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:

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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.

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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

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

STATE OF WISCONSIN

Plaintiff,

Vs.

DA Case No.: 2024DD000911
Assigned DA/ADA: Andrea M Will
Agency Case No.: 24-05140

CRIMINAL COMPLAINT

Jeramie Chalker
Waupun Correctional Institution
PO Box 351
Waupun, WI 53963-0351
DOB:
Sex/Race: M/W
Eye Color:
Hair Color:
Height: 0 ft 0 in
Weight: 0 lbs
Alias: Also Known As Jeramie Heyward Chalker

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

Sarah Am Ransbottom
200 S Madison St; Waupun Correction
Waupun, WI 53963
DOB: 09/25/1988
Sex/Race: F/W
Eye Color: Blue
Hair Color: Brown
Height: 4 ft 11 in
Weight: 105 lbs
Alias:

Defendant,

Jamall R Russell
200 S Madison St; Waupun Correction
Waupun, WI 53963
DOB: 08/23/1984
Sex/Race: M/U
Eye Color:
Hair Color:
Height: 0 ft 0 in
Weight: 0 lbs
Alias

Randall R Hepp
200 S Madison St; Waupun Correction
Waupun, WI 53963
DOB:
Sex/Race: M/W
Eye Color: Blue
Hair Color: Blonde
Height: 6 ft 3 in
Weight: 245 lbs
Alias:

Alexander John Hollfelder
Waupun Correctional Institution
PO Box 351
Waupun, WI 53963-0351
DOB:
Sex/Race: M/U
Eye Color:
Hair Color:
Height: 0 ft 0 in
Weight: 0 lbs
Alias: Also Known As Alexander J Hollfelder

Jessica Ann Hosfelt
200 S Madison St; Waupun Correction
Waupun, WI 53963
DOB: 05/16/1977
Sex/Race: F/W
Eye Color: Brown
Hair Color: Blonde
Height: 5 ft 11 in
Weight: 230 lbs
Alias:

Defendant,

The undersigned, being first duly sworn, states that:

Count 1: MISCONDUCT/OFFICE-FAIL/PERFORM KNOWNDUTY (As to defendant Randall R Hepp)

The above-named defendant from February 16, 2024 through February 22, 2024, in the City of Waupun, Dodge County, Wisconsin, the defendant, who is a public employee. intentionally failed to perform a known mandatory, nondiscretionary, ministerial duty of his employment in the manner require by law, to-wit: failed to comply with Wis. Stat. Sec. 302.04., contrary to sec. 946.12(1), 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 Brandon James Fisher)

The above-named defendant from February 16, 2024 through February 22, 2024, 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 Alexander John Hollfelder)

The above-named defendant from February 16, 2024 through February 22, 2024, 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 4: ABUSE OF RESIDENTS OF PENAL FACILITIES (As to defendant Jessica Ann Hosfelt)

The above-named defendant from February 16, 2024 through February 22, 2024, 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 5: ABUSE OF RESIDENTS OF PENAL FACILITIES (As to defendant Jamall R Russell)

The above-named defendant from February 16, 2024 through February 22, 2024, 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 6: MISCONDUCT/OFFICE-FAIL/PERFORM KNOWNDUTY (As to defendant Jamall R Russell)

The above-named defendant from February 16, 2024 through February 22, 2024, in the City of Waupun, Dodge County, Wisconsin, the defendant, who was a public employee and who, in his capacity as an employee, made an entry in a report, which he intentionally falsified in a material respect., contrary to sec. 946.12(1), 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 7: MISCONDUCT/OFFICE-FAIL/PERFORM KNOWNDUTY (As to defendant Jeramie Chalker)

The above-named defendant from February 16, 2024 through February 22, 2024, in the City of Waupun, Dodge County, Wisconsin, the defendant, who was a public employee and who, in his capacity as an employee, made an entry in a report, which he intentionally falsifies in a material respect., contrary to sec. 946.12(1), 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 8: MISCONDUCT/OFFICE-FAIL/PERFORM KNOWNDUTY (As to defendant Sarah Am Ransbottom)

The above-named defendant from February 16, 2024 through February 22, 2024, in the City of Waupun, Dodge County, Wisconsin, the defendant, who was a public employee and who, in her capacity as an employee, made an entry in a report, which she intentionally falsified in a material respect., contrary to sec. 946.12(1), 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.

