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*Milwaukee County*

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December 12, 2017

Sheriff Richard R. Schmidt  
 821 W. State Street, Room 107  
 Milwaukee WI 53233

RE: In-Custody Death of Clarence Wilson on August 29, 2017

Dear Sheriff Schmidt:

On August 29<sup>th</sup>, 2017 inmate Clarence Wilson (DOB: 07/27/1966) complained of medical distress and was moved to the Milwaukee County Jail's medical infirmary where emergency life-saving measures were continued. Mr. Wilson became unresponsive at the jail medical clinic and was declared deceased by City of Milwaukee Fire Department paramedics in consultation with emergency medical doctors. The Waukesha County Sheriff's Office was asked to conduct a death investigation and the following assessment is based on their thorough review of what happened to Mr. Wilson from the time he was arrested by the Milwaukee Police Department at the request of the Wisconsin Department of Corrections (Mr. Wilson was on supervision with the Department of Corrections) until the time he expired in the medical clinic.

While not required by state law, the decision to invite review from an outside independent investigative agency is consistent with best practice and I believe in this case that the WCSO conducted a professional and independent inquiry. Because that agency has experience in correctional settings I found their investigation to be very comprehensive and well organized. I incorporate the WCSO's investigative summary into my findings.

**General Facts, Initial Review**

Mr. Wilson was taken into custody by the Milwaukee Police Department on 08/28/17 at 2046 hours for a Probation Violation after a urinalysis test conducted at his residence resulted in a positive indication for cocaine. Wilson was taken to Columbia St. Mary's hospital after complaining of arm pain during the arrest. Upon medical clearance from Columbia St. Mary's at 0025 hours on 08/29/17, Wilson was transported to Milwaukee Police Department District #3 at 0056 hours to complete the booking process. Wilson was then transported to the Milwaukee County Jail arriving at 0200 hours. Wilson was booked and assigned to Pod 3B Cell #43 at 1025 hours on 08/29/17.

Near the end of the second shift (1400-2230) on 08/29/17, Correctional Officer Cristal Jackson called for an unknown medical emergency over her jail issued radio at 2156 hours.

Wilson was immediately provided medical treatment and was transported to the Jail Medical Clinic while awaiting transport to a local hospital by EMS for further medical treatment. During this time, staff determined that Wilson was not breathing and did not have a pulse. CPR was administered and the use of an AED was attempted by staff until the Milwaukee Fire Department arrived on scene who continued resuscitation efforts in the Medical Clinic. After consulting with a physician at Froedtert Hospital, Wilson was pronounced deceased at 2255 hours on 08/29/17.

MCSO staff stated that there were no obvious injuries to Wilson and there were no concerns reported by jail or medical staff prior to the medical emergency. Wilson was in a single person cell at the time of this incident and the pod was in lockdown status at the time of the emergency. There was no indication of an altercation between him and other inmates.

### **Medical Examiner's Findings**

On 08/30/17 Detective Christopher Kohl attended the autopsy of Clarence Wilson which was conducted at the Milwaukee County Medical Examiner's Office. The preliminary cause of death was natural and related to heart disease. A final report was conducted by the M.E.'s Office on 09/05/17 with the following ruling noted:

Cause of Death: Acute Coronary artery thrombosis due to atherosclerotic coronary vascular disease.

Other significant condition: Hypertension

Manner of Death: Natural

### **Summary of Investigative Interviews of Witnesses**

The WCSO conducted interviews with all of the law enforcement personnel and medical staff who had direct contact with Mr. Wilson from the time of his detention. A summary of the investigation is provided in chronological order.

On 08/28/17 Clarence Wilson was arrested at his residence after failing a mandatory drug screen through Probation and Parole Agents Christy Mueller and Heather Reihl-Vogel. Wilson was taken into custody by City of Milwaukee Police Officer Artavious Bradford, and during the arrest Wilson was argumentative and later complained of a sore shoulder and arm due to attempting to jerk away from the Officer's grasp. EMS was called at the request of Wilson, and responded. While EMS was evaluating, Wilson became lethargic according to Curtis EMS personnel and was given narcan per their protocol, due to his suspected drug (cocaine) use. Wilson then requested to be seen at a hospital for his arm pain and was subsequently transported to Columbia St. Mary's Hospital for further treatment.

After being medically cleared from Columbia St. Mary's Hospital, Wilson was transported to Milwaukee Police Department District #3 for booking purposes. Upon completion of the



booking process Wilson was transported to the Milwaukee County Jail where Wilson was turned over to jail staff. Wilson was then assigned to Pod 3B of the Milwaukee County Jail and placed into cell #43.

Wilson does not appear to be in any distress and did not advise nursing staff of any health concerns upon his arrival to the jail on 08/29/17. Wilson spent the second half of dayshift in the Pod and was interacting with others and had lunch. Wilson also interacted and had dinner during second shift and neither C.O. Giese nor C.O. Jackson reported any concerns or behavioral issues with Wilson during the shifts on 08/29/17. Wilson's pod was locked in for the evening on 08/29/17 at 2059 hours. The nurse entered the pod at 2100 hours and conducted a medication pass. At 2115 hours 5 new inmates were assigned to the pod and were placed into their assigned cells and entered into the system. C.O. Jackson exited the pod at 2126 hours.

