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STATE OF WISCONSIN **CIRCUIT COURT** **DODGE COUNTY**

STATE OF WISCONSIN
Plaintiff,

Vs.

DA Case No.: 2024DD000881
Assigned DA/ADA: Andrea M Will
Agency Case No.: 23-33129

CRIMINAL COMPLAINT

Brandon James Fisher
200 S Madison St; Waupun Correction
Waupun, WI 53963
DOB: 06/06/1994
Sex/Race: M/W
Eye Color: Blue
Hair Color: Blonde
Height: 6 ft 01 in
Weight: 175 lbs
Alias: Also Known As Brandon J Fisher

Tanner J Leopold
Waupun Correctional Institution
PO Box 351
Waupun, WI 53963-0351
DOB: 08/04/1996
Sex/Race: M/W
Eye Color: Brown
Hair Color: Brown
Height: 5 ft 10 in
Weight: 160 lbs
Alias: Also Known As Tanner Jay Leopold

Gwendolyn Vick
200 S Madison St; Waupun Correction
Waupun, WI 53963
DOB: 07/11/1973
Sex/Race: F/W
Eye Color:
Hair Color:
Height: 0 ft 0 in
Weight: 0 lbs
Alias:

Defendant,

The undersigned, being first duly sworn, states that:

Count 1: ABUSE OF RESIDENTS OF PENAL FACILITIES (As to defendant Brandon James Fisher)

The above-named defendant on or about Sunday, October 29, 2023, in the City of Waupun, Dodge County, Wisconsin, having been employed by Waupun Correctional

Institution, a penal institution, did knowingly neglect Victim A, who was confined in Waupun Correctional Institution. The neglect was committed by the defendant by failure to act which caused unreasonable suffering, misery, or physical harm to Victim A., contrary to sec. 940.29, 939.50(3)(i) Wis. Stats., a Class I Felony, and upon conviction may be fined not more than Ten Thousand Dollars ($10,000), or imprisoned not more than three (3) years and six (6) months, or both.

Count 2: ABUSE OF RESIDENTS OF PENAL FACILITIES (As to defendant Tanner J Leopold)

The above-named defendant on or about Sunday, October 29, 2023, in the City of Waupun, Dodge County, Wisconsin, the defendant having been employed by Waupun Correctional Institution, a penal institution, did knowingly neglect Victim A, who was confined in Waupun Correctional Institution. The neglect was committed by the defendant by failure to act which caused unreasonable suffering, misery, or physical harm to Victim A., contrary to sec. 940.29, 939.50(3)(i) Wis. Stats., a Class I Felony, and upon conviction may be fined not more than Ten Thousand Dollars ($10,000), or imprisoned not more than three (3) years and six (6) months, or both.

Count 3: ABUSE OF RESIDENTS OF PENAL FACILITIES (As to defendant Gwendolyn Vick)

The above-named defendant on or about Sunday, October 29, 2023, in the City of Waupun, Dodge County, Wisconsin, the defendant having been employed by Waupun Correctional Institution, a penal institution, did knowingly neglect Victim A, who was confined in Waupun Correctional Institution. The neglect was committed by the defendant by failure to act which caused unreasonable suffering, misery, or physical harm to Victim A., contrary to sec. 940.29, 939.50(3)(i) Wis. Stats., a Class I Felony, and upon conviction may be fined not more than Ten Thousand Dollars ($10,000), or imprisoned not more than three (3) years and six (6) months, or both.

PROBABLE CAUSE:

The undersigned has reviewed the reports of the law enforcement officers referenced below and believes them to be true and correct as these reports were created by law enforcement officers while they were acting in their official capacity.