From the reports of Detective Dean Hopp, Kasey Young and Justin Kontny all of the Dodge County Sherriff's Department:

From Detective Hopp's reports:

On February 22, 2024 at approximately 4:21 pm, I, Detective Hopp was informed of an unanticipated death at the Waupun Correctional Institution (WCI) located at 200 S. Madison Street in the City of Waupun, Dodge County, Wisconsin. I spoke with Security Director Yana Pusich, who advised that Victim A was found unresponsive in his cell at approximately 3:28 pm. Victim A was housed in cell A227 of the Restrictive Housing Unit (RHU). It was learned that Victim A was transferred from the Behavioral Health Unit (BHU) to the RHU on February 13, 2024 after a disciplinary incident.

Upon arriving on the scene, I was met by Dodge County Medical Examiner PJ Schoebel and a Deputy Medical Examiner. The door to cell A227 was closed and secure, but had not been sealed with evidence tape. Cell A227 is a suicide observation cell. Viewing into the cell, I observed there to be a body lying on a yellow suicide smock that was covered with a blue blanket. There was also a black bed mat near the body.

Once the cell door was open, I was able to smell the strong odor of bodily fluids and urine. I also observed there to be food and garbage clutter strewn about the cell. There were three green food trays laying randomly on the floor along with a bag lunch and milk carton. There was another bag lunch still sitting in a trap underneath an observation window along with legal paperwork.

Focusing on the body, I observed that the victim's lower legs and feet were sticking out from underneath a blue blanket. Leg irons were in place and I observed the feet and toes to be purple in color as if lividity was present. With the body uncovered, I found the body to be in a supine position with the hands secured in handcuffs post medical treatment. WCI staff reported finding Victim A to be laying in a fetal position on his right side facing the door to the cell. The arms appeared to be rigid. The fingernails and fingertips were purple in color. I did not observe any blood to be seeping from the body or any obvious external signs of trauma or injury. I did, however, observe that the chest was sunken.

Conducting an assessment of the body, Medical Examiner PJ Schoebel reported that the body was cold to the touch. He related that the eyes displayed equal dilation, but were unresponsive. He reported no petechiae present. He reported rigor to be set in the jaw, upper extremities, and lower extremities. The only place rigor was partially broken was in the left elbow. Fixed lividity was reported on the right side of the head and back. He reported no obvious external injury or signs of self-harm, but did note multiple abrasions to the hands, feet, and right elbow. On the right side of the torso, midline tow marks were observed that ran parallel with the body. I inquired about that and was advised that Victim A had received a drive stun application from a Taser suspected of being in that area when being moved to RHU on February 13, 2024. Medical Examiner PJ Schoebel pronounced the time of death to be 6:18 P.M. Based on the Medical Examiner's observations, he believed that Victim A would have passed away sometime in the morning hours of February 22, 2024.

Upon reviewing the histology of Victim A's placement in the prison system, Victim A had been in the prison system consecutively since June 18, 2012 and was transferred from the Wisconsin Resource Center to WCI on December 4, 2023. He was housed in the BHU until his transfer to RHU on February 13, 2024.

A canvas was performed of the inmates surrounding Victim A's cell in the RHU. The inmates reported that Victim A did not speak to other inmates. He would rattle his trap, make incoherent sounds like growling or roaring like an animal. A neighboring inmate also reported that Victim A flooded his cell and the correctional officers turned his water off as a result of this action.

As a result of the preliminary information obtained on scene, Detective Young and Detective Kontny conducted a death investigation. They reviewed numerous documents from WCI, including internal policies and incident reports. Detectives reviewed body worn camera footage, which is required to be activated while on the RHU range and Range video footage. Detectives also conducted numerous interviews of employees of WCI.

A timeline of the significant events was put together based on the investigation.

From Detective Kontny's reports:

On February 13, 2024, Second Shift Lieutenant Kelsey Stone authorizes a cell entry on Victim A while housed in Behavioral Housing Unit (BHU) and requests the assistance of a nurse. Following the cell entry that was conducted due to Victim A being unresponsive in his cell, he was to be transferred to the Hospital Services Unit (HSU) for medical evaluation. Victim A became alert and resistive during the move and was Tased by Lieutenant Kelsey Stone to gain compliance, then redirected to the Restricted Housing Unit (RHU). HSU does did not conduct a complete medical evaluation due to Victim A being uncooperative and, instead, he wass released into cell A227 and never further evaluated in person, or removed from his cell, until he is found deceased on February 22, 2024.

Victim A either refused or was not provided medication for any of his known medical and psychological issues ever during his approximately nine days in RHU with the exception of one possible distribution, but it is unknown if he actually ingested the medication given to him.

Victim A has known and documented severe mental health issues and medical problems requiring medication and continual treatment that had him appropriately housed in the BHU of WCI prior to his placement into RHU. Victim A is noted by multiple staff as not being able to have a conversation with, or effectively communicate his needs. Victim A has documented hearing problems along with delusional disorder. Victim A's inability to speak coherently to articulate his medical needs was likely a factor in him not receiving needed medical and psychological intervention.

