

Florida Department of Corrections



Office of the Inspector General

**CRIMINAL INVESTIGATION
INVESTIGATIVE ASSIST
CASE # 17-04481**



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIVE ASSIST 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>	6
<u>VIII. CONCLUSION</u>	7



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIVE ASSIST SUMMARY REPORT



Case Number: 17-04481

OIG Inspector: Inspector Jonathan Warren

Outside Agency: Florida Department of Law Enforcement

Outside Agency Investigator: Special Agent Nicole Miller

Date Assigned or Initiated: March 20, 2017

Complaint Against: N/A

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

Complainant: Correctional Officer Captain Jonathan Rummel

Outside Agency Case #: OR-37-055

Use of Force Number: N/A

PREA Number: N/A

Classification of Incident: In-Custody Death

Confidential Medical Information Included: Yes No

Whistle-Blower Investigation: Yes No

Chief Inspector General Case Number: N/A



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIVE ASSIST 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
INVESTIGATIVE ASSIST 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.

Investigative Assist Closed

Refers to a disposition of an investigative assist, where the conduct being investigated by the outside agency did not concern allegations against a Department employee, contractor, inmate, offender, or other person either employed or under the supervision of the Department.



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIVE ASSIST SUMMARY REPORT



V. PREDICATE

On March 19, 2017, Inmate Carl Singleton (323272) was pronounced deceased at the Central Florida Reception Center (CFRC). Special Agent Nicole Miller of the Florida Department of Law Enforcement and Inspector Jonathan Warren (37424) responded to the institution. The FDLE initiated case # OR-37-055. On March 20, 2017, Inspector Warren was assigned Investigative Assist # 17-04481.

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:

Inmate Carl Singleton (323272) was assigned to cell E4-205U at the Central Florida Reception Center (CFRC) on March 19, 2017. Inmate Singleton was pending a review for protective management due to allegations that he had made about unidentified members [REDACTED] and was the only person assigned to the confinement cell. Correctional Officer Zachary Neubauer (89136) and Sergeant Mathew Myers (65258) reported that they discovered Inmate Singleton [REDACTED] a sheet tied around his neck at approximately 7:20am on March 19. The sheet was attached to the upper bunk of the cell. The officers were conducting the first cell front inspection of their shift which began at 7:00am. Inmate Singleton was pronounced deceased at 8:07am.

Inspector Jonathan Warren (37424) and Special Agent (SA) Nicole Miller of the Florida Department of Law Enforcement (FDLE) responded to the CFRC to initiate an investigation of the in-custody death. SA Miller was assigned FDLE Case # OR-37-055. Inspector Warren was assigned to assist her as requested. SA Miller interviewed the involved staff members, examined and photographed the decedent, and searched and photographed cell E4-205. The decedent was released to the District Nine Office of the Medical Examiner after the preliminary investigation was complete. An information brief was completed.

A review of the fixed wing video was conducted. The footage that was reviewed was captured by camera [REDACTED] digital video recorder between 5:41am and 8:00am on March 19, 2017. The timestamp on the video was approximately one hour and six minutes behind; the times from the video have been adjusted for the purposes of this summary. The following is a timeline of the relevant events shown in the video:

- 5:43am: Inmate Singleton accepted a tray for the Morning Meal and was viewed by a staff member believed to be Sergeant Atiq Johnson (71126). This is the last time a staff member looked into cell E3-204 prior to Inmate Singleton [REDACTED] at 7:24am.
- 6:08am: Inmate Singleton moved inside of cell E4-205. This is the last time the video showed motion inside of the cell.
- 7:24am: Sergeant Myers and Officer Neubauer walked to the front of cell E4-205. The officers knocked on the door and repeatedly called for Inmate Singleton.
- 7:26am: An additional officer responded to the front of cell E4-205.



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIVE ASSIST SUMMARY REPORT



- 7:27am An additional officer responded to the front of cell E4-205 with a cell extraction shield. Captain Jonathan Rummel (43571) responded to the front of cell E4-205. The cell door was opened.
- 7:29am [REDACTED] entered cell E4-205.
- 7:32am Inmate Singleton was removed from the view of the camera [REDACTED] [REDACTED] responding correctional officers, and inmate orderlies.

