

Leon County Sheriff's Office

Summary of Three most Recent Jail Death Investigations

LCSO Case 04-227822. On 31 October 2004 inmate Steven Tomiano w/m DOB 8-14-72 was found hanging by a sheet in his cell. He had been in jail on a drug charge since 12 Sept. 2004. Tomiano was from Connecticut and had previously been in prison for armed robbery. Investigation found no foul play. Death was ruled asphyxia due to hanging.

LCSO Case 03-98930. On 12 June 2003 inmate Clyde Fuller b/m DOB 2-15-77 was found deceased in the Medical Unit of the jail. Fuller would not cooperate with the intake process and began screaming and spitting at staff members. He was sprayed with pepper spray and placed in a restraint chair. He later was found deceased. An autopsy discovered the following, cocaine toxicity, myocardial hypertrophy and intramuscular coronary artery with associated ischemic changes.

LCSO Case 03-82193. On 16 May 2003, inmate Ruth Hubbs w/f DOB 9-10-63 was found deceased in the jail Medical Unit. Inmate Hubbs had been acting strange and by some accounts appeared to be over-medicated. The autopsy findings indicated inmate Hubbs suffered from Doxepin intoxication. Doxepin was one of the drugs inmate Hubbs was taking in the jail. Subsequent investigation was unable to determine whether Ms. Hubbs secretly stored pills (cheeking) and possibly took an overdose or whether medical personnel over-medicated her.

LEON COUNTY SHERIFF'S OFFICE OFFENSE/INCIDENT REPORT (SHORT FORM)

Attachment # 1
Page 2 of 87

Reported		AGENCY ORI # 370000				JUVENILE	ORIGINAL SUPPLEMENT 1	INCIDENT REPORT #	04227822							
DATE	TIME	DISPATCHED	ARRIVED	COMPLETED	OCCURRED DATE	TIME	TO	TIME								
Sunday	10-31-04	1942	1942	2156	10-31-04	1815	10-31-04	1816								
EVENT	1	Type	OFFENSE	Death Investigation			AC	STATUTE	999	99	UCR					
	2	Type	OFFENSE				AC	STATUTE			UCR					
	3	Type	OFFENSE				AC	STATUTE			UCR					
INCIDENT LOCATION								TALLAHASSEE, FL	ZIP	32304	CR	TL/LC				
AREA IDENTIFIER / NAME OF BUSINESS / NEIGHBORHOOD, ETC.								RE	OCC	LOCATION	WEAP TYPE	#OFFENSES	#VICTIMS	OFFENDERS	#PRISM ENTERED	#VEH STOLEN
Leon County Jail 535 Applewood Drive								07	79	99	1	1	0	0	0	
PERSON	OFF #	VWS #	TYPE	NAME (Last, First, Middle)			HOME PHONE									
	1	U1	3	DOMIANO, Steven			SPN # 169564		N/A							
	ADDRESS							ARRRESTED?	ALT. CONTACT PHONE (REQUIRED)							
	1310 BIRD LANE TALLAHASSEE, FL							<input type="checkbox"/> YES <input type="checkbox"/> NO								
ADDITIONAL DESCRIPTION / ALTERNATE CONTACT AND ADDRESS, INCLUDING WORK (REQUIRED FOR VICTIMS)												D.I. / SSN / SPN	169564			
RACE	SEX	DOB	R.T.	R.L.	BOI	INI. TYPE	RELATION	HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	SPECIAL IDENTIFIERS				
W	M	8-14-72	1	1	3	99	00	604	170	BRN	BRN					
OFF #	VWS #	TYPE	NAME (Last, First, Middle)			HOME PHONE										
ADDRESS							ARRRESTED?	ALT. CONTACT PHONE (REQUIRED)								
<input type="checkbox"/> SAI							<input type="checkbox"/> YES <input type="checkbox"/> NO									
ADDITIONAL DESCRIPTION / ALTERNATE CONTACT AND ADDRESS, INCLUDING WORK (REQUIRED FOR VICTIMS)												D.I. / SSN / SPN				
RACE	SEX	DOB	R.T.	R.L.	BOI	INI. TYPE	RELATION	HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	SPECIAL IDENTIFIERS				
OFF #	VWS #	TYPE	NAME (Last, First, Middle)			HOME PHONE										
ADDRESS							ARRRESTED?	ALT. CONTACT PHONE (REQUIRED)								
<input type="checkbox"/> SAI							<input type="checkbox"/> YES <input type="checkbox"/> NO									
ADDITIONAL DESCRIPTION / ALTERNATE CONTACT AND ADDRESS, INCLUDING WORK (REQUIRED FOR VICTIMS)												D.I. / SSN / SPN				
RACE	SEX	DOB	R.T.	R.L.	BOI	INI. TYPE	RELATION	HEIGHT	WEIGHT	EYE COLOR	HAIR COLOR	SPECIAL IDENTIFIERS				
VWS #	VH #	STAT	DMG	TYPE	YEAR	MAKE	MODEL	STYLE	TAG							
STATE	COLOR		VIN / HULL / FAA				RC	HOLD	NCIC / R/C							
VALUE \$	OWNER		RSC DATE		REC. VALUE \$	TOWED BY										
VWS #	ITEM #	STAT	DMG	TYPE	QTY/UNITS	NAME	BRAND	MODEL	D		ACT.					
									R		TYPE					
SERIAL NUMBER						OWNER APPLIED NUMBER	DESCRIPTION									
VALUE \$	VALUE RECOVERED \$		DATE RECOVERED		NCIC/PCIC ENTERED (Y/N) BY WHOM:											
VWS #	ITEM #	STAT	DMG	TYPE	QTY/UNITS	NAME	BRAND	MODEL	D		ACT.					
									R		TYPE					
SERIAL NUMBER						OWNER APPLIED NUMBER	DESCRIPTION									
VALUE \$	VALUE RECOVERED \$		DATE RECOVERED		NCIC/PCIC ENTERED (Y/N) BY WHOM:											
SEE ATTACHMENTS																
DRUG REPORTING / WITNESSING																
SUPERVISOR REVIEWING																
CLEARANCE																
ADULT / JUVENILE																
DATE CLEARED																
ARREST NUMBER																
NUMBER ARRESTED																
EXCEPTION TYPE																
OBTS NUMBER																

CASE NUMBER
042227822

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE <u>NO</u>	ORIGINAL - 1 SUPPLEMENT - 2	<u>1</u>	REPORTED DATE	<u>10/31/04</u>	INCIDENT REPORT #	<u>014227822</u>
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On 31 Oct 2004, at approximately 1815 hours, I Officer Booker #544 responded to pod A, after hearing from Central Control over the air page, that all available officers needed to be in route to pod A. As I arrived into pod A, Sgt. Parramore #103 told me to get the camera out of Central Control. After returning with the camera, I began videoing the incident that occurred in pod A, room number 43, which inmate Tomiano, Steven #169564 was housed in. After approximately 20 mins of videoing the incident Sgt. Parramore #103 told me to give the camera to Officer White and to return to my pod.

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____
 _____ Personally Known _____ Identified By ID # _____

Certifying Officer 48

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
<u>Gary Booker / Gary Booker</u>	<u>544</u>	<u>10-31-04</u>	<u>1</u>	<u>OF 1</u>
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		
<u>Sgt Bill Parramore</u>	<u>103</u>	<u>10-31-04</u>		

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Attachment # 1

Original Page 4 of 87
Supplemental Adult Juvenile

Agency Report Number: 04-227822

Victim Name(s): Tomiano, Steven P.

Date Reported: 10-31-04

Officer Reporting: <u>Donnie Jacobs</u>	ID#: <u>321</u>	Date: <u>11-01-04</u>
Officer Reviewing: <u>(Signature)</u>	ID#: <u>157</u>	Date: <u>11-5-04</u>

Offense(s): Death Investigation

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On 31 Oct 04, at 1910 hours, I was notified in reference to a death investigation at the Leon County Jail. Upon my arrival, I met Detective Dawn Butler, who said that Mr. Steven Peter Tamiano appeared to have hung himself in his jail cell. Detective Pat Lyons also responded to assist with the investigation.

SCENE

Pod A, Cell number 43. Mr. Tamiano had already been transported to the emergency room at Tallahassee Memorial Hospital when I arrived. I found the cell to be littered with materials used by the medical responders, in an effort to revive Mr. Tamiano. A sheet was tied around the shelf in the cell, but was cut off and taken from around his neck. I video taped and photographed the scene, and collected a video shot by Jail personnel at the time of the discovery. Mr. Tomiano's personal papers taken from a storage tub under his bunk. I then responded to the hospital and took photographs of the deceased. The body was placed in a body bag and sealed, then placed in the morgue.

ADDITIONAL INFORMATION

The autopsy was scheduled for 0900 hours, 01 Nov 04. Detective Butler and I attended. The medical examiner, Dr. Sgan, noted the ligature marks around the victims neck, and internal bruises. I took additional photographs that were added to the case file. Mr. Tomaino's clothing was seized, which included his shirt, pants, socks and wristband.

EVIDENCE

- 1) Portion of sheet taken from shelf
- 2) Portion of sheet taken from floor
- 3) Personal papers taken from storage tub under bunk
- 4) Video shot by Jail personnel
- 5) Crime Scene Video
- 6) Clothing taken from autopsy, to include shirt, pants, socks, and wristband.

DISPOSITION RECOMMENDED

Pending

43

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Original: Supplemental: X Juvenile:

Agency Report Number: **04-227822** Victim Name(s): **Tomaino, Steven**

Date Reported: **10-31-04**

Officer Reporting: Butler D.D. ID#: 327 Date: 11-04-04

Officer Reviewing: J. Clark ID#: 117 Date: 11-15-04

Offense(s): **Death Investigation**

Case Status: 1 UCR Clearance: 3 Date Cleared: 11/15/04 OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Sunday 31 October 2004 at approximately 1920 hours I responded to the jail in reference to a death investigation. I was advised that an inmate hung himself inside his cell. The inmate was transported to TMH but, was not expected to live. Upon arrival contact was made with Sgt. Parramore, Lt. Taylor, and Lt. Mckissack. I was advised that inmate Steven Tomiano was last seen alive at 1750 hours locked down in his cell by Officer Harris. At approximately 1804 hours the inmates doors were cycled for feed up. Officer Harris noticed that inmate Tomiano did not exit his room for his food tray. She attempted to call him on his intercom but, he did not respond. At approximately 1815 hours she sent Inmate Thomas Davis to ask inmate Tomiano if he was going to eat. Inmate Davis approached the door, pushed it open and told Officer Harris that inmate Tomiano looked dead. Officer Harris responded to Tomiano's cell at which time she observed Tomiano with a sheet tied around his neck and a shelf on the wall. She called for assistance and medical. She then locked the pod down. At approximately 1816 hours medical staff and Sgt. Parramore arrived. At 1828 hours EMS arrived on scene. At 1845 hours Inmate Tomiano was transported to Tallahassee Memorial. Officer Harris advised this writer that no one went in or out of Tomiano's cell between 1804 hours when she rolled the doors and 1815 hours when Inmate Davis found him deceased. She further advised that she is not aware of any problems that Tomiano was having while there. He was booked into the jail on 12 September 2004 by TPD. He was charged with possession of cocaine and evidence tampering. He was being held on a \$2,500.00 bond. Jail phone records revealed that Tomiano only attempted to make one phone call while incarcerated. That call was unsuccessful. Written statements were obtained from Officer Harris, Inmate Davis, Sgt. Parramore, Officer White, Officer King, Officer Booker, R.N. Delaney, RMA Lane, RMA Bratcher, and paramedic O'Neal.

Inmate Tomiano was pronounced dead by Dr. Jusina at approximately 1915 hours. Detective D. Jacobs photographed the scene, collected evidence, and attended the autopsy. (See his continuation) I observed cell #43 which is a double bunk cell. There were numerous articles of medical nature on the floor. I observed a white bed sheet tied on to a shelf on the wall. The sheet appeared to be cut. The other section of sheet was located on the floor of the cell. A search of the cell for a suicide note met with negative results. Inmate Tomiano's personal information sheet listed his parents as deceased with no contact information for the next of kin.

At approximately 2134 hours Detective Jacobs and I responded to TMHER at which time we made contact with Officer King. Inmate Tomiano's neck injury was photographed by Detective Jacobs. After observing his body we found no signs of foul play. Rigor Mortis was not present at the time of our investigation. He was secured in a body bag and transported to the morgue. This writer made contact with on-call medical examiner Dr. Sgan. He advised that he would perform an autopsy on 01 November 2004 at 0900 hours.

On 01 November 2004 I attended the autopsy. A visual inspection of the body revealed no injuries other than linear bruising to his neck consistent with hanging. The hyoid bone was still intact. The autopsy revealed that one of Tomiano's kidneys and spleen had been surgically removed in the past. There were no signs of foul play.

On 01 November 2004 at 1213 hours I contacted Tomiano's mother Patricia Tomaino in Niantic, Connecticut. She advised that she has not seen or heard from her son for over 10 years. She stated that he was last known to be in prison in North Carolina for an armed robbery. She advised that during the robbery he was shot by police and that is

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Agency Report Number: 04-227822 Victim Name(s): Tomaino, Steven

Original: Supplemental: X Juvenile:

Date Reported: 10-31-04

how he lost his kidney and spleen. At her request I made arrangements for his property to be sent to her in Connecticut. While speaking to her I became aware that his last name is spelled Tomaino instead of Tomiano that he was booked in under. His drivers license and criminal history were also under Tomaino.

On 02 November 2004 I received two written statements from Lt. Taylor. The statements were authored by inmate Allen Paris and inmate William Edenfield. Mr. Edenfield made allegations that Officer Harris did not complete her rounds as she stated in her report. Inmate Paris made statements that he has seen the deceased in a private conversation with an inmate occupying cell #26. These statements do not alter or affect the criminal investigation in any way however; they may affect the administrative investigation. I advised Detective McBride of these statements.

This death investigation has been determined to be suicide by hanging with no evidence of foul play.

DISPOSITION RECOMMENDED

Exceptionally Cleared

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Original: Yes Supplemental: No Juvenile: No

Agency Report Number: 04227822 Victim Name(s): Tomiano, Steven Date Reported: 10-31-2004

Officer Reporting: Patricia Harris ID#: 471 Date: 10-31-2004

Officer Reviewing: Sgt. Bill Parramore ID#: 103 Date: 10-31-04

Offense(s): Death Investigation

Case Status: UCR Clearance: Date Cleared: OBTS Number: Related Report #:

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

I was assigned to Pod A on the 1700 to 0500 shift on 31 October 2004. After assuming duties, I completed a Visual Inspection at 1750 hours of all inmates. All inmates appeared to be resting or waiting to eat. I started feed up at 1804 hours and completed at 1811 hours. I noticed that Inmate Steven Tomiano #169564 had not eaten. I attempted to call him on the intercom but did not hear a response. I then asked Inmate Thomas Davis #593 who was assisting with feed up to go and ask the inmate in room 43 if he was going to eat. Inmate Davis went to room 43, he then called me over to room 43. I went to room 43 and saw Inmate Tomiano with a sheet tied around his neck and around the shelf. He was sitting on the floor and appeared to have hung himself. I called for assistance and medical on the radio, I then ordered the pod to lock down. At 1815 hours, Nurses Bob Delaney, Michelle Lane, Kathy Bratcher and Sergeant Bill Parramore arrived. Emergency personnel arrived from the Fire Department and Ambulance Service at 1828 hours. Inmate Tomiano was taken out of Pod A on a stretcher at 1845 hours. "See Nurses Inmate Progress Report"

During my tour of duty in Pod A, I did not see anyone go into room 43 and I did not have any problems with Inmate Tomiano.

See Attachments

Supplements from Sergeant Bill Parramore, Officers Kevin White, Clete King, and Garry Booker.
See documentation from Nurses Bob Delany, Kathy Bratcher, Michelle Lane and Travis Oneal
See Sworn Affidavit from Inmate Thomas Davis #593
Leon County Sheriff's Officer Property Receipt

DISPOSITION RECOMMENDED

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Original: Yes Supplemental: No Juvenile:

Agency Report Number: 04227822 Victim Name(s): Tomiano, Steven Date Reported: 10-31-2004

Officer Reporting: *Sgt Bill Parramore 103* ID#: 103 Date: 10-31-2004
Officer Reviewing: *Dianne Sheffield* ID#: 127 Date: *OCT. 31, 04*
Offense(s): Death Investigation

Case Status: UCR Clearance: Date Cleared: OBTS Number: Related Report #:

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On 31 October 2004, at approximately 1815 hours, I responded to Pod A because of a call for assistance. I arrived at the same time as Charge Nurse Bob Delaney, and Nurses Kathy Bratcher and Michelle Lane. As soon as we entered Pod A Room 43, I observed Inmate Steven Tomiano #169564 in a sitting position with one end of a sheet tied around his neck. The other end of the sheet was tied around the towel rack. Inmate Tomiano was unresponsive and his body was limp. As medical personnel cut the sheet and started treatment, I sent officer Gary Booker to get a video camera. I then instructed Central Control to call for an ambulance at the request of Nurse Delaney. At approximately 1817 hours, Officer Booker returned with the video camera and started recording this incident. I then instructed Officer Gene Wood in Central Control to call Captain Kim Petersen and advise her of this incident. At approximately 1830 hours, members of the Tallahassee Fire Department and Leon County Ambulance Service arrived and started treating Inmate Tomiano. The Ambulance departed with Inmate Tomiano at approximately 1900 hours en route to Tallahassee Memorial Hospital. Officer Clete King was sent with Inmate Tomiano and remained until he was relieved by Detective Dawn Butler at approximately 2134 hours.

DISPOSITION RECOMMENDED

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Agency Report Number: 04-227822 Victim Name(s): Tomiano, Steven Date Reported: 10-31-2004

Officer Reporting: Officer Kevin White ID#: 475 Date: 10-31-2004

Officer Reviewing: Sgt. H. B. 113 Thomas Steg ID#: 113 Date:

Offense(s): Death Investigation

Case Status: UCR Clearance: Date Cleared: OBTS Number: Related Report #:

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On the above date at approximately 1815 hours, I responded to Pod A due to a call for assistance. Upon arrival I observed Nurses Michelle Lane, Bob Delaney, and Kathrine Bratcher performing CPR on inmate Tomiano, Steven Spn# 169564 in cell 43. I assisted by obtaining the oxygen bottle from Medical and delivered it to the Medical Staff. At approximately 1840 hours, I was instructed by Sergeant William Parramore to take over the video camera from Officer Gary Booker. I continued to film the incident until approximately 1850 hours, when inmate Steven Tomiano was placed in the ambulance and the doors were secured.

DISPOSITION RECOMMENDED

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Agency Report Number: 04-227822 Victim Name(s): Tomiano, Steven

Date Reported: 10-31-2004

Officer Reporting: Clete King *[Signature]* ID#: 400

Date: 10-31-2004

Officer Reviewing: *[Signature]* ID#: 103

Date: _____

Offense(s): Death Investigation

Case Status: _____ UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On 31 October 04 at approximately 1850 hours, I was instructed by Sergeant Stege #113 to follow the ambulance containing Inmate Tomiano, Steven Spin # 169564 to Tallahassee Memorial Hospital 10-18. I arrived at TMH at approximately 1911 hours and followed EMS into the Emergency Room. At approximately 1914 Inmate Tomiano was seen by Doctor Jusino and pronounced dead at approximately 1915. I then secured the room as a crime scene and remained with Inmate Tomiano until relieved by Detective Dawn Butler at approximately 2134 hours.

DISPOSITION RECOMMENDED



LEON COUNTY SHERIFF'S OFFICE
OFFICE OF INTERNAL AFFAIRS
REPORTING FORM



AIB CASE NO: A04-101A
DATE RECEIVED COMPLAINT: 31 October 2004
DATE REPORT COMPLETED: 19 November 2004
COMPLAINANT: Capt. Karen Bodiford
MEMBER INVOLVED: C.O. Patricia Harris
INVESTIGATOR: Det. Melinda McBride *Mem*
Office of Internal Affairs

DISCIPLINARY STANDARD

042-A Standard of Conduct/Integrity - Gross Violation : Employees shall not engage in any conduct that constitutes a gross violation of conduct unbecoming an officer, or any act that is likely to severely affect the discipline, good order, or reputation of the agency, or that will compromise the integrity of the employee. Employees shall refrain from any conduct that grossly detracts from or severely affects public faith and trust in the agency, i.e., being arrested for committing a felony, or a misdemeanor involving dishonesty, perjury, a false statement or an immoral act and such arrest being sustained by an administrative investigation. Employees shall comply with the Cannon of Ethics as found in General Order 1.2 (*Level Five Violation*).

SYNOPSIS OF COMPLAINT

It is alleged that Officer Patricia Harris failed to do a visual check/count of inmates upon arriving on duty and relieving the off going officer in pod A on 31 October 2004 at 1650 hours. It's alleged that she falsified the official pod log book by logging that she did a visual check/count at 1650 hours and another at 1750 hours. At or around 1813 hours it was discovered that an inmate in that pod (room 43) had hung himself. That death investigation was conducted by the LCSO Violent Crimes Unit Det. Butler.

INVESTIGATIVE NARRATIVE

On 31 October 2004 I responded to the Leon County Jail (Pod A), in reference to an inmate hanging himself. Upon arrival, LCSO Violent Crimes Unit Det. Dawn Butler and Lt. Todd McKissack, along with Crime Scene Detectives Donnie Jacobs and Pat Lyons were on scene. Also present was the jail staff Sgt. Parramore, Lt. Taylor, and C.O. Patricia Harris, who was assigned to pod A for the evening shift (1700-0500). Inmate Steven Tomiano (SPN# 169564) had already been transported by EMS to Tallahassee Memorial Hospital, where he was later pronounced dead at 1915 hours by Dr. Jusina. Det. Dawn Butler was assigned to conduct the death investigation (case #04-227822)

A review of the scene was conducted upon my arrival to the jail and I observed a bed sheet tied around a metal rack/towel hanger in room #43 that appeared to have been cut. The other part of the sheet was on the floor. I also observed numerous empty packages from medical supplies that were left by the jail medical staff and EMS. I also viewed the pod log which showed that Ofc. Harris had done visual checks of the inmates at 1650 hours and 1750 hours. A copy of the log book for the is included in this case.

A copy of the Offense/Incident Report - Death Investigation by Det. Butler is included in this file. It includes the reported chain of events surrounding this incident to include the autopsy, as well as information gathered about Inmate Tomiano's history. Det. Butler completed her investigation and the case was closed exceptionally cleared. She noted that this investigation had been determined to be suicide by hanging with no evidence of foul play.

During this investigation I was notified that two inmates, William Edenfield (SPN# 99763) and Allan Paris (SPN#23862), had written sworn affidavits in reference to this incident. Also, Inmate Michael Robbins (SPN# 84854) had written a request to speak to the Chaplain about Inmate Tomiano. A copy of the statements and request are included in this file.

Inmate Edenfield's statement alleged that Officer Harris never made her rounds when she relieved Officer Williams on 31 Oct. 2004. Inmate Edenfield was released from jail before receipt of his statement. Therefore, he was not interviewed.

Inmate Paris' statement referenced several inmates having conversations and was not specifically related to this incident. He was not interviewed.

On 05 November 2004 I conducted a tape recorded interview with Inmate Michael Robbins, after he was advised of and signed a Confidentiality Notice. Inmate Robbins had written a request to speak with the chaplain about Inmate Tomiano. Inmate Robbins advised that as far as Inmate Tomiano's death, he was 100% shocked that it happened. He stated that the day of his death, he had been talking to him and Inmate Tomiano seemed to be in good spirits and he was calm. He added that they also talked about trading some canteen items that they were preparing to order, which they discussed right at lock down at 1610 hours. Inmate Robbins advised that Inmate Tomiano had previously told him that he was somewhat depressed about his current charges and the issue of him being on parole from another state. However, he did not seem to be depressed to the point of committing suicide and he never made any comments about suicide. Inmate Robbins said that Inmate Tomiano had filled out several request, two or three of them he actually saw him fill out because he lent him a pencil to do so, to go to medical and talk to someone about him feeling depressed. He noted that he doesn't know whatever happened to the request. Inmate Robbins did advise that he was aware that Inmate Tomiano went to medical several times for treatment due to a spider bite and he told him to just talk to them then about his depression.

