STATE OF WISCONSIN CIRCUIT COURT BARRON COUNTY

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STATE OF WISCONSIN,

Plaintiff,

v.

RICE LAKE DAY TREATMENT CENTER,
(a.k.a. Northwest Guidance and Counseling Clinic, Inc.)

Defendant.

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# AFFIDAVIT

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I, JOHN KNAPPMILLER, BEING FIRST DULY SWORN UPON OATH DO HEREBY STATE THAT:

1. I am employed as the Chief Investigator for the Medicaid Fraud Control Unit of the Wisconsin Department of Justice and that pursuant to my duties I had the occasion to investigate the death of Angellika Arndt (Angie) while receiving services at the Rice Lake Day Treatment Center (the facility) on May 25, 2006.
2. In the course of my investigation, I collaborated with Detective Chris Fitzgerald of the Rice Lake Police Department. Together we interviewed numerous citizen witnesses, reviewed documents and examined medical records.
3. The results of my investigation are set forth herein; first by way of a brief summary of the circumstances surrounding Angie's death and then set forth with specific detail as to the circumstances supporting criminal charges against the corporate defendant.

## Summary of Investigation

4. My investigation has revealed that Angie was admitted to the facility for treatment of mental disorders, after having been cared for by a previous treatment facility located in Eau Claire, Wisconsin.

5. My investigation has further revealed that from the time of her admission to the time of her death, there had been numerous acts and omissions by employees of the facility that had compromised Angie's safety. Arguably however, none of those acts or omissions have sufficient evidence to support criminal charges, *beyond a reasonable doubt*, except those contained, infra, under "Stipulated Facts". Some of the acts and omissions include the following:

   a. At the time of admission, staff failed to adequately consult records containing the medical/psychological history of Angie, including the evaluations of interventions used in her placement at the Eau Claire facility.

   b. Essential staff failed to consult the treatment plan prepared for Angie upon admission prior to providing services to her.

   c. Although the facility maintained the authority to restrain Angie, insufficient guidance was provided to staff members in the proper implementation of the facility's highly ambiguous written restraint policy.

      i. This internally inconsistent policy inadequately defined what circumstances required restraint, vesting broad decision-making authority in largely unskilled staff.

   d. The "emergency" restraint policy became the justification for the almost daily physical restraint of Angie.

e. Failure of internal communications, inadequate record keeping and a lack of coherent supervisory oversight contributed to the failure to adequately respond to the behavioral needs of Angie.

    i. Despite having a physician and registered nurse on staff, evidence of a pattern of defiance and aggressive behavior by Angie was not addressed by medical professionals or a multidisciplinary team in a timely fashion, resulting in the *defacto* use of restraint as a disciplinary measure.
    ii. Consultation with the Eau Claire facility staff and Angie's former teachers would have revealed that, at no time, were they ever required to physically restrain her. Such an exchange of information may have been useful to the facility in devising an effective treatment plan.

f. The staff member that was responsible for the training of all staff in proper restraint techniques, Mr. Tim McIntyre had, himself, never actually received any appropriate training. Rather, the methods that McIntyre taught were self-devised and substandard, including his use of the *face-down-on-the-floor-hold* used on Angie on the day of her death*.

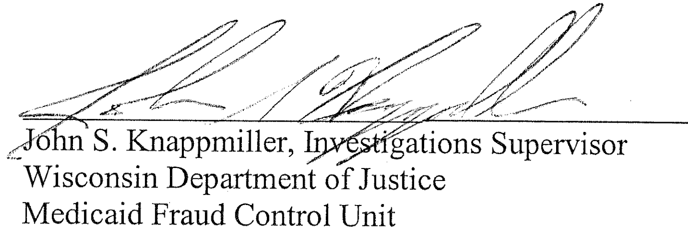
    i. (*However, available evidence suggests that, as inappropriate as the restraint methods taught by McIntyre were, had this particular method been faithfully executed in accordance with the his instructions, it is plausible that Angie may not have died as a result of the restraint.)

**Stipulated Facts**

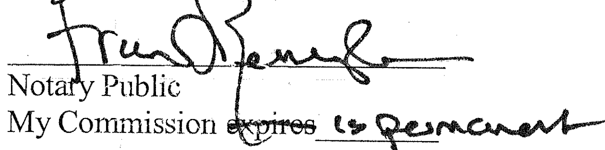
6. My investigation has revealed that on May 25, 2006, Angellika Arndt (Angie) age 7, was a patient at the Rice Lake Day Treatment Center (the facility), located at 413 South Main Street, in the City of Rice Lake, Barron County, a licensed treatment center and a program of Northwest Guidance and Counseling Clinic, Inc. (the defendant)

7. On that date, Mr. Brad Rideout was employed by the defendant and was working in the facility.
8. Pursuant to his duties, Rideout was summoned to assist another employee in the restraint of Angie. At that time, Angie was laying in a prone position, face down on a thinly-carpeted cement floor. The other employee restrained Angie's legs while Rideout covered Angie's upper torso with his own, initially supporting the majority of his weight by his elbows. During this lengthy period of restraint, Angie was crying, screaming and resisting his efforts to restrain her. During the later course of the restraint, Rideout reached over and attempted to control Angie's head, which was thrashing about. After Rideout had restrained her for a period of approximately 30 minutes, Angie became calm and ultimately, listless. Although initially believing that she had fallen asleep, Rideout, upon rolling Angie over, observed that she had turned a bluish color and was non-responsive. Attempts at reviving Angie were unsuccessful.
9. An autopsy was conducted by the Hennepin County, Minnesota, Medical Examiner's Office. This office ruled that Angie's death was caused by positional asphyxia. A review of records reveal that Angie died in the course of Rideout's restraint; his body weight upon her back significantly impaired and ultimately precluded, her ability to breath.

Dated this 29th day of November, 2006.



John S. Knappmiller, Investigations Supervisor
Wisconsin Department of Justice
Medicaid Fraud Control Unit



Subscribed and sworn to before me
this 29th day of November, 2006

Notary Public
My Commission ~~expires~~ is permanent