Florida Department of Corrections

Office of the Inspector General

CRIMINAL INVESTIGATION

Case # 15-6588

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FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL

CASE SUMMARY REPORT

Case Number: 15-6588

Inspector: Inspector Conan Davidson

Date Assigned or Initiated: April 20, 2015

Complaint Against: N/A

Location of Incident – Institution/Facility/Office: Tomoka Correctional Institution

Complainant: N/A

Use of Force Number: N/A

PREA Number: N/A

Classification of Incident: Assist in Death Investigation

Confidential Medical Information Included: X Yes ___ No

Whistle-Blower Investigation: ___ Yes X No

Equal Employment Opportunity Investigation: ___ Yes X No

Chief Inspector General Case Number: N/A

I. AUTHORITY

The Florida Department of Corrections, Office of the Inspector General, by designation of the Secretary and § 944.31, Florida Statutes, is authorized to conduct any criminal investigation that occurs on property owned or leased by the department or involves matters over which the department has jurisdiction.

The testimony references included in this report are summations of oral or written statements provided to inspectors. Statements contained herein do not necessarily represent complete or certified transcribed testimony, except as noted. Unless specifically indicated otherwise, all interviews with witnesses, complainants, and subjects were audio or video recorded.

II. METHODOLOGY

The investigation reviewed the derivations of the allegation advanced by the complainant. The scope of this investigation does not seek to specifically address tort(s), but violations of criminal statutes. The criterion used to evaluate each contention or allegation was limited to the following standard of analysis:

1. Did the subject's action or behavior violate Florida criminal statutes?

III. ANALYSIS

The standard and analysis in this investigation is predicated with the burden of proving any violation of law, established by probable cause. The evidence considered for analysis is confined to the facts and allegations stated or reasonably implied. The actions or behavior of the subject are presumed to be lawful and in compliance with the applicable Florida law, unless probable cause indicates the contrary.

IV. DEFINITIONS

Unfounded:
Refers to a disposition of a criminal case for which probable cause does not exist to suggest the suspect's behavior or action occurred nor is an arrest or formal charge being initiated.

Closed by Arrest:
Refers to a disposition of a criminal case for which probable cause exists that an identified subject committed the offense and one for which an arrest or formal prosecution has been initiated.

Exceptionally Cleared:
Refers to a disposition of a criminal case for which probable cause exists that an identified suspect committed the offense, but one for which an arrest or formal charge is not initiated, or in the case of a death investigation, one for which no evidence exists that the death was the result of a crime or neglect.

Open-Inactive:
Refers to a disposition of a criminal case for which a criminal investigation commenced, but where evidence is insufficient to close as unfounded, closed by arrest, or exceptionally cleared.

V. PREDICATE

On April 18, 2015, the Department of Corrections, Office of the Inspector General received notification reference Inmate George Grayson, DC# 266303, had a [redacted] while assigned to Tomoka Correctional Institution and later died at [redacted] Upon review of the information and Memorandum of Understanding with the Florida Department of Law Enforcement, the Office of the Inspector General assigned an Investigative Assist - Criminal case to Inspector Conan Davidson on April 20, 2015.

VI. SUMMARY OF INVESTIGATIVE FINDINGS

Based on the exhibits, witnesses' testimony, subject officer's statements, and the record as a whole, presented or available to the primary inspector, the following findings of facts were determined:

On April 18, 2015, at 2:30 am, this inspector received a call from Supervisor Daryl McCasland reference a death of Inmate George Grayson, DC# 266303, from Tomoka CI, 3950 Tiger Bay Road, Daytona Beach Florida 32124.

While en-route, this inspector received a call from FDLE Agent Troy Cope, (407) 252-1148, who stated he and Special Agent Michael Bishop were also en-route to Tomoka CI as the lead agents in the case. Agent Cope stated he would meet in the parking lot at Tomoka CI to discuss an investigative plan.

At 3:30 am, this inspector arrived at Tomoka CI and entered through the main security gate.

After being introduced and meeting with involved security staff, Captain Robert Carroll, who was the Officer-in-Charge (OIC) for this day, briefed this inspector as to the prior events of the evening.

To get further details and indentify witnesses involved in the incident, this inspector gathered the available Incident Reports from staff and inmate witnesses.

- Incident Report written by Correctional Officer Chad Cales.

  In his Incident Report, Officer Cales wrote that on April 17, 2015, at approximately 12:02 am, he was supervising inmates assigned to A-Dormitory. As he was working, Officer Cales was alerted by other inmates in the dormitory that Inmate George Grayson, DC# 266303, was on the floor in

the A-2 side dayroom having [redacted] For safety, using his two-way radio, Officer Cales alerted and requested help from other security staff.

