Filed in District Court
State of Minnesota
3/7/2025

State of Minnesota
County of Beltrami

District Court
9th Judicial District

Prosecutor File No. 36.GI60.0204
Court File No. 04-CR-25-620

State of Minnesota,

Plaintiff,

vs.

MICHELLE ROSE SKROCH DOB: 01/15/1988

608 Kendall Court
Sartell, MN 55377

Defendant.

COMPLAINT

Summons

The Complainant submits this complaint to the Court and states that there is probable cause to believe Defendant committed the following offense(s):

COUNT I

Charge: Manslaughter in the Second Degree – Culpable Negligence
Minnesota Statute: 609.205(1)
Maximum Sentence: Imprisonment for not more than 10 years, or to payment of a fine of not more than $20,000, or both
Offense Level: Felony

Offense Date (on or about): 09/01/2018 to 09/02/2018

Control #(ICR#): 20200459

Charge Description: The defendant, Michelle Rose Skroch, caused the death of H.S. on or about September 2, 2018, by her culpable negligence, whereby the defendant created an unreasonable risk, and consciously took chances of causing death or great bodily harm to H.S. on or about September 1, 2018, through September 2, 2018, in Beltrami County, Minnesota.

COUNT II

Charge: Criminal Neglect – Felony Deprivation – Knowingly Deprived
Minnesota Statute: 609.233.1a(1)
Maximum Sentence: Imprisonment for not more than 10 years, or to payment of a fine of not more than $10,000, or both
Offense Level: Felony

Offense Date (on or about): 09/01/2018 to 09/02/2018

Control #(ICR#): 20200459

Charge Description: On or about September 1, 2018, through September 2, 2018, in Beltrami County, Minnesota, the defendant, Michelle Rose Skroch, a caregiver or operator, intentionally deprived H.S., a vulnerable adult, of necessary food, clothing, shelter, health care, or supervision, when the defendant was reasonably able to make the necessary provisions, the defendant knew or had reason to know the

deprivation could likely result in substantial bodily harm or great bodily harm to H.S., and the conduct resulted in great bodily harm to H.S.

COUNT III

Charge: Criminal Neglect – Felony Deprivation – Extended Period of Time
Minnesota Statute: 609.233.1a(2)
Maximum Sentence: Imprisonment for not more than 10 years, or to payment of a fine of not more than $10,000.00, or both
Offense Level: Felony

Offense Date (on or about): 09/01/2018 to 09/02/2018

Control #(ICR#): 20200459

Charge Description: On or about September 1, 2018, through September 2, 2018, in Beltrami County, Minnesota, the defendant, Michelle Rose Skroch, a caregiver or operator, intentionally deprived H.S., a vulnerable adult, of necessary food, clothing, shelter, health care, or supervision, when the defendant was reasonably able to make the necessary provisions, the deprivation occurred over an extended period of time, and the conduct resulted in great bodily harm to H.S.

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Your Complainant, Sam McGinnis, states as follows:

I am an Assistant Special Agent in Charge ("ASAIC") with the Minnesota Bureau of Criminal Apprehension ("BCA"), and I am a licensed peace officer in the State of Minnesota. As part of my duties as a BCA ASAIC, I investigate violations of Minnesota law, including criminal offenses under Minnesota Statutes, Chapter 609.

I base this complaint on my personal knowledge, as well as information I have received from other law enforcement personnel and persons with knowledge of relevant facts, including, but not limited to: reports by other BCA agents and other law enforcement agencies; witness interviews; and other records and evidence I have reviewed during the course of my investigation, including surveillance footage. I have not included every fact known to me concerning this investigation. I have set forth only the facts that I believe are necessary to establish probable cause to believe that the defendant, Michelle Rose Skroch (DOB 01/15/1988) ("Defendant"), committed the offenses alleged in this Complaint.

Defendant began working as a nurse for MEnD Correctional Care, LLC ("MEnD") in 2010, and was a board-licensed registered nurse ("RN") in Minnesota until 2023. In 2012, Defendant earned a Certified Correctional Health Professional ("CCHP") certification from the National Commission on Correctional Health Care ("NCCHC"). She later earned an advanced CCHP certification with an RN endorsement ("CCHP-RN") from the NCCHC. From 2011 to 2014, Defendant trained MEnD staff and became MEnD's Director of Training. In 2017, Defendant became the Director of Nursing Services for MEnD. As the Director of Nursing Services, she oversaw the nursing care provided to inmates at all MEnD facilities and occupied a position of managerial or supervisory authority.

