KENOSHA NEWS

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RETRIAL OF 1998 DEATH

SEAN KRAJACIC, KENOSHA NEWS

Dr. Mary Mainland, former Kenosha County Medical Examiner, right, goes over her notes with Special Prosecutor Robert Jambois, center, and Jeremy Perri, one of Mark Jensen's attorneys, during the trial at the Kenosha County Courthouse on Tuesday.

Ex ME calls it homicide

Forensic pathologist details antifreeze evidence in victim's body

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Former Kenosha County Medical Examiner Dr. Mary Mainland took the witness stand Tuesday in the homicide retrial of Mark Jensen, the man accused of poisoning, drugging and then suffocating his wife to death over three days in December 1998.

Mainland, a forensic pathologist who testified in 2008 during the first trial of Mark Jensen in Kenosha County Circuit Court, testified again about the toxic substances found in Julie Jensen's body after her death.

Mainland said she strongly believes the manner of the 40-year-old mother of two's death was homicide, and the causes were antifreeze poisoning and asphyxiation.

Mainland, now retired, testified in person during the third week of the jury retrial of Mark Jensen for most of the morning. She strongly believes Julie Jensen did not die by suicide.

Mark Jensen, now 63, was convicted in February 2008 for the murder of his wife inside their Carol Beach neighborhood home near the lakefront. He is standing trial again here after years of

M. Jensen

J. Jensen

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DHS orders changes after death of resident

Police probe of Dec. 19 incident in hands of county DA

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The state has ordered a Kenosha assisted-living facility to make changes after a resident was found dead in the facility's courtyard on Dec. 19.

As a result of the Wisconsin Department of Health Services investigation, Parkside Manor, 6300 67th St., was ordered not to admit new residents until all recommended changes are corrected and compliance is verified by the DHS.

The Department of Health Services issued its report after an investigation of the 80-year-old Parkside Manor resident's death.

The DHS report states the resident, who was admitted as a patient with a dementia diagnosis on June 29, 2022, secretly exited the facility at 12:40 a.m. She was discovered missing over six hours later at 7:40 a.m. when the day shift staff conducted resident checks.

When she was found in the courtyard, she was unresponsive and not breathing the report states. She was pronounced dead at 9:25 a.m.

The Kenosha Police Department investigated the incident.

"Criminal charges are still being considered at this time by the District Attorney's (office), but no specific person has been criminally charged up to this point," Kenosha Police Sgt. Jeff Galley stated.

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Gateway to review college's diversity policies

DAVE FIDLIN
KENOSHA NEWS CORRESPONDENT

On the heels of a Virginia report that gained national attention, Gateway Technical College officials have set in motion a planned report and review of the college's policies pertaining to diversity, equity and inclusion.

Scott Pierce, a member of Gateway's District Board of Trustees, asked for the review at a meeting last week. It is anticipated college administrators will provide data and other details in a report, perhaps as soon as the next District Board meeting in February.

Pierce

Last month, reports surfaced in Fairfax County of schools withholding National Merit Scholarship awards from students. The thinking behind the withholding was to give students of all racial, socioeconomic and cultural backgrounds an even footing in the educational arena.

However, the strategy has garnered criticism, in part because it could penalize high-achieving students. In some instances, students who have not received notification of National Merit Scholarship awards in the Virginia instance reportedly have lost out on opportunities for scholarships.

In light of the recent reports, Pierce said, "I think it behooves us to revisit and give us an update about our diversity, equity and inclusion (DEI) program."

"Who knows, in the name of equity, where else we are seeing school districts taking positions to make sure that all students are being treated fairly and equitably," Pierce said.

"This national issue is out there. I think it's important we talk about it locally, so we can ensure people, if it comes up, that we are not engaged in those kinds of issues," he said.

Within the landscape of technical colleges, Pierce asked several open-ended questions, which likely will be explored further when the report is given. For instance, he said he would like to know if grade inflation — particularly for specific demographic groups — is taking place.

Pierce received support from his colleagues on the District

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Weather
Cloudy with some snow
High 36 • Low 26
FORECAST • B5

Inside

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Probe

From A1

Parkside Manor declined to comment.

A timeline

According to the DHS report, three caregivers were scheduled for the night shift Dec. 18, which ran from 10 p.m. to 6 a.m. In that time, it was reported one caregiver for the memory care unit arrived an hour late, and then left at some point in the night and did not return until 2 a.m. The other two caregivers were left to attend to the assisted living and memory care units.

One of those caregivers reported hearing a door alarm sound go off and found a resident in the day room. Believing that the resident was the one who tripped the alarm, the caregiver escorted the resident back to the resident's room. The door alarm was turned off.

The investigating Kenosha Police officer, who viewed the resident's escape through video surveillance, said the door was never fully opened, nor did anyone check outside.

According to the caregivers who were present, as part of staff policy, resident checks were conducted. One caregiver stated the checks performed ensured the doors were closed, but each resident was not individually checked. The night of the incident, the caregiver who was not present at the facility for a portion of the night was the caregiver responsible for the now-deceased resident.

When the morning staff arrived at 5:55 a.m. the following morning, they noted there were no staff present. One caregiver said a head count, which was policy, was not conducted. During that caregiver's rounds, a search was done both inside and outside the facility until the resident was found outside.

KENOSHA NEWS PHOTO BY SEAN KRAJACIC

As a result of the Wisconsin Department of Health Services investigation, Parkside Manor, 6300 67th St., was ordered not to admit new residents until all recommended changes are corrected and compliance is verified by the DHS.

History of escapes

The DHS report notes it was not first attempt at leaving by the resident involved.

The state report indicates, in a progress note dated Aug. 8, she was placed on hourly checks and attempted to push the exit door open. Her Individual Service Plan was not updated to reflect the new intervention, according to the DHS report.

In a "Resident Service Note" dated Sept. 21, she was reported to have been able "to exit the memory care unit." She was placed on 30 minute checks, but her ISP was not updated to reflect the change, the DHS report indicated.

In another progress note, dates Nov. 1, she reportedly attempted to exit the facility and set the alarm off. Staff noted she was redirected from the door by caregivers.

Her Notification of Change in Individual Service Plan Form, dated Nov. 1, indicated the resident required "more frequent checks and more redirection." The form, which was completed by the facility's assistant administrator, was utilized to update staff of changes in a resident's service plan. The form contained signatures from the assistant administrator and a staff member, indicating their awareness of the change in resident care needs.

According to the DHS report, the resident's ISP dated Nov. 10, "was not updated to reflect the change in the level of supervision and the 30-minute checks, frequent checks and (resident's) exit-seeking behaviors."

Changes ordered

The DHS report called for corrective measures including a written procedure for door alarms, which will include procedures for the use, monitoring, and staff response to alarmed door systems, and behavioral management.

They are expected to identify "specific behavior patterns that are or may be harmful to the resident or others," assess and document contributing factors to the behaviors, develop and implement the Individualized Service Plan (ISP) with specific individualized interventions to reduce incidences of these behaviors and more.

According to the special order, within 45 days of receiving the notice and order from DHS, the facility must, "Review each current resident's assessment to ensure the assessment identifies the person's behavior patterns that are or may be harmful to the resident or others, including wandering and elopement, develop or revise, as necessary, the resident's individualized service plan to comprehensively document the level and frequency of services needed, including the level of supervision required in the home and community and ensure all staff responsible for providing services to residents review the resident's individualized service plan and will provide services in accordance with the plan."

Parkside Manor must also forfeit a total of $1,900 within 10 days after receiving the notice and order from DHS.