently injecting drugs, and that he had last injected heroin at 8 a.m. that morning.

35. Needle tracks were visible on Mr. Madden's arms and hands when he underwent an initial health screening at intake on the day he was arrested. In other words, it was apparent that Mr. Madden had been taking drugs intravenously in the time before he was detained, including that day.

36. During initial and ongoing assessments, Mr. Madden repeatedly reported to nursing staff that he had a congenital heart valve defect, and his reports were documented in his chart.

37. Based on his history of intravenous drug use and congenital heart defect, Mr. Madden was at very high risk for infective endocarditis.

38. Pursuant to physician order, Mr. Madden was initially placed on an opiate withdrawal protocol, and from September 29 through October 8, he was screened for withdrawal symptoms once or more per day. By October 8, however, Mr. Madden had stabilized and the withdrawal screening was terminated.

39. After he was removed from the withdrawal screening protocol, Mr. Madden demonstrated a series of classic signs and symptoms of infective endocarditis, and his deteriorating condition and worsening symptoms were not consistent with and could not be explained by opiate withdrawal.

40. Nursing documentation shows that Mr. Madden was experiencing tachycardia—an abnormally high heart rate—on October 8, October 11, October 13, and October 14.

41. On October 11, nursing documentation demonstrates that Mr. Madden had extremely low blood pressure, was pale, and was so weak that he could not walk. He needed to be transported by wheelchair, and staff noted that he was in "poor" condition.

42. On October 13, during further nursing evaluation for his acute medical condition, Mr. Madden complained of chest pain. He also had a low-grade fever.

43. On October 14, Mr. Madden was evaluated by Nurse Practitioner Mercy Mahaga on a medical sick call, and he was obviously ill. Though Nurse Mahaga had examined Mr. Madden on October 5, including his heart, and did not note a heart murmur,

the nurse practitioner found that Mr. Madden had a new heart murmur during the examination of October 14.

44. Further, Mr. Madden had weighed 149 pounds when he was initially screened and assessed on September 29, but he weighed only 142 pounds when he was examined by Nurse Mahaga on October 14. He had lost 7 pounds in 2 weeks.

45. By October 14, Nurse Mahaga and Armor staff: knew and documented Mr. Madden's history of recent intravenous drug use and existing heart defect; knew and documented that he had been suffering from a rapid heart rate, a fever, flu-like symptoms, fatigue and weakness, weight loss, and chest pain; knew that Mr. Madden had developed a new heart murmur, a significant change in his condition and highly indicative of the development and progression of infective endocarditis; and therefore knew or strongly suspected that Mr. Madden was in serious medical need.

46. Between October 14 and 25, there is virtually no nursing documentation about Mr. Madden's medical condition in his chart, and neither Nurse Mahaga nor any other staff member followed up on or continued to monitor Mr. Madden's persistent, ongoing symptoms.

47. On October 25, Mr. Madden submitted a written Health Care Request Form to be seen by medical staff. He reported that he was experiencing "bad symptoms" for what he thought was severe allergies. He also asked for medication to help alleviate his symptoms.

48. After the Health Care Request Form was submitted, Armor staff again knew that Mr. Madden was in serious medical need, but Mr. Madden was not evaluated within 24 hours of his request as required by standard practice and policy, he did not receive any

medications, and he did not receive any additional attention from staff until he fell terminally ill early on October 28.

49. At no time before he became terminally ill was a plan entered to monitor Mr. Madden's persistent symptoms, was diagnostic testing performed on or ordered for Mr. Madden, was a medical doctor consulted about Mr. Madden's condition or symptoms, or was Mr. Madden transferred to an outside provider for specialized medical evaluation or services. Under the circumstances, these failures violated the standard of care, common practice, policy, and Mr. Madden's constitutional rights.

D. Actively Dying, Clearly in a State of Emergency, and Punished

50. At about 1:23 a.m. on October 28, nursing staff responded to Mr. Madden's calls for help. Nursing staff recognized that Mr. Madden was in a state of "medical emergency," the staff members removed him from his cell, and they placed him in a chair in a common area. Correctional Officer Brian Piasecki and a correctional lieutenant were also present at the time.

51. On nursing assessment, Mr. Madden reported that his chest hurt and that he couldn't breathe.

52. A short time later, Mr. Madden began hyperventilating and—consistent with someone who has entered an active stage of dying—became restless, was jerking around, was twitching, and was confused as he sat in his chair.

