UNITED STATES DISTRICT COURT FOR
THE WESTERN DISTRICT OF WISCONSIN

---

SYDNI BRIGGS
(by her guardian Jennifer Briggs),

Plaintiff,

v. Case No.: 17-CV-62

ANDREW YORDE, STACEY DAIGLE,
JAMES LARKIN, TONI MOORE,
MARK SKOLASKI, DARRELL STETZER,
DR. GABRIELLA HANGIANDREOU,
CASSANDRA JENNINGS, ED WALL,
JOHN OURADA, WENDY PETERSON,
PAUL WESTERHAUS and THE MEDICAL COLLEGE OF WISCONSIN, INC. and
WISCONSIN INJURED PATIENTS COMPENSATION FUND,

Defendants.

---

**COMPLAINT**

---

NOW COMES THE PLAINTIFF, Sydni Briggs, by her attorneys Atterbury, Kammer & Haag, by Eric J. Haag and Gingras, Cates & Luebke by Paul A. Kinne, and hereby states the following as her Complaint in the above-referenced matter.

**NATURE OF THE PROCEEDINGS**

1. This is a civil action under 42 U.S.C. sec. 1983, the Fourth, Eighth and Fourteenth Amendments to the United States Constitution, including but not limited to the Substantive Due Process Clause, and state law negligence claims brought to redress the cruel and unusual punishment the defendants inflicted upon Briggs when they were deliberately indifferent to her serious medical condition (suicidality and mental illness), their deliberate indifference to her suicide attempt, and / or their negligent treatment of her.

**PARTIES**

2. At all times relevant to this case, Sydni Briggs (Briggs) has been a minor residing within the Western District of Wisconsin.

3. Briggs is legally disabled. Her guardian is her mother, Jennifer Briggs.

4. At all times relevant hereto, Andrew Yorde (Yorde) was a Youth Counselor working at the Copper Lake facility. All conduct attributed to him in this complaint was undertaken intentionally, under color of state law and within the scope of his employment. Briggs brings her complaint against him in his individual capacity.

5. At all times relevant hereto, Stacey Daigle (Daigle) was a Youth Counselor Advanced working at the Copper Lake facility. All conduct attributed to her in this complaint was undertaken intentionally, under color of state law and within the scope of her employment. Briggs brings her complaint against Daigle in Daigle's individual capacity.

6. At all times relevant hereto, James Larkin (Larkin) was a Youth Counselor Advanced working at the Copper Lake facility. All conduct attributed to him in this complaint was undertaken intentionally, under color of state law and within the scope of his employment. Briggs brings her complaint against him in his individual capacity.

7. At all times relevant hereto, Toni Moore (Moore) was a Youth Counselor working at the Copper Lake facility. All conduct attributed to her in this complaint was undertaken intentionally, under color of state law and within the scope of her employment. Briggs brings her complaint against Moore in Moore's individual capacity.

8. At all times relevant hereto, Mark Skolaski (Skolaski) was a Supervising Youth Counselor working at the Copper Lake facility. All conduct attributed to him in this complaint

was undertaken intentionally, under color of state law and within the scope of his employment. Briggs brings her complaint against him in his individual capacity.

9. At all times relevant hereto, Darrell Stetzer (Stetzer) was a Youth Counselor working at the Copper Lake facility. All conduct attributed to him in this complaint was undertaken intentionally, under color of state law and within the scope of his employment. Briggs brings her complaint against him in his individual capacity.

10. Dr. Gabriella Hangiandreou (Hangiandreou) was employed by The Medical College of Wisconsin, Inc., but was working under contract at Copper Lake as a psychiatrist at all times relevant to this complaint. With respect to federal claims, all conduct attributed to her in this complaint was undertaken intentionally, under color of state law and within the scope of her employment. Briggs brings her complaint against Hangiandreou in Hangiandreou's individual capacity.

11. Cassandra Jennings (Jennings) was at all times relevant to this complaint working at the Copper Lake facility as a psychologist. All conduct attributed to her in this complaint was undertaken intentionally, under color of state law and within the scope of her employment. Briggs brings her complaint against Jennings' in Jennings' individual capacity.

12. At all times relevant hereto, Ed Wall (Wall) served as the State of Wisconsin Secretary of the Department of Corrections. All conduct attributed to him in this complaint was undertaken intentionally, under color of state law and within the scope of his employment. Briggs brings her complaint against him in his individual capacity.