On February 16, 2024 at about 12:45 A.M., Victim A's water is requested to be shut off to his cell by Correctional Officer Michael Lueneburg and is disabled by the bubble officer. It is unknown and undocumented whether or not water was provided to Victim A during the shut off periods. It should be noted there were claims the water was briefly turned back on for periods of time during interviews, however, clarification was provided that Victim A was never made aware of the water being on when activated. Captain Joel Sankey was working as the shift commander during this time and does a wellness check on Victim A on February 16, 2024 at 12:45 A.M. and again at 2:10 A.M. with no further documentation of a water shut off or turn on, or an incident report.

On February 16, 2024 at around 9:25 A.M., Victim A speaks with Dr. Casey Roca and is removed from observation, but refuses to take clothing or property allowed. Victim A speaks of his desire for water (states he wants water, water, water, all the water in the world) and Dr. Casey Roca informs staff. It is unknown if water was turned on for him to utilize or provided in another way. On February 16, 2024, multiple officers report noting Victim A exhibiting unusual behaviors and activities such as drinking from the toilet, acting like he is swimming in his cell, speaking incoherently, and making repeated statements about wanting water. No further wellness checks (out of cell) are performed.

On February 17, 2024, at 8:18 A.M., it is heard over the radio to turn on the water to cell A227. At 3:11 P.M and 3:54 P.M., Victim A is still asking staff for water during rounds. At 4:03 P.M., it is documented in the log book that water is turned off to A227 due to flooding. Correctional Officer Jenny Vaillancourt was the acting sergeant at that time. At 4:24 P.M., Victim A is again asking for water. At 4:51 P.M., Correctional Officer Jenny Vaillancourt and Lieutenant Bradley Lewin discuss water issues at the front of cell A227. At 5:33 P.M., Victim A is again asking for water. At 5:34 P.M., Correctional Officer Ernesto Martinez is heard via radio requesting the bubble officer to turn water on then back off. At 7:35 P.M., Victim A still asking for water to drink. Victim A's last meal consumed, noted by the removal of an empty tray, was delivered during dinner on February 17, 2024. Captain Joel Sankey was working as the shift commander during this time. He is notified by Correctional Officer Jenny Vaillancourt of the water being

shut off to Victim A's cell and tells her to turn the water back on with no further documentation of a water shut off or turn on, or an incident report.

On February 18, 2024, at about 12:28 A.M., Correctional Officer Nathan Shreve requests over the radio to turn off the water in cell A227. Correctional Officer Carlee Martin (bubble officer) shuts off the water to cell A227 and, per interviews, stated that she had turned water on and off throughout the night, but never notified Victim A when it was on. Sergeant Dustin Wiltgen is notified by Correctional Officer Nathan Shreve of the water shut off who in turn notifies Captain Joel Sankey who was working as the shift commander during this time. Captain Joel Sankey tells Sergeant Dustin Wiltgen to turn the water back on with no further documentation of a water shut off or turn on, or an incident report.

On February 18, 2024, during breakfast delivery, Victim A is not fed as no tray is delivered. No known meals going forward are consumed until he is discover deceased on February 22, 2024.

On February 18, 2024 at the beginning of Correctional Officer Carlee Martin's shift at around 10:00 P.M., she notices water is still off in cell A227 and asks Sergeant Dustin Wiltgen if Victim A is still in a dry cell and is notified that he is not. Per Correctional Officer Carlee Martin's interview, she turned the water back on after this conversation.

On February 19, 2024, multiple staff (Captain Scott Kinnard, Correctional Officer Jamall Russell, Sergeant Melissia Tempski, and Correctional Officer Maria Gomez-Sena) observe notable deterioration in Victim A's condition, yet no one initiates further intervention, or an out of cell examination, nor does any cell entry take place.

On February 20, 2024, during dayshift, Dr. Kayla Meedema and Captain Scott Kinnard attempt contact with Victim A at his cell and get no verbal response. They speak about Victim A being very shaky and again try to address him getting property. There is a conversation about what is "Plan B" although it is not specified, and they move on with no further intervention.

On February 20, 2024, during second shift, Correctional Officer Devyn Urban, Sergeant Aimee Marshall, Lieutenant Eric Henrichs, and RN Jessica Hosfelt all observe inmate Victim A unresponsive verbally, laying in the cell, shaking. They all look closer (through cell window) for a potential medical emergency or seizure, and ultimately take no action, (other than looking into his cell) and no in person intervention takes place.