53. As nursing staff pleaded with Mr. Madden to try to slow his breathing, calm down, and relax, Mr. Madden attempted to get out of the chair so he could lay down onto the floor. Correctional Officer Piasecki ordered Mr. Madden to sit up in the chair and, when

Mr. Madden could not comply, Correctional Officer Piasecki grabbed Mr. Madden by the back of the shirt and threw him into the chair. He ordered Mr. Madden to "sit the fuck up."

54. A short time later, Mr. Madden slid to the ground. He landed on his hands and knees, looked as if he were experiencing a seizure, and started to forcefully vomit a thick, viscous, orange discharge.

55. Nursing staff decided that Mr. Madden needed to be transferred to the facility's medical clinic for further evaluation, and Correctional Officer Piasecki commanded Mr. Madden to get up and walk to the clinic. When Mr. Madden physically could not, Correctional Officer Piasecki and another officer grabbed Mr. Madden by the arms and began dragging him to the exit.

56. On the way to the exit, the officers let go of Mr. Madden. Mr. Madden fell to the floor, landing at Correctional Officer Piasecki's feet in a sitting position. Correctional Officer Piasecki looked down and repeatedly yelled at Mr. Madden to "get the fuck up."

57. Mr. Madden could not get up. Slumped over and unable to rise on his own, he ultimately fell to his right. In the process, his head crashed into a wall.

58. Correctional Officer Piasecki then yanked Mr. Madden up to his feet, instructed Mr. Madden to walk, again released Mr. Madden from his grip, and stepped aside. Mr. Madden fell right down, and this time the back of his head smashed onto the concrete floor. Nearby nurses heard a very loud thud at the moment of the impact and described the blow to Mr. Madden's head as "very hard."

59. When Mr. Madden was finally transported by wheelchair and arrived in the clinic, he was not breathing. Resuscitative efforts failed, and Mr. Madden was ultimately pronounced dead at 2:23 a.m. on October 28, 2016.

60. An autopsy report concluded that the cause of Mr. Madden's death was infective endocarditis with myocarditis.

E. The County Jail's Pattern of Deliberate Indifference to Detainee Medical Needs and Failures in Times of Medical Emergency

61. At all times relevant, Milwaukee County had a non-delegable duty to provide constitutionally adequate and non-negligent medical care and services to all detainees, including Mr. Madden, at the County Jail.

62. The physical and mental anguish endured by Mr. Madden during his medical crisis in October 2016 was not an isolated event, but rather part of a persistent and widespread pattern and practice of disregarding the constitutionally mandated medical care required for detainees.

63. More specifically, in 2001, Milwaukee County entered into a Consent Decree governing medical care at the jail pursuant to *Christensen v. Sullivan*, Milwaukee County Circuit Court Case No. 1996-CV-1835. The Decree identified several requirements for the jail relative to medical care and population control, including the requirement that Milwaukee County have adequate, well-trained staff to provide reasonably necessary care to detainees.

64. Under the Decree, Dr. Ronald Shansky was appointed as the medical monitor of the County Jail, and Dr. Shansky has published reports documenting ongoing deficiencies at the jail.

65. Over several years, including in the time leading up to Mr. Madden's death, Dr. Shansky repeatedly documented inadequate medical and correctional staffing at the County Jail.

66. In his reports, Dr. Shansky explained again and again that as a result of inadequate staffing at the jail and inadequate monitoring of detainee medical needs, detainees were not receiving the care they needed and suffered from severe delays in receiving critical care.

67. Dr. Shansky also explained that correctional officers and others would choose to ignore symptoms reported by detainees, causing a further break-down in the provision of medical care at the County Jail.

68. Dr. Shansky's reports clearly put Defendants on notice about the pattern of inadequate care, inadequate access to care, and inadequate staffing at the County Jail.

69. Despite Dr. Shansky's repeated admonitions that staffing was not adequate to meet the serious medical needs of detainees and inmates, Milwaukee County and County Jail leaders Sheriff David A. Clarke, Jr. and Jail Inspector Richard R. Schmidt failed to implement and comply with Dr. Shansky's recommendations.

70. The Decree remains in force nearly two decades after it was originally entered because the County Jail is still not in substantial compliance with its provisions relative to medical care.

71. In addition to Dr. Shansky's findings, a series of failures in responding to serious medical conditions and medical emergencies at the County Jail has resulted in a

number of injuries and deaths that also demonstrate a pattern of disregard for the medical needs of detainees.

72. In fact, Mr. Madden's death was the fourth fatality of 2016 at the County Jail caused by an inadequate response to a detainee's serious need for medical care.

73. Indeed, in April 2016, Terrill Thomas was detained at the County Jail and suffering from bipolar disorder. Correctional officers shut off water to Mr. Thomas' cell, neither correctional officers nor nursing staff responded to Mr. Thomas' clearly deteriorating condition for seven days, and Mr. Thomas ultimately died of profound dehydration.