13. At all times relevant hereto, John Ourada (Ourada) served as the Superintendent or Deputy Superintendent at the Copper Lake facility. All conduct attributed to him in this complaint was undertaken intentionally, under color of state law and within the scope of his

employment. Briggs brings her complaint against him in his individual capacity.

14. At all times relevant hereto, Wendy Peterson (Peterson) was employed at Copper Lake either as the Superintendent or the Deputy Superintendent. All conduct attributed to her in this complaint was undertaken intentionally, under color of state law and within the scope of her employment. Briggs brings her complaint against Peterson in Peterson's individual capacity.

15. At all times relevant hereto, Paul Westerhaus (Westerhaus) served as the Superintendent at Copper Lake. All conduct attributed to him in this complaint was undertaken intentionally, under color of state law and within the scope of his employment. Briggs brings her complaint against him in his individual capacity.

16. Defendant Wisconsin Injured Patients Compensation Fund was created pursuant to sec. 655.27, Wis. Stats., having its principal place of business at 125 S. Webster St., Madison, Wisconsin, 53702, and is liable for damages incurred as a result of the negligence of Dr. Hangiandreou, which are in excess of the limits specified in sec. 655.23(4), Stats.

**JURISDICTION and VENUE**

17. This court has jurisdiction over plaintiff's claims pursuant to 42 U.S.C. sec. 1983, the Fourth, Eighth and Fourteenth Amendments to the United States Constitution, and 28 U.S.C. secs. 1331 and 1343. It has jurisdiction over the state law claims pursuant to 28 U.S.C. sec. 1367(a).

18. Venue in the Western District of Wisconsin pursuant to 28 U.S.C. sec. 1391 is proper insofar as the parties are or were located in this district, and the events giving rise to the claims took place within this district.

## FACTUAL ALLEGATIONS

19. Copper Lake School for Girls and Lincoln Hills are juvenile detention centers managed by the State of Wisconsin Department of Corrections.

20. It is the duty of the State of Wisconsin Department of Corrections to assure the safe, secure and humane treatment of youth entrusted to their custody.

21. In 2011, the administration of Governor Scott Walker closed two juvenile facilities in southeastern Wisconsin as a cost saving measure. It moved all juvenile detainees to Copper Lake and Lincoln Hills, two facilities that existed physically side by side, only separated by a fence and razor wire, and shared staff. It moved the male juveniles to Lincoln Hills, and the female juveniles to Copper Lake. The shared facility is located near Irma, Wisconsin.

22. Detainees at Lincoln Hills and Copper Lake frequently suffered from mental health issues, which led to increased behavioral issues.

23. More than 100 inmates were transferred to Lincoln Hills alone over several months in 2011, nearly doubling the population there. While the number of detainees increased dramatically, the amount of staff at Lincoln Hills and Copper Lake did not. There were chronic shortages of staff at the two facilities, and those who did work at the facilities were overworked and stretched thin.

24. Staff was also plagued by a lack of training or inadequate training.

25. A video used for training staff at the facilities actually used excessive force, a fact since verified by the Department of Corrections.

26. At the same time staff at Lincoln Hills and Copper Lake were experiencing difficult working conditions, Act 10 led to a decrease in their wages.

27. Guards at Lincoln Hills and Copper Lake are referred to as Youth Counselors.

28. Copper Lake had policies and procedures with respect to suicide prevention. The policy stated that all youth were to be screened at intake for suicide risk and risk of self-harm.

29. The policy further stated that all youth who had a history of serious self-harm behavior, or who engaged in self-harm after arriving at the facility, were designated as an "At Risk" youth, and assigned a "-2" status.

30. Staff was to document any indications of youth self-harm behavior, and communicate that information to other staff and the psychologist assigned to the youth's living unit or the on-call psychologist.

31. Room assignments were to take into consideration self-harm risk. No youth was to be assigned to a room with a bunk bed unless that youth had a roommate. In fact, unless the circumstances precluded it, all youth were to be assigned a roommate.

32. Careful observation was an essential component of a suicide prevention program.

33. Youth who engaged in significant self-harm behavior or who appeared to be at high risk for self-harm were to be placed in a security living unit with limited access to items the youth might use to harm herself. The youth was also to be placed on Observation Status if she appeared to be mentally ill and dangerous or if she was experiencing acute mental distress.