On February 21, 2024, at 9:16 A.M., Sergeant Alexander Hollfelder, Correctional Officer Lajuan Lewis, and RN Brian Taplin, check on Victim A for possible seizure activity or other possible medical emergency and take no action to intervene. Dr. Jaime Engstrom comes to see Victim A for a scheduled out of cell meeting and is advised by staff that he is refusing the meeting. Dr. Jaime Engstrom goes to the cell and raises concerns to RN Brian Taplin after observing Victim A's frail condition. No further medical or wellness intervention takes place

On February 21, 2024, during second shift, Sergeant Jacob Aaronson speaks with another officer he believed to be Correctional Officer Benjamin Nichols in the unit and determines the water was still off in cell A227 and turns it back on. It should be noted Victim A never gets off the floor of his cell after this time. At 5:03 P.M., Sergeant Aaron Arzenhofer is notified by Correctional Officer Benjamin Nichols that victim A is not doing well, and is directed to "keep an eye on it" and do an incident report if it continues. At 9:07 P.M., Correctional Officer Benjamin Nichols reports to Lieutenant Brandon Fisher that Victim A is shaking in his cell appearing to be having a seizure and no intervention takes place.

On February 22, 2024, during dayshift, Correctional Officer Guillermo Avila, Captain Scott Kinnard, Correctional Officer Maria Gomez-Sena, Correctional Officer Leopoldo Escorza, Correctional Officer Dustin Fay, Correctional Officer Robert McGuinness, and Social Worker Karisa Smits all observe Victim A on the floor of his cell non-responsive, and no intervention takes place. No cell entry or in person examination takes place.

On February 22, 2024, at about 3:41 P.M., Victim A is discovered deceased in his cell on second shift by Correctional Officer Charles (Charlie) Zuhlke. Correctional Officer Charles (Charlie) Zuhlke notifies Lieutenant Brandon Fisher of his findings and a cell entry is performed only to find Victim A obviously deceased. Lifesaving efforts are attempted and are fruitless.

An autopsy was performed by Dr. Adam Covach, the Chief Medical Examiner in Fond du Lac County. The cause of death was determined to be probable dehydration and failure to thrive due to malnutrition. The other significant conditions were hypertensive cardiovascular disease, myocardial scarring of unknown etiology, acute kidney injury, possible rhabdomyolysis and delusional disorder.

Dodge County Medical Examiner ruled the manner of death as homicide.

From the reports of Detective Young:

As to count 1 for Hepp:

After reviewing this case in its entirety, Randall Hepp did not enforce the rules of the department for the administration or officers. Randall Hepp did not oversee his staff to ensure they followed all policies/procedures which led to the demise of Victim A. Randall Hepp did not follow through the requirements of his position required by law as the staff at WCI are poorly trained on many policies and procedures regarding missed meal(s), water restrictions, medication refusals, round checks, and more.

From Detective Kontny's reports:

On May 2, 2024 Detective Hopp and Detective Kontny conducted an interview with Warden Randall Hepp. Warden Randall Hepp has been working for the Department of

Corrections (DOC) for the past 40 years and has held a multitude of positions from correctional officer, sergeant, lieutenant, captain, security director, program director, contract monitor, assistant administrator, deputy warden, and warden, at various institutions throughout the state during the course of his career.

During the interview, Detective Kontny noted that a nurse was present during Victim A's intake into RHU, but did not proceed with an evaluation due to Victim A being verbally abusive. Victim A was placed into cell A227 and never again removed or seen in person (other than through a window) to determine if he required medical attention. I emphasized that not one time was Victim A removed from his cell during the entire duration of time in RHU and multiple opportunities to be removed and further checked upon during court appointments, PSU appointments, rule violation hearings, etc., were missed. Warden Randall Hepp advised that if medical personnel made the call to not see Victim A then it is their call and explained that if the decision was not agreed upon by the security supervisor, he would imagine the security director or someone would have to get involved to make a determination on how to proceed. I informed Warden Randall Hepp that based upon my knowledge obtained through interviews, Lieutenant Kelsey Stone did not remain in RHU during Victim A intake and continued on to other duties after he was turned over. Warden Randall Hepp informed me that there may not have been a supervisor on site in RHU during that hour of the night on second shift to even make that call.

I described that the existing policy for water shut off was not followed. I asked Warden Randall Hepp if it was normal practice to perform a water shut off as described. Warden Randall Hepp replied explaining that in a circumstance where someone is using the water to flood a cell, the authorization to shut the water off requires a supervisor's permission (clarified as a Lieutenant or higher), according to DOC policy regarding control of water supply. Warden Randall Hepp advised that a water shut off would also require an incident report, and if shut off for more than two hours, an entire protocol is enacted, where a nurse is advised, the security director is advised, then water has to be offered, documented that is has been offered, and noted at what times. Detective Hopp and I asked if this would be something that was taught during training, and Warden Randall Hepp advised, "I don't know if you could talk to everybody that started working at any prison and say did somebody talk to you specifically about control of water supply, I don't know that you would get that." Warden Randall Hepp was not certain if it was a topic covered at the DOC Academy either.