At this point, per policy and procedure, C.O. Jackson should have transferred over control over her pod to Floor Control. The purpose of completing this action is to ensure that in case there is an emergency in the pod or an inmate has an emergency, Floor Control would be able to answer any emergency intercom calls. C.O. Jackson exited her pod without turning over control, which simply consists of her signing out of her Officer Station terminal. This information was later confirmed with the Floor Control Officer. C.O. Jackson returned to her pod at 2156 hours and was immediately notified by inmates that cell #43 was in trouble.

C.O. Jackson immediately responded to Wilson's cell and he advised her that he was having trouble breathing and C.O. Jackson called for a medical emergency. As C.O. Jackson returned to her Officer Station to let other officers in the pod, she realized that her computer screen was "lit up" with inmate's emergency intercom alarms, indicating that inmates had activated their emergency alarms in an attempt to notify staff of the problems. When asked how many had activated their alarms, C.O. Jackson stated "pretty much all of them". That is when C.O. Jackson realized she had not turned over control of the pod to floor control. C.O. Jackson was very honest about not turning over control. Based on statements and video that was obtained, there is nothing to suggest that C.O. Jackson was aware of any distress that Wilson may have been in prior to her exiting the pod. In addition, based on the statements of the pod inmates, which are very consistent, it appears that Wilson does not start suffering from his medical condition until after C.O. Jackson exited the pod.

Once MCSO and medical staff were on scene, Wilson was treated and immediately transported to the medical clinic for further treatment with the expectation to transport him to a hospital for advanced treatment. There did not appear to be any delay in treatment for Wilson after MCSO staff were made aware of Wilson's medical emergency. The time from the original medical emergency call, made by C.O. Jackson, to the MFD arriving on scene was 19 minutes. Staff did not hesitate to start CPR when it was determined that Wilson was PNB, and staff attempted to use an AED during this time.

There is no evidence of foul play and the only concern would be the fact that even though C.O. Jackson knew she should have turned over control of her pod to Floor Control, she did not. There is nothing to suggest that this was an intentional act, as it appears that Wilson was not showing any signs of distress prior to C.O. Jackson leaving the pod and C.O. Jackson

admits she was in a rush near the end of her shift. If C.O. Jackson had in fact turned over control of her pod as trained, it more than likely would have meant a more timely response to the activation of emergency intercom calls.

### **Other Evidence Examined**

The WCSO secured video footage from all relevant times related to Mr. Wilson's detention from time of arrest until his death. There is no indication of abuse or mistreatment of Mr. Wilson captured. In addition, the WCSO interviewed all the police officers, Department of Corrections personnel, medical personnel and County correctional officers who were involved in this time period. Every inmate on Mr. Wilson's pod during his detention was interviewed and the WCSO reviewed all the relevant log data and Armor Correctional medical information related to Mr. Wilson.

### **Legal Assessment**

Sec. 940.285 of the Wisconsin Statutes reads in relevant part:

(a) Any person, other than a person in charge of or employed in a facility under s. 940.29 or in a facility or program under s.940.295(2), who does any of the following may be penalized under par. (b):

1. Intentionally subjects an individual at risk to abuse.
2. Recklessly subjects an individual at risk to abuse.
3. Negligently subjects an individual at risk to abuse.

The area of criminal legal concern related to the natural death of Mr. Wilson while in jail custody is whether or not the failure of Correctional Officer Jackson to switch over the master control function while she left the pod constitutes "subjecting an individual at risk to abuse". In this particular set of circumstances, while obviously of deep concern, the facts do not support a charge for that offense. First, Mr. Wilson's medical issues had been cleared by numerous trained medical professionals. He did not raise any concerns to C.O. Jackson prior to her leaving the pod for the short period of time; Second, C.O. Jackson took immediate and appropriate steps to medically intervene as soon as she became aware of Mr. Wilson's condition; Third, Mr. Wilson was still responding to treatment after he was removed from the cell and taken to the medical clinic. For purposes of criminal liability, it would require evidence on the part of a medical expert to say that the delay in treatment was determinative in the ultimate death of Mr. Wilson. The medical examiner's determination that the manner of death was natural makes criminal liability for "negligently subjecting an individual to abuse" unsupportable.

It is clear from the evidence that C.O. Jackson did not intentionally or recklessly subject Wilson to abuse. With regard to the third prong, under a negligence framework, even acknowledging the strict liability standard of care, I feel the State would still have to demonstrate beyond a reasonable doubt that C.O. Jackson's actions constituted "abuse" and that she should have reasonably known that her actions were likely to cause abuse or harm. The evidence does not support that. This was a mistake by a recently trained correctional

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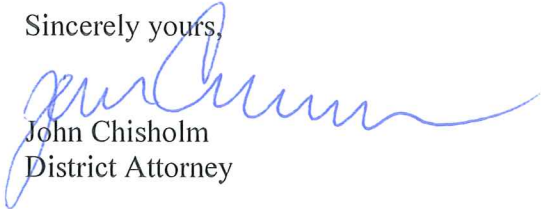
December 12, 2017

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officer. It certainly bears review for administrative correction and training, but it does not rise to the level of criminal misconduct.

I met with a relative of Mr. Wilson accompanied by the lead investigator for the Waukesha Sheriff's Department and investigators from my office and provided him access and information related to the investigation and informed him of this decision.

Sincerely yours,



John Chisholm  
District Attorney

JC/sks

cc: Chief Deputy District Attorney Kent Lovern  
Deputy Inspector Torin J. Misko, Waukesha County Sheriff Department