Inmate Robbins stated that Ofc. Stephon Williams was on the day shift and he was relieved by Ofc. Patricia Harris. He went on to say that the pod (A) was permitted outside on the incident date. They came in around 1600 hours and the pod was locked down around 1610 hours. He said that he recalls Officer Williams doing a visual check right after lock down. Inmate Robbins said that when Officer Harris came on duty she did not do a visual check of the inmates. He said that she sat at the officer's desk and ate something and watched television. He advised that she never did a visual check up until Inmate Tomiano was discovered, which was by the inmate assisting with feed up. He said that he knows she didn't do a visual check because he stays by his door looking out. Inmate Robbins also advised that Inmate Tomiano talked to another inmate named Scott, who was housed in room 41. He noted that other than the two of them, Inmate Tomiano didn't really talk to anyone else.

*** End of Statement ***

On 08 November 2004 I conducted a tape recorded interview with Inmate Scott Collins (SPN#150417), after he was advised of and signed a Confidentiality Notice. Inmate Collins advised that he had been talking with Inmate Tomiano, who on the day of this incident told him that he would come to his (Inmate Collins) ministry program when released. He advised that they talked outside that day and being that their rooms were next to each other they spoke every day. Inmate Collins relayed that he does recall Inmate Tomiano asking officer's several times to go to medical. He noted that Inmate Tomiano had a spider bite that he was being treat

for. He stated that he observed Inmate Tomiano write a medical request, but he could not advise what he did with it. Inmate Collins also advised that to best of his recollection Officer Harris did not do a visual check of the inmates when she came on duty. He added that until this incident most of the officers didn't do visual checks. *** End of Statement ***

On 08 November 2004 I conducted a tape recorded interview with Correctional Officer Stephon Williams, after he was advised of and signed a Confidentiality Notice. Officer Williams worked pod A on the day shift on 31 October 2004 and he was relieved by Officer Harris at or around 1645 hours.

Officer Williams advised that he took the inmates outside that day. They came in for lock down at 1600 hours and he conducted a visual check of the inmates at 1608 hours. Ofc. Williams said at that time all inmates, including Inmate Tomiano, were reading, writing, or resting on their bunks. He advised that was the last visual he conducted. Officer Harris came in the pod at 1645 hours and he turned over all equipment, etc. to her. Officer Williams advised that Officer Harris *did not* conduct a visual/count of the inmates at the time she relieved him or prior to him leaving the pod. He clarified advising that means she did not go around the pod and do a visual check/count of the inmates. He stated that they talked for a brief moment, she signed off on the log (noting that she did a visual check/count), and told him she had to make a phone call. He left and she went to the bathroom.

Officer Williams was asked if he was aware of Inmate Tomiano having put in any request for medical. He could not advise if Inmate Tomiano had or had not. He stated that he usually gives the inmates back their medical request to give directly to the nurse when he or she makes rounds in the pod, because medical prefers that being that the nurse has to sign off on them.

*** End of Statement ***

On 09 November 2004 I served Officer Patricia Harris with a Notification of Administrative Investigation. I also conducted a tape recorded interview with her after all applicable notices were given and signed. Ofc. Harris was advised that during the Administrative Review/Investigation of the death of Inmate Tomiano, allegations came forth from inmates that she did not conduct a visual check/count of the inmates when she relieved Ofc. Williams on 31 October 2004.

Ofc. Harris first asked how would we know if she did a visual check or not. As I began to inform her how the allegations came forth, she interjected answering in question form "the inmates". I advised her that this information came from the inmates and Ofc. Williams was also interviewed. I informed her that Ofc. Williams attested to what took place upon her relieving him, until he left the pod and he said that she did not do the visual check/count during that time. Ofc. Harris then said that she didn't do the visual while he was there. She added that usually no one does the

visual when relieving, it's done afterwards. I then showed her the log book for pod A, confirming that the entries referenced were made by her. I referred to the entry she made at 1650 hours stating that she did a visual check. She was asked if she did the visual as she logged in the book and she said "no". She was then asked if she did the visual check at 1750 hours that she logged. She thought for a moment and said that she probably didn't do that one either. Officer Harris then said "because I be doing so much stuff until it just, you can't really, if I get to it I get to, I mean sometimes I can't sometimes I can". She was asked if procedure was to conduct these checks every hour and she "no, I walk around every-when-ever, not every hour but like 40-50 minutes or something like that". She confirmed that she did not do the checks as she logged in the log book at 1650 hours and 1750 hours. She was asked for any explanation and she said she was preparing for feed up with an inmate assisting her.

Ofc. Harris advised that when she finished feed up, Inmate Tomiano didn't come to get his food. She had the inmate assisting with feed up go to his room door to ask if he was going to eat. That's when it was discovered that Inmate Tomiano had hung himself. At that time she locked the pod down, notified medical and supervisors.

I asked Ofc. Harris if she had actually done the visual checks that she logged during the shift other than the two noted and she said that she did. Both of the visual checks Ofc. Harris logged, but admits she did not do, were prior to discovering that Inmate Tomiano had hung himself.

Ofc. Harris was again asked if there was any explanation that she would like to give in her defense and she said no.

I also asked her if she recalled Inmate Tomiano giving her any sick call forms. She said he had not and usually when inmates write up sick calls they keep them to give directly to the nurse.

*** End of Statement ***

Contact was made with the medical staff and a copy of Inmate Tomiano's medical file was obtained. The file was secured by the medical staff administrator, Ms. Leticia Wright. In reviewing the file, Inmate Tomiano had in fact put in three sick call requests for a foot fungus, spider bite, and for the release of his medical status for trustee duty. Inmate Tomiano was being treatment for the foot fungus and spider bite. There were no other medical issues or requests in his file. Ms. Wright also stated that there were no indications that Inmate Tomiano was considering suicide.

I obtained the log book for pod A and made copies of the entries for the day and evening shift on 31 October 2004. I also reviewed Inmate Tomiano's inmate file and found that he had not reported any problems and he had not been disciplined for any reason. I did find that he was actively seeking to become a trustee. The pod log indicates that Officer Williams conducted a

visual inspection of the inmates at 1608 hours and completely locked the pod down at 1630 hours after clean up. At 1650 hours, Office Harris came on duty and logged a visual check and the receipt of the keys, radio, etc. She also logged a visual check of inmates at 1750 hours.

Also, obtained was the door activity for room 43 on 31 Oct. 2004. As it relates to the discovery of Inmate Tomiano, it shows that at 18:07:00 hours his door was unlocked. This would have been for feed up. Prior to that it had been locked since lock down at 1600 hours. At 18:13:21 hours the intercom was activated by the officer calling the inmate. At 18:14:21 the door was opened. This was when it was discovered that he had hung himself.

Officer Harris also documented an Offense/Incident Report titled Death Investigation. Attached to her report are the continuations from all responding personnel, including medical personnel. A statement from Inmate Thomas Davis (SPN# 593) was also included. He was the inmate assisting with feed up and who discovered Inmate Tomiano, after Officer Harris sent him to Inmate Tomiano's room door to see if he was going to eat. It should be noted that Ofc. Harris also wrote in her report that she completed a visual inspection at 1750 hours of all inmates.

CONCLUSION

During this investigation statements were gathered from Inmates William Edenfield (written only), Michael Robbins, and Scott Collins alleging that Officer Harris did not conduct the visual check/count of inmates when she arrived on duty. A statement was also obtained from Ofc. Williams, who Ofc. Harris relieved, advising that he too did not observe Ofc. Harris conduct a visual check/count upon her arrival or before he left the pod. Ofc. Harris also admitted in her own interview that she *did not* conduct the visual checks that she logged in the official pod log book for pod A on 31 Oct. 2004 at 1650 hours and 1750 hours.

Based on this information and Ofc. Harris' own admission, she willfully neglected her job duties and she knowingly made a false statement in writing (log book and offense/incident report), thus falsifying an official record. This conduct constitutes a gross violation of conduct unbecoming an officer, it compromises the integrity of an officer, and it severely affects the reputation of this agency. Initially Ofc. Harris was served notification with the charges' Untruthfulness Not in an Official Proceeding and Willful Neglect of Job Duties. *However, this conduct supports a sustained finding for Standard of Conduct/Integrity - Gross Violation.*

FINDINGS

042-A Standard of Conduct/Integrity - Gross Violation - Sustained

ATTACHMENTS

- 1) Notification of Administrative Investigation (Ofc. P. Harris)
- 2) Notice of Agency Policy Violation (Ofc. P. Harris)
- 3) Employee Rights Interview (Ofc. P. Harris)
- 4) Confidentiality Notice (Ofc. P. Harris)
- 5) Confidentiality Notice (Ofc. S. Williams)
- 6) Confidentiality Notices (Inmates Michael Robbins, Scott Collins)
- 7) Written sworn affidavits (Inmate William Edenfield, Allen Paris)
- 8) Copy of inmate request from Inmate Robbins
- 9) Copy of pod A log for 31 Oct. 2004 (both day/night shifts)
- 10) Copy of Inmate Tomiano's medical file.
- 11) Copy of Death Investigation report written by Ofc. Harris
- 12) Email from Sam Adams ref: Pod A, Room 43 door activity
- 13) Copy of video tape of incident after discovery
- 14) Copy of scene photographs
- 15) Copy of LCSO Death Investigation Report (case #04-227822)
- 16) Cassette tape recorded interviews (Inmate Robbins, Inmate Collins)
- 17) Cassette tape recorded interview (Ofc. S. Williams)
- 18) Cassette tape recorded interview (Ofc. P. Harris)
- 19) Investigative Findings Form
- 20) Prior Discipline Worksheet
- 21) Disciplinary Recommendation Form

LEON COUNTY SHERIFF'S OFFICE
OFFENSE/INCIDENT REPORT (SHORT FORM)

AGENCY ORI #370000		JUVENILE	ORIGINAL 1	INCIDENT REPORT #	03098923		
REPORTED	DATE	TIME	DISPATCHED	ARRIVED	COMPLETED	OCCURRED DATE	TIME
THU	6/12/03	0417	0417	0417	0418	6/2/03	0400
OFF #	DATE	OFFENSE	AC	STATUS			
1	3	RESISTING O.C. FOAM	C	84302			
2	4	DEATH INVESTIGATION	AC	4999999			
INCIDENT LOCATION		TALLAHASSEE ZIP					
535 ADLEYARD DA		32304	8-16 TL				
AREA IDENTIFIER		LEON COUNTY JAIL	000	007	000	002	000
OFFENSE ENTRY (E.L.)		OCCUPANCY (OCC.)	LOCATION TYPE	TYPE WEAPON			
1. No		1. Occupied	01. Residence - Single	01. Knife			
2. No		2. Unoccupied	02. Apartment / Condo	02. Gun			
3. No		3. Abandoned	03. Residence - Other	03. Hammer			
4. No		4. Occupied	04. Hotel / Motel	04. Saw			
5. No		5. Occupied	05. Convenience Store	05. Shotgun			
6. No		6. Occupied	06. Gas Station	06. Stun Gun			
7. No		7. Occupied	07. Liquor Store	07. Tear Gas			
8. No		8. Occupied	08. Bar / Nightclub	08. Bomb			
9. No		9. Occupied	09. Supermarket	09. Firearm			
10. No		10. Occupied	10. Gas / Oil Station	10. Knife			
11. No		11. Occupied	11. Laundry Store	11. Firearm			
12. No		12. Occupied	12. Drug Store/Hospital	12. Firearm			
13. No		13. Occupied	13. Bank / Financial Inst.	13. Firearm			
14. No		14. Occupied	14. Commercial / Office Bldg.	14. Firearm			
15. No		15. Occupied	15. Industrial / Shop	15. Firearm			
16. No		16. Occupied	16. Change	16. Firearm			
17. No		17. Occupied	17. Gov't / Public Bldg.	17. Firearm			
18. No		18. Occupied	18. Airport	18. Firearm			
19. No		19. Occupied	19. Bus / Fuel Tanker	19. Firearm			
20. No		20. Occupied	20. School / University	20. Firearm			
21. No		21. Occupied	21. Jail / Prison	21. Firearm			
22. No		22. Occupied	22. Construction Site	22. Firearm			
23. No		23. Occupied	23. Other Structure	23. Firearm			
24. No		24. Occupied	24. Parking Lot / Garage	24. Firearm			
25. No		25. Occupied	25. Highway / Freeway	25. Firearm			
26. No		26. Occupied	26. Park / Recreational Field	26. Firearm			
27. No		27. Occupied	27. Other	27. Firearm			
28. No		28. Occupied	28. Other	28. Firearm			
29. No		29. Occupied	29. Other	29. Firearm			
30. No		30. Occupied	30. Other	30. Firearm			
31. No		31. Occupied	31. Other	31. Firearm			
32. No		32. Occupied	32. Other	32. Firearm			
33. No		33. Occupied	33. Other	33. Firearm			
34. No		34. Occupied	34. Other	34. Firearm			
35. No		35. Occupied	35. Other	35. Firearm			
36. No		36. Occupied	36. Other	36. Firearm			
37. No		37. Occupied	37. Other	37. Firearm			
38. No		38. Occupied	38. Other	38. Firearm			
39. No		39. Occupied	39. Other	39. Firearm			
40. No		40. Occupied	40. Other	40. Firearm			
41. No		41. Occupied	41. Other	41. Firearm			
42. No		42. Occupied	42. Other	42. Firearm			
43. No		43. Occupied	43. Other	43. Firearm			
44. No		44. Occupied	44. Other	44. Firearm			
45. No		45. Occupied	45. Other	45. Firearm			
46. No		46. Occupied	46. Other	46. Firearm			
47. No		47. Occupied	47. Other	47. Firearm			
48. No		48. Occupied	48. Other	48. Firearm			
49. No		49. Occupied	49. Other	49. Firearm			
50. No		50. Occupied	50. Other	50. Firearm			
51. No		51. Occupied	51. Other	51. Firearm			
52. No		52. Occupied	52. Other	52. Firearm			
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62. No		62. Occupied	62. Other	62. Firearm			
63. No		63. Occupied	63. Other	63. Firearm			
64. No		64. Occupied	64. Other	64. Firearm			
65. No		65. Occupied	65. Other	65. Firearm			
66. No		66. Occupied	66. Other	66. Firearm			
67. No		67. Occupied	67. Other	67. Firearm			
68. No		68. Occupied	68. Other	68. Firearm			
69. No		69. Occupied	69. Other	69. Firearm			
70. No		70. Occupied	70. Other	70. Firearm			
71. No		71. Occupied	71. Other	71. Firearm			
72. No		72. Occupied	72. Other	72. Firearm			
73. No		73. Occupied	73. Other	73. Firearm			
74. No		74. Occupied	74. Other	74. Firearm			
75. No		75. Occupied	75. Other	75. Firearm			
76. No		76. Occupied	76. Other	76. Firearm			
77. No		77. Occupied	77. Other	77. Firearm			
78. No		78. Occupied	78. Other	78. Firearm			
79. No		79. Occupied	79. Other	79. Firearm			
80. No		80. Occupied	80. Other	80. Firearm			
81. No		81. Occupied	81. Other	81. Firearm			
82. No		82. Occupied	82. Other	82. Firearm			
83. No		83. Occupied	83. Other	83. Firearm			
84. No		84. Occupied	84. Other	84. Firearm			
85. No		85. Occupied	85. Other	85. Firearm			
86. No		86. Occupied	86. Other	86. Firearm			
87. No		87. Occupied	87. Other	87. Firearm			
88. No		88. Occupied	88. Other	88. Firearm			
89. No		89. Occupied	89. Other	89. Firearm			
90. No		90. Occupied	90. Other	90. Firearm			
91. No		91. Occupied	91. Other	91. Firearm			
92. No		92. Occupied	92. Other	92. Firearm			
93. No		93. Occupied	93. Other	93. Firearm			
94. No		94. Occupied	94. Other	94. Firearm			
95. No		95. Occupied	95. Other	95. Firearm			
96. No		96. Occupied	96. Other	96. Firearm			
97. No		97. Occupied	97. Other	97. Firearm			
98. No		98. Occupied	98. Other	98. Firearm			
99. No		99. Occupied	99. Other	99. Firearm			
100. No		100. Occupied	100. Other	100. Firearm			

(SEE ATTACHED)

OFFICER PRESCRIBING	ID NUMBER	UNIT	DATE	RELATED CASE NUMBER
Det. Jay Evans Terry Kyr 105			6-12-03	
OFFICER REVIEWING	ID NUMBER	ROUTED TO	REFERRED TO	ASSIGNED TO
LT. Howard Campbell				
PAGE	OF			
1	3			

**LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 2	1	REPORTED DATE	06/12/03	INCIDENT REPORT #	03098923
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On 6-12-2003 inmate Clyde Fuller was transported to the Jail at 0150 hours. At 0336 hours he was booked into the Jail and processed and showered. At 0345 hours nurse Debra Linton was unable to screen inmate Clyde Fuller in booking due to him talking to himself. At 0355 hours inmate Clyde Fuller was escorted to medical by officer Craig Carroll and myself because the charge nurse McCabe wanted to evaluate inmate Clyde Fuller in medical. Nurse McCabe wanted inmate Fuller placed in a paper gown and in room # 515 under direct supervision. myself and officer Craig Carroll started to escort inmate Fuller to his cell when he became combative and he was restrained on the floor by myself and officer Craig Carroll. Officer James Morgan arrived to assist in restraining inmate Fuller. Inmate Fuller continued to resist so officer James Morgan sprayed inmate Fuller with OC foam in the facial area. At that point inmate Fuller was secured with handcuffs and leg shackles and nurse McCabe ordered that inmate Fuller be placed in the restraint chair due to his management behavior. At 0400 hours inmate Clyde Fuller was placed in the restraint chair by myself, officer Chris Bryant, and officer Charles Johnson. ONCE inmate Fuller was placed in the restraint chair nurse McCabe gave inmate Fuller a shot and he became calm and he was placed in room # 515 on direct observation. At 0423 hours officer William Summerlin called for assistance down at medical direct. When I arrived nurse McCabe informed me that inmate Fuller had a weak pulse and low breathing. Officer Georgia Woerner began CPR on Inmate Fuller.

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____
 _____ Personally Known _____ Identified By ID # _____

Certifying Officer _____ 43

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
Sgt. Terry Fryar Sgt. Terry Jumper	105	6-12-03	2	OF 3
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 2	1	REPORTED DATE	6/12/03	INCIDENT REPORT #	031098191213
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EMS was called by nurse Debra Linton and they arrived at 0437 hours (Paramedic Scott Hill and George Azar). At 0500 hours I called Captain Mills, Major Bennett, Captain Bodiford, Lieutenant Taylor, Lieutenant Butler, and Dispatch. Dispatch called the on call persons Investigator. NO officers were injured during the incident

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____

____ Personally Known ____ Identified By ID# _____

Certifying Officer 48

OFFICER REPORTING	ID#	DATE	PAGE	PAGE
Sgt. Terry Fryar Terry Fryar 105	105	6-12-03	3	OF 3
OFFICER REVIEWING (IF APPLICABLE)	ID#	DATE		

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 2	1	REPORTED DATE	6/12/03	INCIDENT REPORT #	0309189123
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On 12 June 2003, at approximately 0400 hours, I responded to a call for assistance in medical. When I arrived on scene, Sergeant Fryar and two other officers had a inmate restrained on the floor. The inmate was identified to me as Fuller, Clyde ssn 109820. Fuller was spitting, cussing and attempting to get away from the officers restraining him. Sergeant Fryar ordered me to hold a towel over inmate Fuller's face while we placed him in the restraint chair, to keep him from spitting on the officers. I then assisted in placing the inmate's left leg in restraints while a officer held the towel over his face. I then helped restrain his upper torso while officers restrained inmate Fuller's arms. I did this by placing my left hand on his chest. Once inmate Fuller was secure and placed in holding cell 1-515 I returned to booking.

At approximately 0420 hours on this same day, I again responded to another call for assistance in medical for inmate Fuller. Upon arriving in medical I observed nurse McCabe and nurse Bratcher in holding cell 1-515 with inmate Fuller. Nurse McCabe advised that inmate Fuller was not breathing properly and had a very low pulse rate. The nurse stated that the inmate had gone into arrest. At this time I started removing the restraint straps off of inmate Fuller so C.P.R. could be better administered. Once inmate Fuller was unsecured I assisted in placing him on his bunk so C.P.R. could be conducted in a better manner. Once inmate Fuller was placed on his bunk I held his neck in a manner to give proper air-flow. I exited inmate Fuller's room when the E.M.S. Paramedics arrived and took over.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____

Certifying Officer

Personally Known Identified By ID # _____

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OFFICER REPORTING
Chris Myant ID# 327 DATE 12 June 2003

PAGE _____ OF _____

OFFICER REVIEWING (IF APPLICABLE) ID# _____ DATE _____

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 2	REPORTED DATE	INCIDENT REPORT #	03-98923
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AT APPROXIMATELY 0355 HOURS ON 12 JUN 03 SERGEANT FRYER AND I WERE ESCORTING INMATE CLYDE FULLER SPN# 109820 TO MEDICAL TO BE SEEN BY THE NURSE. NURSE MCCABE ADVISED THAT THE INMATE SHOULD BE PLACED ON DIRECT. WE BEGAN ESCORTING THE INMATE TO THE BACK OF MEDICAL AND THE INMATE BEGAN TO RESIST AND SAT ON THE FLOOR. OFFICER MORGAN CAME TO ASSIST US IN MOVING THE INMATE AND THE INMATE BEGAN TO GET VIOLENT KICKING SPITTING AND TRYING TO SWING HIS ARMS. WE PLACED THE INMATE FACE DOWN ON THE FLOOR TO SECURE HIM. INMATE FULLER REFUSED TO COMPLY AND OFFICER MORGAN SPRAYED INMATE FULLER WITH O.C. FOAM. INMATE FULLER STILL WOULD NOT COMPLY. OFFICER MORGAN AND I PLACED HAND CUFFS ON INMATE FULLER AND DOUBLE LOCKED THEM. I HELPED OTHER OFFICERS PLACE INMATE FULLER INTO THE RESTRAINT CHAIR PER NURSE MCCABE. ALL RESTRAINTS WERE CHECKED AND THE INMATE WAS PLACED IN ROOM # 515 IN THE BACK OF MEDICAL. AT APPROXIMATELY 0430 HOURS I RESPONDED TO A CALL FOR ASSISTANCE IN MEDICAL ON INMATE FULLER. I ENTERED ROOM 515 NURSE MCCABE AND BRATCHER

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____
 Personally Known Identified By ID # _____

Certifying Officer

43

OFFICER REPORTING <i>Craig H. Carroll</i>	ID # 392	DATE 12 Jun 03	PAGE 1	PAGE OF 2
OFFICER REVIEWING (IF APPLICABLE) <i>[Signature]</i>	ID # 144	DATE 17 Jun 03		

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 1	REPORTED DATE	INCIDENT REPORT #	03-98923
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WERE PRESENT IN THE ROOM AND INMATE FULLER SEEMED TO BE UNRESPONSIVE. I ASSISTED IN REMOVING INMATE FULLER FROM THE RESTRAINT CHAIR AND PLACING HIM ON THE BED. THE NURSE AND OTHER OFFICERS STARTED CPR ON INMATE FULLER. THE ENT ARRIVED AT APPROXIMATELY 0437 HOURS. I RELIEVED THE NURSE ON THE RESUSCITATION BAG AND CONTINUED IT UNTIL INMATE FULLER WAS PRONOUNCED DEAD AT 0500 HOURS.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____
 _____ Personally Known _____ Identified By ID # _____

Certifying Officer

43

OFFICER REPORTING
Craig H. Carroll ID# 392
 OFFICER REVIEWING (IF APPLICABLE)
Robert... ID# 107

DATE 12 June 03
 DATE 17 07

PAGE 2 OF 2

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE <input checked="" type="checkbox"/>	ORIGINAL - 1 SUPPLEMENT - 2	REPORTED DATE	6/12/03	INCIDENT REPORT #	03098923
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On 12-June-2003 at approximately 0400 hours I responded to medical, when I arrived I saw inmate Fuller, Clyde son 109820 actively resisting Sgt. Eric 105 and Officer Morgan 431. At this time I assisted in placing Fullers left leg in a shackle. The order was then given to place Fuller in the restraint chair where I assisted by holding a towel over inmate Fullers face using my left index finger and thumb. While the restraint was being applied I also assisted by securing the pull straps in back of the chair. Inmate Fuller was then placed in room 515 in medical on direct supervision.

