

Florida Department of Corrections



Office of the Inspector General

CRIMINAL INVESTIGATION

Case # 14-15



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
CASE SUMMARY REPORT



Table of Contents

<u>I. AUTHORITY</u>	4
<u>II. METHODOLOGY</u>	4
<u>III. ANALYSIS</u>	4
<u>IV. DEFINITIONS</u>	5
<u>V. PREDICATE</u>	6
<u>VI. SUMMARY OF INVESTIGATIVE FINDINGS</u>	6
<u>VII. CHARGES</u>	9
<u>VIII. CONCLUSION</u>	10



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
CASE SUMMARY REPORT



Case Number: 14-15

Inspector: Lark Napier III

Date Assigned or Initiated: 03 January 2014

Complaint Against: N/A

Location of Incident – Institution/Facility/Office: Central Florida Reception Center – Main Unit

Complainant: Correctional Officer Captain Edward Taylor

Use of Force Number: N/A

PREA Number: N/A

Classification of Incident: In-Custody Death Investigation [REDACTED]

Confidential Medical Information Included: Yes No

Whistle-Blower Investigation: Yes No

Equal Employment Opportunity Investigation: Yes No

Chief Inspector General Case Number: N/A



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
CASE SUMMARY REPORT



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.



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
CASE SUMMARY REPORT



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.



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
CASE SUMMARY REPORT



V. PREDICATE

On or about 31 December 2013, the Department of Corrections, Office of the Inspector General received information indicating that at approximately 2013 hours on 31 December 2013, Inmate William Walker (K67610 W/M 04/14/1983) was discovered [REDACTED] in Cell E4-209 at Central Florida Reception Center – Main Unit [REDACTED]. Inmate Walker was pronounced deceased at 2101 hrs. by attending [REDACTED]. Upon initial review of the information, the Office of the Inspector General initiated an investigation into the allegations on 03 January 2014.

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:

At 2126 hours on 31 December 2013, this Inspector was contacted by On-call Inspector Supervisor Joe Hamner to respond to Central Florida Reception Center – Main Unit for an In-Custody Inmate Death investigation.

At approximately 2220 hours, this Inspector arrived at Central Florida Reception Center. Captain Edward Taylor provided a Critical Incident Briefing, during which he indicated at approximately 2019 hours on 31 December 2013, during the evening "Mail Call", Inmate William Walker (K67610 W/M 04/14/1983) was discovered [REDACTED] in Cell E4-209 with a ligature constructed from a torn state issued bed sheet secured around his neck. Inmate Walker was on Administrative Confinement Status, pending a Management Review for Protective Management and he was housed alone in the secured cell.

After severing the ligature, responding Security Staff [REDACTED] and Inmate Walker was [REDACTED] Central Florida Reception Center compound [REDACTED] "Called" Inmate Walker's time of death as 2101 hours on 31 December 2013.

The decedent's body was secured [REDACTED] and Cell E4-209 was secured as a crime scene. Security Personnel were posted in each location, pending this Inspector's arrival.

During his initial briefing, Captain Taylor further indicated that [REDACTED] were removed from Cell E4-209 prior to the cell's closure. The [REDACTED]



FLORIDA DEPARTMENT OF CORRECTIONS
 OFFICE OF THE INSPECTOR GENERAL
 CASE SUMMARY REPORT



Walker a [REDACTED]
 The letters were reviewed and secured as evidence at 2235 hours.

[REDACTED]

[REDACTED]

[REDACTED]

The [REDACTED] will be returned to the Chaplain's Office at Central Florida Reception Center – Main Unit for return to the Decedent's family upon the conclusion of this investigation.

At approximately 2240 hours, this Inspector conducted a preliminary review of the decedent's body. Inmate Walker [REDACTED] consistent with a body weighted ligature which had been secured around his neck. [REDACTED] was observed on Walker's state issued white t-shirt, however, [REDACTED] was noted on the [REDACTED] [REDACTED] was consistent with [REDACTED] and not consistent with any form of criminal battery. After documentary photographs were completed, the decedent's hands were covered with brown paper bags to preserve trace evidence and [REDACTED] was re-secured. A Correctional Officer was posted at the secured door. Documentary photographs were taken and shall be downloaded to disc and forwarded to Central Records for inclusion with this report.