No one entered or exited cell E4-205 between 5:43am and 7:27am.

Multiple staff members and inmates responded to the cell after the door was opened. Not all of these individuals could be clearly identified by a review of the video and sworn statements. All of the staff members and inmates involved moved quickly and appeared to be assisting in either treating Inmate Singleton or removing him from the cell. The events depicted in the video are consistent with the sworn statements collected from staff members and inmates during SA Miller's investigation.

The interior of cell E4-205 [REDACTED] The staff members who were interviewed during the FDLE investigation reported that Correctional Officer Duane Udo (85767) and Captain Rummel entered the cell and lifted Inmate Singleton after the cell door was opened. Officer Neubauer cut the sheet that was around Inmate Singleton's neck, and Captain Rummel and Officer Udo lowered him to the floor of the cell. Officer Udo [REDACTED] Inmate Singleton. Officer Udo removed the portion of sheet that was around Inmate Singleton's neck [REDACTED] Officer Udo [REDACTED] Inmate Singleton until he was relieved [REDACTED].

Inmate Singleton [REDACTED] the CFRC where [REDACTED] [REDACTED].

Inmate Singleton was examined and photographed by SA Miller on March 19. Inmate Singleton [REDACTED] [REDACTED] Inmate Singleton's [REDACTED] Inmate Singleton [REDACTED].

SA Miller photographed and searched Cell E4-205. A portion of a white sheet was attached to the upper bunk of the cell. A ligature that had been made from another portion of a white sheet was on the floor of the cell. The two portions of sheet, the original housing unit logs from E-Dormitory, Inmate Singleton's [REDACTED], a security seal found on the floor of the cell, and the fixed wing video recordings of camera [REDACTED] were collected and submitted to the District Seven Regional Evidence Control Area. The seal on the floor of the cell was determined to be from the ligature cutter that was used to cut the sheet that was around Inmate Singleton's neck.

Associate Medical Examiner Jennifer Park conducted an autopsy of Inmate Singleton on March 20, 2017. Dr. Park determined that Inmate Singleton's [REDACTED]. After conducting the autopsy and reviewing the circumstances surrounding the death, Dr. Park determined that the manner of death was suicide.



FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL
INVESTIGATIVE ASSIST SUMMARY REPORT



SA Miller provided a case summary for FDLE Case OR-37-055. The summary was reviewed and uploaded into the Inspector General's Investigative and Intelligence System (IGIS). SA Miller found that Inmate Singleton's death was a suicide [REDACTED]. The condition of the cell, the content of the video, and the findings of the medical examiner are consistent with the statements provided by the staff members and inmates interviewed during the FDLE investigation. It is recommended that this in-custody death investigation be termed exceptionally cleared.

No Department staff member conducted a cell front inspection of Cell E4-205 or the surrounding cells between 5:43am and 7:24am. This failure is a violation of Post Order 10, the post order governing housing sergeants and officers assigned to confinement units. Post Order 10 requires that cell front inspections be conducted at least every 30 minutes in all confinement units. The D Shift of the CFRC was on duty from 7:00pm on March 18 to 7:00am on March 19 and was responsible for the inspections that should have been conducted between 5:43am and 7:00am. Sergeant Johnson, Correctional Officer Luby Garcia (83183), and Correctional Officer Erick Green (85162) were the staff members assigned to E-Dormitory at the time of the missed inspections. The administration of the CFRC issued these officers written reprimands for this violation. No administrative investigation will be initiated because the subject officers have already been disciplined.

No other violations of Department procedure or Florida Administrative Code were identified during the review of the FDLE case summary.

VII. CHARGES

List alleged violations of Florida Law:

No violations of Florida law were alleged or identified during this investigation.

VIII. CONCLUSION

Based on the information gathered during their investigation, it is the recommendation of FDLE Special Agent Nicole Miller that the in-custody death of Inmate Carl Singleton be termed as follows:

1. Exceptionally Cleared.

Inspector Warren reviewed the investigation completed by the SA Miller of the FDLE. It was determined that Sergeant Johnson, Officer Garcia, and Officer Green failed to conduct required cell front inspections between 5:43am and 7:00am on March 19, 2017. An administrative investigation will not be initiated because the officers were already disciplined (see summary).