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From the investigative reports of Detective Dean Hopp and Detective Andrew Rolfs of the Dodge County Sheriff's Office:

From Detective Hopp's reports:

On October 30, 2023, at 11:18 A.M., I, Detective Dean Hopp of the Dodge County Sheriff's Office, was notified of an unanticipated inmate death at the Waupun Correctional Institution (WCI) located at 200 S. Madison Street in the City of Waupun, Dodge County, WI. I was advised that inmate Victim A was found unresponsive in cell

#A215 of the Restrictive Housing Unit (RHU) at approximately 10:00 A.M. Entry was made into the cell at approximately 10:30 A.M. Victim A was housed in this cell alone and had been housed there since September 2, 2023.

I responded to the WCI along with Dodge County Deputy Medical Examiner Brooke Kaat. We were led to the (RHU) "A" Range and specifically cell #A215. Upon arrival, we found and were advised that Victim A had been removed from his cell for medical treatment purposes. We were advised that when found unresponsive, he was lying on his back on a mattress on the floor of the cell with his head toward the cell door almost underneath the toilet in the cell. Blood was reported as coming from his head. Currently, he was lying on a mattress at the end of the "A" Range corridor in a supine position. There were barriers set up for privacy and to contain the scene. He was in handcuffs to the front and had leg iron shackles in place on his lower legs. His upper body was unclothed and he was wearing a pair of orange prison pants on his lower torso along with undergarments. I observed there to be foam coming from his mouth and blood coming from his nose. I observed the bed sheet he was laying on to be stained with a combination of bodily fluids consistent with being blood, spit, vomit, sweat, and possibly urine.

Deputy Medical Examiner Brooke Kaat performed an initial assessment on the body. She reported the body to be cold to the touch. She did not observe there to be any external signs of trauma, deformities, or injury. She stated that rigor was set in the jaw, arms, and legs. Slight lividity was present on the back of the body. Deputy Medical Examiner Brooke Kaat pronounced the time of death to be 12:48 P.M.

The Dodge County Sheriff's Office reviewed numerous incident reports authored by WCI staff, and conducted numerous interviews. Detectives and other members of the Dodge County Sheriff's Office reviewed Body Worn Camera footage and Range footage. Correctional Officers are required per Department of Corrections policy to activate their Body Worn Camera anytime they are on Range. The Range footage is always recording.

Through investigation, an interview was conducted with Financial Specialist Erin Carley, who was acting as a Due Process Advocate for internal inmate discipline. She stated that on October 27, 2023 at approximately 9:30 am, she had contact with Victim A for a due process review. While speaking with Victim A, she stated that he did not respond to her and kept staring forward. She confirmed that he was standing at the cell window. Carley asked if Victim A was okay or if he needed anything and he did not respond. She stated that she asked him a second time and he responding by saying, “I need a hospital.” She clarified with him that he needed to go to the hospital and she indicated that he stated, "Yes". She advised that once she left high A-range, she told Correctional Officer Adam Martin and Correctional Officer Nathan Pach that Victim A in A215 was requesting to go to the hospital, but that Victim A did not communicate to her as to why. Based on the review of available evidence no action was taken for Victim A at that time.

Investigation showed there were other possible medical incidents that were not followed up on by Correctional Staff. On October 26, 2023, Victim A was found on the floor of shower stall #1. Victim A needed assistance getting up and was returned to his cell in a

wheelchair. Once at his cell, he crawled back into his cell. This incident was observed by Correctional Officer Marco Stephenson and Sergeant Jordan Kijek. On camera, Sergeant Kijek states on camera that he tried calling HSU but there was no answer. It appears that there was no following up on this as there are no notes in the medical records by HSU staff on this date. This event was not passed on to anyone.

On October 28, 2023, Victim A was being escorted back to his cell from an HSU visit and he stumbled and collapsed. He was being escorted by Correctional Officer Nathaniel Silva and Correctional Officer Robert McGuinness at the time. They assisted him back to his cell. There is no documentation that this information was passed onto any other person.

