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MIED (Rev. 03/11) Prisoner Civil Rights Complaint

Official Use Only	
Case Number	Judge

Case:2:11-cv-13435
Judge: Battani, Marianne O.
MJ: Whalen, R. Steven
Filed: 08-08-2011 At 01:25 PM
PRIS TAUL V TRI COUNTY METRO NARCOT ICS, ET AL (EB)

PRISONER CIVIL RIGHTS COMPLAINT

This form is for use by state prisoners filing under 42 U.S.C. § 1983 and federal prisoners filing pursuant to Bivens v. Six Unknown Named Agents of Federal Bureau of Narcotics, 403 U.S. 388 (1971).

Plaintiff's Information

Name	Charles Taul	Prisoner No.	218952
Place of Confinement Ryan Road Correctional Facility			
Street 17600 Ryan Road	**City** Detroit	**State** Mi	**Zip Code** 4821[illegible]

Are there additional plaintiffs? ☐ Yes ☑ No

If yes, any additional plaintiffs to this action should be listed on a separate 8½" x 11" sheet of paper and securely attached to the back of this complaint. You must provide names, prisoner numbers and addresses for all plaintiffs.

Defendant's Information

Name	Tri County Metro Narcotics Etc. All Gene Wrigglesworth	Position	Sheriff Etc All
Street/P.O. Box 640 N Cedar	**City** Mason	**State** Mi	**Zip Code** 48854

Are you suing this defendant in his/her: ☐ Personal Capacity ☐ Official Capacity ☑ Both Capacities

Are you suing more than one defendant? ☑ Yes ☐ No

If yes, any additional defendants to this action should be listed on a separate 8½" x 11" sheet of paper and securely attached to the back of this complaint. You must provide their names, positions, current addresses and the capacity (personal, official or both) in which you are suing them.

Dockets.Justia.com

I. PREVIOUS LAWSUITS

Have you filed any other lawsuits in state or federal court relating to your imprisonment?

☑ Yes ☐ No

If "Yes," complete the following section. If "No," proceed to Part II.

Please list all prior civil actions or appeals that you have filed in federal court while you have been incarcerated.

Docket or Case Number:	? Between 1994 + 1998
Name of Court:	Western District
Parties (Caption or Name of Case):	Charles Taul v Michigan Parole Board
Disposition:	Defaulted (Released from Prison)

Docket or Case Number:	
Name of Court:	?
Parties (Caption or Name of Case):	Charles Taul v Gene Wrigglesworth
Disposition:	My fault for filing fees

Docket or Case Number:	
Name of Court:	
Parties (Caption or Name of Case):	
Disposition:	

Any additional civil actions should be listed on a separate sheet of 8½" x11" paper and securely attached to the back of this complaint.

Tri County Metro Narcotic was investigating Larry Steed for trafficking cocaine from about 1976 thru 1980.

During this time, the plaintiff, his brother and the plaintiff's mother resided with Larry Steed.

During this time, the plaintiff's mother, Lummie Taul, was Mr. Steed's live-in girlfriend. They were committing welfare fraud.

During this time, there was a drug raid conducted at the residence on Armstrong in Lansing, Michigan; the plaintiff was present in the home.

During this time, the plaintiff made a domestic violence call from a neighbor's house on Armstrong to the Lansing Police Department; said assault was against the plaintiff's mother from Mr. Steed. Afterwards, the family moved to a residence on Dobbie Rd. in Okemous, Michigan.

During Tri County Metro's ongoing investigation Larry Steed overdosed at the new residence on Dobbie Rd. in Okemous, Michigan.

There had to be an Emergency Room Discharge Report regarding Mr. Steed's overdose at the family's Dobbie Rd. residence in Okemous, Michigan.

During Tri County Metro's investigation there was a violent knife assault against plaintiff's mother, Lummie Taul, from Mr. Steed at the Dobbie Rd. residence in Okemous, Michigan; said assault required surgery.

During their investigation the plaintiff was behind in his class while attending Okemous Little School and residing with Mr.

Steed at the Dobbie Rd. residence in Okemous, Michigan.

Due to Tri County Metro's ongoing investigation Mr. Steed was arrested for trafficking 650 grams of cocaine while residing at the family's Dobbie Rd. residence in Okemous, Michigan.

Larry Steed made bond for an unknown amount.

Due to Tri County's ongoing investigation Larry Steed was arrested again for Trafficking 650 grams of cocaine while residing at the family's Dobbie Rd. residence in Okemous, Michigan while on bond.

A short time later, the plaintiff found his mother nearly decapitated with three dozen wounds to the chest, etc., while coming home from school at 10-years old.

As a result of Tri County Metro's failure to file a report with the Family Independence Agency of Ingham County or their failure to investigate such a report of suspected abuse or neglect in violation of MCL 722.623(A) the plaintiff also suffered ongoing emotional and mental abuse to include, some physical and sexual abuse causing lifetime disablement due to Major Depression and Severe/Chronic PTSD (Post Traumatic Stress Disorder).

Statue Of Limitations

For the defendant's attorney to argue this issue for a recently diagnosed disability he is essentially stating that a person with mental disabilities must know there is a injury. In fact, a person with mental disabilities may not know or even be able to accept that they have a disability. In this situation,

the person cannot file a claim until he can make a healthy decision after accepting a disabling diagnosis which is a question for a qualified mental health physician or jury. See Hover v. Chrysler Corp., 209 Mich 319, 320 (1995), Makarow v. Volkswagon of America, Inc., 157 Mich App 401, Davidson v. Baker Vonder Veen Construction, Co., 35 Mich App 293, 192 NW2d 312 (1971).

The Michigan Supreme Court has ruled that a claim occurs when all elements of a cause of action have occurred and when a plaintiff knows, or should have known, of the occurrence of the elements. Connelly v. Paul Ruddys Equipment Repair & Service Co., 388 Mich 146, 150; 200 NW2d 70 (1972), Williams v. Polgar, 391 Mich 6, 23-25; 215 NW2d 149 (1974).

To date, due to prisoners not having the right to F.O.I.A. and the plaintiffs mental status there has been no other inquires requesting documents from said agencies to show said actions or conspiracy.

Immunity Issue

In Brown v. Nationbank Corp., 188 F3d 579 (1999), the court ruled that deliberate indifference depends on the set of circumstances where there can be some deliberation as to how to act. Also see Canon v. Thumudo, 430 Mich 326; 422 NW2d 688 (1988).

Most recently the Michigan Court of Appeals ruled in Swan v. Wedgwood Family Services, 230 Mich App 196 (1998), that MCL. 330.1496; MSA 14.800 (946), requires a mental health provider to

warn police, etc., of a real threat to someone made by a patient.

Clearly, the plaintiff deserved the same Equal Protection and Due Process of Law under Michigan's mandated statue MCL 722.623(A).

In William v. Coleman, 194 Mich 607 (1992), the court ruled there was no immunity for the violation of mandated statue MCL 722.623(A).

In Brooks v. George County, 84 F3d 157 (5th Cir 1996), the court ruled there is no qualified immunity available where there is a statutory duty but one fails to act.

Due Process

The U.S. Supreme Court in Wolf v. McDonnel, 418 U.S. 539-558 (1994), and in Sacramento v. Lewis, 118 S. Ct. 1710, Substantial Due Process is to prevent arbitrary actions by the government and its employees. Again, MCL 722.623(A) is very specific in meaning.