74. In July 2016, Shade Swayzer was detained at the County Jail when she was nearly nine months pregnant. Ms. Swayzer went into labor in her cell, her calls for help went ignored, and she did not receive medical care that was urgently needed. Her daughter, Laliah, did not survive the ordeal and died shortly after her birth.

75. In August 2016, just one month before Mr. Madden was detained, Kristina Fiebrink was detained on August 24 at the County Jail after having recently used heroin. She displayed clear signs of being under the influence, but was not closely monitored and was not assessed by a medical practitioner. On the night of August 27, Ms. Fiebrink began screaming, begging, and pleading for help in her cell. Though she was in desperate need of medical attention, staff members ignored her pleas. She died in her cell the next morning.

76. From March 2009 through October 2014, jail staff failed to adequately respond to serious medical conditions or medical emergencies at least 6 times leading to injury or death to detainees.

77. At all times relevant, Milwaukee County officials, including Sheriff Clarke and Jail Inspector Schmidt, were aware of and knew about the long history and pattern of injuries and deaths at the County Jail.

78. In short, in the time period leading to Mr. Madden's unnecessary death on October 28, injuries and deaths did not occur in isolation from each other at the County Jail. Rather, the Defendants knew about the inadequate care provided to detainees at the County Jail, took no actions in any way to remedy and prevent instances of inappropriate care, and consistently failed to provide adequate medical care for detainees.

F. Defendants' Violation of Mr. Madden's Constitutional Rights and Their Duty of Care

79. By September 2016, Sheriff Clarke and Jail Inspector Schmidt were on notice of a widespread practice at the County Jail in which the serious medical needs and medical emergencies of detainees like Mr. Madden were ignored, thereby exposing the detainees to unreasonable risks of harm. Moreover, Sheriff Clarke and Jail Inspector Schmidt were on notice that requests from detainees with clear symptoms of serious medical illness, injury, or conditions for medical care or to see a medical doctor were routinely delayed or completely ignored.

80. Specifically, there existed a widespread practice at the County Jail under which staff, including correctional officers and medical personnel, commonly failed or refused to:

a. properly examine a detainee with a serious medical condition or emergency;

b. provide proper medication to a detainee with a serious medical condition or emergency;

c. respond to detainees who requested medical attention, medication, or to see a doctor;

d. respond to detainees who exhibited obvious signs of serious medical condition or illness; and

e. adequately staff the jail with the correctional and medical personnel necessary to respond to detainee needs.

81. This widespread practice was allowed to flourish because Sheriff Clarke and Jail Inspector Schmidt directly encouraged and were thereby the moving force behind the very type of misconduct at issue by failing to adequately train, supervise, and control correctional officers and medical personnel, and by failing to adequately punish and discipline prior instances of similar misconduct, thus directly encouraging future abuses such as those affecting Mr. Madden. In this way, Sheriff Clarke and Jail Inspector Schmidt violated Mr. Madden's rights by maintaining policies and practices that were the moving force driving the foregoing constitutional violations.

82. Similarly, as the provider of medical care and services to detainees at the County Jail, Armor had notice of the policies and widespread practices pursuant to which detainees like Mr. Madden were routinely denied medical care and evaluation, denied access to medical care and evaluation, and exposed to unreasonable risks of harm. Moreover, Armor was on notice that requests from detainees with clear symptoms of serious medical illness, injury, or conditions for medical care or to see a medical doctor were routinely delayed or completely ignored.

83. Despite knowledge of these problematic policies and practices, Armor did nothing to ensure that detainees at the County Jail received adequate medical care and access to medical care, thereby acting with deliberate indifference. The widespread practices were allowed to flourish because Armor directly encouraged the type of misconduct at issue in this case, failed to provide adequate training and supervision of employees, and failed to adequately punish and discipline prior instances of similar misconduct. In this way, Armor violated Mr. Madden's rights by maintaining policies and practices that were the moving force driving the foregoing constitutional violations.

84. At all times relevant, Milwaukee County, Sheriff Clarke, Jail Inspector Schmidt, and Armor, with deliberate indifference, failed to develop and implement policies, practices, and procedures to ensure that detainees at the County Jail would receive appropriate care and monitoring for serious illnesses and, if necessary, diagnostic testing, referral to a medical doctor, and/or outside medical services.