Warden Randall Hepp was asked if employees have to sign off that they know and understand the policy or what the protocol is. He said there are certain policies that employees are provided copies of when they are first hired and referenced them being regarding fraternization, the Prison Rape Elimination Act, etc., but did not believe control of water supply would have been one of them. Warden Randall Hepp continued that "this is a challenge that probably every agency faces.. when you're addressing large numbers of shortages, time, and this will come across as an old guy sitting on the porch saying get off my yard, but we, we submit policies to staff by email and say, here is 12 policies, read them." Warden Randall Hepp elaborated, "That does not give you

the same type of learning, as if it was addressed in a different way, and, and I think that that's the computer age, and I know that I am talking like an old guy, ya know, has done tremendous benefit in a lot of ways, but I think learning has been sacrificed for convenience." Warden Randall Hepp stated, "I don't know that at any institution you are going to find great recognition of each of those policies, or that people read them, because they come to work and they start working." I stated to Warden Randall Hepp that his assessment was consistent with my many interviews with staff that, for the most part, they have no idea of a requirement for an incident report, or that they needed approval from a white shirt (supervisor). I emphasized the failure in communication between line staff and supervisors, shift to shift, and with other stakeholders, such as HSU, PSU (Psychological Services Unit), etc. was notably deficient. I noted how something as crucial as the access to water not being sufficiently communicated. I gave the example of Sergeant Melissia Tempski who was the observation checker on February 16, 2024 coming in to work during dayshift and hearing Victim A asking for water (6:22 A.M.), then responding to him that he has it, seemingly unknowing of the likelihood of water being off to his cell from the prior shift.

I asked Warden Randall Hepp what he expects from his correctional officers doing meal hand out and an inmate either states that he does not want to eat, or just does not touch the meal, or does not even move to retrieve it. Warden Randall Hepp stated that if it was a single meal, he would not see the refusal as an issue. Warden Randall Hepp stated that three consecutive meals missed is the threshold and we inquired as to how the missed meals are tracked. Warden Hepp retorted, "Find me a jail in the country that does it, that records every meal, I mean is that possible to do?" "Is it something that may occur retroactively? Yeah, but it is not there now or it wasn't there then."
I asked Warden Randall Hepp what had broke down in his eyes. Warden Randall Hepp explained that based upon the information I provided in the interview, he saw the issue being that staff in close contact with Victim A did not have full awareness of the policy expectations related to water. Warden Randall Hepp cited that everything goes from that. Warden Randall Hepp continued, "If I am not aware of the water control policy, because I am not aware that his water was shut off, I'm not necessarily going to attach significance to that, and as you were kind of detailing that I was like, how many different people is this?" "You know and I think, you know if they are equally unaware, that the water is off, I'm not sure that if you say well here is nine people in a row to which he still talking about water, if any of them are going to connect that to being significant, if they are not aware the water is shut off, and not aware that the other eight people, had a similar interaction."

Warden Randall Hepp did state that he cannot get his mind at the number of people who went to the cell and said they wanted to talk to this guy (Victim A), got nothing, then left. Warden Randall Hepp further recalled another recent inmate death where that inmate was observed on body-worn camera in an unusual body position and, in that incident, staff also failed to make a decision to make entry or intervene to attempt to render aid.

I asked if it was it common for an inmate to go nine days without stepping out of a cell at any point? Warden Randall Hepp stated it would not be something that would raise an alarm if an inmate did not come out for showers, rec, or any other reason.

Warden Randall Hepp referenced an attitude of "just get by" from staff in restrictive housing, citing it is not the most popular job, and very few have it as their regular post. The result is a lack of ownership within the unit, combined with lower numbers of staff supervising the inmates. With less supervision, inmates get away with more, and become less accustomed to and more resistive to being supervised. Warden Randall Hepp discussed inmates, "going from a reluctant compliance down a continuum towards aggressive opposition." Warden Randall Hepp referenced correctional officers' willingness to put in the work if the result would be things getting better on the unit, but are not willing to when they "take a whole ration of garbage for the day, and then leave, then tomorrow be somewhere else." Warden Randall Hepp stated, "I don't want to say that people are apathetic, but once you learn a bad way to do things, you have to get back to normal in order to create the way you want things done." "This is the inevitable outcome of a long term staffing deficit in this type of environment, this is what you are going to get."