Negligence

The courts have well established the standard to determine if defendants are guilty of negligence. McKay v. Hargis, 351 Mich 490; 88 NW2d 456 (1958), Connelly v. Paul Ruddys Co., 388 Mich 150 (1972), Cole v. Rife, 77 Mich App 550 (1977), Swan v. Wedgewood Family Services, 230 Mich App 195 (1998).

The standard set forth involves a four prong test by the courts:

1.) The existence of a legal duty by the defendant towards the plaintiff.

2.) The breach of such duty.

3.) A proximate casual relationship between that breach of such duty and the injury to the plaintiff.

4.) The plaintiff must have suffered damages.

1. Michigan mandated statue MCL 722.623(A) clearly establishes the existence of a statutory duty to the plaintiff.

2. The defendants breach that duty.

3. The plaintiff is disabled due to that breach of duty.

4. The plaintiff has suffered a insurmountable damages physically, emotionally, financially and property wise due to being disabled.

Conspiracy

Due to the number of agencies and people involved that could have, at any time, acted on Michigan's mandated statue MCL 722.623(A) but failed to do so, there had to be a conspiracy individually and in concert.

In US V. McKinzie, 768 F2d 602 (1985), the court ruled that circumstantial evidence can be used to show that one person is just as guilty as the person committing the act. Also, see US v. Tincher, 749 F. Supplement 1498 (1990). The McKinzie court also ruled that if a supervisor know of misconduct by an officer and failed to sanction or supervise him properly he can be held liable as well.

In Adicks v. S.H. Kress Co., 398 U.S. 144 (1970), the court ruled that a person doesn't have to prove that each person knew of the details of the plan or all the participants. All one has

to show is there was a single plan known to each person who is to be held responsible.

In Sharp v. City of Houston, 164 F3d 923, 925 (5th Cir 1999), a supervisor that's been in office long enough can be held liable even if it is difficult to learn of misconduct due to a code of silence in the department.

The court ruled in Hampton v. Hanahan, 600 F2d 620-624, when it comes to conspiracies a person doesn't have to show details or the extent of the plan and a jury should be able to consider circumstantial evidence as to if there was a meeting of the minds for said conspiracy.

Relief Requested

1. Plaintiff ask permission to amend any future motions, complaints or relief requested as needed.

2. Plaintiff ask for the appointment of counsel due to the disabilities that this action is brought before this court for:

a) The complete defense(s) that maybe asserted by the attorney for the defendants.

b) Prisoners not having the right to F.O.I.A. and no family support.

c) Due to a history of grievances against local, county and state agencies. See exhibits for Appointment of Counsel.

d) Due to the Department of Civil Rights refusing to reconsider that they are at fault for my untimely response and the closing of recent complaint.

3. Plaintiff ask for separate discoveries orders for the

agencies named and enclosed herein (See Motion for Discovery).

4. Plaintiff demand trial by jury.

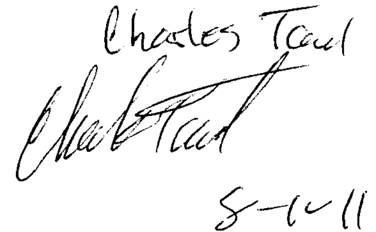
5. Defendants are and/or was acting under the color of law at all times and are being sued in their individual and official capacities.

6. If counsel is not appointed and this complaint is dismissed, plaintiff ask that such dismissal be without prejudice due to his disabilities and lack of understanding about the complex defenses that may be asserted.

7. Plaintiff ask for $5,000,000.00 (Five-Million Dollars) against each defendant, etc., and all.

8. Plaintiff ask for $10,000,000.00 (Ten-Million Dollars) in punitive damages against each defendant, etc., and all.

9. Plaintiff ask for three separate orders to be issued and mailed back to the plaintiff, or that this Honorable Court service these orders itself while placing plaintiff on notice of such action taken by this Honorable Court should appointed counsel be denied. (See Motion For Discovery)



Charles Taul

v

Gene Wrigglesworth

Exhibits for Motion for Appointed Counsle

1) Mental Health Symtoms
2) Anouther Grievance
3) History of Grievances
4) Dep of Civil Rights

Charles Taul
Charles Taul
8-1-11

TAUL #218952

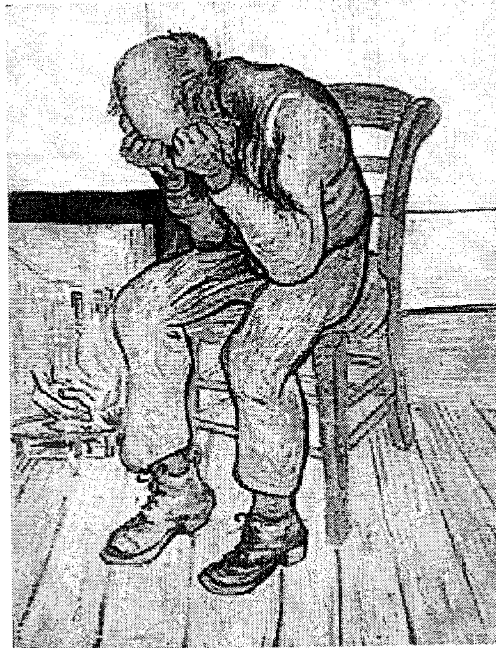
Major depressive disorder

From Wikipedia, the free encyclopedia

Major depressive disorder (MDD) (also known as **recurrent depressive disorder**, **clinical depression**, **major depression**, **unipolar depression**, or **unipolar disorder)** is a mental disorder characterized by an all-encompassing low mood accompanied by low self-esteem, and by loss of interest or pleasure in normally enjoyable activities. This cluster of symptoms (syndrome) was named, described and classified as one of the mood disorders in the 1980 edition of the American Psychiatric Association's diagnostic manual. The term "depression" is ambiguous. It is often used to denote this syndrome but may refer to other mood disorders or to lower mood states lacking clinical significance. Major depressive disorder is a disabling condition which adversely affects a person's family, work or school life, sleeping and eating habits, and general health. In the United States, around 3.4% of people with major depression commit suicide, and up to 60% of people who committed suicide had depression or another mood disorder.[1]

Major Depressive Disorder

Classification and external resources



Vincent van Gogh's 1890 painting *At Eternity's Gate*

ICD-10	F32. (http://apps.who.int/classifications/apps/icd/icd10online/?gf30.htm+f32), F33. (http://apps.who.int/classifications/apps/icd/icd10online/?gf30.htm+f33)
ICD-9	296 (http://www.icd9data.com/getICD9Code.ashx?icd9=296)
OMIM	608516 (http://omim.org/entry/608516)
DiseasesDB	3589 (http://www.diseasesdatabase.com/ddb3589.htm)
MedlinePlus	003213 (http://www.nlm.nih.gov/medlineplus/ency/article/003213.htm)
eMedicine	med/532 (http://www.emedicine.com/med/topic532.htm)
MeSH	D003865 (http://www.nlm.nih.gov/cgi/mesh/2011/MB_cgi?field=uid&term=D003865)

The diagnosis of major depressive disorder is based on the patient's self-reported experiences, behavior reported by relatives or friends, and a mental status examination. There is no laboratory test for major depression, although physicians generally request tests for physical conditions that may cause similar symptoms. If depressive disorder is not detected in the early stages it may result in a slow recovery and affect or worsen the person's physical health. Standardized screening tools such as Major Depression