MEnD was a medical service provider for correctional facilities. MEnD contracted with over 40 county jail facilities within, and outside, Minnesota to provide inmate patient care. MEnD originally entered into a contract to provide medical services at the Beltrami County Jail on July 1, 2012, and entered into an amended agreement in December 2012. MEnD had an active contractual agreement to provide medical care to inmates at the Beltrami County Jail in Bemidji, Beltrami County, Minnesota, at the time of this incident in the fall of 2018. The contract specifically required MEnD to provide "health and medical services to the detainees and the inmates of the Beltrami County Jail." In acquiring the contract, MEnD further agreed to "coordinate care when emergency services are required in any medical case within the jail facility."

On August 24, 2018, H.S. was booked into the Beltrami County Jail at approximately 5:30 p.m. During booking, H.S. appeared to be talking and walking normally. The interaction between H.S. and correctional officers, and subsequent events at the jail, were captured on surveillance footage.

On August 25, 2018, H.S. participated in an initial health assessment. H.S.'s blood pressure was high at the time of his assessment, measuring 152/106. H.S. also had a pulse of 80, an oxygen level of 96 percent, and a temperature of 98.3. During the assessment, H.S. reported a history of treatment for high blood pressure with Lisinopril and a recent incident of respiratory failure. H.S. also reported migraines and upper back pain. H.S.'s main concern at the time was migraines and Nurse C.P.'s assessment note indicated that H.S.'s blood pressure would be monitored. Nurse C.P. described H.S. as "very outgoing and happy, smiling."

On August 26, 2018, H.S.'s blood pressure measured 146/101, indicating continued hypertension.

On August 27, 2018, H.S. complained of chest pain and requested another blood pressure check. H.S. described his chest pain as beginning near his collar bone and extending into his neck, lasting approximately 45 minutes. H.S. was sweating and reported that the fingers on his left hand were tingling. H.S. reported that he had been experiencing severe pain in his lower back and between his shoulder blades for the last several months. H.S.'s blood pressure was 159/104, indicating continued hypertension. Nurse C.P. performed an electrocardiogram ("EKG"). After receiving the EKG results, Dr. T.L. prescribed ibuprofen, Tylenol, and hydroxyzine.

On August 28, 2018, Nurse C.P. learned that H.S. had not had his blood pressure medication filled since January 2018. Nurse C.P. conducted another medical assessment, and H.S. tearfully complained of back pain, numbness on his right side, and pain while walking and lying prone. H.S. reported falling out of his bunk bed that day and lying on the floor for 25 minutes. H.S. was assisted back onto his bunk bed by his cellmates. H.S.'s blood pressure was 156/117, indicating continued hypertension. H.S also had a pulse of 95 and temperature of 98.3. Nurse C.P. called Dr. T.L. to discuss her assessment.

Dr. T.L. concluded that H.S. suffered an injury from falling from his bunk bed. He prescribed ibuprofen, in addition to Flexeril and Lisinopril. Dr. T.L. also requested that H.S. be moved to a lower bunk bed. At approximately 8:00 p.m. on August 28, 2018, H.S. submitted a Medical Request Form, requesting medical attention and stating, "I need to be seen and taken to the hospital on account of i cant feel my legs and cannot be physically mobil [*sic*] .. Plz be fast about this because im also in incruciating [*sic*] pain in all my muscles all over my body..."

On August 29, 2018, Nurse C.P. was informed that H.S. was unable to feel his legs or ambulate, and that his pain was getting worse. Nurse C.P. evaluated H.S. that morning. His blood pressure was 162/116, indicating continued hypertension. H.S. also had a pulse of 83 and an oxygen level of 98 percent. H.S. reported that he had numbness starting around his belly button and traveling bilaterally down through his legs. When Nurse C.P. asked H.S. to lift his hands to remove the oxygen sensor, he reported that he could not. H.S. reported that he was unable to move his legs or lift his hands for two days, which resulted in his inability to eat. Dr. T.L. discontinued Flexeril. That day, in his cell, H.S. fell out of his cot and landed face-down on the floor. It took several officers to move H.S. back onto his cot. Surveillance footage shows H.S. lying on his cot, the floor, or sitting in his wheelchair, struggling to move. H.S. did not eat his food that day.