At approximately 0423 hrs I again responded to medical and video taped the effort to administer CPR on inmate Fuller, Clyde.

At approximately 0500 hrs I was assigned to secure 515 until the persons investigator arrived. At no time did anyone enter the room. At 0645 hours I was relieved by Officer Owens 447.

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____

Personally Known Identified By ID # _____

Officer Reporting: [Signature] ID# 344 DATE 12-JUNE-03

Officer Reviewing (if applicable): Sgt. Terry Fray 105 ID# _____ DATE 17-JUNE-03

Certifying Officer _____

PAGE 1 OF 1

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE <u>N</u>	ORIGINAL - 1 SUPPLEMENT - 2 <u>1</u>	REPORTED DATE <u>6/12/03</u>	INCIDENT REPORT # <u>01310191819123</u>
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At approximately 0420 hours, I responded to a 10-24 in medical direct, male side. Inmate Fuller, Clyde Spn# 109802 was still restrained in the pro-restraint chair that was ordered by medical due to an incident occurring 10 minutes prior. Nurses Macabe and Bratcher were examining inmate Fuller in an effort to start CPR. I assumed a position in front of inmate Fuller and began chest compressions. Ofc. C. Bryant unrestrained the inmate and the inmate was moved to the bed in order to continue CPR and other medical aid that was being administered. I continued chest compressions until the paramedics pronounced him dead at approximately 0504 hours.

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____
 _____ Personally Known _____ Identified By ID # _____

Certifying Officer _____
 43

OFFICER REPORTING <u>Georgia Woerner</u>	ID # <u>479</u>	DATE <u>12 Jun 03</u>	PAGE OF
OFFICER REVIEWING (IF APPLICABLE) <u>Sgt. Terry Foy</u>	ID # <u>105</u>	DATE <u>12 June 03</u>	

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE <u>N</u>	ORIGINAL - 1 SUPPLEMENT - 2 <u>1</u>	REPORTED DATE <u>06/12/03</u>	INCIDENT REPORT # <u>01310918191213</u>
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On June 12, 2003 at approximately 04:00 hours, I officer Charles Johnson #350 responded to a call for help in medical. Upon arriving in medical I observed Sgt. Fryar, Off Morgan and Otc. Carroll with inmate Fuller, Clyde Spivey # 109820 on the floor. I assisted in placing inmate Fuller in restraint chair by securing inmate Fuller's left arm and left leg.

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____
 _____ Personally Known _____ Identified By ID # _____

Certifying Officer _____

OFFICER REPORTING: Charles Johnson - 350 ID # _____ DATE 6/12/03 PAGE _____ OF _____

OFFICER REVIEWING (IF APPLICABLE): Sgt Terry Fryar 105 ID # Kerry Fryar 105 DATE 6-12-03

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 2	1	REPORTED DATE	6/12/03	INCIDENT REPORT #	0310989123
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ON 12 JUNE 03 I WAS WORKING ON MEDICAL DIRECT. NURSE MCCAIG ENTERED THE AREA AT APPROXIMATELY 0420 HRS. TO CHECK ON TIM FULLER IN RM 515. SHE FOUND HIM UNRESPONSIVE, AND HAD ME CALL FOR HELP ON THE RADIO. C.P.R. WAS STARTED AND CONTINUED UNTIL 0500 HRS. AT WHICH THE INMATE WAS PRONOUNCED DEAD.

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____

____ Personally Known ____ Identified By ID# _____

Officer Reporting: William Sumner ID# 469 DATE 12 JUNE 03

Officer Reviewing (if applicable): _____ ID# _____ DATE _____

Certifying Officer _____ PAGE 1 OF 1

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 2	REPORTED DATE	INCIDENT REPORT #	
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ON 12 JUNE 03 AT APPROXIMATELY 0645 I RELIEVED DEPUTY DAVID BROWN ID#344 OF DUTIES SECURING ROOM NUMBER 1-515 MEDICAL DIRECT AREA WITH INMATE FULLER, CLYDE SPN# 109820 PRESENT.

AT APPROXIMATELY 0651 DETECTIVE STEVE WOODCOCK ID#245 ENTERS ROOM # 1-515 AND BEGINS INVESTIGATION.

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____
 _____ Personally Known _____ Identified By ID # _____

Certifying Officer _____

OFFICER REPORTING <u>C.S. OWENS / C.S. OWENS</u>	ID # <u>447</u>	DATE <u>12 JUNE 03</u>	PAGE <u>1</u>	PAGE <u>OF 1</u>
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 2	REPORTED DATE	06/12/03	INCIDENT REPORT #	031019181213
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ON 11 JUNE 2003 I WAS ASSIGNED TO THE MEDICAL UNIT OF THE LEON COUNTY JAIL ON THE HADADSDSD SHEET.
 ON 12 JUNE 2003 AT APPROXIMATELY 0430HRS AFTER COMPLETING FEED UP IN THE MALE INMATE I HEARD A
 COMMOTION AND OBSERVED SGT. FEYAR AND OR. CARROLL EXCORTING INMATE CLYDE FULLER SEN *INDEED TOWARDS ME FROM
 THE BOOKING UNIT. THEY WERE WALKING BEHIND HIM GIVING VERBAL COMMANDS TO CONTINUE WALKING. HE OFFERED
 PASSIVE AND ACTIVE RESISTANCE ATTEMPTING TO NOT GO FORWARD AS THEY HAD THEIR HANDS ON EITHER OF
 HIS SHOULDERS. HE WAS ALSO CURSING AND YELLING, SOMETIMES IN AN INCOMPREHENSIBLE MANNER. UPON THE
 OFFICERS ENTERING THE HALLWAY WITH THE SUBJECT HE SQUATED AND SAT ON THE FLOOR. HE CONTINUED TO RANT
 AND PULL AWAY FROM SGT. FEYAR AND OR. CARROLL. SGT. FEYAR CONTINUED GIVING VERBAL COMMANDS TO
 STAND AND WALK ASSISTED BY OR. CARROLL WHEN INMATE FULLER BEGAN TURNING HIS HEAD FROM SIDE TO
 SIDE AND SPITTING. I WALKED OVER TO ASSIST THEM BY GIVING HIM THE COMMAND TO STAND AS I
 GRABBED HIS LEFT ARM TO HELP HIM STAND. AS HE BEGAN TO STAND HE SUDDENLY WRITHED VIOLENTLY BY
 PUSHING AND PULLING AGAINST US WHILE KICKING AT THE SAME TIME. I LOST MY BALANCE TEMPORARILY
 AS I HELD ON TO HIS LEFT ARM AND WE WRESTLED HIM TO THE FLOOR. SGT. FEYAR ATTEMPTED TO RADIO
 FOR MORE ASSISTANCE. I SPRAYED HIM ABOUT THE FACE WITH APPROXIMATELY A 1 TO 2 SECOND STREAM
 OF O.C. SPRAY. I RESECURED MY SPRAY AND CONTINUED TO HELP CONTROL INMATE FULLER WHO AT
 THIS TIME WAS ON HIS STOMACH WITH HIS RIGHT ARM TUCKED UNDER HIS BODY. I ORDERED HIM TO
 STOP RESISTING BUT HE WOULD NOT COMPLY. HE OFFERED AN EXTRAORDINARY AMOUNT OF RESISTANCE AS IT
 TOOK BOTH ME AND OR. CARROLL TO APPLY MY HANDCUFFS BEHIND HIS BACK AND DOUBLE LOCK THEM
 WHILE SGT. FEYAR CONTROLLED HIS HEAD TO KEEP HIM FROM SPITTING AT US. OTHER OFFICERS RESPONDED
 AND ASSISTED AS I PLACED SHACKLES ON HIS ANKLES AND DOUBLE LOCKED THEM. I THEN ASSISTED
 IN CONTROLLING INMATE FULLER'S LEFT ARM AS HE WAS SECURED IN THE RESTRAINT CHAIR.
 AT APPROXIMATELY 0423HRS I RESPONDED TO OR. SUMMERLIN'S REQUEST FOR HELP TO THE DIRECT
 OBSERVATION ROOM #1-SIS IN THE MEDICAL UNIT WHERE HE REPORTED THAT INMATE FULLER WAS
 UNRESPONSIVE AT THAT TIME. WHEN I ARRIVED NURSES MCGABE AND BRATCHEL WERE PRESENT
 ATTENDING TO INMATE FULLER. I ASSISTED OFFICERS CARROLL AND WOELNER WHO ALSO RESPONDED.
 TOGETHER WE REMOVED INMATE FULLER FROM THE RESTRAINT CHAIR TO THE BUNK. AT NURSE BRATCHEL'S
 REQUEST I OPERATED THE ARTIFICIAL BREATHING MASK UNTIL THE E.M.T.'S ARRIVED AND TOOK OVER.

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____	Certifying Officer
<input type="checkbox"/> Personally Known <input type="checkbox"/> Identified By ID # _____	43

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
Anna A. Jones Morgan	431	12 JUN 03	1	1
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION
 Agency Report Number: 03-98930 Victim Name(s): CLYDE FULLER

Officer Reporting: ANNALIESE WIERENGAID#: 252Date: 06-18-03Officer Reviewing: [Signature]ID#: 118Date: 7-2-03Offense(s): DEATH INVESTIGATIONCase Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On 12 June 2003, I responded to the Leon County Detention Center in reference to a death investigation. Upon arrival, I was advised that Inmate Clyde Fuller died while confined in the medical unit. The circumstances surrounding his death are as follows:

Inmate Fuller was transported to the Leon County Detention Center at 0150 hours by the Tallahassee Police Department. TPD Officer Damm #794 charged Fuller with trespassing and resisting without violence.

Intake officer Donald Hudson #345 completed an initial medical screening questionnaire which was signed by Fuller. Fuller answered "yes" to the following questions:

- 1.) Are you currently being treated for any medical problems.
- 6.) Seizures
- 9.) Are you addicted to drugs/ alcohol {Fuller circled "alcohol"}
- 10.) Are you currently under the influence
- 11.) Have you ever had D.T.'s or seizures after you quit drinking or using drugs

Fuller was then required to shower and provided with a detention center uniform.

*** The following information was obtained from the Prison Health Services paperwork and Nurse Linton's progress notes

At 0345 hours, Nurse Debra Linton attempted to complete a medical screening on inmate Fuller with negative results. Nurse Linton stated that Fuller refused to cooperate with the screening process, or sign any of the required paperwork. Her report indicated that at one point he was speaking clearly but as the interview progressed he became increasingly agitated. She also described his behavior as "bizzare."

Nurse Linton stated that Fuller advised her that he had a history of seizures and that he had not taken his prescribed medication since 06-08-03.

Fuller further stated that he had prescriptions for the following medications: Dilantin, Depakote, Phenobarbitol.

Fuller also told nurse Linton that he had not consumed any drugs or alcohol prior to his arrest. Given his medical history, and the fact that she was unable to complete the screening, Nurse Linton requested that he be sent to the medical unit for further evaluation.

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION
Agency Report Number: 03-98930 Victim Name(s): CLYDE FULLER

Original: Supplemental: X Juvenile: _____
Date Reported: 06-12-03

Per Sgt. Fryar's incident report, at 0355 hours, he and Officer Craig Carroll escorted Fuller to the medical unit.

According to Sgt. Fryar, Fuller was "talking to himself." Nurse McCabe attempted to complete the screening process however, Fuller refused to answer any questions. At that point, Nurse McCabe requested that inmate Fuller be placed in a paper gown and housed in the direct observation unit. Sgt. Fryar and Officer Carroll attempted to escort Fuller to room # 515. Fuller refused to walk and made several evasive movements. He then sat down on the floor refusing to move.

Officer James Morgan observed the altercation and rushed over to offer assistance. Fuller was cursing and screaming and spitting at the officers. He also started pushing and kicking violently. Fuller was then wrestled to the floor. Sgt. Fryar stated that Fuller continued to actively resist their efforts to control him and that he was put face down on the floor.

Officer Morgan sprayed Fuller in the facial area with OC pepper spray. At approximately 0400 hours, Sgt. Fryar ordered that the incident be videotaped. Officer Georgia Worener responded to the unit and videotaped the incident. Fuller was then placed in handcuffs and leg shackles. A towel was placed over Fuller's face to prevent him from spitting on the officers. According to Sgt. Fryar, the decision was made to place Fuller in the restraint chair. Officer's Fryar, Carroll, Bryant, Brown and Johnson placed Fuller in the restraint chair. After he was secured in the chair, Nurse McCabe administered a one milligram injection of Ativan. Nurse McCabe indicated on tape that the straps were satisfactory.

At 0412 hours, Inmate Fuller was wheeled into direct observation room # 515. The chair was positioned facing away from the glass window towards the wall. Officer Summerlin was assigned to the direct observation unit and was responsible for monitoring the inmates. According to the log book, Nurse McCabe returned to the unit at 0428 hours to check on Inmate Fuller. She observed that his head was slumped back on the chair, and noted that he was unresponsive to verbal stimuli. Nurse McCabe called for assistance and entered the room. She noted that Fuller's breathing was quite shallow and that his pulse was approximately thirty beats per minute. CPR was initiated by Officer Woerner and Nurse McCabe requested that Emergency Medical Services be notified. Fuller was removed from the restraint chair and placed on a bed. Nurse McCabe started an IV and hooked him up to the Auto External Difibulator device. At 0430 hours, Dr. Primas of the Prison Health Services was notified by phone of the incident.

At 0437 hours, EMS /Paramedic's Scott Hill and George Azar arrived on scene. Nurse McCabe informed them that the AED device she was utilizing was advising that the patient was in full arrest and needed to be shocked. According to Nurse McCabe the paramedics opted to utilize their own AED Device. Fuller did not respond to CPR or the AED Treatments administered by the paramedics. At 0505 hours, the ER Physician was called and Fuller was pronounced dead.

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION
Agency Report Number: 03-98930 Victim Name(s): CLYDE FULLER

Original: Supplemental: X Juvenile:
Date Reported: 06-12-03

I responded to room #515. I observed Inmate Fuller lying on his back on the bed. He was dressed in a detention center uniform. The breathing apparatus utilized to revive him was still attached to his face and the AED stickers were attached to his chest. I observed debris from the medical procedures scattered on the floor. Fuller sustained a small laceration / abrasion on his right wrist as well as a slight abrasion to his left wrist. I also observed an abrasion on his right big toe and the top of his right foot. There were no other signs of trauma to the body.

Sgt. Fryar provided me with two videotapes. He stated that one of the tapes depicted the *use of force* utilized to control inmate Fuller and the other tape depicted the *medical procedures* utilized to revive him.

Detective Steve Woodcock of the LCSO Crime Scene Unit responded to the detention center. He videotaped and photographed the scene. I turned the aforementioned tapes over to him to be placed in evidence. Strong and Jones Funeral Home transported the body to the morgue.

Detective Jim Tyson and I conducted taped interviews with the following individuals: The correctional officers also submitted supplemental written reports.

Sgt. Terry Fryar
Officer Craig Carroll
Officer James Morgan
Officer Chris Bryant
Officer David Brown
Officer Georgia Woerner
Officer Charles Johnson
Nurse Debra Linton
Nurse Catherine Bratcher
Nurse Cathy McCabe

Interview Summaries:

Sgt. Terry Fryar's statements concurred with his written report. He added that Fuller became increasingly agitated when he learned that he was going to be housed in the medical unit. Fuller was very vocal and adamant about the fact that he did not want to stay in the medical unit and that he did not want to be placed in the "restraint chair." According to Sgt. Fryar, there was no mention of the chair prior to Fuller's arrival in the medical unit.

Officer's Carroll, Morgan, Bryant, Brown, Woerner and Johnson's statements concurred with their written reports.

Officer Bryant added that he was assigned to the booking unit as an intake officer. He stated that upon Fuller's arrival, he conducted a search of Fuller and also printed him. He stated that Fuller had a strong smell of alcohol beverage on his person. Fuller also smelled like he had been smoking some type of substance. Bryant stated that he asked Fuller what he had been smoking and Fuller replied "cigarettes."

Nurse Catherine Bratcher stated that she responded to room #515 in reference to an inmate in distress. She stated that upon arrival, Officer Woerner was performing CPR on inmate Fuller. Nurse Bratcher stated that she assisted with ventilation efforts.

Nurse Debra Linton stated that she attempted to complete a medical screening on Inmate Clyde Fuller. She stated that he was cooperative at first and advised her that he suffered from seizures. He also stated that he had not taken any seizure medication since 06-08-03. She stated that he became increasingly agitated and refused to answer any more questions or complete the necessary paperwork. She stated that given his demeanor and medical condition, she felt like he needed to be evaluated in the medical unit. She stated that she contacted Nurse Bratcher by phone and advised her that Fuller was being transferred to medical for further evaluation.

Nurse Cathy McCabe provided the following information. She stated that she was assigned to the medical unit as the "charge nurse." She stated that Nurse Bratcher advised her that Inmate Fuller was being escorted to the unit for further evaluation. She stated that she met with Inmate Fuller and two correctional officers outside the nurse's station. She stated that Fuller was seated on a bench. Nurse McCabe stated that she asked him if he had any drugs in his system. She stated that Fuller would not answer any questions. She stated that he then began yelling at the officers stating "I'm not going to stay in the medical unit and I'm not going to be put in that chair." Nurse McCabe stated that there had been no mention of the restraint chair. She stated that given his current behavior and the fact that he had a history of seizures, she advised the officer that Fuller should be housed in the direct observation unit. She stated that at that point, Fuller went "ballistic." She stated that he began violently struggling with the officers and knocked over a nearby food cart. She stated that it took three officers to subdue him. She stated that Fuller was eventually put face down on the floor. She stated that he continued to resist the officer's efforts to control him. She stated that there was some discussion about putting him in the restraint chair. She stated that additional officers responded to the unit and that Fuller was placed in the restraint chair. She stated that after checking the restraints, she gave Fuller a one milligram injection of Ativan. She stated that he was then taken to room #515 in the direct observation unit.

Nurse McCabe stated that she returned to the unit a short while later. She stated that she observed that Fuller's head was slumped back in the chair and that he seemed unresponsive. She stated that she had Officer Summerlin unlock the door in order for her to check on his condition. She stated that he did not appear to be breathing and that his heart rate was approximately thirty beats per minute. She stated that she immediately called for assistance. She stated that several officers arrived and CPR was initiated. She stated that Fuller was removed from the chair and placed on the bed.

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION
Agency Report Number: 03-98930 Victim Name(s): **CLYDE FULLER**

Original: Supplemental: X Juvenile:
Date Reported: **06-12-03**

She stated that she began an IV and also hooked him up to the AED machine. She stated that the machine indicated that he was in full arrest and needed to be shocked. She stated that at that point, the paramedics arrived. She stated that they essentially took over the revival efforts. She stated that they elected to utilize their own AED machine.

She stated that Fuller was unresponsive. She stated that approximately thirty minutes later, the paramedics consulted with a Tallahassee Memorial Hospital ER doctor. At 0505 hours, Fuller was pronounced dead.

At 1000 Detective Tyson and I responded to the morgue. Dr. Steve Sarbeck performed the autopsy. Dr. Sarbeck stated that his findings were inconclusive pending a toxicology report.

Detectives David Graham, and Mike Halligan responded to 1809 Saxon Street to make a death notification. They spoke with Mr. Fuller's grandmother, Evelyn Brown and his girlfriend Daquardra Kelly. Ms. Kelly stated that she would notify Mr. Fuller's father, Clyde Fuller Sr. Ms. Kathy Connolly of the Victim's Advocate Unit also responded and provided grief counseling to the family members.

Ms. Connolly later advised that Ms. Kelly stated that Mr. Fuller had been diagnosed as an epileptic. She stated that he had not been taking his prescribed seizure medicine. She further advised that he had a seizure approximately two weeks ago. Family members were unable to provide the name of Mr. Fuller's personal physician.

On 06-24-03, I met with Dr. Sarbeck and Dr. Stewart of the Medical Examiner's Office. They requested to review a copy of the videotape depicting the use of force methods utilized to control Inmate Fuller. Dr. Stewart stated that in his opinion there was no excessive force used to restrain Fuller.

On 06-25-03, I spoke with Dr. Sarbeck. He stated that he received a preliminary toxicology report. The report indicated that Fuller had marijuana and a significant amount of cocaine in his blood system. Dr. Sarbeck stated that Fuller may fit the profile of "sudden custody death syndrome." Dr. Sarbeck stated that he would provide me with a detailed report of his findings at a later date.

DISPOSITION RECOMMENDED
Pending

FLORIDA OFFENSE / INCIDENT REPORT - SUPPLEMENTAL / CONTINUATION

Agency ORI Number
FLO 370000

Agency Name
LEON CO. S.O.

Agency Report Number
03-98930

1. Original
2. Supplemental 2

Juvenile

Victim Name(s) Clyde Fuller	Original Date Reported (MDY) 12 June 03
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ADDITIONAL INFORMATION

On 12 June 03 at approximately 0619 hours I responded to 535 Appleyard Dr., the Leon County Jail, in reference to a death investigation. Upon arrival at approximately 0636 hours contact was made with Sgt. Curtis Parker who advised that the victim, an inmate identified as Mr. Clyde Fuller, B/M, DOB- 02-15-1977, was incarcerated last night and during the booking process Mr. Fuller had to be sprayed with pepper spray and restrained in a restraint chair. He was then taken to the medical ward and placed in a medical cell in the chair under observation. A short time later he was discovered to be unresponsive in the chair. He was removed from the chair by medical and jail staff personnel and CPR was performed without success. The scene was videotaped, photographed and evidence collected.

SCENE

The scene was 535 Appleyard Dr., The Leon County jail medical ward room 1-515. Upon entering this room a bed is to the left and a small block partition that comes out from the wall on the right. Behind this partition is a toilet/ sink combination. There was misc. medical debris on the floor and bed area. A grey mattress was on the bed. The victim was located on his back on the bed. His head was face up with his arms down by his side. His feet were hanging over the end of the bed. The victims shirt was open exposing his chest. He also was wearing long blue jail pants and white underwear. The victim had white medical patches on his chest and back with smaller medical patches on his left and right shoulders. I observed an IV attached to his left arm at the inside of the elbow. A tube was attached with the end attached to an IV bag. A tube was inserted into his mouth with a strap around his head to hold it in place. I observed two small scratches on his right outer wrist and one on his left wrist. He also had an abrasion on his right big toe. I observed no obvious trauma to the body. Rigor Mortis was present throughout the body.

The chair which the victim had been placed in was in a hallway just outside this room. I also obtained two video tapes from Det. Wierenga which were videos from the use of force and the medical help provided to the victim. Strong and Jones funeral home then responded to the scene and transported the victim to Tallahassee Memorial Hospital morgue.

On 12 June 03 at approximately 1000 hours I attended the autopsy of the victim which was performed by Dr. Sarbeck. I photographed the procedure and collected the victims clothing.

Evidence

- Exh#1- VHSc video (use of force)
- Exh#2- VHSc video tape (medical treatment)
- Exh#S1- VHS video of scene
- Exh#S2- clothing from victim
- Exh#S3- armband of victim

DISPOSITION RECOMMENDED

Pending

Officer Reporting Detective Steven F. Woodcock <i>SW</i>	ID Number 245	Date 13 June03	Page 1 of 1
Original Offense Death Investigation		Reclassify To	
Continuation Contains			
<input type="checkbox"/> 1. Victim Statements	<input type="checkbox"/> 3. Evidence	<input type="checkbox"/> 5. Investigative Leads	
<input type="checkbox"/> 2. Witness Statements	<input type="checkbox"/> 4. Confession of Defendant	<input type="checkbox"/> 6. Other	
Case Status	UCR Clearance Status	Date Cleared (MDY)	OBTS Number
1. Closed _____	1. Arrest/Adult	4. Exceptional/Juvenile	_____
2. Pending _____	2. Arrest/Juvenile	5. Unfounded	_____
3. Other _____	3. Exceptional/Adult	_____	_____
Officer Reviewing (if applicable) <i>Sgt. Donna Cormier</i>		Date 06-13-03	

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION
Agency Report Number: 03-098923 Victim Name(s): Fuller, Clyde

Original: Supplemental: 2 Juvenile:
Date Reported: 06-12-03

Officer Reporting: **Detective Michael Halligan** ID#: 254 Date: 06-14-03
Officer Reviewing: J. O. Hall ID#: 118 Date: 7-2-03
Offense(s): **Death Investigation**

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Thursday 06-12-03, Detective David Graham, Kathy Connolly (Victim's Advocate), and this detective responded to 1809 Saxon Street to make a death notification. Detective Graham and myself spoke with Evelyn Brown (grandmother) and Daquardra Kelly (girlfriend, and mother of his child). I advised both of them that Clyde Fuller had passed away at the Leon County Jail earlier that morning. Daquardra Kelly advised that she would tell Clyde Fuller's father. Kathy Connolly provided comfort and relief to both Daquardra Kelly and Evelyn Brown.