34. Staff was to use in-room cameras to monitor At-Risk youth behavior.

35. Youth who committed acts of self-harm were to be placed on Observation Status, which entailed extra room checks, special clothing and medical care.

36. Untrained staff was to make the determination as to whether a youth was mentally ill and dangerous or experiencing acute mental distress.

37. The policies at Copper Lake also noted that following a suicide attempt, the manner and promptness of staff's intervention often determined the fate of the victim. During a

life threatening self-harm emergency, the staff member discovering the situation was to set off his or her personal alarm, and to immediately enter the youth's room if the youth's life appeared to be in immediate jeopardy.

38. When a staff member concluded that a delay of even a few minutes could increase the chance of a youth's death, the staff member was to immediately call 911 for emergency help.

39. Youth at Copper Lake are housed in locked rooms, or cells, along corridors. Each cell is equipped with a call light that detainees are to use if they need assistance. The policy at Copper Lake is that someone is always to be stationed at the command center ("the bubble") to monitor and respond to the call lights. The call lights are the only way in which a youth can signal staff that there is an emergency.

40. In late 2011 or early 2012, a Lincoln Hills detainee was forced to perform oral sex on his roommate, and then he was savagely beaten by his roommate afterwards. Workers at Lincoln Hills discovered the assault at 4:00 p.m., but did not seek medical care for the abuse victim until three hours had passed. Six hours after the assault, hospital workers, not Lincoln Hills staff, reported it to the police. When the victim returned to Lincoln Hills, he was sent to segregated housing as punishment for disruptive behavior.

41. Staff's explanation for not immediately responding to the emergency was that it would have required them to interrupt a basketball game.

42. In February 2012, Racine County Circuit Court Judge Richard Kreul wrote to Governor Scott Walker and expressed grave concerns about the safety of youth at the facilities: "Almost 50 years in the legal system and I've seen and heard a lot, so [I'm] not naïve as to what 'prison' is all about. But the indifference in this sordid tale is absolutely inexcusable. I'll be thinking long and hard before sending another youth to that place!"

43. Being sent to segregation meant the detainee would be separated from the population and isolated. Staff at the facilities was sending kids to segregation even when psychologists were recommending against it.

44. By fall, 2014, many detainees at Lincoln Hills and Copper Lake were not being offered any schooling.

45. In 2014, the Wisconsin Department of Corrections launched an internal investigation into misconduct at Lincoln Hills and Copper Lake.

46. In early 2015, a criminal investigation into misconduct at Lincoln Hills and Copper Lake commenced. The criminal investigation focused upon allegations of prisoner abuse, child neglect, sexual assault, intimidation of witnesses and victims, strangulation and destroying evidence.

47. In July, 2015, an audit of Lincoln Hills and Copper Lake found that notification lights over the doors of individual cells lit by the detainee remained on without an immediate response from staff. Policy dictated that the staff office respond to the light by two-way intercom to determine the detainee's need, and then extinguish the light. Remedial training on responding to the notification lights was to be immediately undertaken.

48. On October 1, 2015, both staff and detainees at Copper Lake were yelling and quarreling. A dispute arose between one of the detainees (a female) and a Youth Counselor (male). It ended with the guard pushing the female against the wall by the neck.

49. Staff at Lincoln Hills and Copper Lake were also using physical restraint techniques that were dangerous. For example, staff was trained to use a knee to the back to restrain a resisting detainee, when that could cause suffocation. Video surveillance confirmed that staff was using the technique.

50. The staff member in charge of training other staff on the use of physical restraint failed to contact nurses when detainees were injured; he changed techniques by his own decision instead of getting supervisor approval; and he did not require staff under his supervision to file reports when they used force, in spite of the rules. In July, 2015, this staff member led a group of Youth Counselors on a pepper spray attack that created a cloud of gas so thick that the Youth Counselors could not enter the room of the detainee targeted by the pepper spray.

51. On October 22, 2015, Lincoln County Circuit Court Judge Robert Russell found reason to believe that second-degree sexual assault, physical child abuse, intimidation of victims and witnesses, child neglect, abuse of prisoners, strangulation and suffocation, abuse of pepper spray, tampering with public records and misconduct in public office had been committed, leading to the creation of a John Doe investigation into Lincoln Hills and Copper Lake.