On August 30, 2018, Nurse C.P. assessed H.S. H.S.'s blood pressure was 168/109, indicating continued hypertension. H.S. also had a pulse of 92 and an oxygen level of 98 percent. H.S. reported that he could not feel anything from his waist down and urinated himself because he could not move to use the toilet. He also reported having difficulty swallowing because his throat felt swollen. Nurse C.P. attempted to give H.S. ibuprofen and Lisinopril, but H.S. could not swallow the medication. She also tested H.S.'s reflexes, and H.S. "did not move" when Nurse C.P. ran a thermometer stick along the bottom of both feet. Nurse C.P. noted H.S.'s presentation was "dramatically different." Nurse C.P. stated that H.S.'s condition deteriorated every day she saw him, and he was getting weaker by the day. Nurse C.P. discussed her concerns with Dr. T.L., and they agreed that H.S. needed to be seen at a hospital, which Nurse C.P. discussed with jail administration to arrange transport. At approximately 3:17 p.m. surveillance footage shows H.S. attempting to pull on an adult diaper and pants to no avail. During this process, H.S. fell out of his wheelchair onto the floor, with his naked lower body exposed. Three correctional officers assisted H.S. back into his wheelchair.

On August 31, 2018, H.S. was assessed by Nurse S.L. Nurse S.L. found H.S. lying on a mat on the concrete floor of his segregation cell. She noted that his cell smelled strongly of sweat and urine. She observed that the right side of H.S.'s mouth was drooping, his speech was slurred, and he had defecated himself. He shared that he could not feel below his waist. H.S. began crying and begging for help. Nurse S.L. noted that his chart indicated that his numbness had been worsening for several days. H.S.'s blood

pressure was 183/116, his oxygen level was 84 percent, his pulse was 132, and he had no Babinski reflex. Jail administration transported H.S. to the emergency room at Nurse S.L.'s direction. Thereafter, Nurse S.L. discussed H.S.'s symptoms with Dr. T.L., who told Nurse S.L. that H.S. was exhibiting classic signs of Guillain-Barré Syndrome, a rare autoimmune disorder affecting the peripheral nervous system.

H.S. was transported to the Sanford Bemidji Medical Center ("SBMC") on August 31, 2018. Dr. D.K., the emergency room physician at SBMC, examined H.S., finding that he had upper and lower extremity weakness, facial droop, and difficulty swallowing. H.S. also did not withdraw from painful stimuli. Because SBMC did not have an MRI machine, H.S. was transferred to Sanford Medical Center Fargo ("SMCF"). SMCF staff described the visit basis as "a lack of coordination that led to falls." A physical health assessment of H.S. indicated that his blood pressure was 174/118, his pulse was 128, and his oxygen level was 100 percent. MRI results indicated no abnormalities. A correctional officer informed Dr. D.L., the emergency room physician at SMCF, that H.S. had been observed on camera moving his limbs without difficulty. Dr. D.L. diagnosed H.S. with malingering and weakness. H.S. was released from SMCF at approximately 10:00 p.m. with written discharge instructions. The discharge instructions stated:

> YOU SHOULD SEEK MEDICAL ATTENTION IMMEDIATELY, EITHER HERE OR AT THE NEAREST EMERGENCY DEPARTMENT, IF ANY OF THE FOLLOWING OCCURS:
>
> • Confusion, coma, agitation (becoming anxious or irritable).
> • Fever (temperature higher than 100.4°F / 38°C), vomiting.
> • Severe headache.
> • Signs of stroke (paralysis or numbness on one side of the body, drooping on one side of the face, difficulty talking).
> • Worsening weakness, difficulty standing, paralysis, loss of control of the bladder or bowels or difficulty swallowing.

H.S. arrived back at the Beltrami County Jail on September 1, 2018, at approximately 12:30 a.m. Once back at the jail, H.S. fell out of the transport vehicle onto the concrete floor. He was lifted by several correctional officers and placed back into his wheelchair. One of the correctional officers described H.S. as "limp." While in the wheelchair, H.S. was unable to control the movement of his head, which tilted backward until a correctional officer pushed his head forward. Three correctional officers carried H.S. into the medical segregation jail cell and placed him on a cot. At 2:33 a.m., H.S. fell off the cot, face-down, and was immobile. He remained face-down on the floor for over five hours.

On September 1, 2018, Defendant arrived for her shift at the Beltrami County Jail shortly before noon. Defendant reviewed H.S.'s emergency room records and received an update from correctional officers on H.S.'s medical condition. Defendant admitted to having received and "paged through" H.S.'s emergency discharge paperwork and instructions. Defendant also received an oral report from Nurse C.P. regarding H.S.'s condition.