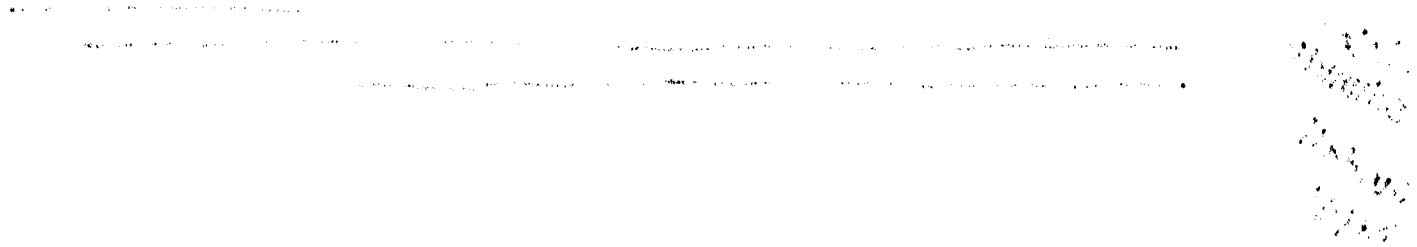
Warden Randall Hepp explained that in the end, the accountability for what happened in any Department of Corrections facility is in the secretary's office, then to the administrator's office, then the warden's office. Warden Randall Hepp explained that what happens on "these 22 acres" is on him. He continued that he understood for example if staff was not trained on the water control policy, it is he who answers, "why weren't they?" which he stated he could line up a whole bunch of reasons, but stated in the end he wasn't sure it was going to change anyone's opinion. Warden Randall Hepp stated, "from tragedy can come improvement." and continued that he did not know either Victim, but he hates the fact that they are no longer alive.

dale schmidt randall hepp

I asked Warden Randall Hepp about the Management Teams (MTEAM) meeting from 02/20/2024. Warden Randall Hepp recalled that he does attend the meetings, but could not specifically remember the MTEAM meeting from 02/20/2024. I inquired specifically about the issue of Victim A not taking clothing and Captain Scott Kinnard expressing concern over the matter. Warden Randall Hepp agreed with the decision not to make a cell entry on that sole issue (not taking clothes), but agreed if more was known regarding the water, food, and other issues, an entry should have been made.

As to count 2 for Fisher:

Per review of camera footage, incident reports, and interviews, on February 21, 2024, Brandon Fisher is informed by correctional officers about Victim A's condition by staff. Brandon Fisher makes no attempt to further investigate the condition of Victim A or his well-being. Brandon Fisher was working February 14, 15, 16, 19, 20, 21, 22; each shift every day of 2:00 P.M. to 10:00 P.M. as the lieutenant of Restrictive Housing Unit.
In an interview with Detective Young and Detective Kontny, Lieutenant Fisher denied having any knowledge of the Victim A being on a hunger strike or having his water shut



off. Lieutenant Brandon Fisher advised that on the 02/21/2024, he had received notification from Correctional Officer Benjamin Nichols, who was working the unit, that they were concerned Victim A may be having a seizure. The two had a conversation as to what signs Victim A was exhibiting, which were described as shaking like he was cold. Lieutenant Brandon Fisher advised that, at that time, based on the correctional officer's description, he did not believe it was a seizure and was pulled away to another higher priority issue on the unit. Lieutenant Brandon Fisher did not recall any information passed to him between shifts from other staff regarding inmate Victim A other than the notification from Captain Scott Kinnard that Victim A was not accepting clothes after being released from observation and was not responding to staff.

As to count 3 for Hollfelder:

Per review of camera footage, incident reports, sergeant logs, and interviews, Alexander Hollfelder was notified of Victim A's deteriorating condition by multiple officers over the course of his shifts on February 21, 2024 and February 22, 2024. Alexander Hollfelder personally observed Victim A's condition on February 21, 2024. On February 22, 2024, he was again advised of Victim A's condition and failed to proceed further with notifying superior staff to initiate a cell entry or welfare check.

An interview was conducted with Sergeant Alexander Hollfelder on February 27, 2024. When asked while working as segregation sergeant if he had any roles or responsibilities, he said he makes sure count is correct, inmates go to the correct bed, and know where inmates go if they leave. He also stated he "Cover the officer's asses" if anything happens or goes down as he is in charge. He should be the one to make the emergency calls and should help out on one of the ranges if he has time. He said A Range upper and lower are range partners and the same for B Range, however, C Range only has one officer and he should help out C Range if possible with meds and meal passes. He knew that Victim A did not have any clothes since Friday. On Wednesday, he was notified by Correctional Officer Luis, that was his first physical contact with inmate Victim A, something was not right with Victim A as he was laying on floor, left hand up on the sink, knees bent, kind of shaking a little bit, feet towards the door, shaky and moving, and overall just didn't look right. He walked off range and grabbed the nurse to have him come with him. Nurse Brian Taplin, a male nurse, arrived at the cell and viewed Victim A from the outside for a period of time. Nurse Brian Taplin looked at him through the window and said he thought Victim was coming out of a seizure and said it was not needed to go in and look at him. He thought Victim A had a seizure disorder. That interaction on Wednesday occurred at around 1:00 P.M. and he never had any contact with Victim A after that. We asked if any other coworkers came to him Wednesday or Thursday and advise him that Victim A did not look alright on Thursday at all. He said no, but Thursday they have SRT that come and check on certain segregation guys to see how they should be reclassified, etc. On Thursday, after SRT was on the range, the captain made the comment something like "what are we going to do with [Victim A], he still isn't taking clothes" and that is where it was left. He did admit he knows he stands in the middle of a "shit storm" because it happened during his shift.