52. On November 29, 2015, staff at Lincoln Hills had an altercation with a male juvenile detainee. A staff member forcibly threw the juvenile into his cell and slammed the door, crushing his foot. The door had slammed so powerfully on his foot that he lost parts of two toes. Staff at Lincoln Hills waited two hours to provide care to the juvenile, eventually taking him to the hospital where the juvenile received surgical care, partially amputating his two toes.

53. In a December 2, 2015 memo from Secretary Wall to "All Division Administrators" and "Chief Legal Counsel," Wall disclosed that as a result of DOJ's recent investigation, they were concerned that there was a "culture at CL/LHS with some staff that may leave youth at risk for harm."

54. Prior to November, 2015, suicide attempts had become disturbingly common at the two juvenile detention centers, but especially at Copper Lake. One Youth Counselor commented that he had to sharpen his "911 knife" – a device used to cut ligatures detainees had

tied around their necks – at the beginning of every shift. Suicide attempts at Copper Lake had become so common that the Youth Counselor had lost track of how many had taken place. In the time leading up to Briggs' suicide attempt, suicide attempts at Copper Lake were occurring at a rate of about two per week. (One term used for these attempts was "tying off," and staff characterized the behavior as merely attention seeking.) Girls who "tied off" were not sent for follow-up examinations, contrary to policy.

55. One attempt – a female detainee took pills and tried to hang herself – took place in December, 2015, during the state's investigation into Copper Lake and Lincoln Hills. She was discovered unconscious.

56. Hangings and suicide attempts were not the only form of self-harm that were a problem at Copper Lake and Lincoln Hills. Many detainees would cut themselves with objects, or intentionally open wounds with whatever they could find.

57. Briggs lived with her mother, father and siblings earlier in her life. However, due to poor choices and a difficult and unstable upbringing, she turned to drugs and alcohol for comfort. She ended up associating with peers who used poor judgment, and she started committing petty crimes.

58. Briggs was assigned to group homes, but she would run away. Eventually, she was assigned to Copper Lake.

59. Briggs began her incarceration at Copper Lake on July 8, 2015. She was officially incarcerated for burglary and theft. Her target release date was February, 2016. She was 16 years old when she entered Copper Lake.

60. Upon intake, Briggs noted that she had in the past seriously thought about suicide.

61. On July 9, 2015, Jennings noted that Briggs was prescribed psychotropic drugs

that she was not taking, and that she had been diagnosed with bipolar disorder and anxiety. On that same date, Briggs herself admitted to at least three acts of self-harm, one occurring within the previous six months.

62. Also on July 9, 2015, Jennings noted and was aware of Briggs' alcoholism and her history of drug use. Jennings classified Briggs as a Serious Mental Health Need case.

63. On July 13, 2015, in a session with Dr. Hangiandreou, Briggs reported her history of self-harm and significant suicidal thoughts.

64. On July 27, 2015, Hangiandreou noted Briggs' family history of successful suicide attempts and a history of physical abuse.

65. On July 30, 2015, Jennings noted that Briggs had experienced a significant traumatic event when she was 13 years old, and Jennings noted a recent act of self-harm.

66. By August 10, 2015, Copper Lake records indicate that Briggs was depressed and homesick. She had also already engaged in multiple acts of self-harm while at Copper Lake for just over a month.

67. On August 27, 2015, Briggs engaged in another act of self-harm. She used her fingernails to gouge a cut into her arm. Days later, she had picked the scab off, not allowing the wound to heal.

68. On September 14, 2015, Hangiandreou made reference to Briggs' depression and suicidal thoughts. She further made reference to Briggs' mental illnesses, including Post Traumatic Stress Disorder (PTSD).

69. On September 30, 2015, Briggs notified Copper Lake staff that she was not taking her medication.

70. On October 12, 2015, Briggs engaged in an act of self-harm. She used her

fingernails to gouge cuts into her arm. Medical staff placed her on 15 minute checks. That is, staff was supposed to make visual contact with her at least every 15 minutes to ensure that she had not harmed herself, or was not in the process of doing so.

71. On October 12, 2015, Jennings noted Briggs' increased thoughts of self-harm, and her history of self-harm. She noted a traumatic event that was causing Briggs to experience intrusive thoughts, and that Briggs felt depressed. Briggs was to remain in her cottage, on 15 minute checks.