- 10 Notes
  - 10.1 References
  - 10.2 Selected cited works
- 11 External links

Symptoms and signs

Major depression significantly affects a person's family and personal relationships, work or school life, sleeping and eating habits, and general health.[5] Its impact on functioning and well-being has been equated to that of chronic medical conditions such as diabetes.[6]

A person having a major depressive episode usually exhibits a very low mood, which pervades all aspects of life, and an inability to experience pleasure in activities that were formerly enjoyed. Depressed people may be preoccupied with, or ruminate over, thoughts and feelings of worthlessness, inappropriate guilt or regret, helplessness, hopelessness, and self-hatred.[7] In severe cases, depressed people may have symptoms of psychosis. These symptoms include delusions or, less commonly, hallucinations, usually unpleasant.[8] Other symptoms of depression include poor concentration and memory (especially in those with melancholic or psychotic features),[9] withdrawal from social situations and activities, reduced sex drive, and thoughts of death or suicide.

Insomnia is common among the depressed. In the typical pattern, a person wakes very early and cannot get back to sleep,[10] but insomnia can also include difficulty falling asleep.[11] Insomnia affects at least 80% of depressed people.[11] Hypersomnia, or oversleeping, can also happen,[10] affecting 15% of depressed people.[11] Some antidepressants may also cause insomnia due to their stimulating effect.[12]

A depressed person may report multiple physical symptoms such as fatigue, headaches, or digestive problems; physical complaints are the most common presenting problem in developing countries, according to the World Health Organization's criteria for depression.[13] Appetite often decreases, with resulting weight loss, although increased appetite and weight gain occasionally occur.[7] Family and friends may notice that the person's behavior is either agitated or lethargic.[10]

In children

Although it is common for most children and teenagers to feel down or sad sometimes, a smaller number of youth experience a more severe phenomenon known as depression. Such young people, who are often described as "clinically" depressed, feel sad, hopeless, or irritable for weeks or even months at a time. They may lose interest in activities that they used to enjoy (e.g., playing with friends), their sleeping and eating habits often change (i.e., they may eat or sleep either more or less than usual), and they may have trouble thinking or paying attention, even to TV programs or games.[14] Depressed children may often display an irritable mood rather than a depressed mood,[7] and show varying symptoms depending on age and situation.[15] Most lose interest in school and show a decline in academic performance. They may be described as clingy, demanding, dependent, or insecure.[10] Diagnosis may be delayed or missed when symptoms are interpreted as normal moodiness.[7] Depression may also coexist with attention-deficit hyperactivity disorder (ADHD), complicating the diagnosis and treatment of both.[16]

Of particular concern, youths who are clinically depressed may think or talk a lot about death and some

The understanding of depression has also received contributions from the psychoanalytic and humanistic branches of psychology. From the classical psychoanalytic perspective of Austrian psychiatrist Sigmund Freud, depression, or *melancholia*, may be related to interpersonal loss[70][71] and early life experiences.[72] Existential therapists have connected depression to the lack of both meaning in the present[73] and a vision of the future.[74][75] The founder of humanistic psychology, American psychologist Abraham Maslow, suggested that depression could arise when people are unable to attain their needs or to self-actualize (to realize their full potential).[76][77]

Social

Poverty and social isolation are associated with increased risk of mental health problems in general.[54] Child abuse (physical, emotional, sexual, or neglect) is also associated with increased risk of developing depressive disorders later in life.[78] Such a link has good face validity given that it is during the years of development that a child is learning how to become a social being. Abuse of the child by the caregiver is bound to distort the developing personality and create a much greater risk for depression and many other debilitating mental and emotional states. Disturbances in family functioning, such as parental (particularly maternal) depression, severe marital conflict or divorce, death of a parent, or other disturbances in parenting are additional risk factors.[54] In adulthood, stressful life events are strongly associated with the onset of major depressive episodes.[79] In this context, life events connected to social rejection appear to be particularly related to depression.[80][81] Evidence that a first episode of depression is more likely to be immediately preceded by stressful life events than are recurrent ones is consistent with the hypothesis that people may become increasingly sensitized to life stress over successive recurrences of depression.[82][83]

The relationship between stressful life events and social support has been a matter of some debate; the lack of social support may increase the likelihood that life stress will lead to depression, or the absence of social support may constitute a form of strain that leads to depression directly.[84] There is evidence that neighborhood social disorder, for example, due to crime or illicit drugs, is a risk factor, and that a high neighborhood socioeconomic status, with better amenities, is a protective factor.[85] Adverse conditions at work, particularly demanding jobs with little scope for decision-making, are associated with depression, although diversity and confounding factors make it difficult to confirm that the relationship is causal.[86]

Evolutionary

Main article: Evolutionary approaches to depression

From the standpoint of evolutionary theory, major depression is hypothesized, in some instances, to increase an individual's reproductive fitness. Evolutionary approaches to depression and evolutionary psychology posit specific mechanisms by which depression may have been genetically incorporated into the human gene pool, accounting for the high heritability and prevalence of depression by proposing that certain components of depression are adaptations,[87] such as the behaviors relating to attachment and social rank.[88] Current behaviors can be explained as adaptations to regulate relationships or resources, although the result may be maladaptive in modern environments.[89]

From another viewpoint, a counseling therapist may see depression not as a biochemical illness or disorder but as "a species-wide evolved suite of emotional programmes that are mostly activated by a

depressive episode. The ICD-10 system does not use the term *major depressive disorder*, but lists very similar criteria for the diagnosis of a depressive episode (mild, moderate or severe); the term *recurrent* may be added if there have been multiple episodes without mania.[121]

Major depressive episode

Main article: Major depressive episode

A major depressive episode is characterized by the presence of a severely depressed mood that persists for at least two weeks.[7] Episodes may be isolated or recurrent and are categorized as mild (few symptoms in excess of minimum criteria), moderate, or severe (marked impact on social or occupational functioning). An episode with psychotic features—commonly referred to as *psychotic depression*—is automatically rated as severe. If the patient has had an episode of mania or markedly elevated mood, a diagnosis of bipolar disorder is made instead.[122] Depression without mania is sometimes referred to as *unipolar* because the mood remains at one emotional state or "pole".[123]

DSM-IV-TR excludes cases where the symptoms are a result of bereavement, although it is possible for normal bereavement to evolve into a depressive episode if the mood persists and the characteristic features of a major depressive episode develop.[124] The criteria have been criticized because they do not take into account any other aspects of the personal and social context in which depression can occur.[125] In addition, some studies have found little empirical support for the DSM-IV cut-off criteria, indicating they are a diagnostic convention imposed on a continuum of depressive symptoms of varying severity and duration:[126] Excluded are a range of related diagnoses, including dysthymia, which involves a chronic but milder mood disturbance;[127] recurrent brief depression, consisting of briefer depressive episodes;[128][129] minor depressive disorder, whereby only some of the symptoms of major depression are present;[130] and adjustment disorder with depressed mood, which denotes low mood resulting from a psychological response to an identifiable event or stressor.[131]

Subtypes

The DSM-IV-TR recognizes five further subtypes of MDD, called *specifiers*, in addition to noting the length, severity and presence of psychotic features:

- **Melancholic depression** is characterized by a loss of pleasure in most or all activities, a failure of reactivity to pleasurable stimuli, a quality of depressed mood more pronounced than that of grief or loss, a worsening of symptoms in the morning hours, early morning waking, psychomotor retardation, excessive weight loss (not to be confused with anorexia nervosa), or excessive guilt.[132]
- **Atypical depression** is characterized by mood reactivity (paradoxical anhedonia) and positivity, significant weight gain or increased appetite (comfort eating), excessive sleep or sleepiness (hypersomnia), a sensation of heaviness in limbs known as leaden paralysis, and significant social impairment as a consequence of hypersensitivity to perceived interpersonal rejection.[133]
- **Catatonic depression** is a rare and severe form of major depression involving disturbances of motor behavior and other symptoms. Here the person is mute and almost stuporous, and either remains immobile or exhibits purposeless or even bizarre movements. Catatonic symptoms also occur in schizophrenia or in manic episodes, or may be caused by neuroleptic malignant syndrome.[134]
- **Postpartum depression**, or **mental and behavioural disorders associated with the puerperium, not elsewhere classified**.[135] refers to the intense, sustained and sometimes

disabling depression experienced by women after giving birth. Postpartum depression has an incidence rate of 10–15% among new mothers. The DSM-IV mandates that, in order to qualify as postpartum depression, onset occur within one month of delivery. It has been said that postpartum depression can last as long as three months.[136]
- **Seasonal affective disorder** (SAD) is a form of depression in which depressive episodes come on in the autumn or winter, and resolve in spring. The diagnosis is made if at least two episodes have occurred in colder months with none at other times, over a two-year period or longer.[137]

Differential diagnoses

Main article: Depression (differential diagnoses)

To confer major depressive disorder as the most likely diagnosis, other potential diagnoses must be considered, including dysthymia, adjustment disorder with depressed mood or bipolar disorder. Dysthymia is a chronic, milder mood disturbance in which a person reports a low mood almost daily over a span of at least two years. The symptoms are not as severe as those for major depression, although people with dysthymia are vulnerable to secondary episodes of major depression (sometimes referred to as *double depression*).[127] Adjustment disorder with depressed mood is a mood disturbance appearing as a psychological response to an identifiable event or stressor, in which the resulting emotional or behavioral symptoms are significant but do not meet the criteria for a major depressive episode.[131] Bipolar disorder, also known as *manic–depressive disorder*, is a condition in which depressive phases alternate with periods of mania or hypomania. Although depression is currently categorized as a separate disorder, there is ongoing debate because individuals diagnosed with major depression often experience some hypomanic symptoms, indicating a mood disorder continuum.[138]

Other disorders need to be ruled out before diagnosing major depressive disorder. They include depressions due to physical illness, medications, and substance abuse. Depression due to physical illness is diagnosed as a mood disorder due to a general medical condition. This condition is determined based on history, laboratory findings, or physical examination. When the depression is caused by a substance abused including a drug of abuse, a medication, or exposure to a toxin, it is then diagnosed as a substance-induced mood disorder.[139] In such cases, a substance is judged to be etiologically related to the mood disturbance.

Schizoaffective disorder is different from major depressive disorder with psychotic features because in the schizoaffective disorder at least two weeks of delusions or hallucinations must occur in the absence of prominent mood symptoms.

Depressive symptoms may be identified during schizophrenia, delusional disorder, and psychotic disorder not otherwise specified, and in such cases those symptoms are considered associated features of these disorders, therefore, a separate diagnosis is not deemed necessary unless the depressive symptoms meet full criteria for a major depressive episode. In that case, a diagnosis of depressive disorder not otherwise specified may be made as well as a diagnosis of schizophrenia.

Some cognitive symptoms of dementia such as disorientation, apathy, difficulty concentrating and memory loss may get confused with a major depressive episode in major depressive disorder. They are especially difficult to determine in elderly patients. In such cases, the premorbid state of the patient may be helpful to differentiate both disorders. In the case of dementia, there tends to be a premorbid history of declining cognitive function. In the case of a major depressive disorder patients tend to exhibit a relatively normal premorbid state and abrupt cognitive decline associated with the depression.

Electroconvulsive therapy

Electroconvulsive therapy (ECT) is a procedure whereby pulses of electricity are sent through the brain via two electrodes, usually one on each temple, to induce a seizure while the patient is under a brief period of general anaesthesia. Hospital psychiatrists may recommend ECT for cases of severe major depression which have not responded to antidepressant medication or, less often, psychotherapy or supportive interventions.[207] ECT can have a quicker effect than antidepressant therapy and thus may be the treatment of choice in emergencies such as catatonic depression where the patient has stopped eating and drinking, or where a patient is severely suicidal.[207] ECT is probably more effective than pharmacotherapy for depression in the immediate short-term,[208] although a landmark community-based study found much lower remission rates in routine practice.[209] When ECT is used on its own, the relapse rate within the first six months is very high; early studies put the rate at around 50%,[210] while a more recent controlled trial found rates of 84% even with placebos.[211] The early relapse rate may be reduced by the use of psychiatric medications or further ECT[212][213] (although the latter is not recommended by some authorities)[214] but remains high.[215] Common initial adverse effects from ECT include short and long-term memory loss, disorientation and headache.[216] Although memory disturbance after ECT usually resolves within one month, ECT remains a controversial treatment, and debate on its efficacy and safety continues.[217][218]

Prognosis

Major depressive episodes often resolve over time whether or not they are treated. Outpatients on a waiting list show a 10–15% reduction in symptoms within a few months, with approximately 20% no longer meeting the full criteria for a depressive disorder.[219] The median duration of an episode has been estimated to be 23 weeks, with the highest rate of recovery in the first three months.[220]

Studies have shown that 80% of those suffering from their first major depressive episode will suffer from at least 1 more during their life,[221] with a lifetime average of 4 episodes.[222] Other general population studies indicate around half those who have an episode (whether treated or not) recover and remain well, while the other half will have at least one more, and around 15% of those experience chronic recurrence.[223] Studies recruiting from selective inpatient sources suggest lower recovery and higher chronicity, while studies of mostly outpatients show that nearly all recover, with a median episode duration of 11 months. Around 90% of those with severe or psychotic depression, most of whom also meet criteria for other mental disorders, experience recurrence.[224][225]

Recurrence is more likely if symptoms have not fully resolved with treatment. Current guidelines recommend continuing antidepressants for four to six months after remission to prevent relapse. Evidence from many randomized controlled trials indicates continuing antidepressant medications after recovery can reduce the chance of relapse by 70% (41% on placebo vs. 18% on antidepressant). The preventive effect probably lasts for at least the first 36 months of use.[226]

Those people who experience repeated episodes of depression require ongoing treatment in order to prevent more severe, long-term depression. In some cases, people need to take medications for long periods of time or for the rest of their lives.[227]

Cases when outcome is poor are associated with inappropriate treatment, severe initial symptoms that may include psychosis, early age of onset, more previous episodes, incomplete recovery after 1 year, pre-existing severe mental or medical disorder, and family dysfunction as well.[228]