Within just a few minutes of making the call for needing assistance, Correctional Officer Sergeant David DeLong and Correctional Officer David Hyman arrived and took charge of the scene. Because Inmate Grayson was [redacted] the [redacted] Unit was called and responded to A-Dormitory. In just a few minutes of being called, at 12:06 am [redacted] Raymond Kalmar arrived with a [redacted] and began an [redacted] of Inmate Grayson.

To continue his duties, Officer Cales remained in A-Dormitory Control Room.

- Incident Report written by Correctional Officer Sergeant Sherman Richards

In his Incident Report, Sergeant Richards wrote on April 18, 2015, at approximately 12:02 am, he received a call, via his two-way radio, from security staff in A-Dormitory, side 2, reference Inmate Grayson having what appeared to be a [redacted] Sergeant Richards responded to A-Dormitory and arrived at about the same time as the [redacted] staff, who had also been called. [redacted] Kalmar, who was already doing a [redacted] indicated Inmate Grayson needed to be transported to the [redacted] Unit for [redacted] Sergeant Richards and other security staff assisted in placing Inmate Grayson in a [redacted] then pushing him out of the front door of the dormitory and on the sidewalk towards [redacted] unit. As they were pushing Inmate Grayson on the sidewalk, it was observed he had [redacted] To perform [redacted] the pushing was stopped so Inmate Grayson could be removed from the [redacted] and placed on the sidewalk. [redacted] was started by Sergeant Richards and Officer David Hyman.

To get advanced [redacted] 9-1-1 was called and Volusia County Fire Department and E.V.A.C. unit #48 arrived at Tomoka CI Front Gate. After clearing security, the emergency personnel from these units were brought to the scene. E.V.A.C. took over [redacted] After being [redacted] Inmate Grayson was placed in the [redacted] and transported to [redacted] where, after continued [redacted] Inmate Grayson was pronounced dead by [redacted] Peterson.

- Incident Report written By Correctional Officer Sergeant David DeLong

In his Incident Report Sergeant DeLong wrote on April 18, 2015, at 12:02 am, he was assigned as the B-Dormitory supervisor when he was alerted and responded to A-Dormitory reference an

inmate having [redacted] When Sergeant DeLong arrived in A-Dormitory, because of his rank, he took control of the scene, [redacted] Inmate Grayson and briefed the Control Room, via two-way radio, as to the situation. When Sergeant DeLong first arrived at the scene and made contact, he found Inmate Grayson was [redacted] Sergeant Delong attempted to interact with Inmate Grayson asking him about what happened and why he was [redacted] As they were talking, Inmate Grayson suddenly had [redacted] Unit was called and arrived shortly after being called in A-Dormitory. [redacted] unit attempted [redacted] Inmate Grayson with limited success. Inmate Grayson [redacted] and became alert enough to get off the floor to his feet and assist being placed in a [redacted] so he could be transported to the [redacted] unit for additional [redacted] After being placed in the [redacted] Sergeant Richards and Sergeant DeLong began pushing Inmate Grayson towards the [redacted] nit with [redacted] Kalmer walking with them assisting and monitoring him. While en route, [redacted] Kalmer became concerned and told Sergeant DeLong Inmate Grayson wa [redacted] and there seemed to [redacted] So [redacted] could be initiated, Inmate Grayson was taken out of the [redacted] and placed on the sidewalk. Several staff members who were at the scene took turns [redacted] Inmate Grayson. [redacted] continued until the Volusia County Fire Department arrived and took over [redacted] While at Tomoka CI, Inmate Grayson did [redacted] and was transported [redacted]

Sergeant DeLong went back to his assigned duties.

- Incident Report written by Correctional Officer David Hyman

In his Incident Report Officer Hyman wrote on April 18, 2015, at 12:02 am, he was assigned to supervise inmates in B-Dormitory. Officer Hyman was alerted, via radio, that there was an inmate [redacted] in A-Dormitory so he responded with other security staff who were nearby. When he arrived in A-Dormitory, Officer Hyman found Inmate Grayson [redacted] Other security staff were controlling the scene and attempting to [redacted] Inmate Grayson and determine his [redacted] staff arrived with a [redacted] and while he was [redacted] they placed Inmate Grayson in the chair so he could be moved to the [redacted] unit. En-route to the [redacted] unit, [redacted] almer, who was monitoring Inmate Grayson, found he had [redacted] To start [redacted] Kalmer, had staff place take Inmate Grayson out of the [redacted] and place him on the ground. Once on the ground, several security staff members [redacted] until the Volusia County Fire Department arrived and took over. Inmate Grayson [redacted] For further [redacted] Inmate Grayson was placed in the [redacted]

Officer Hyman had no further contact with Inmate Grayson.

