May 13, 2005

Kevin Watson
CCA Bay County Jail/Annex Facility Administrator
314 ½ Harmon Avenue
Panama City, Florida 32401

SUBJ: UNUSUAL INCIDENT REVIEW - - SUICIDE DEATH OF INMATE JAMES T. SLY, JR.

Dear Kevin:

I have attached for your and your staff's review my unusual incident report concerning the suicide death of inmate James T. Sly, Jr. that occurred at the main jail on April 5, 2005. It includes my findings and required corrective actions.

Please distribute it to your entire management team including your two Health Care Services Administrators. Also provide a corrective action plan and proof of compliance by May 31, 2005.

Please contact me at your earliest convenience if you have any questions. I want to thank you and your staff for your cooperation while I was reviewing this matter.

Sincerely

Roger E. Hagen
Correctional Program Manager/Contract Monitor

Attachment

Cc;
Bay County Board of County Commissioners
Deputy County Manager
Chief of Emergency Services
Correctional Program Coordinator
CCA Quality Assurance Manager

May 10, 2005

TO: Joy Bates, Deputy Director

THROUGH: Robert J. Majka Jr. Chief Emergency Services

FROM: Roger E. Hagen, Correctional Program Manger/Contract Monitor

SUBJ: **Unusual Incident Review—Suicide death of Inmate James T. Sly, Jr.**

At approximately 0340 hours on Tuesday, April 5 2005 I was notified by Corrections Corporation of America (CCA) Chief of security Michael Thompkins that an inmate had committed suicide at the main jail. I have conducted a review of this incident to assess the level of compliance with: Florida Model Jail Standards (FMJS); CCA policies and procedures; and the terms and conditions in the contract between CCA and Bay County to provide jail operator services. The review included the inmate's case file, his medical record, applicable CCA policies and post orders, CCA incident report, visitation logs, mail logs, floor movement logs, witness statements, crime scene pictures, discussion with FDLE who investigated the incident at the request of the U. S. Marshal, and discussions with CCA staff and managers at both the mail jail and the annex.

BACKGROUND

Inmate James T. Sly Jr. was a 35 year old black male who entered the Bay County jail on January 18, 2005 after being arrested by the Springfield Police Department (SPD) for aggravated fleeing and eluding law enforcement, aggravated assault on a law enforcement officer and aggravated child abuse.

In January 17, 2005 the SPD was investigating a reported domestic disturbance. As they were interviewing the victim the alleged perpetrator (inmate Sly) arrived at the scene and then fled after seeing the officers there. The SPD pursued but inmate Sly was able to elude them after a high speed chase. On January 18, 2005 at 0050 hours inmate Sly was apprehended on the DuPont Bridge threatening to commit suicide. Intake at the jail occurred at 0110 hours. Inmate Sly was medically screened at 0130 hours and determined to need mental health referral. He was placed

on suicide precautions and assigned to a strip cell at the jail annex. He was evaluated by a licensed outside contract mental health professional on January 19, 2005 and found to no longer require suicide precautions. On January 20, 2005 inmate Sly was assigned to general population housing at the main jail.

On April 5, 2005 at 0230 hours inmate Sly was found hanging by a sheet tied around the shower head in the 5-C housing pod day room shower. He was pronounced dead per the Bay Medical EMS at 0300 hours. A suicide letter to his wife was found in his cell. Also a letter postmarked April 1, 2005 (logged into the jail on April 4, 2005) from a friend suggesting his wife was seeing someone else was found in his cell.

CHRONOLOGY OF EVENTS

January 17, 2005

- 1548 Springfield P.D. investigated a domestic violence report when the alleged perpetrator inmate Sly drove up and then drove off after seeing the officers. The officers pursued but he was able to elude them after a high speed chase.

January 18, 2005

- 0050 Inmate Sly was arrested by SPD while threatening to commit suicide by jumping off the DuPont Bridge.

- 0110 Intake of inmate Sly into the main jail occurred.

- 0130 Inmate received health care screening from a licensed CCA nurse and placed on suicide precautions including 15 minute observations.

- 0415 Inmate Sly was moved to the annex for strip cell housing.

- 0440 Inmate was housed in a strip cell.

- 0741 Inmate was served and ate breakfast.

- 1031 Inmate was moved to the jail for his first appearance hearing.

- 1303 Inmate was returned to the annex and strip cell housing.

- 2010 Inmate was moved to medical for health care assessment by a licensed CCA nurse.

- 2024 Inmate was returned from medical to his strip cell housing.

January 19, 2005

- 1407 Inmate was evaluated by an outside contract licensed mental health professional and found to no longer require suicide precautions.

- Inmate was medically released from strip cell housing at the annex.

January 20, 2005

- Inmate was moved to the main jail and housed in a cell in housing pod 5-C.