DISPOSITION RECOMMENDED
PENDING

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LEON COUNTY SHERIFF'S OFFICE
ADMINISTRATIVE INVESTIGATIVE
REPORTING FORM



AIB CASE NO: A03-21

DATE RECEIVED COMPLAINT: 12 June 2003

DATE REPORT COMPLETED: 9 July 2003

COMPLAINANT: Major Carl Bennett
Leon County Jail
922-3500

MEMBER INVOLVED: Not Applicable

INVESTIGATOR: Sgt. Tim Baxter 
Administrative Investigations Bureau

KWB
7-9-03

DISCIPLINARY STANDARD

Not applicable.

Jail Death/Administrative Review

SYNOPSIS OF COMPLAINT

On 16 June 2003, Inmate Clyde Fuller SPN 109820 was discovered deceased in a medical infirmary cell. He died while restrained in a restraint chair.

INVESTIGATIVE NARRATIVE

On 12 June 2003 at 0150 hours Clyde Fuller was brought to the Leon County Jail by the Tallahassee Police Department. He was booked in for Trespassing and Resisting An Officer Without Violence. He was processed at 0336 hours. During the processing Nurse Debra Linton was unable to do a thorough medical screening due to his abhorrent behavior. He was talking to himself, and otherwise not giving needed information. Based on this Nurse Cathy McCabe made the decision for him to be taken to medical to be better evaluated. She wanted him placed in direct observation in a paper gown. At approximately 0355 hours he was escorted to the medical unit by Sgt. Terry Fryar and Officer Craig Carroll. Once in the medical receiving area he began to resist, first by squatting on the floor and refusing to move, then escalating to active physical resistance. His resistance included the flailing of his arms and legs as well as spitting at the officers. At one point pepper spray was utilized but it had little affect. Once he was restrained with handcuffs and leg irons Nurse McCabe authorized his being placed in a restraint chair due to his continued aggressive mannerisms. Due to his continued attempts to spit on the officers Sgt. Fryar ordered a towel be draped over his face. Once he was secured in the restraint chair Nurse McCabe administered an injection of Ativan to him. At this point he appeared to calm down. He was then placed in a direct observation cell. The time was approximately 0412 hours. At approximately 0428 hours Nurse Braethcher went in the cell to check on Inmate Fuller. She discovered he was in medical distress and assistance was summoned. CPR and other lifesaving measures were initiated to no avail. The room was then secured and the proper persons notified to begin the necessary investigations.

The death investigation was conducted by Detective Analiese Wierenga of the Crimes Against Persons Unit. A copy of her report is included in this case file. Several references will be made to her investigation in this report. The death investigation revealed no foul play was involved in the death. An autopsy on Inmate Fuller revealed no readily apparent visual cause of death. Toxicology results are forthcoming. A video tape of the struggle with Inmate Fuller and the placing of him into the restraint chair was seized by Detective Wierenga in her investigation. It shows the level of resistance being displayed by Inmate Fuller as well as the officer's response to it. It reveals no improper actions on the part of the involved employees. The tape is started at the point Inmate Fuller is being restrained on the floor and terminates with his being placed into a medical unit cell in the restraint chair. There is a second tape that show the lifesaving measures attempted by correctional and medical staff. These video tapes are stored under case number 03-98930 in this agencies evidence section,

Following is information obtained in interviews of the involved correctional and medical staff by myself and Detective Wierenga.

Sgt. Terry Fryar

He was the on duty shift sergeant at the time of this incident. At approximately 0150 hours Inmate Fuller was brought into the jail by TPD. Around 0355 hours he was escorted to medical due to abhorrent behavior while Nurse Linton was attempting to interview him. The inmate did tell her he had "seizures." Officer Carroll and himself walked the inmate to medical. The inmate

was mumbling and nonsensical. Nurse McCabe ordered for him to be put in a paper gown and placed in direct observation. They told him to stand up (he was seated on a bench), so they could walk into the back. He started saying, "I don't wanna go in the chair, I don't wanna go in the chair." He then squatted on the floor and began to physically resist the officer's efforts to control him. Officer Morgan sprayed him in the facial area in an attempt to make him comply. At that point they were able to get his hands secured with handcuff. Nurse McCabe then said to place him in the restraint chair. They then got him off the floor and placed him in the restraint chair. He estimates they got him in the chair at about 0405 hours. Nurse McCabe gave him an injection to calm him. He almost immediately calmed down. During the struggle a towel was draped over the inmates face due to him spitting at the officers. When they placed him in the room the towel was removed from his face. Sgt. Fryar also returned back to the medical unit to assist in the lifesaving measures. **End of statement.**

Officer James Morgan

He was the assigned medical officer on the night/morning of this incident. He had just finished serving feed up in the infirmary when he heard a commotion in the medical unit receiving area. He observed Sgt. Fryar and Officer Carroll escorting Inmate Fuller to one of the direct observation rooms. He was being resistant and was cursing loudly. At one point he squatted on the floor and refused to move any further. They tried to get him up and he began to increase his physical resistance. He also was attempting to spit on the officers. At this point Officer Morgan went over to assist. Inmate Fuller began to flail his arms and legs around attempting to strike the officers. The officers were having a hard time controlling him. They finally took him to the floor where he continued to struggle. Officer Morgan then deployed OC spray to his facial area. The spray seemed to have no affect. Constant verbal commands were being given by the officers. They were able to get him handcuffed and shackled. Then Officer Morgan assisted getting him into the restraint chair. A towel was draped over Inmate Fuller's face to prevent him from spitting on the officers during this struggle. Officer Morgan ended his assistance once Fuller was restrained in the chair. He did not notice at any time during the struggle that Inmate Fuller was in any type medical distress. **End of statement.**

Officer Chris Bryant

He was the assigned as the male booking officer on the night of this incident. His initial contact with Inmate Fuller consisted of normal intake procedures, pat down, fingerprinting, etc... He did note that Fuller appeared "agitated," and smelled of alcoholic beverages. He later responded to the altercation in medical. When he arrived Inmate Fuller was on the floor in handcuffs with Sgt. Fryar, Officer Carroll, and Officer Morgan attempting to control him. He was cursing, yelling and attempting to "wiggle" away. Inmate Fuller then began to try and spit on the officers so Sgt. Fryar told Officer Bryant to get a towel and hold it over Fuller's face. They then got him into the restraint chair. Inmate Fuller continued to resist the officer's attempts. Nurse McCabe gave the inmate a shot in his left arm. After the injection was given they wheeled him into room 515. His behaviors had calmed considerably at this time. Officer Bryant then returned to his post in booking. He was then called back to medical when the inmate was discovered to be in medical distress. **End of statement.**

Officer Georgia Woerner

Officer Woerner was assigned to female booking on the night of this incident. Her initial contact with inmate Fuller involved the video taping of the struggle in medical. She then later responded to the medical distress call, the nurses in the room stated he was "dying." so she began chest compressions on inmate Fuller. She did continual chest compressions until inmate Fuller was pronounced by the emergency room doctor. **End of statement.**

Officer Craig Carroll

Officer Carroll was assigned as the property officer on the night of this incident. At approximately 0345 hours he took inmate Fuller from booking to the shower. The inmate was verbally rambling but was not uncooperative or aggressive. He was dressed in blues and taken back to booking to be medically screened by Nurse Linton. He was uncooperative so she was unable to screen him. Officer Carroll then escorted the inmate to medical and was assisted by Sgt. Fryar. He was seated on a bench to be interviewed further by medical staff. Nurse McCabe attempted to get more information but was unsuccessful. She then ordered him to be placed in direct observation in a paper gown. They attempted to escort him the medial infirmary. Inmate Fuller sat down on the floor. As they attempted to get him up he began to kick at them and swing his arms. They placed him face down on the floor and he continued to struggle. Officer Morgan sprayed him with OC foam. He still did not comply. They were able to get handcuffs on inmate Fuller. With the assistance of other officers they placed him in a restraint chair. A towel was held over his face due to his attempting to spit on the officers. They then placed him in a direct observation cell. He responded to the medical distress call and assisted in getting Fuller out of the restraint chair. He assisted at one point with the ambulatory bag. **End of statement.**

Nurse Debra Linton

Nurse Linton is a registered medical assistant. She is an employee of Prison Health Services. On the night of this incident she was assigned as the medical staff worker in booking. She attempted to do a medical screening of inmate Fuller. She was unable to complete it because he was uncooperative. He did tell her he had a history of seizures, was on medication for them, and had not been taking them. She did not notice any indications he had been consuming alcohol or drugs. He also denied having consumed any. As time went on he became more and more agitated. She called medical to inform them she was sending inmate Fuller down for further evaluation. **End of statement.**

Nurse Cathy McCabe

Nurse McCabe was the charge nurse on the night of this incident. She is an employee of Prison Health Services. She is a Registered Nurse. She recalls Inmate Fuller being brought into medical about 0400 hours. Nurse Debra Linton had briefed her on Inmate Fuller's demeanor. She was told he was cooperative at first in booking but then refused to sign anything or give more information. He had told Nurse Linton he was on seizure medication and had not had it since Sunday 8 June 2003. As he continued to stay longer in booking he got more and more agitated. When Nurse McCabe first observed him he was sitting on a bench in medical. He was very agitated. She asked him if he had used any drugs or anything else. He would not answer

her. He was yelling at the officers saying he was not going to stay in medical and he would not be put in the "chair." His agitation increased markedly at this time. They then went to escort him to an observation room. The inmate then went "ballistic." He began to physically resist very aggressively. He "jumped" on the officers. He attempted to kick, hit, and spit on them. He was almost "crazy." The officers got him to the floor on his stomach. During the struggle he was pepper sprayed. A food cart was knocked over. Nurse McCabe was "surprised" at the strength the inmate was displaying considering his small stature. The three officers were having a difficult time physically controlling him. They were finally able to get handcuffs and shackles on him. The chair was called for. She is not sure who initiated the request for the chair. He was placed in the chair and she checked his restraints. He had no obvious signs of injury. She did give him a one milligram injection of Ativan to calm/relax him. She stated once he was placed in the chair he had already began to calm down. She did not believe the injection had any immediate affect on him. He was then placed in the observation room. She did a check on him a short time later. She observed his head slumped back in the chair. She had Officer Summerlin let her into the room. The inmate was unresponsive. He did not appear to be breathing and his heart rate was around 30 beats a minute. She told the officer to call EMS. She and responding personnel initiated CPR on him. They also removed him from the chair to better facilitate this. She started an I.V. and gave him an injection of epinephrin. EMS responded and took over the lifesaving measures to no avail. **End of statement.**

Nurse Catherine Braetcher

Nurse Braetcher is a registered nursing assistant. She is an employee of Prison Health Services. She received a call from nurse Linton about inmate Fuller becoming agitated in the booking area. She told nurse Linton to go ahead and bring him down to the medical unit. She did not observe any of the struggle. She did go down to the cell once the inmate was in medical distress. She used the ambulatory bag to provide breathing assistance to the inmate. She started this while he was still in the restraint chair. **End of statement.**

Officer Charles Johnson

Officer Johnson arrived at medical once they were getting ready to be place Inmate Fuller in the restraint chair. He assisted in securing the inmate into the chair. He recalls the inmate continually struggling even while being secured in the restraint chair. A towel was draped over the inmates face due to his continued efforts to spit on the officers. Once the nurse gave the injection to the inmate he seemed to immediately calm down. Officer Johnson did not observe the inmate in any type medical distress during the struggle. **End of statement.**

Officer David Brown

Officer Brown was the assigned internal escort officer on the night of this incident. He responded to the medical unit in response to the call for assistance. Several officers were on the floor struggling with Inmate Fuller at the point he arrived. Inmate Fuller's hands were cuffed. Officer Brown went to the front desk and retrieved shackles for him. He observed a towel draped over the inmates face. As they were placing the inmate in the chair he held the towel on the inmates face. While in the chair the inmate was given an injection by one of the nurses. The inmate was then placed into an observation room. At that point Officer Brown removed the towel from over the inmates face. He then returned to his assigned area. He came back to

medical when the call for an inmate in distress went out. He filmed the lifesaving measures.
End of statement.

Officer William Summerlin

Officer Summerlin was the assigned Direct Observation Officer on the night of this incident. He overheard the struggle in the medical receiving area. The inmate (Fuller) was hollering and screaming. The officers kept attempting to get him to calm down. One of the officers came and got the restraint chair. They then rolled the chair into the room with the inmate in it. The inmate's head was slumped back in the chair and he had a "pillowcase" draped over his face. Once they had him in the room the "pillowcase" was removed. A short time later Nurse McCabe came in to check on him and discovered him unresponsive. Lifesaving measures were immediately initiated. **End of statement.**

On 24 June 2003 Detective Wierenga met with Doctors Sarbeck and Stewart of the Medical Examiner's Office. They viewed the video tape of the use of force on Inmate Fuller. They determined that in their opinion no excessive force was used.

On 26 June 2003 Dr. Sarbeck advised Detective Wierenga that a preliminary toxicology report indicated Inmate Fuller had marijuana and a "significant" amount of cocaine in his system. He also stated Inmate Fuller may fit the profile of a "sudden custody death syndrome." The autopsy report and completed toxicology report is forthcoming.

FINDINGS

My investigation of this incident reveals no General Orders were violated.

ATTACHMENTS

- 1) Use of Force Reports by all involved officers, attached to this report.
- 2) Offense Report #03-98930, attached to this report.
- 3) Video tapes of the use of force and lifesaving measures, stored in evidence.
- 4) Cassette taped interviews of: Sgt. Terry Fryar; Craig Carroll, James Morgan, David Brown, Chris Bryant, William Summerlin, Charles Johnson, Georgia Woerner, Cathy McCabe, Debra Linton, and Catherine Braetcher; copies attached to this file.
- 5) Direct Observation Log

LEON COUNTY SHERIFF'S OFFICE
OFFENSE/INCIDENT REPORT

Attachment # 1
Page 44 of 87

AGENCY ORI #370000		JUVENILE	ORIGINAL 1	INCIDENT	REPORT # 03082193																		
REPORTED	DATE	TIME	DISPATCHED	ARRIVED	COMPLETED	OCCURRED DATE	TIME	TO DATE	TIME														
FRIDAY	5/16/03	0440	0440	0440	0505	5/16/03	0440	5/16/03															
OFF #	TYPE	OFFENSE	AC	STATUTE	UCR																		
1		DEATH INVESTIGATION		919.9 9.9																			
2																							
3																							
INCIDENT LOCATION								TALLAHASSEE ZIP	GEO	T/L/C													
535 APPLEYARD DRIVE								32304	8-16	76													
AREA IDENTIFIER								F.E.	OCC.	LOCATION	WEAP. TYPE	# OFFENSES	# VICTIMS	# OFFENSES	# PRESENT	# MEDIA	# OTHER						
LEON COUNTY JAIL								01	1/9	0.0	0.0	0.1	0.0	0.0	0.0	0.0	0.0						
FORCED ENTRY (F.E.)			OCCUPANCY (OCC.)			LOCATION TYPE			DRUG TYPE			VICTIM TYPE			STATUS CODE			DAMAGE CODE					
1. Yes 2. No			1. Occupied 2. Unoccupied			01. Residence - Single 02. Apartment / Condo 03. Residence - Other			A. Amphetamine B. Cocaine C. Heroin D. Marijuana E. PCP / Phencyclidine F. Barbiturate G. Benzodiazepine H. Ecstasy I. GHB J. Inhalant K. Ketamine L. LSD M. Methamphetamine N. Oxycodone P. Propofol R. Sedative S. Stimulant T. Valium U. Other			1. Adult 2. Child 3. Juvenile 4. Unknown 5. Other			1. Stolen 2. Damaged 3. Other			1. None 2. Minor 3. Major 4. Severe 5. Other					
PROPERTY TYPE																							
A. Auto/Bicycle/Motorcycle B. Boat C. Camera/Photo Equip D. Cell Phone E. Clothing/Fur F. Desk/Chair G. Electronics H. Furniture I. Jewelry/Jewelry J. Musical Instrument K. Office Equip L. Tools/Hand Tools M. Television/VCR N. Video/Audio O. Vehicle/Parking P. Other																							
DRUG ACTIVITY																							
1. Possession 2. Sale 3. Manufacture 4. Distribution 5. Production/Cultivation 6. Use 7. Other																							
RESIDENCE TYPE (R.T.)						RESIDENCE STATUS (R.S.)						EXTENT OF INJURY (E.I.)						INJURY TYPE (I.T.)					
1. City 2. Rural 3. Suburban 4. Other						1. Full Year 2. Part Year 3. Non-Resident 4. Other						1. None 2. Minor 3. Serious 4. Fatal						01. Laceration 02. Bruise 03. Contusion 04. Fracture 05. Penetration 06. Burn 07. Loss of Teeth 08. Head Injury 09. Other					
VICTIM RELATIONSHIP TO OFFENDER																							
1. Spouse 2. Parent 3. Child 4. Sibling 5. Other																							
OFFENSE																							
0104 V 1.3 HUBBS, RUTH																							
ADDRESS																							
1601 PEPPER DR. TALLAHASSEE FLORIDA 32304																							
ADDITIONAL DESCRIPTION/ALT. CONTACT																							
DL																							
RACE SEX DOB HT WT EYE HAIR SPECIAL IDENTIFIERS																							
W F 9/10/62 204 0.0 510 240 BRN BLU																							
OFF # V W S P TYPE NAME (Last, First, Middle)																							
ADDRESS																							
ADDITIONAL DESCRIPTION/ALT. CONTACT																							
DL																							
RACE SEX DOB HT WT EYE HAIR SPECIAL IDENTIFIERS																							
OFF # V W S P TYPE NAME (Last, First, Middle)																							
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OFF # V W S P TYPE NAME (Last, First, Middle)																							
ADDRESS																							
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DL																							
V W S P																							
STATE COLOR VIN / HULL / FAA																							
VALUE OWNER REG. DATE REC. VALUE																							
\$ 100 \$ 100																							
V W S P																							
SERIAL NUMBER OWNER APPLIED NUMBER BRAND MODEL DESCRIPTION																							
VALUE VALUE RECOVERED DATE REC.																							
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SERIAL NUMBER OWNER APPLIED NUMBER BRAND MODEL DESCRIPTION																							
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OFFICER REPORTING ID NUMBER UNIT DATE RELATED CASE NUMBER																							
MASON L. BATH 346 CORRECTIONS 16 MAY 03																							
OFFICER RECEIVING ID NUMBER ROUTED TO REFERRED TO ASSIGNED TO BY DATE																							
JERRY COMPTON 103																							
STATUS CLEAR ADULT JUVENILE DATE CLEARED ARREST NUMBER																							
NUMBER ARRESTED EXCESS TYPE OPTS NUMBER																							
PAGE 7 OF 4																							

**LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE	N ORIGINAL-1 SUPPLEMENT-2	REPORTED DATE	05/16/03	INCIDENT REPORT #	0310821193
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ON 16 MAY 03 AT APPROXIMATELY 0440 HOURS I WAS IN THE PROCESS OF PASSING BREAKFAST FEED UP IN THE MEDICAL UNIT OF THE LEON COUNTY DETENTION FACILITY. NURSE LURLINE BROWN RN WAS ESCORTING ME AS I PASSED BREAKFAST TRAYS TO THE FEMALES HOUSED IN THE MEDICAL UNIT. I UNLOCKED THE DOOR TO ROOM 520-B TO ISSUE A TRAY TO INMATE HUBBS, RUTH M. SPN# 148608. AS I OPENED THE DOOR NURSE BROWN WALKED IN THE ROOM TOWARD THE NORTH EAST CORNER OF THE ROOM WHERE INMATE HUBBS WAS LYING ON THE FLOOR ON HER RIGHT SIDE. I WAS HOLDING THE DOOR OPEN FOR THE NURSE, AND HOLDING THE BREAKFAST TRAY. AT THAT TIME NURSE BROWN DID NOT ACT LIKE THERE WAS ANY CAUSE FOR ALARM, AND SAID "SHE DOES THIS". THEN NURSE BROWN BEGAN TAPPING INMATE HUBBS AND REPEATING "WAKE UP". INMATE HUBBS DID NOT RESPOND. NURSE BROWN BEGAN CHECKING INMATE HUBBS FOR VITAL SIGNS AND THEN INFORMED ME THAT SHE NEEDED TO INITIATE C.P.R. AND TOLD ME TO CALL FOR ASSISTANCE TO MOVE INMATE HUBBS OUT OF THE CORNER OF THE ROOM, AND HAVE AN AMBULANCE ON THE WAY. I CALLED SGT. CHAMBERS ON THE RADIO AND ASKED HIM TO SEND ASSISTANCE, AND CALLED CENTRAL CONTROL ON THE RADIO AND TOLD THEM TO HAVE AN AMBULANCE ON THE WAY. NURSE BROWN EXITED THE ROOM TO GET C.P.R. EQUIPMENT AND SEEK ASSISTANCE FROM NURSE ALICE GRANBERRY LPN. LT. BUSH CALLED ME ON THE RADIO AND ASKED ME IF I NEEDED THE AMBULANCE "10-18", WHICH MEANS LIGHTS AND SIRENS. I WALKED AROUND THE CORNER TO THE NURSE'S STATION AND ASKED NURSE BROWN TO CONFIRM WE NEEDED THE AMBULANCE WITH LIGHTS AND SIRENS, AND SHE SAID "YES". I CALLED LT. BUSH BACK AND CONFIRMED WE NEEDED THEM WITH LIGHTS AND SIRENS. I WALKED BACK TO ROOM 520-B. NURSE BROWN RETURNED WITH THE BAG CONTAINING C.P.R. EQUIPMENT. APPROXIMATELY 1 MINUTE LATER, SGT. CHAMBERS ARRIVED AT ROOM 520-B. SGT. CHAMBERS NOTED THE LARGE SIZE OF THE INMATE AND CALLED ON THE RADIO TO ENSURE THAT OTHER OFFICERS WERE ON THE WAY, AS WE WOULD NEED HELP FOR LIFTING INMATE HUBBS OUT OF THE CORNER. I GRABBED HER ANKLES AND PULLED HER LEGS IN AN

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____
 ___ Personally Known ___ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
<i>Mason L. Ratson</i>	346	16 MAY 03	2	OF 4
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		
<i>Sgt Chambers Robert D. Chambers</i>	103	16 MAY 03		

LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE <input checked="" type="checkbox"/>	ORIGINAL - 1 SUPPLEMENT - 2	REPORTED DATE	05 16 03	INCIDENT REPORT #	0 3 0 8 2 1 9 3
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ATTEMPT TO REPOSITION INMATE HUBBS' LOWER BODY. SGT. CHAMBERS ATTEMPTED TO REPOSITION HER UPPER TORSO DUE TO THE SIZE OF THE INMATE, AND AS SHE SEEMED "WEDGED" BETWEEN HER BUNK AND THE WALL, OUR EFFORTS WERE UNSUCCESSFUL. APPROXIMATELY 1 MINUTE LATER SEVERAL OFFICERS RESPONDED. SGT. RAGANS, OFC. JACOBS, JONAS, HAWKINS, BROOKS, LT. BUSH, AND OFC. KELLERMAN RESPONDED TO THE AREA. I STEPPED OUT OF THE ROOM TO GIVE THE LARGER AND MORE POWERFUL RESPONDING OFFICERS ROOM TO PERFORM. LT. BUSH, SGT. CHAMBERS, SGT. RAGANS, OFC. JACOBS, AND OFC. KELLERMAN SUCCESSFULLY LIFTED INMATE HUBBS FROM THE FLOOR ON TO THE BUNK IN ROOM 520-B. NURSE LURLINE BROWN RN, AND NURSE ALICE GRANBERRY LPN THEN BEGAN TO ADMINISTER C.P.R., OFC. JACOBS WAS THE FIRST OFFICER THAT I REMEMBER SEEING USING A VIDEO CAMERA. HE COMPLAINED THAT HE DID NOT BELIEVE THE CAMERA WAS WORKING PROPERLY, AND IT DID NOT HAVE A TAPE IN IT. A TAPE WAS CALLED FOR, AND RECEIVED A SHORT TIME LATER. NURSE BROWN AND NURSE GRANBERRY CONTINUED C.P.R. UNTIL ED SKINNER, AND MARC DONOFRO OF EMS ARRIVED AT APPROXIMATELY 0500 HOURS. ED SKINNER, AND MARC DONOFRO PRONOUNCED INMATE HUBBS DEAD, ACCORDING TO THEIR EVALUATION, AT APPROXIMATELY 0505 HOURS. I WAS TOLD BY SGT. CHAMBERS TO START A CRIME SCENE LOG. I STARTED THE CRIME SCENE LOG. IT WAS CONTINUED BY OFC. J. COBB AFTER I LEFT THE AREA.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____
 _____ Personally Known _____ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE
<i>Mason L. Batson</i>	346	16 MAY 03	3 OF 5
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE	
<i>Sgt. Chambers</i>	105	16 MAY 03	

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE <u>N</u>	ORIGINAL-1 SUPPLEMENT-2 <u>1</u>	REPORTED DATE <u>5/16/03</u>	INCIDENT REPORT # <u>03082193</u>
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WITNESS:

OFFICER M. BATSON #346

SGT. R. CHAMBERS #103

SGT. R. RAGANS #121

DEPUTY P. HAWKINS #360

OFFICER V. DAVIS #406

OFFICER J. KELLERMAN #361

OFFICER C. JACOBS #502

LT. T. BUSH #64

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____

____ Personally Known ____ Identified By ID # _____

Certifying Officer _____

OFFICER REPORTING <u>Mason L. Batson</u>	ID # <u>346</u>	DATE <u>16 MAY 03</u>	PAGE <u>4</u>	PAGE <u>OF 4</u>
OFFICER REVIEWING (IF APPLICABLE) <u>Sgt. Chambers Robert O. Chambers</u>	ID # <u>103</u>	DATE <u>16 MAY 03</u>		

LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE <u>N</u>	ORIGINAL - 1 SUPPLEMENT - 2 <u>2</u>	REPORTED DATE <u>5/16/03</u>	INCIDENT REPORT # <u>030821193</u>
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On Thursday, May 15, 2003 at approximately 1900 Hours, I relieved Officer Hawkins at the medical front desk. I was briefed by Officer Hawkins and I made my first round at 1923 Hours. I observed Inmate Hubbs, Ruth son #148608 awake and sitting on the floor talking to herself. I asked her if she wanted to eat her Evening Meal and she told me No, that she had already eaten. At 2010 Hours I observed her still sitting on the floor talking to herself. At approximately 2030 Hours, I asked Inmate Hubbs if she wanted her food again and she told me No. I then moved her out of room #520 C to room #520 B and she sat down on her bunk and started talking to herself, she got up off of the bunk and used the restroom, then she sat back down on her bunk. I removed the telephone from room #520 C to the Female holding cell #525 for other inmates to use. On my last observation of inmate Hubbs was at 2105 Hours. I then briefed the officer, Officer King and returned to my duties in Female Booking.

Affiant Signature
Velveta Davies

Sworn to and subscribed before me this _____ day of _____, 19____

____ Personally Known ____ Identified By ID # _____

Certifying Officer _____

OFFICER REPORTING ID # 406 DATE 15 May 03 PAGE 1 OF 1
Velveta Davies

OFFICER REVIEWING (IF APPLICABLE) ID # 103 DATE 16 MAY 03
Sgt. Charles R. ...

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE <input checked="" type="checkbox"/>	ORIGINAL - 1 SUPPLEMENT - 2 <u>2</u>	REPORTED DATE <u>05/16/03</u>	INCIDENT REPORT # <u>030821193</u>
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ON 16 MAY 03 AT APPROXIMATELY 0445 HOURS I RESPONDED TO A CALL FOR ASSISTANCE IN MEDICAL. WHEN I ARRIVED AT ROOM # 1-5208 I ASSISTED SGT CHAMBERS, LT BUSH AND DET. JACOBS. IN LIFTING INMATE RUTH HOBBS (148600) ON TO THE BED. I LIFTED THE INMATE'S LEFT ARM. ONCE THE INMATE WAS ON THE BUNK I LEFT THE AREA SO MEDICAL STAFF WOULD HAVE ROOM TO WORK.

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____

____ Personally Known ____ Identified By ID # _____

Certifying Officer _____

OFFICER REPORTING <u>John Kollerman</u>	ID # <u>361</u>	DATE <u>15 MAY 03</u>	PAGE <u>1</u>	PAGE <u>OF 1</u>
OFFICER REVIEWING (IF APPLICABLE) <u>SGT CHAMBERS Robert D. Chambers</u>	ID # <u>103</u>	DATE <u>16 MAY 03</u>		

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 2	2	REPORTED DATE	05/16/03	INCIDENT REPORT #	03082193
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ON THE ABOVE DATE AT APPROXIMATELY 0455 HOURS, I RESPONDED TO AN EMERGENCY CALL FOR FEMALES OFFICERS TO ASSIST IN MEDICAL. UPON MY ARRIVAL, I SAW RESPONDING OFFICERS, LT. BUSH, SGT'S CHAMBERS, BAGANS, AND OFC'S KELLERMAN, AND JACOBS PICKING INMATE HUBBS, BUTH SPIN # 148608 OFF OF THE FLOOR AND PLACING HER ON THE BUNK. ATTENDING MEDICAL STAFF R.N. BROWN, L.V.N. LVAINE, AND L.P.N. GRANBERRY, ALICE BEGAN FIRST RESPONDER PROCEDURES. APPROXIMATELY 0500 HOURS EMERGENCY MEDICAL STAFF, SKINNER, EDDIE, AND DONOFRIO, MARC RESPONDED AND ANNOUNCED THAT SUBJECT HUBBS, BUTH WAS DECEASED. DURING MY TOUR OF DUTY AS THE INFIRMARY OFC. FROM 1700 HOURS TO 1900 HOURS, HUBBS WAS ALIVE AND SPOKE WITH ME ON SEVERAL OCCASIONS.

Officer Signature: [Signature] P/O Hawks #360

Sworn to and subscribed before me this _____ day of _____, 19____
 _____ Personally Known _____ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
			1	OF 1
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		
SGT CHAMBERSON <u>[Signature]</u>	102	16 MAY 03		

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE <input checked="" type="checkbox"/>	ORIGINAL - 1 SUPPLEMENT - 2	<u>2</u>	REPORTED DATE	<u>05/16/03</u>	INCIDENT REPORT #	<u>01310181211913</u>
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On 16 May 2003 at approximately 0445 hours I was directed by Sgt. Lee #106 to proceed to medical and see if they needed assistance. Upon arrival in medical I was directed to room 520B where I observed inmate Hubbs, Ruth Spn #148608 lying between the north wall and the bunk. I then assisted Lt. Bush #64 and Sgt. Chambers #103 in lifting inmate Hubbs on to her bunk, and then retrieved a camera from central. I recorded medical staff and E.M.S. as they attempted to revive inmate Hubbs, until told to stop recording by Sgt. Chambers #103 at 0505 hours

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____
 _____ Personally Known _____ Identified By ID # _____

Certifying Officer _____

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
<u>Chris Jacob</u>	<u>502</u>	<u>16 May 03</u>	<u>1</u>	<u>OF 1</u>
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		
<u>Sgt Chambers</u>	<u>103</u>	<u>16 MAY 03</u>		

**LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE <u>N</u>	ORIGINAL - 1 SUPPLEMENT - 2 <u>2</u>	REPORTED DATE <u>5/16/03</u>	INCIDENT REPORT # <u>03082193</u>
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ON 16 MAY 2003 AT APPROXIMATELY 0438 I RESPONDED TO MEDICAL DUE TO OFFICER M. BATSON #346 ASKING CENTRAL CONTROL TO CALL FOR AN AMBULANCE. I ARRIVED IN MEDICAL TO FIND INMATE RUTH HUBBS SPN # 148608 LAYING BETWEEN THE END OF THE BED AND THE WALL WITH HER FEET TOWARD THE TOILET. INMATE HUBBS DID NOT APPEAR TO BE BREATHING. RNs LOURLINE BROWN, LCN ALICE GRANDBERRY AND OFFICER BATSON WERE PRESENT. INMATE HUBBS WAS A VERY LARGE PERSON AND I CALLED FOR ADDITIONAL HELP TO LIFT HER ONTO THE BED. SGT. RAGAN, LT. BUSH, OFC. KULLERMAN AND OFFICER JACOBS ARRIVED IN LESS THAN A MINUTE AND ASSISTED ME IN LIFTING INMATE HUBBS ONTO THE BED. NURSE GRANDBERRY AND NURSE BROWN BEGAN CPR. AT APPROXIMATELY 0453 THE AMBULANCE CREW ARRIVED. EMT EDDIE SKINNER AND EMT MARC DONOFRO TOOK OVER THE CARE OF INMATE HUBBS. AT 0505 THE EMT'S SAID THAT THEIR PROTOCAL WITH THEIR ASSESSMENT OF THE INMATE ALLOWED THEM TO PRONOUNCE INMATE HUBBS DEAD. AT 0505 HOURS THE ROOM WAS SECURED WITH THE BODY INSIDE. OFFICER J. LOBB WAS POSTED OUTSIDE THE DOOR AND CONTINUED KEEPING A RECORD OF WHO ENTERED THE ROOM. OFFICER BATSON STARTEN THE LOG.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____
 _____ Personally Known _____ Identified By ID # _____

Certifying Officer

OFFICER REPORTING <u>SGT CHAMBERS #103 Richard. Chambers</u>	ID # <u>103</u>	DATE <u>16 MAY 03</u>	PAGE <u>1</u>	PAGE <u>OF 1</u>
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE <u>N</u>	ORIGINAL - 1 SUPPLEMENT - 2 <u>2</u>	REPORTED DATE <u>5/16/03</u>	INCIDENT REPORT # <u>03082193</u>
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On 15 May 2003, at 0505, I put Inmate Ruth Huggs' #148608 NOWLOG Out. I OBSERVED Inmate Huggs sitting on the floor yelling in room 5209. AT 0605 I RETURNED TO FIND Inmate Huggs STANDING AT THE DOOR. I TRIED TO TALK TO HER, BUT SHE DIDN'T MAKE ANY SENSE. AT 0640 I ESCORTED R.N. LURLINE GOOD-BROWN ON ROUNDS TO TAKE VITALS. R.N. GOOD-BROWN TOOK Inmate Huggs' VITALS AND AGAIN I TRIED TO TALK TO HER WITH NO SUCCESS. Inmate Huggs HAD PUMPED HER MILK INTO HER TRAY AND WAS PLAYING WITH IT. I REMOVED THE TRAY FROM THE ROOM. I RETURNED AT 0740 AND SHE WAS SITTING ON THE FLOOR TALKING TO HERSELF. WHEN I WENT BACK 0912 SHE WAS STILL SITTING ON THE FLOOR TALKING. AT 1008 Inmate Huggs HAD HER SHIRT OFF AND HAD PUT IT IN THE TOILET. I GAVE HER A DRY SHIRT AND HAD HER PUT IT ON. I REMOVED THE WET SHIRT AND A WET BLANKET. AT 1538 I GAVE HER A DINNER TRAY AND REMOVED THE LUNCH TRAY. SHE WAS SITTING ON THE FLOOR SO I SET THE TRAY ON THE BED. AT 1600 SHE HAD TAKEN HER PANTS OFF, BUT HAD NOT TOUCHED HER MEAL. I RETURNED WITH A PAIR OF PANTS AT 1600 AND TRIED TO GET HER DRESSED. HER TOILET WAS NOT WORKING AND MAINTENANCE WAS STANDING BY TO FIX IT. AT APPROXIMATELY 1630 Sgt. Joyce McCary CAME TO TRY AND HELP GET HER DRESSED AND MOVED TO Room 5209 WE WERE UNABLE TO GET HER OFF THE FLOOR. I REQUESTED THE HELP OF R.N. MICHAEL MORGAN TO LIFT HER. HE REFUSED. DR. PRINAS AND ANTOUSHIA CAER (MEDICAL MENTAL HEALTH PERSON), CAME IN TO EVALUATE Inmate Huggs AT Sgt. McCary's REQUEST. DR. PRINAS WAS NOT CONCERNED WITH HER CONDITION. HE TOLD Sgt. McCary TO JUST LET HER LAY THERE ON THE FLOOR. BOTH Sgt. McCary AND I EXITED THE ROOM AT 1650.

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____

____ Personally Known ____ Identified By ID # _____

Certifying Officer _____

OFFICER REPORTING S. DIANNE BENDISKE OFFICER REVIEWING (IF APPLICABLE) Sgt. Joyce McCary	ID # <u>342</u> ID # <u>148</u>	DATE <u>16 May 2003</u> <u>16 May 03</u>	PAGE <u>01</u>	PAGE <u>01</u>
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FM (11/97) 43

**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE <input checked="" type="checkbox"/> M	ORIGINAL - 1 SUPPLEMENT - 2	<u>2</u>	REPORTED DATE	<u>05/16/03</u>	INCIDENT REPORT #	<u>03082193</u>
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On Thursday 15 May 2003, upon making initial contact with Inmate Ruth Hubbs, spr# 148608 at approximately 0821 hours, I observed her sitting on the floor talking to herself. At approximately 1112, I made another hourly check and found her still sitting on the floor talking to herself. I was unable to make sense out of what she was saying. At 1147, I made another hourly check on Inmate Hubbs and she was consistent with the same type of behavior that she had previously exhibited. At approximately 1222 hours, Inmate Hubbs was standing at the door talking, appearing very lethargic. I was still unable to make sense of what she was saying. At approximately 1310 hours, I entered the female infirmary along with Nurse Matilda Grazier and we found Inmate Hubbs on the floor and her legs were under the bed. She stated that she could not get up and her legs were stuck. She also advised us that she had fell. Nurse Grazier checked her head for bumps or bruises. Also her leg and arm were bruised. Nurse Grazier and myself assisted Inmate Hubbs so that she was able to sit up and eventually Nurse Grazier was able to give her the medication. After several attempts she was able to get the medication down. We then attempted to assist her in getting on the bunk and she was able to comply. At approximately

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____
 _____ Personally Known _____ Identified By ID # _____

Certifying Officer

OFFICER REPORTING	ID #	DATE	PAGE	PAGE
<u>Colleen Morge</u>	<u>277</u>	<u>5-16-03</u>	<u>01</u>	<u>02</u>
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		
<u>Sgt. Joyce McCarry</u>	<u>148</u>	<u>5-16-03</u>		

LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT

AGENCY ORI # FLO 370000	JUVENILE <input checked="" type="checkbox"/>	ORIGINAL - 1 SUPPLEMENT - 2	2	REPORTED DATE	05/16/03	INCIDENT REPORT #	03082193
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1438 hours, I made an hourly check on Inmate Hubbs and again found her sitting on the floor, talking incoherently. Each time I entered the infirmary, I found Inmate Hubbs either sitting on the floor or standing at the door, each time appearing very lethargic and incoherent.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____
____ Personally Known ____ Identified By ID # _____

Certifying Officer

OFFICER REPORTING ID# 277 DATE 5-16-03
 OFFICER REVIEWING (IF APPLICABLE) ID# 148 DATE 5-16-03

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**LEON COUNTY SHERIFF'S OFFICE
 NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI# FLO 370000	JUVENILE <u>N</u>	ORIGINAL - 1 SUPPLEMENT - 2 <u>2</u>	REPORTED DATE <u>05/16/03</u>	INCIDENT REPORT # <u>030821193</u>
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ON MAY 15, 2003 WHILE ASSIGNED TO MEDICAL SECURITY AS THE IMMEDIATE SUPERVISOR, I MADE NUMEROUS ROUNDS IN THE MEDICAL INFIRMARY. I DOCUMENTED (3) THREE OF THESE ROUNDS ON THE DAILY CONFINEMENT LOG OF INMATE RUTH HUBBS SPIN # 1481608. AT 0828 HOURS I OBSERVED INMATE HUBBS SITTING ON THE FLOOR NEXT TO HER BUNK SHE APPEARED TO BE UNSTABLE OF HER SURROUNDINGS. SHE WAS PULLING AT HER JAIL UNIFORM TOP AS IF SHE SAW SOMETHING ON IT, CONSTANTLY TALKING TO HERSELF. NURSE EMILLIE BECK D.D.N. WAS PRESENT. SHE ADVISED ME SHE WAS WORKING ON GETTING MORE MEDICAL RECORD INFORMATION ON INMATE HUBBS, AND THAT SHE WAS GOING TO TALK WITH SUE COLE (PRISON HEALTH SERVICES) ADMINISTRATOR. AT 1130 HOURS I OBSERVED INMATE HUBBS SITTING ON HER BUNK TALKING TO HERSELF. AT 1158 HOURS I OBSERVED INMATE HUBBS STANDING NEAR HER BUNK ROLLING UP HER MATTRESS TALKING TO HER SELF. LATER THIS DATE I SPOKE WITH MRS. NAUTOSHIA CARR ABOUT HER BEHAVIOR. MRS. CARR WENT TO THE INFIRMARY AND OBSERVED INMATE RUTH HUBBS BEHAVIOR. MRS. CARR LATER ASKED ME IN A BARRACK CONFERENCE WITH MRS SUE COLE IN HER OFFICE. I SAT DOWN IN MRS COLE'S OFFICE AND SHE ADVISED ME THAT SHE HAD ALREADY TALKED WITH MRS. HUBBS SATURDAY AND INMATE HUBBS RESPONDED TO HER QUESTIONS AND THEY HAD A NORMAL CONVERSATION. MRS. COLE ADVISED THE INMATE HUBBS DO HAVE SOME MENTAL ISSUES BUT HUBBS IS PUTTING ON HECK OF A SHOW. AND THAT HUBB LOVES ATTENTION, AND I LEFT THE OFFICE.

Affiant Signature

Sworn to and subscribed before me this _____ day of _____, 19____
 _____ Personally Known _____ Identified By ID # _____

Certifying Officer

OFFICER REPORTING <u>Sgt. Joyce M. Cary</u>	ID # <u>149</u>	DATE <u>16 May 03</u>	PAGE <u>01</u>	PAGE <u>OF 02</u>
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		

**LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE	N	ORIGINAL - 1 SUPPLEMENT - 2	2	REPORTED DATE	05/16/03	INCIDENT REPORT #	03082193
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I Spoke with Dr. Primas and advised him of the issues on inmate Hubbs left arm. He advised me that he would check it out. Mr. Willie Gibson came down to repair Hubbs toilet, due to it would not flush anymore. He had to wait about (15) minutes for myself and Officer Diane Brooks to get her to put her jail uniform pants on. Inmate Hubbs was still on the floor, she got up and down until she put her pants on. She went from sitting on the floor to her knees. Once she was dressed, I asked her to stand up so we could move her to the room across from where we were so maintenance could repair her toilet. She started to get up on one knee and sat back down. Nurse Michael Moran came to the area just outside the room. Officer Brooks asked him to help get Hubbs up off the floor. He said no, and left the area. I had Mr. Gibson to come in and repair the toilet. He had already been waiting about (15) minutes. Inmate Hubbs was lying on the floor in the middle way of the room. Just laying on her back. She said she was tired and fat. While Mr. Gibson was still repairing the toilet Dr. William R. Primas came to the room door and spoke with inmate Hubbs. He asked her what was wrong with her. She said she was fat. I showed Dr. Primas her left arm and he said nothing needed to be done with it. I asked Dr. Primas to document that he saw her. He said okay and left the area. Inmate Hubbs was still laying on the floor talking about she is fat. Mr. Gibson repaired the toilet and we exited the area.

Affiant Signature _____

Sworn to and subscribed before me this _____ day of _____, 19____	Certifying Officer
____ Personally Known _____ Identified By ID # _____	

OFFICER REPORTING <i>Sgt. Joyce N. Perry</i>	ID # <i>148</i>	DATE <i>16 May 03</i>	PAGE <i>02</i>	PAGE <i>02</i>
OFFICER REVIEWING (IF APPLICABLE)	ID #	DATE		

**LEON COUNTY SHERIFF'S OFFICE
NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT**

AGENCY ORI # FLO 370000	JUVENILE <input checked="" type="checkbox"/>	ORIGINAL - 1 SUPPLEMENT - 2 1	REPORTED DATE 5/16/03	INCIDENT REPORT # 03082193
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On the 16th of MAY 2003 At Approximately 0440 hrs, I responded to Medical, after hearing over the radio, assistance needed in that area. When I arrived to Room 520 B, I observed a female Inmate, Hubbs, Ruth spn 148608 laying on the Floor at the far side of her Room. Sgt. Chamber and several officers were present, attempting to move this inmate from the floor to her bunk. Sergeant chambers instructed me to go and make a copy of the log, which I did. At approximately 0450 hrs, I paged Lt. Charles DAVIS to inform him of this incident. Lt. DAVIS instructed me to contact Lt. Pete Taylor. At approximately 0500 hrs. I contacted Lt. Leroy Johnson, and advised him of this incident. Lt. Bush was also at the Medical Front desk talking with Capt. Peterson, advising her of this situation. I spoke with Capt. Mills at approximately 0515 hrs, advising him of this incident. I left this area at approximately 0530 hrs, in route to booking to attend my normal assigned duties.

Affiant Signature		Certifying Officer	
Sworn to and subscribed before me this _____ day of _____, 19____		_____	
____ Personally Known ____ Identified By ID # _____		_____	
OFFICER REPORTING Seth Ronnie Ragan 121 / Ronnie RAGANS 121	ID #	DATE	PAGE
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LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Agency Report Number: 03-082193 Victim Name(s): Hubbs, Ruth

Date Reported: 05/16/03

Officer Reporting: Detective P. Iadanza ID#: 337

Date: 05/21/03

Officer Reviewing: Sgt. Donna Carmichael ID#: 140

Date: 05-22-03

Offense(s): Death Investigation

Case Status: 2 UCR Clearance: _____ Date Cleared: 05/16/03 OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On the above date, I was called out to process a death investigation scene at the Leon County Jail. Upon my arrival, I made contact with Detective J. Giordano (#224) and Sergeant C. Parker (#118), both of whom are with the Persons Unit.

I was advised, by Detective Giordano, that the inmate, Ruth Hubbs, had been found dead on the cell floor. According to the nurse, she had checked on Ms. Hubbs several times during the night and had noticed that she was sleeping on the floor. He also advised me that he had been informed, by the nurse, that Ms. Hubbs had a habit of sleeping on the floor so she did not think anything was out of the ordinary.

Sergeant Parker advised me that it was discovered that Ms. Hubbs was deceased when the Correctional Officer and the nurse brought in Ms. Hubbs' breakfast. He also advised that the nurses and several correctional officer had moved the victim from the floor to the bed.

I approached the cell, number 1-520 Patient B, and viewed the cell area through the glass opening in the door. I noticed a heavy set white female laying on her back, on the cell bed. She was covered with a sheet and there was an emergency medical bag on the bed, up near her head. I also noted that there were several stick on type patches, of the type similar for EKG leads, that were still attached to her body. On the victim's face some lividity had begun to set in, as well as on some of her extremities.

I proceeded to video the scene, as well as take 35mm and digital photographs, of the entire area. The video and photographs were placed into the evidence vault of the Leon County Sheriff.

I photographed the victim, where she was lying. At this time, the victim was not rolled over or the body examined any further, per Sergeant Parker.

On the same date, I attended an autopsy performed by Dr. Mahoney. Additional photographs were taken at the morgue.

On today's date, I returned to the scene to take measurements of the empty jail cell.