127	Russia	856.718
128	Belarus	855.825

Comorbidity

Major depression frequently co-occurs with other psychiatric problems. The 1990–92 *National Comorbidity Survey* (US) reports that 51% of those with major depression also suffer from lifetime anxiety.[251] Anxiety symptoms can have a major impact on the course of a depressive illness, with delayed recovery, increased risk of relapse, greater disability and increased suicide attempts.[252] American neuroendocrinologist Robert Sapolsky similarly argues that the relationship between stress, anxiety, and depression could be measured and demonstrated biologically.[253] There are increased rates of alcohol and drug abuse and particularly dependence,[254] and around a third of individuals diagnosed with ADHD develop comorbid depression.[255] Post-traumatic stress disorder and depression often co-occur.[5]

Depression and pain often co-occur, especially if it is chronic or uncontrollable pain[*citation needed*]. This conforms with Seligman's theory of learned helplessness. One or more pain symptoms is present in 65% of depressed patients, and anywhere from five to 85% of patients with pain will be suffering from depression, depending on the setting; there is a lower prevalence in general practice, and higher in specialty clinics. The diagnosis of depression is often delayed or missed, and the outcome worsens. The outcome can also obviously worsen if the depression is noticed but completely misunderstood[256]

Depression is also associated with a 1.5- to 2-fold increased risk of cardiovascular disease, independent of other known risk factors, and is itself linked directly or indirectly to risk factors such as smoking and obesity. People with major depression are less likely to follow medical recommendations for treating cardiovascular disorders, which further increases their risk. In addition, cardiologists may not recognize underlying depression that complicates a cardiovascular problem under their care.[257]

History

Main article: History of depression

The Ancient Greek physician Hippocrates described a syndrome of melancholia as a distinct disease with particular mental and physical symptoms; he characterized all "fears and despondencies, if they last a long time" as being symptomatic of the ailment.[258] It was a similar but far broader concept than today's depression; prominence was given to a clustering of the symptoms of sadness, dejection, and despondency, and often fear, anger, delusions and obsessions were included.[72]

The term *depression* itself was derived from the Latin verb *deprimere*, "to press down".[259] From the 14th century, "to depress" meant to subjugate or to bring down in spirits. It was used in 1665 in English author Richard Baker's *Chronicle* to refer to someone having "a great depression of spirit", and by English author Samuel Johnson in a similar sense in 1753.[260] The term also came in to use in physiology and economics. An early usage referring to a psychiatric symptom was by French psychiatrist Louis Delasiauve in 1856, and by the 1860s it was appearing in medical dictionaries to refer to a physiological and metaphorical lowering of emotional function.[261] Since Aristotle, melancholia had been associated with men of learning and intellectual brilliance, a hazard of contemplation and

TAUL 218952

Posttraumatic stress disorder

From Wikipedia, the free encyclopedia

Posttraumatic stress disorder (also known as **post-traumatic stress disorder** or **PTSD**) is a severe anxiety disorder that can develop after exposure to any event that results in psychological trauma.[1][2][3] This event may involve the threat of death to oneself or to someone else, or to one's own or someone else's physical, sexual, or psychological integrity,[1] overwhelming the individual's ability to cope. As an effect of psychological trauma, PTSD is less frequent and more enduring than the more commonly seen acute stress response.

Posttraumatic stress disorder	
Classification and external resources	
ICD-10	F43.1 (http://apps.who.int/classifications/apps/icd/icd10online/?gf40.htm+f431)
ICD-9	309.81 (http://www.icd9data.com/getICD9Code.ashx?icd9=309.81)
DiseasesDB	33846 (http://www.diseasesdatabase.com/ddb33846.htm)
MedlinePlus	000925 (http://www.nlm.nih.gov/medlineplus/ency/article/000925.htm)
eMedicine	med/1900 (http://www.emedicine.com/med/topic1900.htm)
MeSH	D013313 (http://www.nlm.nih.gov/cgi/mesh/2011/MB_cgi?field=uid&term=D013313)

Diagnostic symptoms for PTSD include re-experiencing the original trauma(s) through flashbacks or nightmares, avoidance of stimuli associated with the trauma, and increased arousal – such as difficulty falling or staying asleep, anger, and hypervigilance. Formal diagnostic criteria (both DSM-IV-TR and ICD-10) require that the symptoms last more than one month and cause significant impairment in social, occupational, or other important areas of functioning.[1]

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Classification

Posttraumatic stress disorder is classified as an anxiety disorder, characterized by aversive anxiety-related experiences, behaviors, and physiological responses that develop after exposure to a psychologically traumatic event (sometimes months after). Its features persist for longer than 30 days, which distinguishes it from the briefer acute stress disorder. These persisting posttraumatic stress symptoms cause significant disruptions of one or more important areas of life function.[4] It has three sub-forms: acute, chronic, and delayed-onset.[5]

Causes

Psychological trauma

PTSD is believed to be caused by either physical trauma or psychological trauma, or more frequently a combination of both.[1] According to Atkinson *et al.* (2000)[*citation needed*] PTSD is more likely to be caused by physical or psychological trauma caused by humans such as rape, war, or terrorist attack than trauma caused by natural disasters. Possible sources of trauma include experiencing or witnessing childhood or adult physical, emotional or sexual abuse.[1] In addition, experiencing or witnessing an event perceived as life-threatening such as physical assault, adult experiences of sexual assault, accidents, drug addiction, illnesses, medical complications, or employment in occupations exposed to war (such as soldiers) or disaster (such as emergency service workers).[6]

Traumatic events that may cause PTSD symptoms to develop include violent assault, kidnapping, sexual assault, torture, being a hostage, prisoner of war or concentration camp victim, experiencing a disaster, violent automobile accidents or getting a diagnosis of a life-threatening illness.[1] Children or adults may develop PTSD symptoms by experiencing bullying or mobbing.[7][8] Preliminary research suggests that child abuse may interact with mutations in a stress-related gene to increase the risk of PTSD in adults.[9][10][11]

Multiple studies show that parental PTSD and other posttraumatic disturbances in parental psychological functioning can, despite a traumatized parent's best efforts, interfere with their response to

abuse had PTSD, and 42% of those who had been physically abused fulfilled the PTSD criteria. PTSD was also found in 18% of the children who were not abused. These children may have developed PTSD due to witnessing violence in the home, or as a result of real or perceived parental abandonment.

Diagnosis

Criteria

The diagnostic criteria for PTSD, stipulated in the *Diagnostic and Statistical Manual of Mental Disorders IV (Text Revision)* (DSM-IV-TR), may be summarized as:[1][58]

A: Exposure to a traumatic event

This must have involved *both* (a) loss of "physical integrity", or risk of serious injury or death, to self or others, and (b) a response to the event that involved intense fear, horror or helplessness (or in children, the response must involve disorganized or agitated behavior). (The DSM-IV-TR criterion differs substantially from the previous DSM-III-R stressor criterion, which specified the traumatic event should be of a type that would cause "significant symptoms of distress in almost anyone," and that the event was "outside the range of usual human experience."[59])

B: Persistent re-experiencing

One or more of these must be present in the victim: flashback memories, recurring distressing dreams, subjective re-experiencing of the traumatic event(s), or intense negative psychological or physiological response to any objective or subjective reminder of the traumatic event(s).

C: Persistent avoidance and emotional numbing

This involves a sufficient level of:

- avoidance of stimuli associated with the trauma, such as certain thoughts or feelings, or talking about the event(s);
- avoidance of behaviors, places, or people that might lead to distressing memories;
- inability to recall major parts of the trauma(s), or decreased involvement in significant life activities;
- decreased capacity (down to complete inability) to feel certain feelings;
- an expectation that one's future will be somehow constrained in ways not normal to other people.