- Incident Report written by Correctional Officer Michael Steedley

In his Incident Report Officer Steedley wrote on April 18, 2015, at 12:30 am, he was instructed to assemble the "Inmate Transport Equipment" and get a chase vehicle so he could escort the [redacted] with Inmate Grayson to [redacted] At the [redacted] Officer Steedley maintained his assignment and contact with Inmate Grayson until he was pronounced dead.

- Incident Report written by [redacted] Raymond Kalmar

In his Incident Report [redacted] Kalmar wrote on April 18, 2015, at 12:02 am, he received a call from security staff about an inmate was [redacted] in A-Dormitory, side 1 [redacted] Kalmar responded to A-Dormitory and when he arrived he found Inmate Grayson with [redacted] lying on the floor in the dayroom. Unidentified inmate witnesses in the area told [redacted] Kalmar they had witnessed Inmate Grayson have [redacted] prior to his arrival [redacted] While making his [redacted] of Inmate Grayson, who at this time [redacted] Inmate Grayson again [redacted] Kalmar checked and [redacted] Inmate Grayson [redacted] Needing to further [redacted] and give [redacted] to Inmate Grayson, [redacted] Kalmar ordered staff to placed Inmate Grayson in the [redacted] which had been brought to A-Dormitory, so he could be transported to the [redacted] Unit. After leaving A-Dormitory and traveling on the sidewalk towards the [redacted] Unit, [redacted] Kalmar, who had been monitoring Inmate Grayson's [redacted] noticed he had [redacted] Staff stopped pushing Inmate Grayson and took him out of the [redacted] and placed him on the ground. [redacted] was started by staff and 9-1-1 was called by the Control Room personnel. [redacted] continued until a short time later when Volusia County EVAC arrived and took over [redacted]. Inmate Grayson was transported to the [redacted] by EVAC.

- Incident Report written by Captain Robert Carroll

In his Incident Report Captain Carroll wrote on April 18, 2015, he stated at 12:02 am, he was informed Inmate Grayson was having [redacted] in A-Dormitory side-1 by Sergeant Richards. The information reported by Sergeant Richards was that Inmate Grayson was [redacted] To get help, the [redacted] Unit was called and dispatched to Sergeant Richards location. When [redacted] Kalmar, from the [redacted] Unit, arrived, Inmate Grayson was on the floor in the dayroom [redacted] While making his assessment, [redacted] Kalmar found Inmate Grayson [redacted] and ordered staff to move him to the [redacted] unit. Inmate Grayson was

placed in a [redacted] pushed on the sidewalk from the dormitory traveling to the [redacted] Unit. While traveling on the sidewalk, Inmate Grayson's [redacted] being monitored by [redacted] Kalmar who found that [redacted] To start [redacted] Inmate Grayson was taken out of the [redacted] and placed on the ground. Sergeant Richards, Officer Hyman, Sergeant DeLong and [redacted] Kalmar all took turns [redacted] For [redacted] -1-1 was called and [redacted] until the Volusia County Fire Department arrived and took over [redacted] Inmate Grayson was taken to the [redacted] and was pronounced dead at 1:06 am by the [redacted]

Shortly after it was learned Inmate Grayson had died, Sergeant DeLong and Officer Hyman collected and secured Inmate Grayson's personal property.

When contacted by security staff, Inmates in A-dormitory did not want to give statements at the time.

Based on the briefing, review of the Incident Reports, and evidence gathered there was no evidence of foul play.

Timeline of events based on evidence, witness testimony and reports:

At 2:30 am, on April 18, 2015, this inspector was notified by Supervisor Daryl McCasland of Inmate Grayson's death at Tomoka CI.

Because I was the on-call inspector for this district, I responded directly to Tomoka CI from my home. While en-route, this inspector was contacted by Special FDLE Agent Troy Cope, [redacted] who stated he had been notified of the death and based on the Memorandum of Understanding (MOU) with DOC, would be responding and meet at Tomoka CI.

At 3:30 am, this inspector arrived at Tomoka CI and met with Captain Carroll, Officer in Charge (OIC) who gave a briefing as to the chain of events to this point. Captain Carroll also gave a list of staff and witness inmates to the incident.