DISPOSITION RECOMMENDED: Pending

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Agency Report Number: 03-082193 Victim Name(s): Hubbs, Ruth

Date Reported: 05-16-03

Officer Reporting: Detective James F. Giordano ID#: 224

Date: 06-09-03

Officer Reviewing: Sgt. Parker ID#: 118

Date: 6-19-03

Offense(s): Death Investigation

Case Status: 2 UCR Clearance: Date Cleared: OBTS Number: Related Report #:

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Friday the 16th of May 2003 I was contacted by Lt. Bush the watch commander at the Leon County jail indicating that there had been an in custody death at the Jail. Lt. Bush said that an inmate by the name of Ruth Hubbs had been discovered deceased in a medical holding cell at or around 0440 hrs. I made contact with Sgt. Curtis Parker and made him aware of the incident.

Upon arrival at the Leon County Jail (0602 Hrs.) I was directed to the medical unit (female side) and viewed a deceased white female laying on the metal bunk in room 520-B. The deceased subject was laying face up with her head toward the south and her feet toward the north. Crime scene Detective Patti Iadanza responded to the scene and took control of processing the scene.

At that time I conducted interviews with both correctional staff and the medical staff responsible for care of inmate Ruth Hubbs on the night of question concerning her death. Sgt. Curtis Parker was left in control of the crime scene at that time.

In a taped interview which started at 0653 hrs and ended at 0716 hrs Correctional Officer Batson indicated the following. While he was issuing food trays, he discovered Hubbs laying on the floor in her cell. Hubbs was laying at the foot of her bed between the wall and the bed posts. Accompanying Batson was the nurse on duty Lurline Brown. Lurline Brown indicated that Hubbs was not breathing and requested EMS be called. Additional correctional officers responded to the call for help. Hubbs was picked up off the floor and placed on her bunk. Life saving measures were started and EMS arrived.

At 0727 hrs I conducted a taped interview with Sgt. Robert Chambers which ended at 0731 hrs. He indicated that he responded to medical as the acting supervisor. He also assisted in lifting Hubbs off of the floor.

I spoke to Correctional Officer Christopher Jacobs and our interview was taped. The taping started at 0737 hrs. and ended at 0745 hrs. He indicated that he responded to the medical unit to assist in lifting Hubbs off of the floor. He then went and got a video camera and taped the rest of the immediate incident

A taped interview was conducted with Correctional Officer Hawkins. The taped interview started at 0747 hrs. and ended at 0800 hrs. She indicated that she spoke to Hubbs while she was alive the night of the incident. Hubbs was in room 520-C when spoken to and she had requested to use the telephone. Correctional Officer Hawkins said that when Hubbs died she was not in the same room as she saw her alive in. Correctional Officer Hawkins did not know why Hubbs had been moved or who moved her.

A taped interview which started at 0802 hrs and ended at 0812 hrs was conducted with Lt. Wilson. He said he was the watch commander the night of the incident. He said that he was leaving the Jail when he heard the call and came back to assist. He had no hands on involvement with Hubbs.

Correctional Officer Kellerman was interviewed about his involvement in the incident. The taped interview started at 0814 hrs and ended at 0846 hrs. Correctional Officer Kellerman responded to medical to assist in lifting Hubbs off of the floor. She was purple in the face and not breathing.

A taped interview was completed with nurse Lurline Brown and it ended at 0917 hrs. Brown said that she first had contact with Hubbs on Wednesday the 14th of May. Hubbs was in cell 520-C and she was laying on her bunk. Hubbs appeared to be sleeping but Brown said she saw very little respiration movement. Brown went into the cell and discovered that Hubbs was breathing and was snoring. Later in the morning Brown said that she viewed Hubbs laying on the floor and she was awake.

On Thursday the 15th of May Brown said that she saw Hubbs in 520-B and she was laying on the floor. Hubbs was at the foot of her bed between the bed and the wall. Several hours later Brown discovered Hubbs laying deceased on the floor. Hubbs was found when Nurse Brown went into the cell to check on her welfare. Brown went into the

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Original: Supplemental: X Juvenile:

Agency Report Number: 03-082193 Victim Name(s): Hubbs, Ruth

Date Reported: 05-16-03

cell because Hubbs did not answer when she was called out to. When Brown discovered Hubbs was not breathing she started life saving measures. CPR was done until paramedics arrived and took over.

In a taped interview that started at 0924 hrs. and ended at 0937 hrs. Correctional Officer Velveeta Davies provided the following. Davies had interaction with Hubbs when she asked her to move from cell 520-C over to cell 520-B. When asked to move, Hubbs got up and walked across the hallway. Davies said she asked Hubbs to move because the main log in medical showed her in cell 520-B.

Inmate Hubbs was transported to Tallahassee Memorial Hospital by Clary's Funeral Home. The body was escorted by Detective Dawn Butler to the morgue. An autopsy was performed by Doctor Mahoney at 1100 hrs on 05-16-05. No trauma or injuries which would cause death were located. At the conclusion of that autopsy the medical examiner was not able to determine a cause of death. At this time Doctor Mahoney is awaiting the results from a toxicologist screening of inmate Hubbs blood to further his findings.

A taped interview was completed on Tuesday the 20th of May with Correctional Officer Tillman. The interview started at 1551 hrs and ended at 1604 hrs. Tillman said that on Sunday the 4th of May Hubbs went to sit down on a chair and fell to the floor. Hubbs missed the chair all together and fell straight down on her rear end. Tillman said that she sent Hubbs down to medical to have her checked out. Tillman said that she did not see any apparent injuries to Hubbs that she might have sustained in the fall.

A taped interview was conducted with Correctional Officer Finn on Wednesday the 21st of May. The interview started at 1653 hrs. and ended at 1735 hrs. Finn said that she had dealings with Hubbs while she was in pod-M. Her dealings were of a normal nature. Finn was on duty when Hubbs was moved to medical on Wednesday the 14th of May. Finn said that Lt Liz Black and Sgt Bill Parramore came into the unit on Wednesday the 14th of May and moved Hubbs down to medical.

In a taped interview with Sgt. Parramore (which started at 1732 hrs. and ended at 1744 hrs) he provided the following information about his involvement with inmate Hubbs. On Tuesday the 13th of May and Wednesday the 14th of May Parramore saw Hubbs while she was in her cell in pod-M. Parramore said that Hubbs was sitting on the floor and was speaking in slurred speech. Parramore said that Hubbs was unable to get up off of the floor. Parramore said that on Wednesday the 14th of May he assisted in moving Hubbs down to medical. The moving of Hubbs was based on the fact that Hubbs was not able to get up off of the floor. Parramore said this was the last time he had dealings with Hubbs.

A taped interview was done with Lt. Liz Black which started at 1805 hrs. and ended at 1843 hrs. The interview with Lt. Black provided the following information. Lt. Black also had dealings with Hubbs on Tuesday the 13th of May and Wednesday the 14th of May. Lt Black was the watch commander both of those days. Lt Black said that she assisted in moving Hubbs down to medical on Wednesday the 14th of May. Hubbs was moved due to her inability to get up off of the floor. It was also based on the fact that Hubbs was not able to carry on a normal conversation. When Hubbs was moved down to medical Lt Black said she was put in cell 520-C. This was the last interaction Lt. Black had with Hubbs.

On Tuesday the 27th of May I conducted a taped interview with Correctional Officer Clete King. The interview started at 1311 hrs. and ended at 1322 hrs. King could not provide any additional information pertinent to the death investigation.

On Tuesday the 27th of May I also taped an interview with Doctor Primas. The interview was started at 1210 hrs and concluded at 1304 hrs. Doctor Primas is the medical doctor responsible for the health care at the Leon County Jail. Doctor Primas could not provide any additional information relevant to the death investigation.

At 1330 hrs on Tuesday the 27th of May I conducted a taped interview with Emilie Beck RN D.O.N. Beck did not provide any additional information pertinent to Hubbs Death. The interview ended at 1413 hrs.

All the tapes from the interviews completed were dropped into evidence at the Sheriff's Office. The original affidavits for the warnings of constitutional rights were also dropped into evidence.

In essence Ruth Hubbs had been arrested by the Leon County Sheriff's Office and the Tallahassee Police Department on numerous charges. The charges stemmed from Ruth Hubbs breaking into convenience stores throughout Leon County. Ruth Hubbs was booked into the Leon County Jail on 04-08-2002 and was awaiting trial. Ruth Hubbs also had a hold on her for another county in south Florida.

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION
Agency Report Number: 03-082193 Victim Name(s): Hubbs, Ruth

Date Reported: 05-16-03

On Wednesday the 14th of May 2003 Ruth Hubbs was moved down to the medical unit. On the morning of Friday the 16th of May 2003 at or around 0440 hrs. Ruth Hubbs was discovered deceased on the floor in her cell. After life saving measures were attempted Ruth Hubbs was pronounced deceased at 0505 hrs. by the paramedics. At the conclusion of the autopsy an exact cause of death could not be determined. The results from the toxicologist screening have not been received at the time of this report.

SCENE

Medical Unit (cell 520-B) Leon County Jail
535 Apple Yard Drive
Tallahassee, Florida 32304
850-922-3500

MEDICAL HISTORY

Ruth Hubbs had been admitted to the medical unit within the Leon County Jail on Wednesday 14th of May and had spent two days there prior to her death. Ruth Hubbs had been sent to medical based on the fact that she was not able to get up off of the floor. Hubbs also was having problems with her speech patterns and her ability to make rational statements. For further details concerning Hubbs medical conditions her medical chart can be accessed.

EVIDENCE

Fifteen (15) cassette tapes involving taped interviews with correctional staff and employee's of Prison Health Care. Twelve (12) affidavits of Warning of Constitutional Rights.

VICTIM

Ruth M. Hubbs W/F 09-10-1963 (37 year's old)
LKA: 1601 Pepper Drive
Tallahassee, Florida 32304
Spin # 148608

WITNESS / OTHER

Correctional Officer Mason Batson W/M 04-01-1970
Leon County Jail

Correctional Officer Robert Chambers W/M 06-21-1960
Leon County Jail

Correctional Officer Christopher Jacobs W/M 03-31-1970
Leon County Jail

Correctional Officer Pamela Hawkins B/F 03-01-1971
Leon County Jail

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATIONAgency Report Number: 03-082193 Victim Name(s): **Hubbs, Ruth**Date Reported: **05-16-03****WITNESS / OTHER CON'T**

Correctional Officer Lt. Larry Wilson B/M 10-07-1952
Leon County Jail

Correctional Officer John Keller man W/M 04-13-1968
Leon County Jail

Correctional Officer Velveeta Davies B/F 09-20-1971
Leon County Jail

Correctional Officer Jacqueline Tillman B/F 02-02-1966
Leon County Jail

Correctional Officer Cynthia Finn W/F 04-22-1953
Leon County Jail

Correctional Officer Sgt. Bill Parramore W/M 09-08-1962
Leon County Jail

Correctional Officer Lt. Liz Black W/F 11-06-1949
Leon County Jail

Correctional Officer Clete King W/M 09-12-1970
Leon County Jail

Doctor Primas B/M 12-16-1944
Prison Health Care systems
Leon County Jail

Emilie Beck RN D.O.N W/F 03-09-1940
3991 Four Oaks Blvd.
Tallahassee, Florida 32311
850-656-8107

Lurline B. Good-Brown RN B/F 12-29-1967
1550 Payne Street
Tallahassee, Florida 32303
850-222-3376

DISPOSITION RECOMMENDED
CASE PENDING

LEON COUNTY SHERIFF'S OFFICE NARRATIVE REPORT / PROBABLE CAUSE AFFIDAVIT




AGENCY ORI # FLO 370000	JUVENILE	ORIGINAL - 1 SUPPLEMENT - 2	2	REPORTED DATE	05 16 03	INCIDENT REPORT #	0 3 0 8 2 1 9 3
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On the above date at approximately 0445 hours I responded to medical due to Sergeant Chambers requesting assistance. Upon my arrival I was directed to room #520 B, as I entered the room I observed Sergeant Chambers attempting to pick an inmate off the floor (Inmate Hubbs, Ruth # 148608).

I proceeded to the northeast corner of the room and began to assist Sergeant Chambers. It took myself, Sergeant Chambers, Officer Christopher Jacobs and Officer John Kellerman to remove her from the floor and place her on her bunk.

After placing her on her bunk, I noticed that her face was black/blue in color. On site medical staff began to perform C.P.R.

At this time I exited the room and began to ensure the proper personnel was notified.

Affiant Signature  Tyler Busk		Certifying Officer	
Sworn to and subscribed before me this _____ day of _____, 19____			
<input type="checkbox"/> Personally Known <input type="checkbox"/> Identified By ID # _____			
OFFICER REPORTING  Tyler Busk	ID # 64	DATE 16 MAY 03	PAGE OF 43
OFFICER REVIEWING (IF APPLICABLE)  Kim Petersen	ID # 15	DATE	

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Agency Report Number: 03082193

Victim Name(s): Ruth Hubbs

Date Reported:

Original: Supplemental: X Juvenile:

Officer Reporting: David Graham

ID#: 283

Date: 090303

Officer Reviewing: [Signature]

ID#: 118

Date: 9-4-03

Offense(s): Death Investigation

Case Status: UCR Clearance: Date Cleared: 090403 OBTS Number: Related Report #:

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Wednesday, 03 September 2003, I made contact with Dr. Sadat Mansouri at the Florida State Hospital via telephone. Dr. Mansouri is the former psychiatrist for the Leon County Jail and the former attending psychiatrist for Ruth Hubbs.

Dr. Mansouri was asked specifically why Hubbs was taken off of the medication Prozac and prescribed the medication Sinequan (Doxepin). Dr. Mansouri indicated that all of my questions would be answered if I read her medical chart at the jail. I indicated to Dr. Mansouri that the Sheriff's Office had reviewed Hubbs medical chart and that our intentions for these questions are to clarify why he changed Hubbs medications and later increased the dosage of this medication.

Dr. Mansouri stated that "patients" sometimes experience insomnia as a side effect of taking Prozac. He would have then stopped this medication and prescribed her Sinequan, which would help the patient sleep. I then asked Dr. Mansouri why he ordered an increase (March 08, 2003) in the Sinequan medication for Hubbs from 50 mg. in the morning and 100 mg. at night to 100 mg. in the morning and 150 mg. at night.

Dr. Mansouri stated that the increase was probably due from the patient complaining that she was still experiencing depression. He further indicated that up to 300 mg. of this medication per day was within normal prescribed dosage.

I asked Dr. Mansouri why Hubbs was prescribed Sinequan, which is considered an older medication verses a newer anti-depressant medication.

Dr. Mansouri stated that the newer medications were more expensive and it was "their" policy not to prescribe the newer more expensive medications. When asked who "their" policy was, he indicated the medical provider at the jail. He stated newer medications could be prescribed after a tremendous amount of paper work, which was rarely if at all done.

Dr. Mansouri declined to comment on Hubbs diagnosis without reviewing her medical chart, which he agreed to do at this agencies request.

WITNESS

Dr. Sadat Mansouri, Hm# 671-3837 - cell# 228-4375
3211 Emerson Lane
Tallahassee, Florida
Former LCSO Detention Facility Psychiatrist

DISPOSITION RECOMMENDED

Pending

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Original: Supplemental: X Juvenile:

Agency Report Number: 03082193

Victim Name(s): Ruth Hubbs

Date Reported:

Officer Reporting: David Graham

ID#: 283

Date: 090303

Officer Reviewing: J. Chiles

ID#: 118

Date: 9-9-03

Offense(s): Death Investigation

Case Status: UCR Clearance: Date Cleared: 090703 OBTS Number: Related Report #:

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Friday, 05 August 2003, I made contact with Dr. Sadat Mansouri at the Florida State Hospital in Chattahoochee, Florida.

On arrival, Dr. Mansouri reviewed his medical notes within Hubbs medical chart. Dr. Mansouri indicated that on 09 February 2003, a former detention facility physician (unknown name) discontinued Hubbs Prozac medication and started her on Sinequan (50 mg in the morning and 100 mg at night). Dr. Mansouri said 08 March 2003 was his first encounter with Hubbs. At that time he increased her Sinequan medication to 100 mg. in the morning and 150 mg. at night, due to a depressive disorder.

On 23 March 2003, he diagnosed Hubbs as being bi polar. Hubbs was complaining of mood swings and continued depression. He prescribed her Lithium to be dispensed at 600 mg twice daily along with the Sinequan.

On 06 April 2003, Hubbs complained of hand tremors, which he said is a side effect of the Lithium. He lowered the dosage of the Lithium to 300 mg in the morning and 600 mg. at night. He also ordered her Lithium level checked in one week.

On 19 April 2003, Hubbs complained of continued mood swings and stated that she stopped taking the Lithium because of nausea and flashes. He discontinued the Lithium and continued the Sinequan at it's prescribed dosage. He added the medication Depakene to Hubbs medications and ordered it to be dispensed at 500 mg. twice daily. He again ordered a check of medication levels in one week due to the Depakene. He also ordered a thyroid profile, CBC with differential, and a uranalysis. He noted during this visit that Hubbs complained of hallucinations and of hearing voices. This was the last time he saw Hubbs.

Dr. Mansouri was asked if the Sinequan medication would build up toxic levels after taking it over a period of time. He stated, "no", but the Lithium and Depakene would build up over a period of time in the blood and that is the reason he orders these levels checked on a weekly basis.

Attached is a copy of Dr. Mansouri's medical notes.

DISPOSITION

Pending

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Agency Report Number: 03-082193

Victim Name(s): Hubbs, Ruth

Original: Supplemental: X Juvenile:
Date Reported: 05-16-03

Officer Reporting: Detective James F. Giordano ID#: 224

Date: 09-04-03

Officer Reviewing: *[Signature]* ID#: 118

Date: 9-9-03

Offense(s): Death Investigation

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Tuesday 07-29-03 I received a copy of an Autopsy Report completed on deceased subject Ruth Hubbs. Hubbs was an inmate at the Leon County Jail and was found deceased in her Jail cell. At the time of her death she was being housed in the Medical Unit at the Jail complex.

One of the findings in the report indicated that Hubbs had "Doxepin intoxication. Blood Doxepin quantitation: 3.9 mg/L." Hubbs while an inmate at the County Jail was prescribed the drug Doxepin along with several other medications. In a follow up phone conversation with Doctor Mahoney he indicated the following to me. He said that a subject taking the drug Doxepin should have a therapeutic level of Doxepin in their blood system of .02 mg/L.

On Thursday 07-31-03 I delivered a complete copy of Ruth Hubbs medical chart to Doctor Mahoney at his request. That medical chart was obtained from Prison Health Services. Prison Health Services is the medical provider for inmates at the Leon County Jail. I also presented to Doctor Mahoney a set of questions concerning the Doxepin Intoxication Levels reported in the Autopsy findings. On or around 08-08-03 I received back from Doctor Mahoney his reply to the questions, (See attached copy of the questions and his answers). Arising out of the findings from the autopsy results additional interviews were set up with some of the medical staff at Prison Health Services at the Leon County Jail.

After obtaining information that Hubbs had Doxepin intoxication, I spoke to Sue Cole the administrator of Prison Health Services. I inquired about how medications are obtained for an inmate at the Jail. Sue Cole said that when medications are prescribed the following procedures are followed. The prescription is faxed to Secure Pharmacy Plus Inc. They fill the prescription and then ship it over night back to Prison Health Services. I inquired as to what is done with medications left over when an inmate leaves the Leon County Jail. Sue Cole said that all medications not used by an inmate at the Leon County Jail are sent back to the pharmacy for a credit if they can be reused. On Thursday 08-14-03 I received a copy of the medications belonging to Hubbs that had been sent back to Secure Pharmacy Plus. This information was obtained from Sue Cole at Prison Health Services.

I called Secure Pharmacy and spoke to a Jean Byassee the general counsel for Secure Pharmacy Plus. I requested a copy of the last shipment of medications that Ruth Hubbs got filled at the request of Prison Health Services. I also received a copy of the last medication shipment made for Ruth Hubbs. (See attached information.) Also attached is a copy of the medication administration training policy and procedures for Prison Health Services, Inc.

A study of the above mentioned information concerning medications requested, shipped and then returned for Ruth Hubbs provided the following results. On Friday 05-09-03 two orders of Doxepin were filled. One was for 50 mg.(30 count blister pack) prescription # 3970158 and another was for 75 mg.(30 count blister pack) prescription # 3970173.

By using the medication administration record sheet (M.A.R.'S) for Ruth Hubbs it showed that she was given the following medications from 05-09-03 until 05-16-03 at the time of her death. On 05-09-03 Ruth Hubbs took one dose of 100 mg. of Doxepin. From 05-09-03 until 05-15-03 Ruth Hubbs took seven doses of 150 mg. of Doxepin. On 05-12-03 and 05-14-03 Ruth Hubbs took a dose of 50 mg. of Doxepin for a total of two doses.

In reviewing the records of the medications shipped back to Secure Pharmacy Plus it showed the following. A partial pack of Doxepin 50 mg. (27 count) prescription # 3970158, a partial pack of Doxepin 100 mg. (29 count) prescription # 3824634, and a full blister pack of Doxepin 75 mg. (30 count) prescription # 3970173 were shipped back on 05-19-03.

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Agency Report Number: 03-082193 Victim Name(s): Hubbs, Ruth

Date Reported: 05-16-03

In review of all the records compiled since 05-09-03 through 05-16-03 concerning the medications of Ruth Hubbs the following information was obtained. The blister pack shipped back containing the 30 count of 75 mg. Doxepin prescription # 3970173 is the same blister pack shipped on 05-09-03. The blister pack containing the 100 mg (29 count) of Doxepin prescription # 3824634 shipped back was missing one 100 mg Doxepin believed to have been taken on 05-09-03 by Ruth Hubbs. The blister pack containing the 50 mg of Doxepin (27 count) prescription # 3970158 sent back, amounts for a total usage of 150 mg. This prescription was filled on the 05-09-03. The total unaccounted amount of mg's of Doxepin taken by Ruth Hubbs since 05-09-03 is 900 total mg's. At this time it is unknown which prescriptions those 900 mg's came from. It is not possible to ascertain this information due to no inventory being done on the medication carts.

A taped interview was conducted with Registered Medical Assistant Nadine Thomas on 08-28-03. Nadine Thomas was one of the medical staff that had signed a medication administration record in the last days of Hubbs incarceration. The interview started at 1440 hrs and ended at 1503 hrs. The interview was conducted in the medical unit at the Leon County Jail. Present at the interview was Susan Cole, Harry Knight an investigator with the Department of Health, and Catherine Chapman the legal council for Prison Health Services.

Nadine Thomas said that when she comes to work she is given a set of keys to the medication cart where she obtains medication. She is the only one assigned the keys for that shift and she keeps them on her person the entire time she is working her shift. Nadine Thomas said that she follows the same procedure every time she dispenses medication to an inmate. She looks at the medication chart for the inmate and then places the medication into a 1 oz paper cup. After all the medication for a particular pod is filled the cups are secured in the medication cart. This all takes place in the pharmacy in the medical unit in the jail. The medication cart is then taken to the pods and the inmates line up to have their medications dispensed to them. The arm bands of the inmates are checked and then the pills are floated with water. Floating with water means to cover the pill(s) with water prior to the inmate taking them. Nadine Thomas said she then asks the inmate to open their mouth and she does a visual inspection to see if the inmate has swallowed the pill(s). Nadine Thomas said she learned this procedural process through training at the jail and she had to pass an evaluation period before she was signed off and allowed to work on her own in the medical unit at the Jail. Nadine Thomas said she had two opportunities to meet and see Ruth Hubbs. On one occasion she dispensed medication to her while she was in the pod. The other time was after she did a triage of Hubbs while she was in the pod. After that triage, Thomas sent Hubbs down to medical for further evaluation. Nadine Thomas then went down to the medical unit and administered to her the required medications.

An interview was done with Registered Medical Assistant Amanda Brundidge on Thursday 08-28-03. The interview took place in the medical unit at the Jail. The interview was started at 1508 hrs and ended at 1520 hrs. Amanda Brundidge was one of the medical staff that had signed the (M.A.R.'S) for Ruth Hubbs. Amanda Brundidge indicated she worked the day shift when she administered medications to Hubbs. Amanda Brundidge said that she follows the same routine when she is administering the medications to the inmates.