D: Persistent symptoms of increased arousal not present before

These are all physiological response issues, such as difficulty falling or staying asleep, or problems with anger, concentration, or hypervigilance.

E: Duration of symptoms for more than 1 month

If all other criteria are present, but 30 days have not elapsed, the individual is diagnosed with Acute stress disorder.

F: Significant impairment

The symptoms reported must lead to "clinically significant distress or impairment" of major domains of life activity, such as social relations, occupational activities, or other "important areas of functioning".[60]

Assessment

Since the introduction of DSM-IV, the number of possible events which might be used to diagnose PTSD has increased; one study suggests that the increase is around 50%.[61] Various scales exist to measure the severity and frequency of PTSD symptoms.[62][63] Standardized screening tools such as Trauma Screening Questionnaire[64] and PTSD Symptom Scale[65] can be used to detect possible symptoms of posttraumatic stress disorder, and suggest the need for a formal diagnostic assessment.

Research-based alternative symptom groups

Emerging factor analytic research[66] suggests that PTSD symptoms group empirically into four clusters, not the three currently described in the *Diagnostic and Statistical Manual of Mental Disorders*. One model supported by this research divides the traditional avoidance symptoms into a cluster of numbing symptoms (such as loss of interest and feeling emotionally numb) and a cluster of behavioral avoidance symptoms (such as avoiding reminders of the trauma).[67] An alternative model adds a fourth cluster of dysphoric symptoms. These include symptoms of emotional numbing, as well as anger, sleep disturbance, and difficulty concentrating (traditionally grouped under the hyperarousal cluster).[68][69]

DSM-5 proposed diagnostic criteria changes

In preparation for the May 2013[70] release of the DSM-5,[71] the fifth version of the American Psychiatric Association's diagnostic manual, draft diagnostic criteria was released for public comment, followed by a two-year period of field testing.[72] Proposed changes to the criteria include:[73]

- Criterion A (prior exposure to traumatic events) is more specifically stated, and evaluation of an individual's emotional response at the time (current criterion A2) is dropped.
- Several items in Criterion B (intrusion symptoms) are rewritten to add or augment certain distinctions now considered important.
- Special consideration is given to developmentally appropriate criteria for use with children and adolescents. This is especially evident in the restated Criterion B - intrusion symptoms. Development of age-specific criteria for diagnosis of PTSD is ongoing at this time.
- Criterion C (avoidance and numbing) has been split into "C" and "D":
  - Criterion C (new version) now focuses solely on avoidance of behaviors or physical or temporal reminders of the traumatic experience(s). What were formerly two symptoms are now three, due to slight changes in descriptions.
  - New Criterion D focuses on negative alterations in cognition and mood associated with the traumatic event(s), and contains two new symptoms, one expanded symptom, and four largely unchanged symptoms specified in the previous criteria.
- Criterion E (formerly "D"), which focuses on increased arousal and reactivity, contains one modestly revised, one entirely new, and four unchanged symptoms.
- Criterion F (formerly "E") still requires duration of symptoms to have been at least one month.
- Criterion G (formerly "F") stipulates symptom impact ("disturbance") in the same way as before.
- The "acute" vs "delayed" distinction is dropped; the "delayed" specifier is considered appropriate

Anouther

Grievance

CHAIN OF EVENTS

Another grievance

1) On 09/22/10, I was assaulted with a butcher knife by Karen McNealson.

2) On 09/22/10 - 09/23/10, I was arrested for a parole violation - Failure To Report. During my arrest, by the Ingham County Sheriff Department, I informed them that I wanted to file a formal complaint for felonious assault charge against Karen McNealson, once arriving at the County Jail. The arresting officer told me that it was not their jurisdiction, as did five deputies in Receiving, numerous times.

3) Due to being told that it was not the County Sheriff's jurisdiction, I called the Lansing Police Department to make a formal complaint, with my one free call. When the Lansing Police Dispatch realizes that I am calling from the Ingham County Jail, I am put on hold, Dispatch called the County Jail, and my phone call was terminated.

4) On 09/24/10, with the Day-Shift Sergeant's approval, Deputy Montomeas E-mailed the Holt Police Department to see if they would make a report and accept my formal complaint for felonious assault charge against Karen McNealson.

5) On 09/25/10, the Holt Police Department responded saying that they would not, due to the fact that they had a witness who stated that I had two black eyes a week earlier. The two black eyes had nothing to do with the formal complaint I was making for the felonious assault charge. Even Deputy Montomeas and Ingham County Medical clearly stated, and documented, that the cut on my left arm was a new wound.

6) Between 09/25/10 and 09/27/10, I had seen medical, after writing them and requesting an evaluation and a documented report concerning the knife wound on my left arm. Also, I stated in that request that I planned on contacting the Michigan State Police, Internal Affairs, or the Attorney

General Office if this incident was not documented soon.

7) On 09/28/10, I sent a letter to the Ingham County Sheriff, by Correction Officer Chatick, stating that I needed a report from his deputies concerning this incident, or that I was going to contact the Michigan State Police or Internal Affairs, but received no response as of to date.

8) I sent a copy of the aforesaid letter, by Correction Officer Thomas, but it does not get out because Correction Sergeant Commons intercepts it. This is the Correction Sergeant who denied my request to make a formal complaint on the night of the assault. He gets me out of bed at 0300 hrs and interrogates me for a half an hour. Questions were:

a) How does he know that I did not assault or try to rape the girl?

b) Maybe she felt sorry for me. So she did not file a complaint against me?

c) Is this for profit?

d) What took me so long to want to file a formal complaint?

e) What does Internal Affairs have to do with this, and do I know what Internal Affairs does?

9) Sergeant Commons gave the letter back to me, told me to put in a request to talk with Lansing Detective Unit, and that he would forward it, but he doubted that they would even respond. No response has been received as of to date.

10) On or about 10/05/10, I was transferred to Jackson Prison.

11) On or about 10/07/10, I wrote the Warden requesting that the Michigan State Police be contacted and asked to come and see me so that I would be able to file a formal complaint for the felonious assault charge against Karen McNealson, and to make a report of said incident.

12) On 10/27/10, I met with the MDOC Inspector and he provided me with the address to the Michigan State Police Department.

13) On 11/03/10, the Michigan State Police received my letter of request and suggested that I contact the county or state prosecutor. (See Attached).

14) On or about 12/08/10, I sent a copy of this to, both, county and state prosecutors.

15) Sergeant Commons and I have bumped heads before and I won the legal argument, and I believe that this is personal with him. Also, I had a Federal Court Order against the jail.

IN CONCLUSION:

Phone records will show my call made to the Lansing Police Department.

Video will show my attempts to file in Ingham County Jail Receiving.

E-mail will show the attempt to file with the Holt Police Department.

Medical will show my visit to them and facts are documented.

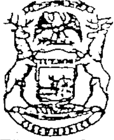
Attached is the response from the Michigan State Police.

Two Ingham County Deputies are willing to testify on my behalf.