72. On October 13, 2015, Jennings noted Briggs' 15 minute checks on the Suicide Check Level, and that she experienced thoughts of self-harm with recent self-harm. Jennings documented that Briggs felt "hopeless" and that she had engaged in previous suicidal behavior. Briggs reported feeling "a lot more depressed" to staff.

73. On October 14, 2015, Jennings noted Briggs' 15 minute checks on the Suicide Check Level, and that she experienced thoughts of self-harm with recent self-harm. Jennings documented that Briggs had engaged in previous suicidal behavior.

74. Jennings removed Briggs from 15 minute checks on the morning of October 14, 2015.

75. On October 15, 2015, Jennings again noted Briggs' feelings of increased depression and self-harm.

76. Jennings reinstated 15 minute checks for Briggs just before noon on October 15th.

77. On October 16, 2015, Jennings noted Briggs' 15 minute checks on the Suicide Check Level, and that she experienced thoughts of self-harm with recent self-harm. Jennings documented that Briggs felt "hopeless" and that she had engaged in previous suicidal behavior.

78. On October 15, 2015, Jennings noted Briggs' increased thoughts of self-harm, and

her history of self-harm. She noted a "recently disclosed traumatic life event," and that Briggs felt depressed. Her records also noted that she was depressed. Briggs was to remain in her room, on 15 minute checks.

79. On October 17, 2015, Skolaski completed a Daily Self-Harm Assessment, wherein he noted that she was "a little depressed" under the category of "Identified Suicidal Behavior." However, he removed Briggs from 15 minute check status in the afternoon of the 17th.

80. On October 19, 2015, Hangiandreou documented numerous alarming things about Briggs, including that she had been having suicidal thoughts and she was suffering from passive thoughts that life was not worth living. Hangiandreou noted that she suffered from worsening anxiety, depression and thoughts of self-injury and suicide. Hangiandreou further noted that Briggs had just recently reported a previously undisclosed traumatic event that she had kept to herself until recently. She reported that Briggs was having an increase in intrusive thoughts and flashbacks related to those events. She noted that Briggs had cut her hair off and that her affect was subdued. Hangiandreou diagnosed Briggs with Post Traumatic Stress Disorder, Bipolar Disorder, and Anxiety Disorder.

81. On October 26, 2015, Briggs' records indicate that her anxiety was worse, thus causing her to create a self-inflicted mouth wound. Briggs was disciplined for engaging in self-harm, even though she explained that she couldn't help herself, she was just too anxious and nervous.

82. In late October and early November, Briggs was showing other clear signs of emotional distress. For example, she had abruptly cut her hair very short. She reported frequent vomiting. She had intentionally chewed on the inside of her mouth until it bled, which was first

documented on October 25, 2015.

83. Despite all of these warning signs and actual self-harm behavior, after her October 19th appointment with Dr. Hangiandreou, Briggs was not placed in observation status, nor were any 5, 10, or 15 minute checks for her well-being implemented, nor were Youth Counselors informed of her risk of suicide, nor was she given a roommate, nor was she placed in a room with a camera.

84. State of Wisconsin Division of Juvenile Corrections Internal Management Procedures regarding Suicide Prevention mandate that each juvenile correctional institution must have policies in place that incorporate certain procedures. Included therein is the mandate that a standardized protocol for handling all incidents of actual self-harm will be adopted in which a youth will be placed on 5 minute checks or 1:1 monitoring after engaging in self harm.

85. After October 25th, Briggs was not placed on 5 minute checks nor was she placed on 1:1 monitoring.

86. On November 9, 2015, Briggs was in Room 6 in the Wells Living Unit. Her cell / room did not have an observation camera. Her room was in the section of Copper Lake reserved for At Risk detainees. She did not have a roommate. She was not on observation status, nor was she on checks, such as 5 or 10 or 15 minute checks. She was not in suicide prevention clothing.

87. Some unknown number of minutes prior to 7:54 a.m., Briggs had pressed her emergency call light in her room. However, neither Yorde nor anyone else responded to her call for assistance, either by intercom or in person.

88. Requests to DOC and Copper Lake for video footage that would show the amount of time Briggs' call light was on prior to being responded to have been denied.

89. After pressing her call light, Briggs tied one end of her T-shirt around the top door

hinge to the inside of her room, and the other end around her neck. She then hanged herself in her room.