Amanda Brundidge said that she pulls the required medications as indicated from the M.A.R.'s. She uses the same procedures as Nadine Thomas in filling the medications.

Amanda Brundidge said she was trained to do this by other staff members at Prison Health Services. She also said she had gone through a sixty day probation period at the beginning of her training period.

Amanda Brundidge said that she did not remember anything special about Ruth Hubbs. She did not remember seeing her in any kind of situation requiring specialized medical attention.

I conducted an interview with Registered Nurse Assistant Katherine Bratcher on 08-28-03. The interview started at 1531 hrs and ended at 1545 hrs. The interview was conducted in the medical unit at the Leon County Jail complex. Katherine Bratcher indicated that she administered Ruth Hubbs medication as per indicated from the M.A.R.'s sheet. Katherine Bratcher said she uses the same procedure every time she dispenses medication to an inmate. She did indicate that she does not check every inmates mouth after each administration of medications.

Katherine Bratcher said that she had seen Ruth Hubbs for the last time when she was in the M pod. She had been notified that Hubbs had been sitting on the floor in her cell. Katherine Bratcher said she was in the process of coming down to get the Charge Nurse but a Lieutenant had came down and made notification to the Charge Nurse.

LAW COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION
Agency Report Number: **03-082193** Victim Name(s): **Hubbs, Ruth**

Original: Supplemental: X Juvenile:

Date Reported: **05-16-03**

I interviewed Licensed Practical Nurse Loretta Hamilton on Thursday 08-28-03 and it started at 1555 hrs. The interview ended at 1616 hrs. Loretta Hamilton indicated that she had administered medications to Hubbs on more than one occasion. Said she is responsible for giving out the medication when an inmate is in the infirmary. She said that when she administers medication to inmates she does it the same way every time. She said that if she noticed an inmate having problems taking medications she will have the inmate return the medication cup and they start the process all over.

Loretta Hamilton said that on the day Ruth Hubbs was moved down from the pod to the infirmary she was the nurse that did the evaluation on her. Hamilton said that Sgt. Parramore and Lt. Liz Black came to her and said that they had an inmate in one of the pods that was not acting right. Hamilton said that Hubbs was acting strange and she felt that it was necessary to move Hubbs to the infirmary. Hamilton said she had Hubbs put in an observation cell in the medical unit.

DISPOSITION RECOMMENDED
PENDING

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Original: Supplemental: X Juvenile:

Agency Report Number: 03-082193 Victim Name(s): Hubbs, Ruth

Date Reported: 05-21-03

Officer Reporting: Detective James F. Giordano *JFG* ID#: 224

Date: 09-10-03

Officer Reviewing: *Sgt. Clark* ID#: 118

Date: 9-11-03

Offense(s): Death Investigation

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Monday 09-08-03 I conducted a taped interview with Registered Medical Assistant Matilda Frazier at the Leon County Jail. The interview was concerning her involvement in the Ruth Hubbs death investigation. The interview was started at 1520 hrs and concluded at 1541 hrs. Matilda Frazier indicated that she had the opportunity to issue Hubbs medication as identified in the medication administration record sheet. She said that she follows the same procedure every time when she issues the medications to the inmates. Matilda Frazier also said that if an inmate is out of medication she can check out medication from the pharmacy. When the Medications are checked out, they then go into a container which stays on the medication cart. Matilda Frazier said that the slips used to check out medication from the pharmacy are kept in the pharmacy on a clip board.

Matilda Frazier said she had the opportunity to see Hubbs in the infirmary. Hubbs had been sent down to get checked out in the infirmary. Matilda Frazier said she had administered medications to Hubbs while she was in the infirmary.

On the same date I conducted a taped interview with Paramedic/ Critical Care Specialist Bob Roddenberry at the Medical Unit at the jail. The interview started at 1541 hrs and concluded at 1600 hrs. Roddenberry said he had the opportunity to issue medication to Hubbs on Sunday 05-04-03. He said that he only gave Hubbs one of her required medications, he said he did not issue the other medication. This was because he had working knowledge about Hubbs possibly "checking her medications." This information had been passed on to him from the day shift medication nurse (possibly Nadine Thomas).

Later in the day Bob Roddenberry was contacted by Sgt. Plummer who called him and said that Hubbs was acting strange. Hubbs was brought down to the medical unit. He said she was acting as if she was sedated.

Bob Roddenberry said that when he issues medication he uses the same procedure every time. His procedures are similar to that of Matilda Frazier. He said that if there are medications that an inmate might be out of he can get extras out of the pharmacy. When medications run out, additional medications are taken out of the bulk supply from the pharmacy. Those drugs are signed for by the person issuing the medications. The medications are then assigned to the particular medication cart the subject is operating. He said that if the medications come in the next day for a particular inmate the medications that were taken out of the pharmacy stay in the cart.

EVIDENCE

Six (6) cassette tapes involving taped interviews with staff of Prison Health services.

WITNESS INFORMATION

Susan Cole W/F 09-19-1951
Health Care Administrator, Prison Health Services
Leon County Jail
850-922-3562 (Wk)

Harry Knight W/M 11-27-191944
Investigator, Division of Medical Quality Assurance
Florida Department of Health
4052 Bald Cypress Way
Tallahassee, Florida 32399
850-922-2709 (Wk) 850-414-2832 (Wk)

Catherine Chapman W/F 05-20-1973
General counsel for Prison Health Services
Attorney At Law.
Andrews, Crabtree, Knox & Andrews, LLP
1558 Village Square Blvd. 32309
850-297-0090 Ext 146 (Wk)

Doctor John Mahoney W/M 05-20-1948
Assistant Medical Examiner
Pathology Associates Inc.
1899 Eider Ct
Tallahassee, Florida 32309
850-942-7473 (Wk)

Nadine Thomas B/F 01-11-1969
Registered Medical Assistant
Prison Health Services
Leon County Jail
850-922-3562 (Wk)

Amanda Brundidge B/F 08-20-1973
Registered Medical Assistant
Prison Health Services
Leon County Jail
850-922-3562 (Wk)

Katherine Bratcher B/F 01-22-1965
Registered Medical Assistant
Prison Health Services
Leon County Jail
850-922-3562 (Wk)

Loretta Hamilton W/F 12-09-1944
Licensed Practical Nurse
Prison Health Services
Leon County Jail
850-922-3562 (Wk)

Matilda Frazier B/F 01-20-1965
Registered Medical Assistant
Prison Health Services
Leon County Jail
850-922-3562 (Wk)

Bob Roddenberry W/M 10-28-03
Paramedic / Critical Care Specialist
Prison Health Services
Leon County Jail
850-922-3562 (Wk)

SUMMARY:

On Friday 05-16-03 I was notified of the death of an inmate at the Leon county Jail. The inmate (Ruth Ann Hubbs) was being housed in the medical unit at the jail. She had been moved out of the general population due to strange behavior. It was indicated that she was having trouble walking and that her speech was slurred. She also was said to have been talking to herself. Hubbs was found deceased in a cell in the medical unit. Life saving measures were done and she was pronounced deceased. An Autopsy was done and no obvious signs of injury or causes of death were noted.

Toxicologist results showed that she had an intoxicating level of the medication Doxepin in her system. Doxepin was one of the medications Hubbs had been prescribed while an inmate. After the results from the Autopsy were made available interviews were completed with the staff from Prison Health Services. After interviews with staff from Prison Health Services I am unable to determine how Hubbs received an intoxicating level of Doxepin in her system.

DISPOSITION RECOMMENDED
PENDING

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Agency Report Number: 03-82193 Victim Name(s): Ruth Hubbs

Original: Supplemental: X Juvenile:

Date Reported: 05-16-03

Officer Reporting: Curtis Parker ID#: 117

Date: 04-02-04

Officer Reviewing: *ht. Hubbs* ID#: 70

Date: 4-2-04

Offense(s): Death Investigation

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On 03-30-04 Emily Beck voluntarily responded to the Violent Crimes Unit at the request of Det. David Graham. This writer interviewed Ms. Beck as Det. Graham was unavailable that day. Ms. Beck had previously been interviewed regarding the Hubbs death investigation by Det. Giordano and Health Department Investigator Harry Knight. These prior interviews occurred in 2003. Ms. Beck had been employed as the Director of Nursing for Prison Health Services at the Leon County Jail at the time of Ms. Hubbs death. Ms. Beck advised sometime prior to her death Ms. Hubbs and two other inmates had been suspected of "storing" medications. Ms. Beck could not advise who the other inmates were or who provided the information alleging they were storing medications and sharing them among each other. This was Ms. Beck's first contact with Ms. Hubbs.

Ms. Beck also advised she had been repeatedly contacted by Ms. Hubbs attorney Steven Glazer who was requesting Ms. Hubbs medical records. According to Ms. Beck, Mr. Glazer was attempting to have Ms. Hubbs placed in some type of treatment facility and needed her medical records to do so. Ms. Beck stated she thought Mr. Glazer had been sent the medical records, but apparently that was not the case as he had received nothing. Ms. Beck then spoke with PHS Administrator Sue Cole who stated she would take care of sending Ms. Hubbs medical records to her attorney.

Ms. Beck advised when Ms. Hubbs was placed in the medical unit for the final time prior to her death she visibly deteriorated. Ms. Beck stated she spoke with Dr. Primus about Ms. Hubbs condition and requested he intervene. According to Ms. Beck, Dr. Primus responded that Ms. Hubbs was a psychiatric patient and not his responsibility. Ms. Beck stated many people were concerned about Ms. Hubbs condition, but she was being treated by psychiatry and they were having difficulty getting a psychiatrist on site. Sue Cole was reportedly conferring with psychiatrist Dr. Larranaga (in Pensacola) via telephone. Ms. Hubbs was on a list to see Dr. Larranaga, however she was way done the list and did not see him when he actually came to the facility approximately one week prior to her death.

Ms. Beck went on to say she submitted her resignation to PHS on 05-08-03 because she could not get anything done for inmates. Ms. Beck was required to work an additional 30 days after submitting her resignation. She further stated she lost her effectiveness and people were not listening to her and in her words were, "blowing her off". She described the working conditions at PHS as very bad at that time. When asked what it would have taken for Dr. Primus to treat Ms. Hubbs, Ms. Beck agreed it would have taken Ms. Hubbs going into cardiac arrest or something similar for her to receive medical treatment. Again, this demeanor on the part of Dr. Primus was because Ms. Hubbs was a psychiatric patient and not a medical patient.

In describing how often Dr. Larranaga met with patients at the Leon County Jail Ms. Beck stated he did so approximately once every two weeks. Dr. Larranaga reportedly met with approximately 30 patients each time he came to Tallahassee (in a one day period). Ms. Hubbs reportedly, as stated earlier was more than 30 people down the list to be seen by Dr. Larranaga. Ms. Beck advised in reviewing Ms. Hubbs chart when she attempted to have her treated by Dr. Primus she observed numerous entries in the medical file documenting correspondence between Sue Cole and Dr. Larranaga in which they were attempting to treat Ms. Hubbs via telephone correspondence. The entries observed by Ms. Beck reportedly included medication changes etc.

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION
Agency Report Number: 03-82193

Victim Name(s): Ruth Hubbs

Original: Supplemental: X Juvenile:
Date Reported: 05-16-03

These alleged entries Ms. Beck states were in Ms. Hubbs medical file are no longer present.

Ms. Beck then stated Dr. Primus would withhold all of a patients prescribed medication if they refused to take a particular medication. According to Ms. Beck, Dr. Primus told patients they would do what he said or receive nothing. Ms. Beck considers this behavior to be unethical. She stated she was "outraged" by this behavior by Dr. Primus. She further stated this tactic by Dr. Primus was common knowledge of PHS employee's. She stated this was a major factor in her decision to resign from PHS.

Ms. Beck described a contact with Sgt. Joyce McCary shortly before Ms. Hubbs death. Sgt. McCary contacted Ms. Beck and told her she felt Ms. Hubbs condition was getting worse. Ms. Beck told Sgt. McCary she agreed with her and had talked to Sue Cole, "until she was blue in the face" and to Dr. Primus and had been unable to get anyone to treat Ms. Hubbs. Sgt. McCary then asked Ms. Beck to speak with Sue Cole again in an effort to get Hubbs medical treatment. Ms. Beck agreed to do so and went to speak with Sue Cole. Ms. Beck told Sue Cole that Ms. Hubbs was deteriorating and getting worse. In addition, she told Sue Cole that Ms. Hubbs attorney was trying to get her out of jail and in a treatment facility and still had not received Hubbs medical file. Sue Cole reportedly replied (without looking up from her desk), "Give me the chart, I'll take care of it". Ms. Beck placed the chart on Cole's desk and at that time she observed approximately 2 pages of medical orders done by Cole in phone consultation with Dr. Larranaga in Pensacola. Ms. Beck then left Cole's office. She returned to Sgt. McCary and told her she was getting nowhere with obtaining treatment for Ms. Hubbs.

This writer asked Ms. Beck why she couldn't have summoned an ambulance for Ms. Hubbs in light of the fact the doctor and PHS Administrator were refusing to treat Ms. Hubbs. Ms. Beck replied that she could not do so without the approval of her superiors. She stated she was required to go through the "chain of command" and failure to go through the proper channels would result in her being fired. It also could affect her nursing license according to Ms. Beck.

Ms. Beck advised she was not aware of any lab work ever being ordered or done for Ms. Hubbs. She stated she asked Dr. Primus for some lab tests for Ms. Hubbs and "he blew me off". Ms. Beck stated she had looked in Ms. Hubbs medical chart and could find no orders for lab work on Ms. Hubbs prior to going to Dr. Primus. At a later date Ms. Beck stated she observed where an unknown person inserted a request for lab work on Ms. Hubbs that had not previously been in Hubbs medical file. Ms. Beck could not determine who wrote the lab request as the handwriting is not familiar and the signature could not be read. Ms. Beck feels this was a fictitious entry in the medical file. The fact no lab work was ever done on Ms. Hubbs supports Ms. Beck's assumption. Ms. Beck further advised it is not possible for an inmate to not "show up" for lab work as is alleged by PHS.

In regards to missing medical file entries made by Nurse Rebecca Mohrman and Robert Roddenberry, Ms. Beck stated she did not observe either Mohrman or Roddenberry place notes in Hubbs medical file. She did observe Mohrman writing the notes in her office. In regards to Roddenberry, Ms. Beck had a telephone conversation with him in which he told her he was withholding Ms. Hubbs medication because he thought she was overmedicated. Ms. Beck stated she told Roddenberry to document what he was doing and place the documentation in Ms. Hubbs medical file. She believes Roddenberry did so.

In regards to protocol's reportedly being violated Ms. Beck confirmed PHS utilizes Clorox bleach to treat fungus problems instead of the preferred fungal creme. She believes this is done as a cost saving measure even though fungal creme reportedly is not very expensive. Ms. Beck advised protocol's are very important because they explain how to treat various problems. She stated she had been attempting to establish protocol's at PHS, but they in large part had not been enacted. She reportedly encountered resistance in this area from Dr. Primus. She believes Dr. Primus compensation is tied into PHS profit margins, however she does not know this

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Original: Supplemental: X Juvenile:

Agency Report Number: 03-82193

Victim Name(s): Ruth Hubbs

Date Reported: 05-16-03

for a fact. This writer contacted LCSO Chief Administrator Captain Scott Bakotic and asked if he knew if Dr. Primus compensation was related to PHS profits. Captain Bakotic stated he did not know, but did not think it was likely.

In summary, Ms. Beck had submitted her resignation to PHS on 05-08-03, but was required to work an additional 30 days. Ms. Beck advised she had ceased communicating with her superiors and felt PHS was doing a poor job treating inmates. Ms. Beck observed Ms. Hubbs deteriorate during her time in the medical unit and attempted to get Sue Cole and Dr. Primus to treat Ms. Hubbs without success. Ms. Beck observed orders in Ms. Hubbs medical file detailing correspondence between Sue Cole and Dr. Larranaga regarding Ms. Hubbs treatment. That correspondence is now missing from Hubbs medical file. Ms. Beck observed nurse Rebecca Mohrman writing an entry for Ms. Hubbs medical file which is now missing from the file. Ms. Beck had a conversation with Robert Roddenberry in which he told her he was withholding Ms. Hubbs medication due to her behavior. Ms. Beck told Roddenberry to document his actions. Roddenberry's report is missing from Hubbs file. Ms. Beck also believes an unknown person made a fictitious entry in Hubbs file ordering lab work. Dr. Primus refused to treat Ms. Hubbs because she was a psychiatric patient and not his responsibility. Sue Cole was asked repeatedly to intervene in Ms. Hubbs treatment, but according to Ms. Beck did nothing. Ms. Beck believes Ms. Hubbs death was preventable and that she received substandard care while in the custody of PHS.

DISPOSITION RECOMMENDED

Pending

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Agency Report Number: 03087193 Victim Name(s): Ruth Hubbs Date Reported: 051603

Officer Reporting: David Graham ID#: 275 Date: 050804
Officer Reviewing: [Signature] ID#: 117 Date: 5-9-04
Offense(s): Death Investigation

Case Status: 2 UCR Clearance: _____ Date Cleared: _____ OBTS Number: _____ Related Report #: _____

Case Status: 1 - Closed 2 - Pending UCR Clearance: 1 - Arrest/Adult 2 - Arrest/Juvenile 3 - Except/Adult 4 - Except/Juvenile 5 - Unfounded

ADDITIONAL INFORMATION

On Friday, 16 May 2003, Violent Crimes Detective James Giordano investigated the death of Ruth Hubbs, who was an inmate at the Leon County Jail.

Detective Giordano's investigation revealed that Hubbs was discovered deceased in a medical holding cell at or around 0440 hours on the above date. Life saving measures had been initiated by medical staff and paramedics who responded to the scene, without success. Responding paramedics pronounced Hubbs deceased at 0505 hours.

Hubbs was found laying on the floor at the foot of her cell's bed, face up with her head toward the south and her feet toward the north.

During Detective Giordano's initial interviews, it was revealed that several of the medical and correctional staff attempted to have Hubbs seen by medical staff due to behavior indicating she was being "over medicated". Medical records do not indicate any type of preventive intervention was ever taken.

No criminal conduct was discovered during Detective Giordano's investigation.

During an Administrative Investigation conducted by Investigator Harry Knight of the Department of Health, he contacted expert witness Professor Paul Doering of the University of Florida College of Pharmacology.

Doering reviewed Hubbs autopsy/toxicology report and a copy of the LCSO investigative report. Doering concluded based upon the information he received, that in all probability it took more than ten doxepin pills to cause Hubbs death. He added it was impossible to know exactly how many pills it would have taken to cause death, but the level of doxepin in Hubbs blood was toxic. This information was based on the strength of the pills, the weight of the patient and the information in the above named report. Doering advised had the patient taken all her medication as prescribed there would not have been a negative outcome. Doering also stated, in his opinion, had there been an evaluation by the doctor at the time requested, the patient would have probably been saved.

Investigator Knight also interviewed several employees of Prison Health Services (PHS). These interviews revealed PHS employees were screening and counseling inmates for psychiatric reasons without licensure through the State of Florida. The investigation also alleged missing medical documents from Hubbs medical file and PHS employees who were concerned for Hubbs well being.

Investigator Knight's interview with Prison Health Services (PHS) employee Natasha Carr revealed that she was employed as a mental health clinician and that she was not licensed in Florida and did not have to be. Carr was responsible for the mental health screening of inmates, making referrals to Psychiatrists, as needed, and mental health counseling upon request.

Based on the information provided in Investigator Knight's report, PHS employees Natasha Carr, Rebecca Mohrman, Robert Roddenberry, Robbie Hilliard, and Nadine Thomas were served with witness subpoenas for reinterview by this writer. These interviews took place at the State Attorney's Office.

On Monday, 29 March 2004 at approximately 1330 hours Sgt. Curtis Parker and I interviewed Natasha Carr at the State Attorney's Office. Carr was placed under oath by Chief State Attorney Warren Goodwin, who was also present during the interview. Carr is and was employed by Prison Health Services as a Mental Health Clinician. She is responsible for mental health screening, making referrals to psychiatrists, and mental health counseling of inmates upon request. Carr advised she was not licensed in the State of Florida to perform these mental health services and did not have to be.

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Original: Supplemental: X Juvenile:

Agency Report Number: 03083193

Victim Name(s): Ruth Hubbs

Date Reported: 051603

Carr recalled one occasion in May of 2003, when she was escorted by Sgt. McCary to the holding cell in the infirmary where Hubbs was being held. Carr stated that it was common for officers to request that she speak with patients being held in the infirmary who are on psychotropic medications. When they arrived at Hubbs cell, Hubbs was sitting on the floor without her pants on, she would not verbally communicate. Carr asked her to put her pants on, Hubbs picked them up, looked at her (Carr) looked at the pants and then put the pants down. Based on Hubbs behavior, Carr placed Hubbs on a list of patients to see the psychiatrist, who at the time was Dr. Larranagga. Dr. Larranagga's office is based in Pensacola, Florida.. Per Carr, as a mental health clinician she could not personally take orders from the psychiatrist. She would report her findings to her supervisor, who is registered nurse Sue Cole. Cole would in turn report these findings to the psychiatrist who would then prescribe medications based on reported behavior. Carr advised she does not know if Dr. Larranagga physically saw Hubbs after her request. Carr advised that Dr. Larranagga was filling in as the psychiatrist for the Leon County Detention Center. Because Dr. Larranagga was based in Pensacola, there was occasion when she reported her findings to Sue Cole, Sue Cole would relay these findings to Dr. Larranagga, who would in turn prescribe medications based on reported behavior.

Carr advised that on one occasion when she reported Hubbs behavior to Sue Cole, Cole stated "She's putting on quite a show". Carr further stated that Cole, even after making the above statement, was concerned about Hubbs behavior. Carr could not provide any further information.

On Monday, 29 March 2004 at approximately 1411 hours, Sgt. Curtis Parker and I interviewed Rebecca Mohrman at the State Attorney's Office. She was placed under oath by Chief State Attorney Warren Goodwin.

Mohrman advised that she is employed as a Registered Nurse by PHS. She is responsible for "histories" and "physicals of inmates" at the jail.

Mohrman said in May of 2003 she had an occasion to see Hubbs. She and Emily Beck, Director of Nursing during this time, were asked to assist officers with Hubbs, who had fallen down. Mohrman said that Beck resigned from her position, Director of Nursing. Mohrman said that Beck resigned because she no longer felt comfortable working for PHS and that "it was a train wreck ready to happen". When Mohrman was asked if she knew what Beck meant by "it was a train wreck ready to happen", Mohrman replied, "I already knew what she meant". Mohrman said that "it just wasn't a team", "it was very difficult to get everyone to work together". When I asked Mohrman why it was very difficult for everyone to work together, she became very visibly upset. She said that it was very difficult for her to say what was going on, because she still works for this company, she enjoys working for this company and she enjoys her job. She continued by saying that she doesn't like saying anything negative about her company. Mohrman began crying at this point and was asked by the attorney representing PHS if she needed a break. Mohrman stated emotionally that she did not know that PHS's attorney would be present during the interview. The interview was temporarily stopped at this time.

After approximately 15 minutes, Mohrman returned to the conference room with PHS's attorney. Mohrman's demeanor noticeably changed after talking with the attorney. Mohrman became very vague in her answers, almost to the point of being defensive.

At this time the line of questioning was changed. Mohrman was asked if she had ever documented anything in Hubbs medical file. She replied, "yes". She stated she documented the incident when Hubbs had fallen and how she was behaving at the time of this incident. Mohrman was then asked if she had the opportunity to look at Hubbs file at a later date. She answered, "Yes". During an interview with Mr. Knight, Mohrman was shown Hubbs file. Mohrman asked Knight, "Where's the rest of them?". She indicated to Knight that the file was incomplete and that her documentation of Hubbs' fall and condition were missing from the file, and that the file looked "different". Mohrman advised that any and all documents placed in a patient/inmates medical file is permanent and should never be removed.