Correctional Officer Alicia Goehl authored an incident report regarding her observations on October 29, 2023. Her report stated that on October 29, 2023 at approximately 3:21 p.m., she was doing medication pass on the upper A range in RHU. When she came to A215, housing Victim A, she observed Victim A laying on his mattress on the right side of his cell near the toilet. Victim A was having loud labored breathing. She asked Victim A if he had any medication. Victim A shook his head slightly. Once the P.M. Med pass was completed, CO Goehl went to the Sergeant's office and informed Sergeant Leopold that Victim A had loud labored breathing. At approximately 3:55 pm, CO Goehl was passing out dinner bags on upper A. When she arrived to A215 she observed Victim A laying in the same location as he was during med pass, but his breathing was no longer loud or appearing labored. She asked inmate Williams if he wanted a dinner bag. She initially did not hear a response so she asked Victim A again if he wanted a dinner bag to which Victim A verbalized “no”. At approximately 4:46 pm, CO Goehl was on upper A range to collect garbage. She observed Victim A continued to lay on the mattress in the same position. She asked Victim A if he would like to throw away any trash, to which she got no response. She repeated the question louder and still received no response. She observed Victim A’s chest rise and fall before moving on to collect the rest of the garbage on range. When she completed 5:00 p.m. count, Victim A continued to remain in the same position from previous rounds on October 29, 2023. At approximately 7:10 p.m., CO Goehl was on range doing Bedtime Med pass. When at cell A215, she was not acknowledged by inmate Williams. CO Goehl stated he did not acknowledge her at 9:00 p.m. count. At shift change, CO Goehl reports that she let Officer Martinez know that Victim A was acting strange and that he was breathing heavy earlier in the shift. She mentioned that he should keep an eye on Victim A and let his sergeant know of any changes.

Detective Rolfs and I, Detective Hopp, conducted an interview with Registered Nurse, Megan Leberak, who was working at WCI in the HSU on October 29, 2023. Megan Leberak confirmed that she worked on October 29, 2023, her shift was from 5:30 A.M. to 5:30 P.M. RN Leberak confirmed she was familiar with Victim A. She advised that she was aware that he received morning medications. She then added that he was transferred out of WCI for some time and then came back. She advised that when he came back, he was different in that prior to leaving, he was more behavioral and when he came back, she didn't notice as many behavioral problems with him. Yet, he was still in RHU. She confirmed again that she would see him during morning "med pass". She also mentioned that she had seen Victim A a week prior to his demise for having an

upset stomach and throwing up. She related that she saw him two times for this. She advised that she witnessed him throwing up the first time. She described this as being minimal and not that concerning to her. She prescribed him a medication for it and she claimed that the next day he said he was feeling better. She stated that this was on October 21, 2023. She explained that she had scheduled him for an X-ray on October 23, 2023, but it didn't happen and got rescheduled for some reason. He was seen by somebody else on the Friday, before he passed, which would have been October 27, 2023, where he was put on for follow-up on Saturday, October 28, 2023. She stated that she saw him on that Saturday, October 28, 2023. RN Leberak advised that he had displayed some manipulative things in that encounter such as rolling his eyes back. She claimed that she could tell that he was doing that on purpose and that wasn't the result of some illness or sickness. She confirmed that she had seen him in the HSU exam room in the RHU facility.

We asked about Victim A's medical complaints on October 28, 2023. RN Leberak stated that he was still complaining about throwing up, which she did not witness this time. She related that the only other thing he complained about was just not feeling good and didn't describe or complain about any specific symptoms. There weren't any references made to chest pain, headaches, or any other type of generalized pain. She added that he mentioned something about not eating as well or wasn't able to drink as many fluids as normal. She related that she drew a urine sample from him to see if he was dehydrated, which came back normal. She also advised that his vital signs were all normal on Saturday (October 28, 2023) when she checked him including his blood pressure. She stated that nothing stuck out to her regarding his overall health. I informed Megan Leberak that Victim A had collapsed when being escorted back to his cell by Correctional Officer Silva and Correctional Officer McGuinness after the appointment with her. She stated that she had not been informed of this and initially found out about it when Internal Affairs was doing their investigation related to his demise. She followed this up by saying that Victim A, he was very vague about symptoms and just said, "I don't feel good". He never gave any specific symptoms and never displayed any physical symptoms that she observed when she saw him.