As to Count 4 Hosfelt:

Per review of camera footage and medical records on February 20th Jessica Hosfelt is notified by security staff of a concern over Victim A not eating food for a couple days, drinking sewage water and playing in the toilet. Jessica Hosfelt did not follow the policy/procedure of a Hunger Strike after being notified.

Detectives interviewed RN Jessica Hosfelt on March 13, 2024. She informed detectives that at 4:05 P.M. on February 20, 2024, while she was in segregation, she was notified by Lieutenant Eric Henrichs, he had asked her to come over and do a welfare check on Victim A, which was the first direct communication with him. RN Jessica Hosfelt and Lieutenant Eric Henrichs proceeded to Upper A range cell A227. Jessica Hosfelt reported observing Victim A seated on his floor in an upright position, nude, rocking back and forth in a controlled motion, and would not respond when asked, but would move his lips and was mumbling to himself. RN Jessica Hosfelt reports that a "peer" in a different cell yelled towards Victim A and she observed him look over to the neighbor cell and responded something that she was unable to make out. RN Jessica Hosfelt stated that Victim A was alert and responsive, with controlled movement, and she did not believe he was having a seizure or other medical emergency. RN Jessica Hosfelt stated that she could request to go in a cell to check vitals, but ultimately it was up to security to decide to go in or not. Since Lieutenant Eric Henrichs was with RN Jessica Hosfelt during her contact, she felt it would have been up to him to go in or not. Other than the observation check performed earlier in the week, RN Jessica Hosfelt was not informed on Victim A's medical history. RN Jessica Hosfelt was not aware why Victim A was on observation as placements are made by PSU. RN Jessica Hosfelt explained that HSU does do meal monitoring and assessments for hunger strikes, however, she had no knowledge of Victim A being on a hunger strike. RN Jessica Hosfelt stated that for an inmate to be placed on a hunger strike, they have been notified by the inmate, PSU staff, or security has documented that an inmate has missed three meals in a day. HSU does a baseline assessment and checks vitals, height and weight, prepping for a potential issue. After three days of documented missed meals, inmates get assessed by a nurse daily and the provider every three days if stable.

Victim A was not evaluated under this criteria as he was never placed on a hunger strike. RN Jessica Hosfelt had no knowledge of Victim A being without water for any period of time. On February 20, 2024, in the morning, RN Jessica Hosfelt reports hearing Captain Scott Kinnard speaking with HSU and the security director, and she recalled them at cell A227 trying to get Victim A to take clothing. RN Jessica Hosfelt only observed this and did not take part in the attempted contact.

As to count 5 and 6 for Russell:

Per review of camera footage, on February 18, 19, 20, and 21, 2024, Jamall Russell does not feed a meal (breakfast or lunch) to Victim A. This results in eight of 12 meals not being fed/consumed by Victim A over a four day period. During six of eight meal deliveries, Jamall Russell does not verbally ask Victim A if he would like to eat. Jamall Russell did not follow the policy/procedure of a hunger strike.

On April 12, 2024, at about 10:00 A.M., I, Detective Justin Kontny #202 of the Dodge County Sheriff's Office, along with Detective Kasey Young #208, met with Correctional Officer Jamal R. Russell (M/B, DOB: 08/23/1984) in the public service room at the Dodge County Sheriff's Office to speak with him regarding the death of Victim A. Correctional Officer Jamall Russell recalled the timeline of his contact with Victim A as being "close to a month" in the segregation unit, but could not provide an exact amount. Correctional Officer Jamall Russell had no previous contact with Victim A prior to him coming to segregation as that is the only unit that he works. After reviewing his schedule, Correctional Officer Jamall Russell was able to verify that he had worked segregation from 02/15/2024 to 02/21/2024 and would have had seven days of contact with Victim A on the unit. Correctional Officer Jamall Russell advised that he informed his sergeant (mentioned Sergeant Alexander Hollfelder and Sergeant Dustin Wiltgen) of the unusual observations of Victim A's activities. Correctional Officer Jamall Russell advised he personally did not document the activities because while on observation it would have been up to the observation checker to document all the activities. Correctional Officer Jamall Russell informed us that he has written incident reports for issues including individuals exhibiting self-harm, or stating they were going to kill themselves, or other suicidal actions. Correctional Officer Jamall Russell said that outside of an incident of that nature, it was not in his opinion or in line with the way he was trained, to write an incident report regarding the flooding of a cell, rolling around in the water, or losing weight and getting thinner. Correctional Officer Jamall Russell advised all the observations noted were reported to his sergeant.