At this time, staff witnesses were in the process of completing and reviewing their Incident Reports for their chain-of-command. Captain Carroll later gave this inspector a copy of all the completed Incident Reports.

Captain Carroll gave this inspector a list of indentified inmate witnesses who were willing to give statements as to what they had seen.

The names were:

1. Wilfredo Orengo, DC# 960745
2. Michael Blithers, DC# H21666
3. Philip White, DC# C08822
4. Michael Hogan, DC# V21612

At 3:40 am, this inspector was taken to A-Dormitory, by Captain Carroll, and shown where Inmate Grayson had been playing cards in the Dayroom and [redacted] on the floor.

To memorialize the scene, photographs were taken of the area.

It was learned that Inmate Grayson's personal property had been gathered by security personnel and placed in the hallway to the Control Room for storage. This inspector searched the personal property but did not find any suspicious items or contraband.

General photographs were taken of the personal property.

At 4:19 am. FDLE Agent Cope and FDLE Agent Bishop arrived at Tomoka CI and met with this inspector. This inspector briefed the agents as to what happened and gave them the witness names obtained so far.

As required, Agent Cope signed a DOC Investigative Demand for Records reference a criminal investigation form. Once completed and signed, a copy of all Incident Reports were made and given to Agent Cope for review.

Because of the travel time it took for this inspector to arrive at Tomoka CI, the District 7 Medical Examiner's Office, (386) 258-4060, had already been called, met and transported Inmate Grayson from the [redacted] to the morgue, 1360 Indian Lake Road Daytona Beach, Florida 32124. At the [redacted] Inmate Grayson had arrived by [redacted] from Tomoka CI and was pronounced dead by the [redacted] There was no evidence of foul play reported by the [redacted] staff. There was no evidence at the [redacted]

For reference, District 7 Medical Examiner's Office case number ME-15-07-215.

Based on DOC and FDLE protocol, Agent's Cope and Bishop began interviewing staff and inmate witnesses.

As they were being interviewed, this inspector gathered copies of the Incident Reports and other related evidence reference the death of Inmate Grayson.

After the interviews and reviewing what the witnesses said, there had been no testimony of foul play.

After checking, this inspector found there [redacted] A-Dormitory.

On April 20, 2015, at 8:09 am, Because Inmate Grayson had died while in DOC custody, an Autopsy was scheduled to determine the cause of death.

Agent Cope met with this inspector at the Medical Examiner's Office.

Doctor Marcela Christe performed the Autopsy examination. In the exam, Doctor Christe did not find any evidence [redacted] or foul play. It was noted an [redacted] An initial drug screen was performed [redacted]

Based on the evidence at this time, the Manner and Cause of death could not be determined. For conclusion in making the finding of death, Doctor Christe sent biological specimens obtained from Inmate Grayson to the lab for further analysis.

The final Autopsy Report is pending.

On June 22, 2015, at 9:30 am, this inspector received a call from FDLE Agent Cope who stated he had just received a copy of Inmate Grayson's Autopsy Report from the Medical Examiner which listed Cause of Death is [redacted] and the Manner of Death was listed as a Suicide. Based on tests from the biological samples, Agent Cope stated there had been a [redacted]

Agent Cope inquired as to how he could obtain copies of Inmate Grayson's [redacted]

[redacted] this inspector could not discuss Inmate Grayson's [redacted] and referred Agent Cope to Attorney Saavedra for guidance in obtaining the records.

For review, this inspector received the Autopsy Report via email from Agent Cope.

On June 23, 2015, at 12:57 pm, in order to determine if there was any prior evidence of a suicide, this inspector obtained and reviewed Inmate Grayson's recorded inmate phone calls starting on December 2014 to the time of death, April 18, 2015.

Based on historical DOC Inmate phone records, the following phone calls were found and reviewed:

1. 12/7/14 at 22:10 (727) 541-7183 Call was disconnected technical problems with the phone system
2. 12/7/14 at 22:12 (727) 541-7183 Inmate Grayson redialed, spoke to his mother Ms. Lorraine Grayson, conversation was about family issues
3. 12/14/14 at 20:13 (727) 541-7183 Inmate Grayson contacted Ms. Lorraine Grayson spoke about family and money issues, general conversation
4. 2/7/15 at 19:38 (727) 541-7183 Inmate Grayson contacted his mother and spoke about family issues, general conversation
5. 2/21/15 at 22:10 (727) 541-7183 Inmate Grayson contacted his mother and spoke about family issues and general conversation
6. 3/01/15 at 13:56 (727) 541-7183 Inmate Grayson contacted his mother and spoke about family issues
7. 3/12/15 at 17:02 (727) 541-7183 Inmate Grayson contacted his mother and spoke about family issues

In the recorded calls reviewed, there was no conversation or evidence in which Inmate Grayson spoke about despair or suicide type issues.