We then discussed her next encounter with Victim A . RN Leberak stated that she received a telephone call from "Seg" around 5:15 P.M. on October 29, 2023 from Sergeant Tanner Leopold. He told her that Victim A was not responding to them and asked her to come over to RHU to verify that he is non-responsive so they can do a cell entry. RN Lebarek complied with this request, responded to RHU, and went to his cell front. She stated that they knocked on the door, yelled, and looked through the trap. She stated that Victim A was breathing, but would not respond. She described him as lying flat on his back on a mattress on the floor to the right side of the cell. She described his feet as being propped up on a desk on the far end of the cell with his head being toward the cell door near the toilet. She couldn't remember which way has head was turned. She also did not know what position his hands were in at that time. She confirmed that she could see the top of his head based on his body positioning. She rationalized that his head must have been turned to the right and away from her because she didn't see his whole face. She reiterated that she saw him breathing. One factor that stood out to her was that she remembered the range being extremely hot. She then exited the range with Sergeant Tanner Leopold.

Once off of RHU upper "A" range, RN Leberak and Sergeant Leopold spoke by the sergeant's office. She advised that she charted what she had seen and gave the go ahead for a cell entry to be conducted. She explained that she quickly responded to the HSU exam room in RHU and stopped back by the sergeant's office speaking with Sergeant Tanner Leopold. She asked if they were going to make entry right away or if it was going to be a little bit. He told her that it was going to be a little bit. She stated that since it was already 5:30 P.M., she informed Sergeant Tanner Leopold that she was going to tell "Wendy", the oncoming nurse, about this. She instructed Sergeant Tanner Leopold to call "Wendy" when they were ready to make entry so she was aware. RN Leberak stated that if it were a case that security staff would have been already suited up to make entry, she would have stayed and had no problem staying late. She confirmed that, at that time, she was under the impression that they were going to make entry. She replied 100% when asked how sure.

RN Megan Leberak went on to explain that, typically when they do a cell entry, they just call them after the fact if there is a medical issue, but this time it was different. She explained that was what made this incident stick out in her mind because it was different. She didn't understand why they called her over to verify that he was not responsive. She seem confused as to why they wanted her to come over because they (security) usually make the decision to go in and if there are any medical concerns, they then call her over. She claimed that this time they called her to verify to make a cell entry. She confirmed that she only talked with Sergeant Tanner Leopold about this, but did mention that Lieutenant Brandon Fisher was already over there doing "obs checks". She stated again that she thought that they were going to go in and the next thing she received a telephone call at home stating that Victim A had passed, which was on Monday morning (October 30, 2023).

Detectives were able to determine that Wendy was Nurse Gwendolyn Vick. Nurse Vick provided a statement to Internal Affairs after she left employment with the Department of Corrections. She did not provide a statement to law enforcement. During the internal affairs interview, Nurse Vick confirmed that she worked a 5:30 P.M. to 5:30 A.M. shift starting on Saturdays at 5:30 P.M. to Sunday at 5:30 A.M. and then Sunday at 5:30 P.M. to Monday at 5:30 A.M.

She was specifically asked about Victim A. She confirmed that she knew who he was. When asked about him she stated the following:

"He called for medical care quite frequently. He liked to swallow things and cut himself, lay on the floor having vomited blood. He was, what we would refer to in our lovely slang, a frequent flyer. We, he was a typical kind of inmate that we spend a lot of time dealing with at Waupun."

She confirmed that she had worked the weekend of October 29, 2023, and October 30, 2023 working her assigned 5:30 P.M. to 5:30 A.M. shift. She was then asked about a conversation she had with Registered Nurse Megan Leberak at shift change and conversations with security staff regarding the condition and status of Victim A. The following is the question and answer response as related to the above:

"Q38: Okay. Could you talk to us about, so when you get in at 5:30 on that day, do you recall having a conversation with Nurse Leberak about [Victim A]?
A38: Yes.