I give up becouse I couldnt get a lawyer to sue or a agencey to make a complaint includeing, the State Police or the attorney general. Please read the conflicting letters

I also had to get a Federal Court Order for denieing me access to the courts in 1999 I believe against Ingham County Sheriffs

There was a time they (Ingham County) Wouldnt Noterize a complaint for me against medical at the jail as well



JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF STATE POLICE
EAST LANSING

COL. EDDIE L.
WASHINGTON JR.
DIRECTOR

November 8, 2010

Mr. Charles Taul, #218952
Charles E. Egeler Reception & Guidance Center
3855 Cooper Street
Jackson, MI 49201-7517

Dear Mr. Taul:

Your correspondence received November 3, 2010, in which you are requesting an investigation into alleged misconduct by the Ingham County Sheriff's Department has been referred to my office for review and reply.

As police officers, we are concerned for the safety and well being of all citizens in Michigan. It is regrettable that you feel distressed with the situations you are experiencing. The Michigan State Police do not oversee police agencies in Michigan, nor do we investigate these agencies based on citizen requests or complaints. The Michigan State Police will only investigate another police agency based on a request from the county prosecutor or the Attorney General's Office of Michigan.

To request an investigation into the Ingham County Sheriff's Department, you may contact the Ingham County Prosecutor's Office at:

Ingham County Prosecutor
Stuart J. Dunnings III
303 W. Kalamazoo St.
Lansing, MI 48933
(517) 483-6108

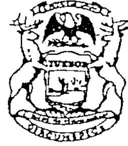
You may also contact your attorney of record, who will provide you the appropriate legal counsel.

Sincerely,

Greg Zarotney, Inspector
Field Services Bureau

GZ:cs

STATE OF MICHIGAN
DEPARTMENT OF ATTORNEY GENERAL



P.O. BOX 30217
LANSING, MICHIGAN 48909

MIKE COX
ATTORNEY GENERAL

December 21, 2010 Received 12-29-10

Charles Taul #218952
Ryan Correctional Facility
17600 Ryan Road
Detroit, MI 48212

Dear Mr. Taul:

Your recent letter to Attorney General Cox in which you request assistance initiating a civil action related to your alleged personal injury and claims against various police agencies has been referred to me for reply.

The Attorney General is responsible for providing legal advice and representation to various state departments and officials. State law, however, does not permit the Attorney General to act as an attorney for private individuals. Therefore, the office of Attorney General is unable to advise or represent you in this matter. I suggest that you consult a private attorney. An attorney would directly represent your interests and is the one whose advice would be most helpful to you.

Very truly yours,

James E. Long
Division Chief
Corrections Division

JEL:msp
Enc.
corr/ac/citltrs/2010/ag/Taul

History of Grievances

In 1990 I was told I didnt qualify for alternative sentencing on my first felony charge when other did and was approved

Around 1994 I had to get a Federal Court Order against Ingham County Sheriff for denieing me access to the court by denieing me filing fees out of prisoner account (See Charles Taul -v- Gene Wrigglesworth)

Around 2005 Sgt Commons thats employed by the Ingham County Sheriff Gene Wrigglesworth refused me a Notary for a complaint against the Ingham County Jail and medical staff for denieing me my mental health medication that my family droped off to me at the jail

Around 2005 Lansing Police Department denied me a investigation and maybe a report when my house was broken into

In 2010 and 2011 I was denied the right to file a complaint for felonious assault by the local police agencies (Holt, Lansing and Ingham County Sheriffs Department)

In 2011 I then tried to file assault charges with the Michigan State Police and was denied I was also denied the investigation I requested into the local police agencies for thier refusal to take a formal complaint

I then tried to have the Attorney General do a investigation into the local police agencies for the refusal of a formal complaint on felonious assault and was denied

I then tried to file a complaint with the Department of Civil Rights and the letter for requested information to me found me one day befor the required deadline when it was wrote on 12-1-10 and post marked 12-27-10 Requested information due by 12-28-11

I wrote the Department of Civil Rights explaining this to them and the response was they cannot make contact with me

JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF CIVIL RIGHTS
LANSING

DANIEL H. KRICHBAUM
DIRECTOR

December 21, 2010

Mr. Charles Taul *MDOC #218952*
Ryan Correctional Facility
17600 Ryan Road
Detroit, MI 48212

RE : MDCR Contact # 420502
Charles Taul v Unknown

Dear Mr. Taul:

On December 15, 2010, you contacted the Michigan Department of Civil Rights about the above matter. In order to continue the processing of your concern you must submit the following required information to the department by December 28, 2010:

For each respondent please answer the following:

What is respondent's name, telephone number and address?

What is the basis of your complaint?

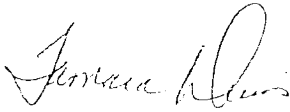
What is the date of the adverse action?

Do you have any evidence to support your allegation? If so, please provide.

If the department does not receive the requested information by December 28, 2010, the department will discontinue processing your concern.

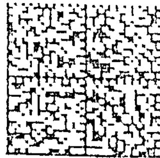
If you have questions, please contact me immediately.

Sincerely,



Tamara Davis
Civil Rights Investigator
phone: (517) 241-0753
fax: (517) 335-3882
email: DavisTx@michigan.gov

MICHIGAN DEPARTMENT OF CIVIL RIGHTS
CAPITAL TOWER BUILDING-8TH FLOOR
110 W MICHIGAN AVE
LANSING MI 48913



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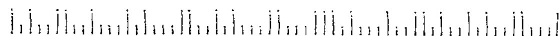


MICHIGAN DEPARTMENT OF CORRECTIONS
PRISONER STATIONARY

CSJ-110 4/00
4835-3110

TO:		
NAME		
NO. AND STREET OR R.R.		
CITY	STATE	ZIP

FROM:	
NAME	
NO.	LOCK
INSTITUTION	DATE

IN CORRESPONDENCE, USE NAME AND NUMBER ON YOUR LETTER AND ENVELOPE

Mrs Davis
Charles Taul MDCR Contact #420502.
Under the circumstances there is and or was no possible way I could possibley get you the information requred by December 28, 2010. Your letter was dated December 21, 2010 and was not postmarked untill December 27, 2010. That is one day delivery; I received it on December 28, 2010. There is no possible way I can be penalized by something I have no controle of. Enclosed, is copies of most everything I have as well as copies of what I just stated.

At this time, since I know nothing about your Department could you please send me some litature on what it is you do, who governs you, employes your department? Do you repasent people in case of trial, do you research only etc etc? With you requesting this information have you accesed my position and if so is it worth pursueing? Whats your departments track record? You have to understand my questions in my position. I do not or am not being rude.

I have to be honest and let you know everything now. This way you dont wast your time and I may not have to loose a possible action. Do to lack of support financialy, incarseration etc I will have problems with FOIA. This means the time requirments for fileing differant things etc may not be met. Would it be best for my release first; it will be possibly in August 2011

MICHIGAN DEPARTMENT OF CORRECTIONS
PRISONER STATIONARY

CSJ-110 4/90
4835-3110

TO:		
NAME		
NO. AND STREET OR R.R.		
CITY	STATE	ZIP

FROM:		
NAME		
NO.	LOCK	
INSTITUTION		DATE

IN CORRESPONDENCE, USE NAME AND NUMBER ON YOUR LETTER AND ENVELOPE

I have not sugarcoated anything in my favor or against anyone.

In closeing, I want to thank you for your interest and responding to my concernes with all honesty.