Despite this information, Defendant did not check on H.S. until 2:05 p.m. MEnD policy required that "anytime an inmate is referred to the emergency department, or other outside medical specialty, medical staff will visit with that inmate on the next clinic day, *or sooner where indicated*." (emphasis added). On September 1, 2018, Defendant only interacted with H.S. for a few minutes. She did not approach H.S. and stood in the doorway of the cell the entire visit, nearly 10 feet away from H.S. Defendant never conducted a standard, basic nursing assessment. Defendant did not assess any of H.S.'s vital signs, stating that she did not think it made "that big of a difference" since H.S. had his vitals documented at the hospital. A correctional officer observed Defendant tell H.S. on September 1, 2018, to "get up and walk" and that "there was nothing wrong with him and he could get up and walk if he wanted to."

During Defendant's interaction with H.S. on September 1, 2018, H.S. pleaded for additional medical attention. Defendant told H.S. that she would not bargain with him, and Defendant did not provide any additional medical care. Defendant documented that H.S.'s cell smelled of urine and feces, but Defendant reported she was not concerned because that is a "common smell" in a jail. Defendant's short 2:05 p.m. visit was the only interaction Defendant had with H.S. on September 1, 2018.

At approximately 5:00 p.m. on September 1, 2018, Defendant wrote in a medical staff narrative note that she spoke to Dr. T.L. after reviewing the complete emergency room records. At that time, Dr. T.L. instructed Defendant to monitor H.S. and that H.S. "should see neurology just to be sure." Defendant did not obtain any vital signs and did not conduct a physical examination. According to correctional officers, Defendant told them that there was nothing medically wrong with H.S., and that they should not be assisting H.S. with basic tasks such as eating, drinking, or toileting. Defendant explained that she did not believe that H.S. was experiencing a medical emergency on September 1, 2018. Surveillance footage, however, shows H.S. was limp, slumped over, and required correctional officers' assistance onto his cot, and to be placed in an upright position, at least six times in less than two hours. Correctional officers reported that H.S. urinated and defecated himself, had difficulty moving, could not support his head, was unable to sit and stand on his own, and had slurred speech.

On September 2, 2018, at approximately 8:15 a.m., Defendant arrived for her shift at the Beltrami County Jail. Correctional officers were preparing to bathe H.S., who was in a wheelchair, covered in urine and feces. Defendant approached H.S., and H.S. explained that he could not bend at the waist. A correctional officer reported that Defendant was then "basically screaming at [H.S.] telling him he's faking, telling him to get up." Surveillance footage shows H.S. unable to control his head or legs. Defendant observed H.S.'s lips appeared dry. She poured apple juice into H.S.'s mouth after H.S. said he could not lift the apple juice carton. Defendant did not perform any further assessment for dehydration. Defendant noticed that H.S. had "facial droop" but claimed it did not persist. Defendant did not take any of H.S.'s vital signs during this visit. Defendant did not perform any medical assessments or perform any other tests to determine whether H.S.'s weakness was worsening. Defendant did not perform any basic neurological assessments, even though Defendant and Dr. T.L. discussed sending H.S. to neurology.

After Defendant's morning interaction, surveillance footage shows H.S. lying motionless and unable to move his limbs as he was bathed. It took three correctional officers to bathe H.S. and place an adult diaper on H.S. Defendant's only interaction with H.S. on September 2, 2018, was observing H.S. in his wheelchair before he was bathed by correctional officers. The only directive provided in Defendant's medical staff narrative note instructed correctional officers to place H.S. in a restraint chair and wheel him into the shower.

At 11:00 a.m., Defendant peeked through the window of H.S.'s cell. Defendant noted that she observed H.S. lying down "comfortably" with a juice box. Defendant called Dr. T.L. and reported that H.S. had "slight[ly] improved" and was "better from the day before." Dr. T.L. told Defendant to "stay the course." This meant to "continue to monitor this patient and look for changes" and to "pass on the information she needed to pass on to both [the] health technician and correctional staff." Defendant, however, did not provide correctional officers with the emergency room discharge instructions or direct them to look for any specific symptoms while monitoring H.S.