January 24, 2005

- Inmate was seen by a licensed CCA Physician Assistant for a general health evaluation.

January 31, 2005

- U.S. Marshal's office placed a hold on inmate Sly.

February 3, 2005

- Inmate was evaluated and counseled by an outside contract licensed mental health professional.

February 20, 2005

- Inmate was seen by a licensed CCA nurse in sick call for a medical concern.

February 26, 2005

- Inmate was seen by a licensed CCA nurse in sick call for a medical concern.

March 8, 2005

- Inmate was seen by a licensed CCA Physician Assistant for a medical condition.

March 14, 2005

- Inmate was evaluated and counseled by an outside contract licensed mental health professional.

March 24, 2005

- Inmate was scheduled for a G.I. consultation by an outside specialist.

March 31, 2005

- Inmate was escorted outside the jail to a G.I. specialist and returned to the jail.

April 4, 2005

- A letter to inmate Sly from a friend confirming his wife's infidelity was logged into the jail.

- Inmate Sly showed his cell partner (inmate Black) the letter from his friend. Inmate Black said inmate Sly started to cry and told him he had tried to kill himself some time back over a similar situation. Inmate Black stated that inmate Sly did not say he was going to try to kill himself that night [this was not reported to CCA staff].

- Inmate Williams stated inmate Sly did not show any signs of being suicidal that day and that he was just acting himself.

- Inmate Garner said that inmate Sly had received a bad phone call that day. When inmate Garner asked inmate Sly if he was okay he said yea- -just a bad phone call [this was not reported to CCA staff].

- Inmate Sly requested that third watch (2200-0600 hours) staff (Harris and Suppes) leave his cell door open during lock down since his toilet was not functioning. This was verified and the door left open so inmate Sly would have access to the day room toilet. Inmate Sly also said he was having diarrhea from bad chili that he ate that night. He further said he liked to shower after he "shit". All other cells were secured during lock down.

April 5, 2005

- 0200 Mid-shift count was started by CCA correctional officers Harris and Suppes.

- 0211 Mid-shift count was completed. C.O. Harris actually conducted the count with Suppes at the door controls. He stated inmate Sly was in his

cell during the earlier midnight count and subsequent floor checks. During this count he was not in his cell and the shower was running. He assumed inmate Sly was in the shower but did not physically observe him as required per CCA policy. Harris stated another inmate asked him a question just as he started to step into the shower area to make his observation of Sly.

•0228 Officers Harris and Suppes heard banging coming from inmates in housing pod 5-C and that they were shouting there was a problem.

•0230 Back up arrived at 5-C and the cell housing pod was secured. Inmate Sly was lifted out of the shower and the sheet secured to shower head and then around his neck in the form of a slip knot was removed. Two CCA nurses began emergency treatment. The AED readout said "no shock required". They continued administration of CPR.

•0240 Bay Medical center EMS arrived and took over emergency treatment.

•0250 The CCA Facility Administrator was notified.

•0300 Inmate Sly was pronounced dead per Bay Medical EMS.

•0305 BCSO was notified and requested to investigate the crime scene.

•0335 The U.S. Marshal's Office was notified because of the hold they had placed on the inmate.

•0340 The Bay County Contract Monitor was notified.

- FDLE was requested to investigate the crime scene by the U.S. Marshal's Office.

- A suicide letter to Sly's wife and the infidelity letter from his friend on the outside were found in his cell.

FINDINGS AND CORRECTIVE ACTIONS OR RECOMMENDATIONS

Compliance FMJS and the terms and the conditions of the jail operator contract between CCA and Bay County was found to exist. However, CCA's policy 9-13 entitled "Count Principles and Procedures" was violated during the third watch mid-shift count on April 5, 2005. No other deficiencies were found in how this inmate was: handled during the intake process; treated during his stay; provided both medical and mental health care; or handled during the entire emergency response. Listed below is a specific finding and required corrective action.

(1) CCA Policy 9-13 requires direct observation of an inmate by the correctional officer conducting the count. The policy specifically states that the officer is to see "living breathing flesh" when making an accurate count. Officer Harris failed to do this when he assumed Inmate Sly was alive taking a shower rather than stepping inside the shower area and actual observing him. It is impossible to determine if the outcome would have been any different had the count been completed correctly.

Required Corrective Action: Take appropriate disciplinary action on the officer and provide special training for all officers on the contents of CCA Policy 9-13. Document their completion of such training. Periodically this needs to be repeated since the taking of inmate counts is done so often it is easy for an officer to become complacent and forget about how critical an accurate count is to the safety of both staff and the inmates.

Copies of his case file, incident report, CCA policies etc. are on file in my office. This review may be amended should the FDLE investigative report (to be provided upon completion) provide new or conflicting information. This report will be formally transmitted to the CCA Facility Administrator upon receipt of your approval.

CC: Ann Cahall