Medication pass refusal was explained by Correctional Officer Jamall Russell as an inmate not responding or saying no when pass is done. In the case of Victim A, Correctional Officer Jamall Russell stated he would either yell obscenities or ignore him completely, so he did not distribute medications to him. Correctional Officer Jamall Russell stated that he would not distribute medications that he could not verify an inmate was taking due to the potential for them to hoard them and abuse them later. A refusal of medication would be documented into an "EMR" in a computer system that should be reviewed by either HSU or PSU depending on the medication. In the event a meal was skipped or refused, Correctional Officer Jamall Russell stated that he notified the sergeant of the unit, usually Sergeant Alexander Hollfelder in the case of Victim A, of each and every meal missed. Correctional Officer Jamall Russell also claimed to have made notification to HSU staff of the unit of the meal refusal, and specifically referenced an instance where he spoke with a nurse he described as a tall female with glasses, believed to be RN Jessica Hosfelt, and told her that he was worried about Victim A since he was not eating, not responding, and his movements were getting slower and his skin appeared to be paler. Correctional Officer Jamall Russell also

stated that he would have relayed the observations of the decline of Victim A to Sergeant Alexander Hollfelder.
Per review of camera footage and Restrictive Housing Unit Round Logs of February 18, 2024, Jamal Russell intentionally initialed that he completed the 0830, 0900, 0930, 1000, 1200, 1230, and 1330 rounds. On the February 19, 2024, Restrictive Housing Unit Round Logs Jamall Russell intentionally initialed that he completed the 0700, 0800, 0900, 0930, 1030, 1100, and 1330 rounds. Surveillance footage does not show Jamall Russell complete any of those rounds on those dates or times. There is documentation of a memorandum sent via email to all staff regarding rounds after the death of an inmate on October 30, 2023.

As to Count 7 for Chalker:

Per review of camera footage and Restrictive Housing Unit Round Logs, on the February 22, 2024, rounds log Jeramie Chalker intentionally initialed that he completed the 1430 and 1500 rounds. Camera footage does not show Jeramie Chalker complete any rounds or even his presence on the range at those times. There is documentation of a memorandum sent via email to all staff regarding rounds after the death of an inmate on October 30, 2023.

On February 27, 2024, detectives interview Sergeant Chalker. Sergeant Jeramie Chalker advised that on February 22, 2024, he was assigned to B Range lower in the segregation unit, also known as RHU (Restrictive Housing Unit), from 7:00 A.M. to 2:00 P.M., then moved to the position of segregation sergeant from 2:00 P.M. to 8:30 P.M. During the first portion of his shift, he advised that he was working Lower B Range with Correctional Officer Dustin Fay assigned to upper A Range and Correctional Officer Robert McGuinness assigned to lower A Range. Sergeant Alexander Hollfelder, the floor lead, was assigned segregation sergeant for dayshift. Sergeant Jeramie Chalker explained that during his first shift, he was assisting (with Sergeant Schuett) in running showers, which was described as a labor intensive activity in the unit requiring inmates to be offered a shower, placed into restraints, and moved from their cells to a shower cell, unrestrained, and allotted time to shower, then restrained again, and escorted back to their cells. Sergeant Jeramie Chalker stated that he was also tasked with feeding the inmates on his assigned range, and also assisted in passing out medication to include on C Range. Sergeant Jeramie Chalker had no recollection of performing rounds on A Range during his shift.

As to Count 8 for Ransbottom:
Per review of camera footage and Restrictive Housing Unit Round Logs, on the February 19, 2024, rounds log (actual date of February 20, 2024) Sarah Ransbottom intentionally initialed that she completed the 0400 and 0430 rounds. On the February 21, 2024, rounds log (actual date of February 22, 2024) Sarah Ransbottom intentionally initialed that she completed the 0200 and 0230 rounds. Surveillance footage does not show Sarah Ransbottom complete any rounds or even her presence on the range at those dates or times. There is documentation of a memorandum sent via email to all staff regarding rounds after the death of an inmate on October 30, 2023.

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 Kasey Young
Complainant