Q39: Could you just talk to me about that conversation with Leberak?
A39: Actually when I arrived, I always arrive prior to my shift starting… And so Megan came back over and said that she'd gotten a call that he was laying on the floor, something was going on. So she went over and she just looked through the window. Security was with her. He was breathing. There was no vomit or blood or anything around him, because he'd like to do that for effect, that she could see. And she said that Security was going to do a cell entry and that they weren't going to like rush in to do it because they had other things going on, but they were going to kind of monitor him, and then they were going to go in probably.

Q40: Okay. And I guess. What did you do with that information from Megan?
A40: I did call over to RHU and talk to, I believe the Sergeant that day was Leopold, and he, I'm just like, I hear you're going to do a cell entry. I'm like, maybe we should hold off a little bit and just see if he gets up off the floor, because he does have that history of laying on the floor and I'm like, if he doesn't get up, then we'll go in later and so, I was just like, just let me know what you decide and let it sit, because I knew I would be going over later and I was going to follow up to see what happened with him, if he got up and stuff, so.

Q41: So when Megan informed you the cell entry was going to be completed, what led you to reaching out to Leopold, saying that one isn't needed at this point?
A41: I didn't exactly say it wasn't needed. I said that maybe we should hold off for a little bit, like they were planning on, and just to see if he continued to, unfortunately he has played possum and laid on the floor before to see, because it takes a lot of time and staff to get people extracted from their cells and he had been pulled out multiple times already that weekend and seen, because I had worked also on the Friday night and he was always trying to get to go to the hospital. So I'm just like, he didn't get that trip yet, so he's still trying to get that trip out.

Q42: And maybe I asked it in the wrong way, but so Megan lets you know that they're going to be doing a cell entry, and then you called Leopold and let him know that one wasn't, not to do it, it wasn't needed right now, you know, maybe in the future. I guess what I'm asking is, like why did you end up calling Leopold? What led you to call Leopold? Did Megan say that Security was waiting to hear from you or hear from nursing?
A42: I really can't answer why I made that decision at that time that I did that.

Q43: Okay. And then.
A43: Obviously, looking back I would have made a different decision.

During the Internal Affairs interview, Nurse Vick was asked if she observed Victim A the rest of her shift, she stated that she “indirectly” observed him during med pass. She stated that no one brought anything to her attention the remainder of her shift.

Detective Rolfs and I, Detective Hopp also interview Sergeant Tanner Leopold at WCI. He confirmed that he has been employed with the Wisconsin Department of Corrections since 2017 and has been assigned to WCI since getting out of the corrections academy. He had no prior correctional experience. He confirmed that he currently has the rank of sergeant and has been in that capacity since 2021. We referred back to 10/30/2023 and he confirmed that he had worked in RHU that day. He also stated that he had not gone in the cell that Victim A was found deceased in and that he didn't believe Victim A was deceased when he had checked on him. He described his breathing as "snoring". As for positioning, Sergeant Tanner Leopold stated that Victim A was lying on his mattress, a hand on his stomach, and his head facing left. He confirmed that he had been laying on his back, head toward the door and his feet were toward the back wall. He confirmed that Victim A had been in cell #A215, which is on the upper "A" range in the back corner. He also confirmed that the mattress was on the floor to the cell.

Sergeant Tanner Leopold stated that he had two contacts with him. He related that the first he was alone and the second was with RN Megan Leberak. He stated that during his first contact, he had called a supervisor as he was not able to get a response from Victim A . This supervisor was Lieutenant Brandon Fisher. He advised that he conferred with Lieutenant Brandon Fisher and it was decided that they were going to contact HSU prior to making entry. He confirmed again that, at one point, he was at Victim A's cell with RN Megan Leberak. He stated that their main concern was that Victim A was alive. He concluded that Victim A was alive as RN Megan Leberak told him that she could visibly see Victim A breathing as well. He claimed that after they both observed Victim A breathing, that RN Megan Leberak went off range to speak with Lieutenant Brandon Fisher. Sergeant Tanner Leopold related that he remained on the range and thought he heard Victim A snoring after she had left to go speak with Lieutenant Brandon Fisher. He advised that he then left the range a short time later to see if he could find out what was going on.