It should be noted, there is no way of knowing if Inmate Grayson placed any other calls using an unauthorized cell phone or communication means which would not be recorded or known by this inspector.

On June 25, 2015, at 3:10 pm, because the Manner of death was classified as Suicide, this inspector again was contacted by Agent Cope, via email, requesting a copy of Inmate Grayson's [redacted] for review.

As previously discussed with Agent Cope, because these [redacted] his inspector contacted Ms. Saavedra, DOC Legal Advisor, for guidance as to how and provide the requested [redacted] Ms. Saavedra sent this inspector an email with subpoena compliance instructions for the [redacted] For review, the instructions were emailed to Agent Cope.

After some discussion, because the [redacted] had already been provided by this inspector to the District 7 Medical Examiner's Office for review at the time of Inmate Grayson's death, Agent Cope stated he would not be seekin [redacted] at this time.

The Medical Examiner had already received and reviewed these [redacted] and did not find any evidence in the [redacted] or request any further [redacted] from this inspector.

On July 1, 2015, at 2:33 pm, this inspector emailed Agent Cope about the recorded phone calls made by Inmate Grayson and asked if he needed a copy of the calls for his case file.

Agent Cope requested this inspector provide a copy of Inmate Grayson's phone calls for review.

Prior to copying the phone calls, based on DOC policy, this inspector emailed Agent Cope an Investigative Demand for Records form for the recorded telephone calls and records pertaining to Inmate Grayson. After review, Agent Cope signed and emailed this inspector the signed Demand for Records form.

In reviewing the case file, this inspector found incomplete and missing pages of the Control Room Log for April 17–18, 2015 that had been originally obtained.

To get a complete log, this inspector emailed Ms. Judith Frank, Secretary to the Colonel, Tomoka CI, and requested all pages of the log for this day. Later, based on the request, Ms. Frank emailed the log to this inspector for review.

For updated information, because this inspector is assisting with the investigation, this inspector emailed Agent Cope the complete Control Room Log for April 17-18, 2015 which had been obtained from Ms. Frank.

On July 2, 2015, at 12:30 pm, based on the request for a copy of the recorded inmate phone calls Inmate Grayson made, this inspector obtained and downloaded the calls to a CD and dropped them off at the

front desk of the Orlando FDLE Office, 500 West Robinson Street Orlando, Florida 32801, for Agent Cope to review.

To interview and possibly find potential witness(s) in the case, this inspector obtained an inmate dormitory roster for A-Dormitory for the day of April 17, 2015. This roster will have a list of the inmates who were assigned in beds near and around Inmate Grayson at the time of his death. Interviewing these inmates, may reveal testimony of whether Inmate Grayson confided in anyone about drug usage or intentions of committing suicide.

There have been no other witnesses known or identified to this date.

Records show Inmate Grayson was assigned to bed A2117L

This list of inmate names and their bed assignments was emailed to Agent Cope.

Based on the roster, Agent Cope stated he would schedule and interview the following inmates:

1. Starling Middleton, DC# R77477 bed A2117U
2. Efrain Martinez-Lopez, DC# C09347 bed A2116L
3. Willie Hampton, DC# 699027 bed A2118L
4. Maharris Warner, DC# 334520 bed A2118U

On October 21, 2015, at 10:24 am, for review and investigative conclusion, this investigator traveled to the Orlando FDLE and obtained a copy of FDLE report, OR-37-0027, which Agent Cope competed reference his investigation.

This inspector reviewed Agent Cope's report and noted he had found no evidence of foul play and had not requested additional investigation. In his conclusion, through witness testimony and evidence obtained, Agent Cope was not able to determine where Inmate Grayson obtained [redacted]

Based on the Autopsy Report and the conclusion of investigation by Agent Cope and this inspector, Inmate Grayson had [redacted] his death.

Cause of Death: [redacted]

Manner of Death: Suicide

No further investigation is needed at this time. There were no Administrative violations discovered during the course of the investigation.

VII. CHARGES

List alleged violations of Florida Law:

1. (None)

VIII. CONCLUSION

Based on the information gathered during this investigation, it is the recommendation of Inspector Conan Davidson that no criminal violations of state statute were committed.

1. Exceptionally Cleared