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Original: Supplemental: X Juvenile:

Agency Report Number: 03083193

Victim Name(s): Ruth Hubbs

Date Reported: 051603

Mohrman further went on to say that around this same time (May of 2003) she had requested lab work on Hubbs because "she was talking out of her head and not acting right". Mohrman, Beck and an officer were talking about Hubbs and the way she was acting. Mohrman said that Hubbs was acting like a patient she once treated that had high ammonia levels. Beck advised her to pull Hubbs medical chart so they could see when the last time she had lab work done. After pulling Hubbs medical file, they could not see where any lab work had been ordered. Beck told Mohrman that she would have the doctor order blood work on Hubbs so they could see where she was at. Mohrman said Beck went next door and spoke with Dr. Primas about getting blood work on Hubbs. According to Mohrman, Dr. Primas told Beck that he was not going to order the labs for Hubbs. Mohrman said the labs would give them a base line showing infection, or if something was amiss. Beck further stated to Mohrman that the reason Dr. Primas didn't want to have labs run on Hubbs was because she was "a psych patient and he did not want to have anything to do with her." When Mohrman was asked why there was no lab work request in Hubbs file she advised the request from her was verbal, not written. She went on to say it's not proper protocol to ask a physician in writing for lab work, a request would not be documented in the patients file.

Mohrman said that on this particular day when she went to Hubbs cell, Hubbs was sitting on the floor, her back against the wall and her legs under the bed. When Mohrman asked Hubbs how she got on the floor Hubbs responded saying she slid on the floor, because she didn't want to roll over on the baby in her bed (the baby was a rolled up blanket in the middle of Hubbs bed). Mohrman said that Hubbs was very disoriented and was having trouble following simple commands.

Mohrman was asked, if in her opinion Hubbs was capable of "cheeking" her medication at the time she saw her, she replied, "no, she wasn't lucid. She couldn't follow simple move your foot?, much less I want to cheek these pills". Mohrman said that the mental health clinician, Natasha Carr, would see Hubbs during her rounds. Mohrman stated Carr made rounds on patients that were referred to her by the registered nurses. To clarify, here a licensed registered nurse refers patients to a non-licensed employee for mental health evaluation.

When Mohrman was asked about her working relationships she described them as very tumultuous and difficult to work during the above time period. There were problems with interpersonal relationships regarding personnel, problems with the way employees reacted to each other.

Mohrman was asked about the missing contents of Hubbs medical file. Mohrman advised that when she was shown the file by Mr. Knight her notes on Hubbs fall were missing. Mohrman was asked if she was familiar with anything Robert Roddenberry may have put in the file that was also not in the file? She stated that she remembered talking to Roddenberry at the nurses station and that he said he had stopped the medications on Hubbs. He also stated that he had documented a couple of pages on Hubbs. Mohrman was then asked if she ever observed those particular entries when she had the file in her possession. Mohrman said she and Emily Beck had gone over Hubbs file together, so they could get a base on what was going on with Hubbs, she only had her that one day and wasn't familiar with her. They both read the file and remembered there were several entries regarding Hubbs, but could not remember the individual people who wrote them. Mohrman could only advise that her notes, because the file was not in front of her at this time, were missing from Hubbs medical file.

Mohrman was asked about PHS protocol, specifically how an inmate is medically treated if he/she has a fungus on their feet or a physical problem of that area. PHS protocol calls for the use of an anti-fungal cream for treatment. Mohrman was asked to elaborate. Mohrman stated that "they" were told to use a diluted bleach spray. Mohrman confirmed that diluted bleach spray was used instead of the fungal cream because of cost (bleach costs considerably less than fungal cream). Mohrman was then asked if she was aware of any other situations similar to this, where people are supposed to be treated one way but like this example, are treated differently? Mohrman hesitated for an extended period of time and then stated she didn't know how to answer the question.

Mohrman was then asked if she knew of any other circumstances where PHS deviated from other medical protocols. Mohrman answered "yes". She then gave the example of if an inmate was brought to the infirmary for chest pain and high blood pressure. The protocol called for giving them nitro and taking their blood pressure. She advised they were told not to give them nitro, do not do an EKG, and if they felt the patient was in distress, they were to call 911, but they are not to treat them. Mohrman said this was contrary to her RN training. When asked if there were any other situations, she again hesitated. Mohrman could not explain the reason for deviating from protocol but did advise they were instructed to do so by Dr. Primas during a staff meeting. Mohrman said that both the EKG and Nitro were inexpensive. When in this staff meeting one of the nurses asked Dr. Primas why they weren't to run an EKG, EKG paper doesn't cost much, Dr. Primas responded by saying "no, it's not an arcade machine". Mohrman stated this later deviation from protocol was effective February 2004. At this point the interview was ended.

On Monday, 29 March 2004 at approximately 1540 hours, Sgt. Curtis Parker and I interviewed Robert Roddenberry at the State Attorney's Office. He was placed under oath by Chief State Attorney Warren Goodwin. Robert Roddenberry was employed by PHS as an Emergency Medical Technician in May of 2003. Roddenberry advised that in May of 2003, he was approached by a medical nurse who had informed him that Hubbs was "out of it". He later received a call from Sgt. Plummer who said there was concern for Hubbs condition. Roddenberry had Hubbs brought down and then he housed her in the infirmary. Roddenberry stated that it was clear that Hubbs was heavily medicated. This was his reason for withholding her medications that evening, however he did state she had received her meds that morning, her a.m. dose. After a period of time, her condition improved. Roddenberry advised he documented one and one-half pages of notes pertinent to her care. He advised he placed these notes in Hubbs file personally, he remembers specifically because he had to take the file apart in order to place these notes in the correct place. He further advised he was sure his documentation was lengthy because a co-worker, Robbie Hilliard, had commented on the length of his documentation, referring to it as a "book". On two later dates, once with Sue Cole and the other with Investigator Knight, Roddenberry had the opportunity to view Hubbs file. On both dates he found his documentation on Hubbs missing.

Roddenberry advised that in his professional opinion, Hubbs showed signs of being over medicated. Two signs he mentioned that caused him to believe Hubbs was over medicated was she was very slow to respond and unable to speak clearly. These are two of the symptoms he, as a paramedic, look for in a tricyclic patient. On a later date Roddenberry had an opportunity to speak with Sue Cole reference to the missing progress notes he had placed in Hubbs medical record. Roddenberry said Cole told him she didn't know what happened to them. Roddenberry stated during his employment with PHS he had never known medical files to go missing from an inmates medical record. When Roddenberry was asked if he was surprised that these documents turned up missing, he said, "it kind of identifies the problem two weeks before something bad happens". Roddenberry said that in his opinion, Hubbs problem was laid out in black and white and it looks bad that nothing was done for two weeks. Roddenberry advised that he spoke with Emily Beck about Hubbs medical condition. Beck told him that she basically "hit a brick wall" trying to get anything done for Hubbs. Roddenberry was told by Beck that she had gone to Sue Cole in an attempt to have Hubbs seen by the psychiatrist or the doctor. Roddenberry advised, that in his opinion Hubbs should have had lab work done. If Hubbs had refused lab work, it would have been documented in her medical file. Roddenberry said an inmate can't just refuse an appointment, they must physically come down, unless they are physically combative, and sign a refusal. Usually once the inmate is already down they go ahead and take their meds or have their labs drawn, whatever the circumstance. He advised for the inmate to get up and go to medical was three quarters of the battle, sometimes they just don't want to get up and go but once they are there they proceed with what they're initially sent there for. Roddenberry was again asked why he thought his notes were missing from Hubbs medical file and he replied, "it identified a problem and she was dead two weeks later, it identified a problem that appears wasn't addressed". Roddenberry further stated that this situation with Hubbs was far more than just "slipping between the cracks".

LEON COUNTY SHERIFF'S OFFICE - SUPPLEMENTAL / CONTINUATION

Agency Report Number: 03083193

Victim Name(s): Ruth Hubbs

Date Reported: 051603

Emily Beck voluntarily came into the Sheriff's Office on 30 March 2004 and was interviewed by Sgt. Curtis Parker in my absence. (See Sgt. Parker's report)

On Thursday, 01 April 2004 at approximately 0910 hours, Sgt. Curtis Parker and I interviewed Robbie Hilliard at the State Attorney's Office. She was placed under oath by Chief State Attorney Warren Goodwin.

Hilliard stated that she never had any contact with Hubbs. She recalled one incident where Roddenberry placed Hubbs in observation in the medical unit until she could be seen by the doctor. She said that Roddenberry told her that Hubbs was not acting normal, so he did not give her the evening dose of her medication. This is the only thing that she could recall him saying.

She went on to say that Roddenberry documented Hubbs behavior in her medical chart. She said that Roddenberry is known for his thorough documentation of patients.

Hilliard said that she has been employed by PHS since November of 2002 as a medical assistant. Currently she is assisting doctors with sick calls. She also passes out medications to patients/inmates without licensed medical personal present. Hilliard said that she is not licensed for this position, but she has had military training as a medical assistant and at one time she was licensed as an EMT, but currently she holds no medical license. She further said that she does not have a degree or certification in this position, just previous training. She could provide no other information regarding this investigation.

On Thursday, 01 April 2004 at approximately 0945 hours, Sgt. Curtis Parker and I interviewed Nadine Thomas at the State Attorney's Office. She was placed under oath by Chief State Attorney Warren Goodwin.

Thomas advised that she is employed as a registered medical assistant with PHS. Her responsibilities are charting, scheduling appointments, chart review, vitals, taking off orders and doing chronic clinics.

Thomas said that on two different occasions she passed medications to Hubbs. She would float the medication, give it to the inmate and then make them open their mouth to ensure that they swallowed their medication.

She said that on one occasion an officer told her that Hubbs was acting strange. The officer told her that Hubbs would not get up and eat and that she was slurring her speech a little. After receiving this information from the officer, she passed Hubbs her medication and went back to the unit and called medical. Thomas said that she spoke to Cole about Hubbs behavior. Cole then called Hubbs to medical.

Thomas said that in May of 2003, she was responsible for stocking the med charts, doing vitals, stocking the rooms, working medical records and passing pills. Thomas was asked the procedure she would follow if an inmate refused medication. Thomas said that she would, "sign the book" and circle it. You also document anything that the inmate might say. Thomas was asked the procedure she would follow if an inmate refused lab work. Thomas said, "now?", if they refuse to have blood drawn. Dr. Primas would send them a letter stating various things including they are taking their care into their own hands, and she believes he gives them two weeks to respond. Thomas stated that it is not possible for an inmate to just not show up for labs. There is always some type of documentation showing refusal, either by the inmate or a refusal written by security on behalf of the inmate.

Thomas was asked if she ever heard of documentation missing from an inmates medical file. Thomas said, "yes", Roddenberry said that some of his documentation was missing from Hubbs medical file. This was the only time she ever heard of any documentation missing from any medical file. When asked if it would be unusual for documentation to be removed from a medical chart, she replied, "yes". At this time Thomas could provide no further information in regards to this investigation and the interview was ended.

In summary this investigation has revealed that Ruth Hubbs had toxic levels of Doxepin in her system at the time of her death. Concerned medical personnel observed Hubbs displaying what they perceived to be signs of being overmedicated.

One example is when medical staff requested Dr. Primas to intervene in Hubbs medical condition, his reply was, she is a psych patient and he didn't want to have anything to do with her. Labs were requested verbally, but for some unknown reason were never ordered by physicians. Hubbs behavior was documented in her medical file, however that specific documentation is no longer in Hubbs medical file.

Medical personnel stated that had the intervention been successful there may not have been a negative outcome. These interviews also revealed that PHS is deviating from their own medical protocols.

PHS has employees who are not licensed, certified or hold degrees (RN, LPN) evaluating mental health patients, counseling mental health patients, and dispensing narcotic medications to inmate patients. In one known situation, Mohrman who is an RN would report her findings to Carr who is a medically unlicensed/uncertified employee. In another situation, Robbie Hilliard who has "some" military training as a medical assistant, but is not medically licensed is dispensing narcotic medications to inmate patients in the absence of any licensed medical personnel. PHS has also had past employees resign due to the companies careless medical practices and inability to set up proper procedure practices.

According to staff, there is no inventory of meds on the medical cart. Staff also indicated that if a patients meds are changed, run out or a new medication is ordered, it is pulled from "bulk stock" (in house pharmacy) until the prescription is filled by the contract outside pharmacy. These prescriptions usually come in the following day. There is no knowledge of what happens to the extra meds placed on the cart, their expiration, or what happens to them if not used by the patient intended.

I have attempted to contact Sue Cole in reference to a follow up interview with negative results. Staff at the Leon County Jail advised that she was no longer employed at the detention facility, but she is still employed by PHS.

I have attempted to contact Dr. William Primas, via messages at the detention facility and via his attorney (Ms. Andrews), also in reference to a follow up interview.

To date, I have not been able to contact Cole or Primas.

This case is pending review by the State Attorney's Office for possible criminal charges and a potential Grand Jury review.



LEON COUNTY SHERIFF'S OFFICE
ADMINISTRATIVE INVESTIGATIVE
REPORTING FORM



AIB CASE NO: A03-18

DATE RECEIVED COMPLAINT: 23 May 2003

DATE REPORT COMPLETED: 23 June 2003

COMPLAINANT: Major Carl Bennett
Leon County Jail
922-3500

MEMBER INVOLVED: Not Applicable

INVESTIGATOR: Sgt. Tim Baxter *(initials)*
Administrative Investigations Bureau *(signature)*

DISCIPLINARY STANDARD
Not Applicable

Jail Death/Administrative Review

SYNOPSIS OF COMPLAINT

At approximately 0440 hours on 16 May 2003 Inmate Ruth Hubbs, #148608 was discovered deceased in her room in the medical unit at the Leon County Jail. There were no immediate signs of foul play indicated. She was the lone occupant of the room.

INVESTIGATIVE NARRATIVE

Ruth Hubbs was incarcerated in the Leon County Jail on 22 March 2002. She has been an inmate since that date. During her time of incarceration she began to complain of depression and other type mental disorders. The appropriate referrals and inmate requests were forwarded by the corrections staff to the medical unit operated by Prison Health Services.

On 16 May 2003 at 0435 hours Ms. Hubbs was discovered deceased in her cell in the infirmary at the Leon County Jail. She was discovered by Officer Mason Batson and Nurse Lurline Brown who were conducting the passing out of meal trays. C.P.R. was initiated to no avail. The observation was made that she appeared to be "wedged" between her bunk and the wall. Due to her large size several other officers responded and at that point they were able to lift her from the floor to the bunk. After E.M.T. responded and confirmed her death the room was secured for investigative purposes. There were no immediate signs of foul play noted by responding detectives.

Following is information related to the contact Leon County Jail Staff had with inmate Hubbs on the days immediately prior to her death.

Lieutenant Liz Black

On 13 May 2003 she was making rounds. At approximately 2318 hours she went into Pod M and made contact with Correctional Officer Cindy Finn. She was also reviewing the logs. She noted that earlier in the day Correctional Officer Nora Schultheis had made a notation that inmate Hubbs had been, "crying, yelling, and had trashed her room." Lt. Black inquired of Finn how Hubbs had been acting. Finn responded that the room was still trashed, and that Hubbs had been sitting on the toilet pressing the intercom every few minutes. Lt. Black called for Sgt. Bill Paramore to come to the pod to assist her. They then responded to Hubb's room to speak to her. They observed her sitting on the floor with her legs stretched out in front of her. She was talking incoherently with slurred speech. She appeared dazed and confused, was unable to state where she was, what the date was or who the president is. She told them she had arrived at her location by "subway." They asked her what was wrong. She responded, "they changed my medication." She was unable to get herself off the floor and instead propelled herself backwards by "hopping" with her buttocks. Black and Parramore then went to medical and made contact with the charge nurse, Kathy McCabe. They informed her of Hubb's condition. Nurse McCabe told them: Hubbs was "faking to look crazy, just acting out," there was "nothing she could do for her," and that they "could bring her down to medical if they wanted to, where she could just sit on the floor in a medical cell, and act crazy."

Based on this response from a trained medical person the decision was made to leave her in the pod. However, Officer Finn was told to keep a close watch on her.

Lt. Black remained very concerned over Hubb's obvious deterioration of her mental/physical state the next day. She contacted Lt. Dan Schmidt from home at approximately 1400 hours to tell him of her concerns so the day shift could monitor on her.

Later during the evening of the 14th Lt. Black's shift returned to work. Hubb's condition had not improved and in fact she now had stopped eating. Lt. Black and Sgt. Parramore went to medical and made contact with charge nurse Hamilton. They began to express their concerns to her. A nurse standing close by (Braetcher) made a comment that she had seen these same behaviors in Hubbs. She stated Hubbs appeared to be "over medicated." Sgt. Paramore inquired of her why would you continue to give her meds if you thought she was over medicated. She replied, "she was not permitted to make that kind of decision. It's ordered by a doctor, and I can't take it upon myself to stop it." He then asked her if she had reported Hubb's condition to anyone. She responded she had reported it to "all the higher ups including Sue Cole." Nurse Hamilton then went with them to the pod to observe Hubbs. After viewing her she told them Hubbs "shows classic signs of being over medicated, and she needs to be taken to the infirmary." With the help of several officers she was carried to a stretcher and wheeled into medical. A memorandum from Lt. Black is included in this report.

End of statement.

Sgt. Bill Parramore

Sgt. Parramore's statement concerning the days just previous to Hubb's death is essentially the same as Lt. Blacks. A memorandum from him is included in this report.

End of statement.

Recorded interviews of Lt. Black and Sgt. Paramore reveal the same information as noted in their memorandums.

The Leon County Sheriff's Office Offense Report concerning the death investigation is filed under case number 03-082193. Several Correctional Officers wrote continuations for that report. Most of those continuations primarily center on the circumstances around the finding of inmate Hubbs deceased. They note that her erratic behavior was continuing while she was in the medical infirmary. Sgt. Joyce McCary does state in her continuation that the staff physician, Dr. William Primas observed Hubbs during the day on 15 May 2003 at her request. According to Correctional Officer Dianne Brooks, he advised them to just let her continue laying on the floor. Also at the same time he was "observing" Hubbs the staff mental health worker (Natasha Carr), was present to evaluate her condition.

While confined in the medical unit Ms. Hubbs was to be checked visually hourly. These checks are recorded on a confinement log. The confinement log for 15-16 May 2003 for Ms. Hubbs is included in this report. It shows hourly checks fom 0505 hours on 15 May to 0410 hours on 16 May. However from 2105 hours until 0010 hours there are no checks recorded. Correctional Officer Clete King was the assigned medical officer during that time. In a recorded statement he advised that he relieved Officer Velveeta Davies at 2100 hours on 15 May 2003. At

approximately 2145 hours he asked Nurse Hamilton to check on the females as he checked on the males. She stated she would once she got a chance. At 2240 hours he asked her if she would accompany him to go check on the females. She stated she was too busy at the current time, but would take care of it just as soon as she got a chance. Officer King further indicates that during his training he was taught that when a male officer is assigned to the front desk it is the responsibility of the nursing staff to check on the female inmates housed in medical. At 2300 hours he was relieved by another officer. There was a violation of the Leon County Jail Standard Operating Procedures by Officer Clete King. Under SOP 6.14- Supervision Of Inmates, it requires all inmates to be visually checked hourly from 2300 hours until 0600 hours with the results recorded and maintained. However Officer King attempted to fulfill this obligation by requesting an on duty female nurse check on the inmates in the female infirmary as he is not allowed to do so without a female escort. This appears to be an inadvertent violation and would be best handled by training and PMP notations.

Detective Giordano's criminal investigation into this death revealed no foul play was involved. His interviews and information gathered also affirms that all the employees of this agency acted in a prudent manner concerning Inmate Hubbs's condition. They sought medical assistance at an appropriate time and also closely monitored her condition while she was in the pod. A copy of his report is included in this file.

On 6 June 2003, I conducted a recorded interview with Sue Cole. She is the Health Services Administrator for Prison Health Services at the Leon County Jail. The purpose of this interview was to determine if the employees of the Leon County Sheriff's Office had acted in a prudent manner concerning Inmate Hubbs. Inmate Hubbs was first diagnosed with "mental problems" over a year ago. Inmate Hubbs was on several psycho-tropic drugs as well as a hormone. Inmate Hubbs was last seen by a Mental Health Services person (Natasha Carr) on 15 May 2003. Ms. Carr noted that Hubbs was seen in the infirmary due to "bizarre behavior." She displayed no verbal communication, she was lying on the floor with her pants off. She was instructed to put her pants on, she grabbed her pants but just looked at them like she was "confused." She continued to sit on the floor with no verbal communication and minimal eye contact. A further note was added to follow up in the A.M. Ms. Cole stated that when Nurse Braetcher informed her that she felt Hubbs was over medicated she contacted the psychiatrist and had her medication reduced. She cannot advise what date that was done other than sometime in May. She did state that nursing staff has the right not to administer medication without a doctor's orders if they feel the medication is causing a problem. They then contact the doctor for confirmation. Hubbs was last actually seen by the psychiatrist in April 2003. My interview with Ms. Cole did not reveal any violations of policy by correctional staff.

The autopsy performed on Inmate Hubbs on 16 May 2003 did not immediately reveal a cause of death. Toxicology results will be forthcoming.

Following is time line containing relevant information concerning this investigation:

- March 20, 2002 - Ruth Hubbs is booked into the Leon County Jail on a number of charges. Her medical screening form does not note any known mental illness or infirmities.
- March 28, 2002 - The medical history and physical appraisal does not reveal any claims of or signs of mental illness.
- May 16, 2002 - Inmate Hubbs is referred to medical due to claimed depression and admitted prior suicide attempts. Medical refers her to the psychiatrist.
- May 24, 2002 - Inmate Hubbs is seen by Dr. Chokhawala. He determines she is "drug seeking" and there is "no need for psycho-tropic drugs at this time."
- Nov. 19, 2002 - Inmate Hubbs is referred to medical due to claimed depression. She indicates she has a desire "not to wake up." But denies suicidal intentions. She is referred to the psychiatrist.
- Nov. 20, 2002 - Inmate Hubbs is seen by the psychiatrist, Dr. Chokhawala. She is tearful, dejected, claims to have lost 30 pounds. She states she stays in bed for 3-4 days at the time. He diagnoses her as depressed and prescribed psycho-tropic medications.
- April 28, 2003 - Inmate Hubbs discovers she is facing a possibility of 10 years in prison. She begins to become more expressive of her distress over this matter.
- May 1, 2003 - The pod officer notes Inmate Hubbs is slurring her words and acting "drunk." She appears disoriented and loses her train of thought.
- May 4, 2003 - Inmate Hubbs fell on the floor in the middle of the pod. She still acts disoriented. She was transferred to the medical unit.
- May 9, 2003 - Inmate Hubbs is returned to the pod from medical.
- May 10, 2003 - Close monitoring of Inmate Hubbs is noted due to fact she appears heavily medicated. Later in date the pod officer notes she is too heavily medicated to remain in the pod. She was transferred to the medical unit again. She was returned back to the pod later that same date.
- May 13, 2003 - Inmate Hubbs is observed in her room in the pod sitting on the floor. Her speech was slurred and could or would not answer questions. She appeared confused. Lt. Black and Sgt. Parramore went to medical seeking assistance. Based on medical's response the decision was made to leave her in the pod.

- May 14, 2003 - Inmate Hubbs condition had not improved and in fact she had stopped eating. Lt. Black and Sgt. Parramore again went to medial. Nurse Hamilton returned to the pod with them. After observing Hubb's behavior it was her judgement she appeared over medicated. She was transported to the medical unit.
- May 15, 2003 - Inmate Hubbs was visually monitored by Dr. Primus and Mental Health Worker Natasha Carr. Dr. Primus is a medical doctor and was there evaluating some abrasions on Hubb's arms.
- May 16, 2003 - Inmate Hubbs is discovered deceased in her room.

FINDINGS

The Administrative Investigation of this death revealed no General Orders were violated by any employee of this agency.

ATTACHMENTS

- 1) Leon County Sheriff's Office Offense Report 03-082193
- 2) Memorandum(Liz Black)
- 3) Memorandum(Bill Parramore)
- 4) Memorandum(Clete King)
- 5) Pod Log
- 6) Medication Logs(Ruth Hubbs)
- 7) Progress Notes(Ruth Hubbs)
- 8) Confinement Log(Ruth Hubbs)
- 9) Cassette Tape Recorded Statement of Sue Cole
- 10) All other recorded statements and evidence is stored in this agency's evidence section under case number 03-082193.