Sergeant Leopold stated that he had a conversation with Nurse Vick around 5:30 P.M. or around shift change for the nursing staff on the weekend. He advised that when he went off the range neither Lieutenant Brandon Fisher nor RN Megan Leberak were around. He stated that they were waiting for a call from a nurse to figure out if they were going to do anything, if they were going to go in. He stated that he received a telephone call from Nurse Gwendolyn Vick telling him that it wasn't necessary at this time to make entry and that they were going to wait because she was aware of something with him or they saw him recently and they weren't going to do anything at that time. He advised that he passed this information on to Lieutenant Fisher. He also advised that Nurse Gwendolyn Vick never came down to look at Victim A around this timeframe.

Sergeant Tanner Leopold confirmed that he had worked a 6:00 A.M. to 10:00 P.M., a 16 hour shift that day. He stated that there was nothing else that stuck out of the ordinary with Victim A for the remainder of his shift. He related that he did not do the rounds on that range that evening shift. He confirmed that rounds are to be done every half hour and that a round log is now kept. He claimed that rounds used to be done one hour apart up until 6:00 P.M. and were then completed every half hour until 6:00 A.M. He also mentioned that the RHU sergeant is supposed to do a round at least once per shift.

Sergeant Leopold's incident report confirms that he was notified by CO Geohl that Victim A had been claiming that he had trouble breathing and chest pain. Based on this information Leopold's report states:

I proceeded up to A-215 which house [Victim A]. I knocked on his door attempting to gain a verbal response from him. I was unable to gain any verbal response. I knocked for a little bit longer and opened the trap and yelled his name which again yielded no response. With the trap open I observed within the cell [Victim A] laying on his mattress which he was on the floor. [Victim A's] mattress was against the wall behind the toilet. I could visibly see [Victim A] laying on his back and breathing with the rise and fall of his chest. [Victim A's] left hand was resting on his stomach and his head turned to the left. (Let it also be known [Victim A] was orientated with his head closest to the cell door and his feet furthest from the door.) I proceeded off range and contacted The RHU Lt. Lt. Fisher. I informed Lt. Fisher of the situation and wanted him to come over to see if he could gain a response and if not prepare a team to remove him. I was informed that I had to contact HSU and they could see him at the door and determine if it was necessary to assemble a team to remove him from the cell. I called HSU and had asked for the RHU nurse to come over. Once the RHU nurse was over I explained her of the information I had been informed of and what has happened transpired. I proceeded on range to A-215 with the RHU nurse she also attempted to gain a response from him and was unable to. The RHU nurse was also able to visually see that he was breathing. Nurse Meghan went off range to speak with Lt. Fisher. I remained on range and continued to attempt to get a verbal response from him. At this time, I was also able to hear him also snoring. I proceeded off range at this time. I also informed Lt. Fisher of this also informing him that I wasn't able to gain a response. While waiting for Lt. Fisher to go up and speak with [Victim A]. I received a call from the Nurse Vick. Informing me that it wouldn't be medically necessary to remove him from the cell. I informed Lt. Fisher of this as well. After it had been determined that it wouldn't be necessary to remove him I then continued on with my duties as the RHU Sgt.

Lieutenant Brandon Fisher authored an incident report that stated as follows:

"On 10-29-23, I Lt Fisher was working my assigned shift. I was notified by Sgt Leopold at approximately 5:20pm that [Victim A] of cell A215 was laying on his mattress on his cell floor and was not responding to staff. Sgt Leopold stated that he could see [Victim A] breathing and slight movement of his head but could not gain a verbal response from him. I then notified Sgt Leopold to have a nurse check on [Victim A] to see if there seemed to be any signs of medical distress. Shortly afterwards I was informed by Sgt Leopold that nursing staff including Nurse Leberak and Nurse Vick did not see a medical reason to remove [Victim A] from his cell after monitoring him at his cell. Due to what I was informed I did not speak with [Victim A] at this time. I was also not notified of any other possible issue with [Victim A] throughout the remainder of the shift. EOR"