85. At all times relevant, Milwaukee County, Sheriff Clarke, Jail Inspector Schmidt, and Armor, with deliberate indifference, further failed to properly train, supervise, and discipline medical personnel at the County Jail so as to ensure that detainees would receive appropriate care and monitoring for serious illnesses and, if necessary, diagnostic testing, referral to a medical doctor, and/or outside medical services.

86. At all times relevant, Milwaukee County, Sheriff Clarke, Jail Inspector Schmidt, and Armor, with deliberate indifference, additionally failed to properly staff personnel at the County Jail so as to ensure that detainees would receive appropriate care

and monitoring for serious illnesses and, if necessary, diagnostic testing, referral to a medical doctor, and/or outside medical services.

87. At all times relevant, Milwaukee County, with deliberate indifference to the serious medical needs of detainees at the County Jail, operated under a contractual agreement that required Armor to pay for diagnostic testing and for outside medical services provided to detainees and inmates at the County Jail thereby creating a powerful financial disincentive for Armor medical staff to conduct diagnostic testing for a seriously ill inmate and/or send a seriously ill inmate to an outside facility for medical services.

88. Plaintiffs' damages were caused by employees of the County Jail and Armor, including but not limited to the individually named Defendants, who acted pursuant to the foregoing policies and practices by engaging in the misconduct described.

89. Specifically, Mr. Madden's medical and personal history in combination with his persistent symptoms provided ample opportunity for Defendants to properly diagnose and treat his infective endocarditis condition.

90. Notwithstanding Defendants' knowledge of Mr. Madden's history and symptoms, Defendants failed to monitor him, to perform any diagnostic testing, to report his condition to a medical doctor, or to transfer him for outside medical services as clearly indicated under the circumstances.

91. As a result of Defendants' actions and inactions, Mr. Madden's infective endocarditis condition, which was treatable with antibiotics or surgery, was greatly aggravated and caused his death.

92. Mr. Madden's death was the direct and proximate result of the failure by Defendants to properly diagnose and timely treat his infective endocarditis condition.

93. At all times relevant, Nurse Mahaga and Armor staff were aware of Mr. Madden's serious medical needs and failed, with deliberate indifference, to ensure that Mr. Madden received the necessary evaluation and treatment.

94. At all times relevant, Correctional Officer Piasecki was aware of Mr. Madden's serious medical needs, intentionally used unnecessary and unreasonable force in handling and harming Mr. Madden, and subjected Mr. Madden to unreasonable and unjustifiable punishment. Moreover, at all times relevant, Correctional Officer Piasecki's conduct created a strong likelihood of serious harm to Mr. Madden and Correctional Officer Piasecki was aware of and disregarded the substantial risk of serious harm.

95. At all times relevant, the Defendants' conduct was negligent and also done in willful, reckless, and callous disregard of Mr. Madden's rights under federal and state law.

96. As a direct and proximate result of the conduct of all Defendants, Mr. Madden experienced enormous physical and emotional pain and suffering.

97. As a direct and proximate result of the conduct of all Defendants, Mr. Madden was caused to lose his life, Ms. Stockton lost her son, and Mr. Madden lost the capacity to earn.

V.

Claims for Relief

Count 1 - Federal Constitutional Claims Against
Milwaukee County, Sheriff Clarke, Jail Inspector Schmidt, and Armor

98. Incorporate by reference all preceding paragraphs.

99. The violations of Mr. Madden's constitutional rights under the Eighth and/or Fourteenth Amendments to the United States Constitution and Plaintiffs' damages were directly and proximately caused by the actions and/or inactions of Milwaukee County, Sheriff Clarke, Jail Inspector Schmidt, and Armor.

Count 2 - Federal Constitutional Claim Against
Nurse Mahaga

100. Incorporate by reference all preceding paragraphs.

101. Nurse Mahaga was deliberately indifferent to Mr. Madden's known serious medical needs and thereby violated Mr. Madden's rights under the Eighth and Fourteenth Amendments to the United States Constitution.

102. Nurse Mahaga's violation of Mr. Madden's constitutional rights directly and proximately caused Plaintiffs' damages.

Count 3 - Federal Constitutional Claim Against
Correctional Officer Piasecki

103. Incorporate by reference all preceding paragraphs.

104. Correctional Officer Piasecki violated Mr. Madden's liberty interest in bodily integrity by intentionally using unreasonable and unnecessary force to harm Mr. Madden, subjecting Mr. Madden to unwarranted and improper punishment, and creating a strong likelihood of foreseeable serious harm to Mr. Madden in violation of the Eighth and Fourteenth Amendments to the United States Constitution.

105. Correctional Officer Piasecki's violation of Mr. Madden's constitutional rights directly and proximately caused injuries.