At 2:00 p.m. Defendant documented that H.S. was lying on a mattress, sleeping "comfortably," with "spit rolling down his cheek." She also wrote that H.S. had "no distress in his breathing." Surveillance footage at 2:00 p.m., however, shows H.S. on a mattress on the floor exhibiting rapid, shallow breaths. Defendant did not perform a medical assessment at that time or return H.S. to the hospital. Defendant later stated that H.S. "didn't present with things, from my observations and assessment that would warrant .

. . him to go back to the ER." Defendant left the Beltrami County Jail shortly after 2:00 p.m. She did not share the emergency room discharge instructions with correctional officers or advise them on continuing care. A correctional officer explained they were "told [by Defendant] the whole time that [H.S.] was okay and perfectly fine."

At 3:46 p.m., H.S. was unable to speak. Correctional officers found H.S. unresponsive at 4:46 p.m. and resuscitation efforts were unsuccessful. H.S. was pronounced dead at the Beltrami County Jail at 5:25 p.m. on September 2, 2018.

The Ramsey County Medical Examiner conducted an autopsy on September 4, 2018, and determined pneumonia and cerebral edema caused H.S.'s death. An outside forensic pathologist (and national expert on deaths in-custody) reviewed the autopsy and concluded that H.S.'s cause of death was complications of "progressive neurological disorder [consistent with] Guillain-Barré Syndrome."

Additionally, an outside jail system medical director and correctional health physician ("correctional health expert") reviewed the in-custody death of H.S. and provided an opinion regarding Defendant's care of H.S. that included the following:

The correctional health expert determined that Defendant's actions fell below "the most basic nursing care." He determined that Defendant "had more than adequate professional education, training, and work experience to know what the nursing standard of care was for assessing and monitoring a patient." He further concluded that H.S.'s core body functions were severely compromised by September 1, 2018, and worsened through September 2, 2018.

As the nurse responsible for H.S.'s care after H.S. returned from the emergency room, Defendant had the training, expertise, and a professional responsibility to provide H.S. with medical care to address his declining condition. The correctional health expert concluded that Defendant's failure to consider the overwhelming objective evidence that H.S. was in medical distress was a clear violation of the standard of care. He noted that "[t]he only way to determine the baseline status of a patient is to complete both the vital sign component of the nursing assessment and the systems components of the assessment to develop a nursing treatment plan. In this case neither were completed. . ." According to the correctional health expert, Defendant's interactions with H.S. fell well below national standards of nursing care.

"For patients like [H.S.] who have a new-onset condition that requires higher levels of care, it would be appropriate to perform a nursing assessment daily to document their condition and to determine if they are responding to the treatment plan or deteriorating to the point that they need to be sent out for higher levels of medical care." The correctional health expert described Defendant's assessment as "wholly inadequate, done from a distance, and professionally beneath the standard of care." He explained that "[v]ital signs are the single most important set of data in assessing any patient," and "[Defendant] failed to complete the most basic nursing function of taking vital signs in her assessment of [H.S.]." He concluded that "[t]he failure to obtain any vital signs on a critically ill patient over two days is such a tremendous breach in the standard of care that it is tantamount to an abandonment of the most basic professional responsibilities of a nurse." The correctional health expert further noted that the emergency room discharge instructions required H.S. to be returned to the emergency room if any of the nine listed symptoms were present. Defendant failed to return H.S. to the emergency room, even when H.S. exhibited at least six of those nine symptoms. The correctional health expert determined that Defendant "demonstrated no urgency or priority in assessing this high risk patient who had been checked out to her," and that Defendant abandoned H.S. intellectually and physically. He concluded Defendant should have recognized the severity of H.S.'s condition and sent him out for comprehensive care at a hospital, that hospital level care would have likely saved H.S.'s life, and Defendant "prevented him from receiving the care that he needed."

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The correctional health expert explained that H.S.'s symptoms were treatable, and his condition was survivable, had Defendant provided basic medical care over the two-day period from September 1, 2018, to September 2, 2018. If Defendant had performed even the most basic nursing care or assessment, H.S.'s "dire condition would have been objectively demonstrated." The correctional health expert noted that H.S. died from Guillain-Barré Syndrome, "a progressive disease process that is serious but treatable," and that the "survival rate from the disease is extremely high" with appropriate treatment.

Great bodily harm and death are known and foreseeable risks in the medical profession that can result from failure to provide care to an individual in medical distress. Defendant was aware of these risks through her training, education, and experience as a registered nurse, having successfully completed a variety of trainings, including such courses as "CPR/AED for Professional Rescuers and Health Care Providers," which trained Defendant to recognize and care for breathing emergencies. Defendant's failure to provide medical care exacerbated H.S.'s condition and ultimately resulted in his death.