90. At the time Briggs pressed her call light, Yorde was responding to a bathroom call in the "high hall" section of Wells. When he returned to "low hall" sometime around 7:54 a.m., he noticed several call lights had come on in low hall while he had been gone. Eventually Yorde went to Briggs' room and inquired as to her needs. When she did not respond, he asked again. Then, he looked in the room and found her hanging from the hinge.

91. Upon discovering her hanging, he activated his body alarm. He did not have the 911 knife, so he asked who had it. Yorde did not immediately enter the room. Eventually, he and Stetzer entered Briggs' room, and cut her down.

92. Daigle responded to Yorde's alarm. When Daigle, who had come from her assigned post in Wells Living Unit, discovered Briggs unresponsive on the floor, Briggs was gray and not breathing. Daigle and Stetzer began cardio pulmonary resuscitation (CPR).

93. When Nurse Haase was originally paged, she was not told that there was a life threatening emergency. When she was finally informed of the nature of the emergency, she had to instruct staff to call 911 since no one had called yet.

94. EMT's eventually arrived and transported Briggs to the hospital.

95. Yorde, Stetzer, Daigle, Skolaski, Moore and Larkin knew that Briggs had a history of self-harm and suicidality; that there had been many other suicide attempts and acts of self-harm by her peers at Copper Lake in the recent past; that she had a history of recent psychological trouble; that she was housed in the At Risk housing section at Copper Lake; that she did not have a roommate; that there was no camera in her room; that she had materials in her room with which she could harm herself; and that her call light was activated. However, none of

them reacted to her call light in a timely, urgent fashion.

96. As a result of the events of November 9, 2015, Briggs suffered a severe anoxic brain injury. She cannot walk. Her speech is comparable to a very young child. She remains severely disabled, and will remain that way for the rest of her life, requiring 24/7 care in a long term care facility.

**FIRST CAUSE OF ACTION AGAINST YORDE, DAIGLE, LARKIN, MOORE, SKOLASKI, and STETZER – DELIBERATE INDIFFERENCE TO A SERIOUS MEDICAL NEED**

97. The plaintiff restates the foregoing paragraphs as if set forth fully herein.

98. Yorde was aware that Briggs' call light was on, but responded in a delayed fashion, in spite of his knowledge that Briggs had a history of self-harm and suicidality; that there had been many other suicide attempts by her peers at Copper Lake in the recent past; that she had a history of recent psychological trouble; that she was housed in the At Risk housing section at Copper Lake; that she did not have a roommate; that there was no camera in her room; that she had materials in her room with which she could harm herself; and that her call light was activated.

99. When Yorde was at Briggs' cell door, he delayed entry and delayed calling 911, in spite of his knowledge that Briggs was hanging.

100. Yorde, Daigle, Larkin, Moore, Skolaski and / or Stetzer knew or should have known that Briggs' call light was on but did not respond at all or in a timely fashion, in spite of the respective knowledge that Briggs had a history of self-harm and suicidality; that there had been many other suicide attempts by her peers at Copper Lake in the recent past; that she had a history of recent psychological trouble; that she was housed in the At Risk housing section at Copper Lake; that she did not have a roommate; that there was no camera in her room; that she

had materials in her room with which she could harm herself; and that Yorde was not present himself to respond.

101. The conduct described above violated Briggs' rights as protected by the Eighth and Fourteenth Amendments to the United States Constitution, in that it constitutes cruel and unusual punishment given their deliberate indifference to her serious medical need: she was at high risk for death by suicide.

102. This conduct has caused severe and permanent emotional, physical and economic damages which are permanent in nature.

**FIRST CAUSE OF ACTION AGAINST HANGIANDREOU AND JENNINGS - DELIBERATE INDIFFERENCE TO A SERIOUS MEDICAL NEED**

103. The plaintiff restates the foregoing paragraphs as if set forth fully herein.

104. Hangiandreou and Jennings failed to communicate to the Youth Counselors or their supervisors the degree of suicide risk Briggs faced. They failed to place her on observation status, in contravention of policy. They knew that Copper Lake was understaffed, and they knew that there had been a regular series of suicide attempts at Copper Lake. They failed to ensure that Briggs was placed in a cell with a roommate; that she was subjected to frequent safety checks; that she was placed in a cell with a camera; and that she was placed in cell without materials that could be harmful to her. They also failed to ensure that Briggs received frequent therapy to treat her condition.