On 31 December 2013 at approximately 2253 hours, this Inspector arrived in Quad 4 of E-Dormitory to begin crime scene documentation and evidence collection. Cell E4-209 was secured with a Correctional Report # - 14-15/10



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
CASE SUMMARY REPORT



Officer posted outside the door. Documentary photographs and sketches, including detailed fixed point scene triangulation measurements, were collected to aid in diagramming and crime scene recreation. Several articles of evidence were collected including, but not limited to:

1. Evidentiary Item E2 - a severed ligature approximately thirty inches (30") in diameter with knotting intact, which appeared to be manufactured from a torn state issued bed sheet; the ligature was secured with an additional knot to the confinement window hand crank which is located forty-seven inches (47") above the cell floor.
2. Evidentiary Item E5 – a state issued bed sheet with the selvage torn away from the entire length of the sheet;
3. Evidentiary Item E5a - a series of strips of cloth consistent with pieces of a state issued bed sheet, which had been knotted together in what appeared to be a failed attempt at creating a ligature.

Preliminary crime scene documentation was completed, and the on duty Investigator for the Ninth (9th) Circuit Medical Examiner's Office was contacted at 0002 hours on 01 January 2014. Arrangements were made for the Decedent's body to be transported to the Medical Examiner's Office for forensic examination. Body Transport Contractor Thomas Stewart removed the Decedent's body from Central Florida Reception Center for transport to the District Nine (9) Medical Examiner's Office at 0205 hours on 01 January 2014.

The Fixed Wing Video was recovered and reviewed by this Inspector. On 31 December 2013 at 1928 and 1929 hours respectively, the light in Cell E4-209 was observed being turned on and off. At 1949 hours, Correctional Officer James Taylor was observed conducting a Security Check of Cell E4-209. It should be noted that in his submitted Incident Report, Officer Taylor noted that Inmate Walker was reclined (on the lower bunk) and that Walker was [REDACTED]. Twenty-four minutes later, at 2013 hours, Correctional Officer Jose Reyes-Garcia discovered Inmate Walker seated [REDACTED] at the back of Cell E4-209. Officer Reyes was observed exiting Wing 4 and returning with Officer Taylor and Correctional Officer Sergeant Nicholas Varcoe. At 2016 hours, the Security Personnel entered Cell E4-209. [REDACTED] and [REDACTED]. At 2026 hours, Inmate Walker was removed from Wing 4. Sergeant Varcoe secured Cell E4-209 at 2030 hours. Prior to the emergency response by Sergeant Varcoe and Officers Taylor and Reyes, Inmate Walker's secured cell was not breached by any observed person.

The Fixed Wing Video disc will be forwarded to Central Records for inclusion with the final Office of the Inspector General Report. A detailed time line of the Fixed Wing Video follows:

Time Stamp	Noted Actions
19:00:00	Video opened



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
CASE SUMMARY REPORT



19:02:23	Obvious movement noted in Cell E4-209
19:04:05	Cell light turned off in E4-209, other Quad 4 cell lights remained on, indicating someone controlling the light within E4-209
19:06:18	Inmate William Walker observed through window in cell door, cell light on
19:08:00	Cell light off
19:13:58	Cell light on
19:14:36	Cell light off
19:16:12	Cell light on
19:19:47	Cell light off
19:28:48	Cell light on
19:29:12	Cell light off
19:48:25	Correctional Officer James Taylor entered Quad 4 through the lower exterior door
19:49:42	Officer Taylor paused at Cell E4-209 and made an observation into the cell with a flashlight
20:13:54	Correctional Officer Jose Reyes-Garcia is observed attempting to deliver mail to the cell front of E4-209, Reyes-Garcia quickly exited Quad 4 camera view
20:16:13	Correctional Officer Sergeant Nicholas Varcoe, with Officers Taylor and Reyes-Garcia, responded to and entered Cell E4-209. Officer Taylor rapidly exited the Quad 4 view and then returned to Cell E4-209.
20:22:18	[REDACTED]
20:26:20	Inmate Walker removed from E4-209 [REDACTED]
20:26:49	Inmate Walker exited Quad 4 camera view
20:29:26	Sergeant Varcoe entered Cell E4-209
20:30:50	Sergeant Varcoe secured Cell E4-209

On 01 January 2014 at 0830 hours, Doctor Joseph Stephany of the District Nine (9) Medical Examiner's Office conducted a forensic examination of the body of William Walker. In the Medical Examiner's Summary Report, the preliminary finding of Doctor Stephany was Walker's 'Manner of Death' was suicide and his 'Cause of Death' [REDACTED]



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
CASE SUMMARY REPORT



On 27 January 2014, this Inspector received the final Medical Examiner's Report, which corroborated Doctor Stephany's preliminary finding and additionally confirmed [REDACTED]
c [REDACTED]

VII. CHARGES

List alleged violations of Florida Law:

No Criminal or Administrative charges are pending.

VIII. CONCLUSION

Based on the information gathered during this investigation, it is the determination of Inspector Lark Napier that the In-Custody Death of Inmate William Walker was the result of his suicide [REDACTED]. Further investigation is not warranted at this time. It is recommended that this case be termed as follows:

- 1. Exceptionally Cleared**