Count 4 – State Law Negligence and Wrongful Death Claim Against Milwaukee County, Sheriff Clarke, and Jail Inspector Schmidt

106. Incorporate by reference all preceding paragraphs.

107. Milwaukee County, Sheriff Clarke, and Jail Inspector Schmidt had a duty to exercise reasonable care in instructing, supervising, and training agents and employees in the standards for reasonable, humane, and constitutionally mandated medical care.

108. Milwaukee County, Sheriff Clarke, and Jail Inspector Schmidt breached the duty of care.

109. Milwaukee County, Sheriff Clarke, and Jail Inspector Schmidt's breach was a direct and proximate cause and a substantial factor in bringing about Plaintiffs' damages.

Count 5 – State Law Negligence and Wrongful Death Claim Against Armor and Nurse Mahaga

110. Incorporate by reference all preceding paragraphs.

111. Nurse Mahaga had a duty to comply with generally accepted standards of care in the treatment provided to Mr. Madden.

112. Armor had a duty to exercise reasonable care in instructing, supervising, and training agents and employees in the standards for reasonable, humane, and constitutionally mandated care.

113. Nurse Mahaga and Armor breached the duty of care.

114. Nurse Mahaga and Armor's breach was a direct and proximate cause and a substantial factor in bringing about Plaintiffs' damages.

115. Because Nurse Mahaga and medical staff were acting as agents, servants, and/or employees of Armor, because they were acting within the scope and course of their

employment, and because they were under the direct control and supervision of Armor, Armor is liable to Plaintiffs on the basis of respondeat superior liability.

Count 6 – State Law Negligence Against
Correctional Officer Piasecki

116. Incorporate by reference all preceding paragraphs.

117. Correctional Officer Piasecki had a duty to prevent foreseeable harm in handling and caring for Mr. Madden.

118. Correctional Officer Piasecki breached the duty of care.

119. Correctional Officer Piasecki's breach of the duty of care directly and proximately caused injuries.

Count 7 – State Law Invasion of Privacy Claim Against
Sheriff Clarke

120. Incorporate by reference all preceding paragraphs.

121. Upon information and belief, Sheriff Clarke issued a non-disclosure order while the Milwaukee County Sheriff's Office investigated Mr. Madden's death. The order prohibited anyone from releasing information to the public regarding the investigation.

122. Upon information and belief, the Office of the Medical Examiner released Mr. Madden's preliminary autopsy report to the Milwaukee County Sheriff's Office, and after the Sheriff's Office received the preliminary autopsy report, the website Watchdog.org published the report. Sheriff Clarke publicly commented to Watchdog.org on the report, attacking Mr. Madden's character.

123. Upon information and belief, the Office of the Medical Examiner released Mr. Madden's final autopsy report to the Sheriff's Office, and after the Sheriff's Office received

the final report, the website Watchdog.org published the report. Sheriff Clarke publicly commented to Watchdog.org on the report and again attacked Mr. Madden's character.

124. Upon information and belief, Mr. Madden's preliminary and final autopsy reports were published in response to questioning of the string of deaths at the County Jail in 2016 and Sheriff Clarke's responsibility for the deaths. Upon further information and belief, Mr. Madden's autopsy results were released by the Sheriff's Office under or at the direction of Sheriff Clarke so as to respond to criticism of Sheriff Clarke with the intent of denigrating Mr. Madden.

125. Wis. Stat. § 995.50 recognizes the right of privacy with respect to confidential information in Wisconsin.

126. There is a public policy interest in protecting the reputations of citizens and that policy interest is violated when confidential information is communicated to the public.

127. Pursuant to federal and state law, healthcare information is well-recognized as highly confidential and private in modern American society.

128. The release of autopsy reports like Mr. Madden's is very offensive because a private citizen's autopsy report reveals confidential information about a decedent's healthcare information and cause and manner of death.

129. Sheriff Clarke's release of and public comments on Mr. Madden's autopsy reports violated § 995.50, and was done with the intent to release Mr. Madden's statutorily protected confidential information and with the intent to harm Mr. Madden's reputation and to benefit Sheriff Clarke.

130. Sheriff Clarke's release of and public comments on Madden's autopsy reports entitle Plaintiffs to damages under § 995.50.

VI.

Requested Relief

Wherefore, Plaintiff respectfully requests:

A. Compensatory damages;

B. Punitive damages;

C. Reasonable attorney's fees and costs; and

D. Such other and further relief as may appear just and appropriate.

PLAINTIFFS DEMAND A JURY TRIAL.

Dated at Brookfield, Wisconsin, this 17th day of May, 2018.

/s/ Patrick O. Dunphy
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