105. By engaging in the foregoing conduct, Hangiandreou and Jennings violated Briggs' rights as protected by the Eighth and Fourteenth Amendments to the United States Constitution, in that it constitutes cruel and unusual punishment given their deliberate indifference to her serious medical need: she was at high risk for death by suicide.

106. This conduct has caused severe and permanent emotional, physical and economic damages which are permanent in nature.

**FIRST CAUSE OF ACTION AGAINST WALL, OURADA, PETERSON AND WESTERHAUS – DELIBERATE INDIFFERENCE TO A SERIOUS MEDICAL NEED**

107. The plaintiff restates the foregoing paragraphs as if set forth fully herein.

108. Wall, Ourada, Peterson and / or Westerhaus were all aware of the chronic problems and deficiencies at Copper Lake. They knew that staff was stretched too thin. They knew that they were under-trained on how to prevent suicide attempts. They knew that a prolonged rash of suicide attempts had taken place at Copper Lake. Given the large number of attempts, it was only a matter of time before one was fatal.

109. In spite of this knowledge, none of the following defendants – Wall, Ourada, Peterson or Westerhaus – provided extra training to staff; implemented new policies; changed non-performing policies; or ensured that staff had the tools necessary to deal with a population at high risk of suicide, i.e., cameras for every room housing an inmate known to be at a higher risk for self-harm.

110. By engaging in the foregoing conduct, Wall, Ourada, Peterson or Westerhaus violated Briggs' rights as protected by the Eighth and Fourteenth Amendments to the United States Constitution, in that it constitutes cruel and unusual punishment given their deliberate indifference to her serious medical need: she was at high risk for death by suicide.

111. This conduct has caused severe and permanent emotion, physical and economic damages which are permanent in nature.

**FIRST CAUSE OF ACTION AGAINST THE MEDICAL COLLEGE OF WISCONSIN, INC.,
HANGIANDREOU– STATE LAW NEGLIGENCE CLAIMS**

112. Plaintiff restates the foregoing paragraphs as if set forth fully herein.

113. Dr. Hangiandreou was employed by The Medical College of Wisconsin, Inc. (MCW), which is self-insured, and was providing psychiatric treatment to youth at Copper Lake through a contract between MCW and the State of Wisconsin, Department of Corrections. That contract obligates MCW to provide malpractice insurance for Dr. Hangiandreou or other MCW doctors practicing at Copper Lake.

114. Dr. Hangiandreou was negligent in her care and treatment of Miss Briggs, and deviated from the applicable standard of care. That failure to exercise the degree of care, skill and judgement that reasonable physicians would exercise under the same or similar circumstances includes but is not limited to: failing to place Miss Briggs on Observation Status or frequent checks; failing to engage in more frequent follow up care with Miss Briggs after the alarming information she learned on October 19th; failing to share the information she learned on October 19th with nurses, supervisors and youth counselors at Copper Lake; failing to recognize signs of suicidality presented by Briggs and failing to determine that Briggs was a high suicide risk; and failing to follow up with Briggs after her October 25th self-harm incident.

115. Such negligence was a cause of harm to Briggs. That harm includes past and future medical expenses, past and future pain and suffering, loss of earning capacity, and loss of enjoyment of life.

WHEREFORE, Briggs prays that this matter be heard by a jury of six competent jurors, and for the following relief:

1. Judgment in an amount sufficient to compensate Briggs for her harms and losses;

2. Equitable relief designed to prevent future violations of the law;

3. Punitive damages sufficient to punish the defendants and deter others from acting

similarly in the future;

4. Pre- and post-judgment interest;

5. An award of attorneys' fees and costs; and

6. Any other relief the Court deems just to award.

Dated this 30th day of January, 2017.

**s/ Eric J. Haag**
Attorney Eric J. Haag
State Bar No.: 1026958
Atterbury, Kammer & Haag
8500 Greenway Blvd. Suite 103
Middleton, WI 53562
Telephone: 608-821-4600
Fax: 608-821-4610
ehaag@wiscinjurylawyers.com

**s/ Paul A. Kinne**
Attorney Paul A. Kinne
State Bar No. 1021493
Gingras, Cates & Luebke
8150 Excelsior Drive
Madison, WI 53717
Telephone: 608-833-2632
Fax: 608-833-2874
kinne@gcllawyers.com