Lieutenant Brandon Fisher was interviewed by Detective Rolfs and Detective Hopp. He stated the following:

Lieutenant Brandon Fisher came into work the day Victim A died. He was notified that he died and he was advised to generate a report about his involvement about the day or two prior. We asked about what was significant at 5:20 P.M. on 10-29-2023 that he had generated a report about. He said the sergeant told him that Victim A was breathing, but he was not responding. Because Victim A had a history of faking things, Lieutenant Brandon Fisher advised that a nurse should be contacted to visually look at him and see if there was a medical reason to pull him out of the cell, but if they don't have a reason, he didn't want to play games with Victim A because he was attention seeking. Victim A wanted people there and dealing with him.

Lieutenant Brandon Fisher had been advised by Sergeant Tanner Leopold, acting as the RHU Sergeant that day, that the nurse had deemed it not medically necessary to remove Victim A from the cell. Lieutenant Brandon Fisher said that HSU (Health Services Unit) staff Gwendolyn Vick was involved and he did not remember who the other one was. Lieutenant Brandon Fisher did not talk to HSU staff, but Sergeant Tanner Leopold did.

There was no disciplinary reason to go in the cell. Lieutenant Brandon Fisher did not go to the cell that day, but was on the range doing observation checks on other inmates and dealing with their requests. Lieutenant Brandon Fisher never went to cell A215.

Lieutenant Brandon Fisher said that certain things are expected in a maximum security prison and gave the example of an inmate that has seizures on a regular basis and that information might not be passed along as it is a normal thing.

Based on a review of video from October 29, 2023 through October 30, 2023, RN Gwendolyn Vick, Sergeant Tanner Leopold and Lieutenant Brandon Fisher never responded back to RHU cell A215 housing Victim A during the remainder of their shifts to check on Victim A, despite the concern about his welfare at 5:30 P.M. on October 29, 2023.

Dr. Lauren Blanchette of the Psychological Services Unit, authored an incident report outlining her contact with Victim A on October 30, 2023. Dr. Blanchette was attempting to conduct a 7-day follow up with Victim A. This follow-up was conducted at approximately 10:00 am. There was a PSU intern that was present. After loudly knocking on the cell, Dr. Blanchette was unable to make contact with Victim A. Upon looking in the cell door, she could only see Victim A’s feet. Dr. Blanchette could not tell if he was breathing. She stated that she contacted Sergeant Reynolds, who was on the Range. Dr. Blanchette stated that Sergeant Reynolds stated over the radio that Victim A is breathing and moving, but PSU is concerned because he isn’t verbally responding. At some point Lt. Gripentrog responded and stated that he was going to check on Victim A. Dr. Blanchette had to reiterate several times that Victim A could not be seen breathing or moving.

Entry was made into Victim A’s cell at appropriately 10:32 am. A nurse made entry into the cell. Victim A was removed from the cell and life saving measures were performed, but were unsuccessful.

An autopsy was performed on Victim A by Dr. Robert F Corliss with the UW Anatomic Pathology Laboratory. He determined that the cause of death was a cerebral infarct (stroke) due to venous thrombosis. Dodge County Medical Examiner PJ Schoebel was able to determine that the date of death was October 29, 2023, the time of death is unknown.

Rounds were sporadically performed throughout the evening and early morning hours of October 29, 2023 and October 30, 2023. All incident reports state that Victim A was in the same position as described by Br. Blanchette, but all correctional officers reported that they observed the rise and fall of Victim A's chest.

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Based on the foregoing, the complainant believes this complaint to be true and correct.

EXT=CODE 1

Subscribed and Sworn to me on 06/05/24
Electronically Signed By:
Andrea M Will
District Attorney
State Bar #: 1064389

Electronically Signed By:
Detective Andy Rolfs
Complainant