Attached, is a issue I have with my phone use here at Ryan Road Correctional Facility. I do not wish to make waves here + you will understand why when you read it. If you can call or send a fax to inspecter in a legal but not threatening way. I havent talked to family in 4 months

Thank You Again
[signature]

PS
Because of money issues I cant send letters asking for a lot of information you ask for

JENNIFER M. GRANHOLM
GOVERNOR

STATE OF MICHIGAN
DEPARTMENT OF CIVIL RIGHTS
LANSING

DANIEL H. KRICHBAUM
DIRECTOR

January 4, 2011

Mr. Charles Taul
MDOC #218952
Ryan Correctional Facility
17600 Ryan Road
Detroit, MI 48212

STATEMENT OF CONCERN

MDCR Contact # : 420502
Responding Party : Unknown

Date(s) of Alleged Incident(s) or Harm:

Dear Mr. Taul:

You recently contacted the Michigan Department of Civil Rights (MDCR) alleging an act of unlawful discrimination. The issues you raised are as follows:

Unknown

A formal civil rights complaint *has not been filed* about the concern described above. The department cannot take further action regarding your concern because :

Efforts to contact you have been unsuccessful.

You may file a complaint with the Michigan Department of Civil Rights within 180 days of an alleged incident of discrimination under Michigan civil rights law. Please be advised that the Michigan Department of Civil Rights investigates complaints of unlawful discrimination based on a person's race, religion, color, sex, national origin, age, disability, marital status, height, weight, familial status, arrest record and/or genetic information/testing in the areas of employment, public accommodation, public service, education, housing and law enforcement.

More information can be found at our website: www.michigan.gov/mdcr.

If the most recent allegation of discrimination is beyond 180 days, and it is an employment issue you may file an employment complaint with our Department for processing by the Equal Employment Opportunity Commission within 300 days of an alleged incident of discrimination under federal civil rights law.

If the most recent allegation of discrimination is beyond the 180 days and it is a housing issue you can file a housing complaint with the Department of Housing and Urban Development (HUD) within 365 days of an alleged incident of discrimination. You may contact HUD at (800) 669-

9777 or visit their website at www.hud.gov.

All complaints with this department must be filed within 180 days of the alleged act(s) of discrimination. You have the right to file your own action in state court within three years of the date of discrimination.

If you wish to appeal the department's decision not to process a formal complaint regarding the above concern, you must file your appeal in writing by February 3, 2011.

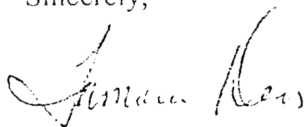
Your appeal should be sent to:

Michigan Department of Civil Rights
SOC Appeal
3054 West Grand Boulevard, Suite 3-600
Detroit, MI 48202

You may also file your appeal at any department office by mail or personal delivery.

If you have any questions, please contact me.

Sincerely,



Tamara Davis
Civil Rights Investigator
Telephone: (517) 241-0753
Fax: (517) 335-3882
Email: DavisTx@michigan.gov

Date 1-7-1[illegible] MDCR 420502

To whom this concernes

My name is Charles Taul and I have received a letter from your office thats disturbing and at this point I have to ask who do you work for?

I recieved a letter requesting some information a day befor your deadline date that was dated a week prior but, never left your office. Is this do to unprofessional help or on purpose by your department? Then there was holiday mail as well.

Today, I receved a letter saying ~~[illegible]~~ that my file has been closed becouse you could not contact me; your letter found me one day befor the deadline and this one as well. I sent you copies, I have myself, and I cant be penalized for things out of my controle.

At this time, I ask for you to reopen my file for discrimination and or send me the directers name so I may put him or her on notice of the relaxed staff that he or she is in charge of. I keep copies of every letter, postage dates etc

[signature]

CC Daniel Krichbaum
Self

STATE OF MICHIGAN
DEPARTMENT OF CIVIL RIGHTS
EXECUTIVE

RICK SNYDER
GOVERNOR

DANIEL H. KRICHBAUM
DIRECTOR

January 4, 2011

Charles Taul #218952
Ryan Correctional Facility
17600 Ryan Road
Detroit, MI 48212

Dear Mr. Taul:

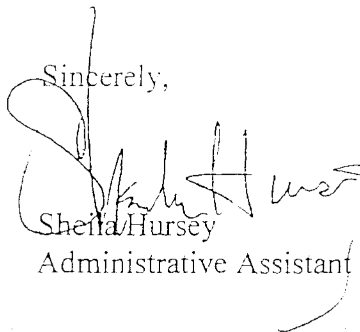
This letter is being sent to acknowledge receipt of your correspondence dated December 6, 2010.

The Michigan Legislature has determined that an individual serving a sentence of imprisonment in a state or county correctional facility is not covered by the Elliott-Larsen Civil Rights Act or the Persons With Disabilities Civil Rights Act. Each law specifically provides that it does not apply to "actions and decisions regarding an individual serving a sentence of imprisonment" in "a state or county correctional facility."

Your request for investigation by the Department of Civil Rights is, however, **denied** for lack of jurisdiction and the Department's case file is **closed.** I trust that the agency(s) forwarded to you will be able to address your concerns.

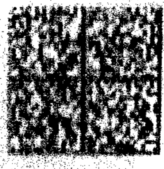
U.S. Department of Justice
Civil Rights Division
Special Litigation Section
950 Pennsylvania Avenue, N.W, PHB
Washington, D.C. 20530

Sincerely,



Sheila Hursey
Administrative Assistant

ENCLOSURE: Pro bono Reference manual


Priority Mail
UNITED STATES POSTAGE
$ 04.9

CIVIL COVER SHEET FOR PRISONER CASES

Case No. 11-13435	Judge: Marianne O. Battani	Magistrate Judge: R. Steven Whalen

Name of 1st Listed Plaintiff/Petitioner: CHARLES TAUL	**Name of 1st Listed Defendant/Respondent:** TRI COUNTY METRO NARCOTICS, ET AL
Inmate Number: 218952	**Additional Information:**
Plaintiff/Petitioner's Attorney and Address Information:	
Correctional Facility: Ryan Correctional Facility 17600 Ryan Road Detroit, MI 48212 WAYNE COUNTY	

BASIS OF JURISDICTION
- ☐ 2 U.S. Government Defendant
- ☒ 3 Federal Question

NATURE OF SUIT
- ☐ 530 Habeas Corpus
- ☐ 540 Mandamus
- ☒ 550 Civil Rights
- ☐ 555 Prison Conditions

ORIGIN
- ☒ 1 Original Proceeding
- ☐ 5 Transferred from Another District Court
- ☐ Other:

FEE STATUS
- ☒ IFP *In Forma Pauperis*
- ☐ PD Paid

PURSUANT TO LOCAL RULE 83.11

1. **Is this a case that has been previously dismissed?**
   ☐ Yes ☒ No
   ➢ **If yes, give the following information:**
   Court: ______
   Case No: ______
   Judge: ______

2. **Other than stated above, are there any pending or previously discontinued or dismissed companion cases in this or any other court, including state court? (Companion cases are matters in which it appears substantially similar evidence will be offered or the same or related parties are present and the cases arise out of the same transaction or occurrence.)**
   ☐ Yes ☒ No
   ➢ **If yes, give the following information:**
   Court: ______
   Case No: ______
   Judge: ______