SIGNATURES AND APPROVALS

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Complainant requests that Defendant, subject to bail or conditions of release, be:
(1) arrested or that other lawful steps be taken to obtain Defendant's appearance in court; or
(2) detained, if already in custody, pending further proceedings; and that said Defendant otherwise be dealt with according to law.

Complainant declares under penalty of perjury that everything stated in this document is true and correct. Minn. Stat. § 358.116; Minn. R. Crim. P. 2.01, subds. 1, 2.

Complainant

Samuel McGinnis
1430 Maryland Avenue E
St. Paul, MN 55106

Electronically Signed:
03/07/2025 09:03 AM
Sherburne County, Minnesota

Being authorized to prosecute the offenses charged, I approve this complaint.

Prosecuting Attorney

Zuri Balmakund
445 Minnesota Street
Suite 1400
St. Paul, MN 55101
(651) 296-3353

Electronically Signed:
03/07/2025 08:48 AM

FINDING OF PROBABLE CAUSE

From the above sworn facts, and any supporting affidavits or supplemental sworn testimony, I, the Issuing Officer, have determined that probable cause exists to support, subject to bail or conditions of release where applicable, Defendant's arrest or other lawful steps be taken to obtain Defendant's appearance in court, or Defendant's detention, if already in custody, pending further proceedings. Defendant is therefore charged with the above-stated offense(s).

[X] SUMMONS

THEREFORE YOU, THE DEFENDANT, ARE SUMMONED to appear as directed in the Notice of Hearing before the above-named court to answer this complaint.

IF YOU FAIL TO APPEAR in response to this SUMMONS, a WARRANT FOR YOUR ARREST shall be issued.

[ ] WARRANT

To the Sheriff of the above-named county; or other person authorized to execute this warrant: I order, in the name of the State of Minnesota, that the Defendant be apprehended and arrested without delay and brought promptly before the court (if in session), and if not, before a Judge or Judicial Officer of such court without unnecessary delay, and in any event not later than 36 hours after the arrest or as soon as such Judge or Judicial Officer is available to be dealt with according to law.

[ ] ***Execute in MN Only*** [ ] ***Execute Nationwide*** [ ] ***Execute in Border States***

[ ] ORDER OF DETENTION

Since the Defendant is already in custody, I order, subject to bail or conditions of release, that the Defendant continue to be detained pending further proceedings.

Bail: $
Conditions of Release:

This complaint, duly subscribed and sworn to or signed under penalty of perjury, is issued by the undersigned Judicial Officer as of the following date: March 7, 2025.

Judicial Officer Annie P. Claesson-Huseby Electronically Signed: 03/07/2025 01:51 PM

Sworn testimony has been given before the Judicial Officer by the following witnesses:

COUNTY OF BELTRAMI
STATE OF MINNESOTA

State of Minnesota

Plaintiff

vs.

Michelle Rose Skroch

Defendant

LAW ENFORCEMENT OFFICER RETURN OF SERVICE
I hereby Certify and Return that I have served a copy of this Summons upon the Defendant herein named.

Signature of Authorized Service Agent:

DEFENDANT FACT SHEET

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Name:	Michelle Rose Skroch
DOB:	01/15/1988
Address:	608 Kendall Court Sartell, MN 55377
Alias Names/DOB:	
SID:	
Height:	
Weight:	
Eye Color:	
Hair Color:	
Gender:	FEMALE
Race:	
Fingerprints Required per Statute:	Yes
Fingerprint match to Criminal History Record:	No
Driver's License #:	
Alcohol Concentration:	

STATUTE AND OFFENSE GRID

Cnt Nbr	Statute Type	Offense Date(s)	Statute Nbrs and Descriptions	Offense Level	MOC	GOC	Controlling Agencies	Case Numbers
1	Charge	9/1/2018	609.205(1) Manslaughter - 2nd Degree - Culpable Negligence Creating Unreasonable Risk	Felony	H5803	N	MNBCA0000	20200459
2	Charge	9/1/2018	609.233.1a(1) Criminal Neglect - Knows/reason to know deprivation will result in substantial or great bodily harm	Felony	I1206	N	MNBCA0000	20200459
3	Charge	9/1/2018	609.233.1a(2) Criminal Neglect - Deprivation occurred over extended period of time	Felony	I1206	N	MNBCA0000	20200459