

Florida Department of Corrections



Office of the Inspector General

**CRIMINAL INVESTIGATION
INVESTIGATIVE ASSIST
Case # 18-09280**



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



Table of Contents

I. AUTHORITY	4
II. METHODOLOGY.....	4
III. ANALYSIS.....	4
IV. DEFINITIONS	5
V. PREDICATE	6
VI. SUMMARY OF INVESTIGATIVE FINDINGS.....	6
VII. CHARGES.....	7
VIII. CONCLUSION.....	7



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



Case Number: 18-09280

Inspector: Inspector Tracy Burge

Date Assigned or Initiated: May 24, 2018

Complaint Against: N/A

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

Deceased: Inmate Paul Thurwanger DC# K86223

Use of Force Number: N/A

PREA Number: N/A

Classification of Incident: Inmate Death

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 a preponderance of the evidence exists to suggest the suspect's alleged behavior or action did not occur.

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 May 24, 2018, the Department of Corrections, Office of Inspector General (OIG) received notification Inmate Paul Thurwanger DC# K86223, had been pronounced deceased at Northwest Florida Reception Center Main Unit from an apparent suicide inside his confinement cell. Florida Department of Law Enforcement (FDLE) notification was made and Inspector Tracy Burge responded to North West Florida Reception Center medical department and provided assistance to FDLE Brian Livesay and Dyana Chase (PE-37-0139). The OIG assigned an investigative assist to Inspector Burge on May 25, 2018.

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:

Inspector Burge was notified Inmate Thurwanger had been found [REDACTED] inside his cell from an apparent suicide. FDLE was notified and Inspector Burge facilitated the needs for FDLE Agents Brian Livesay and Dyana Chase by providing control room logs, fixed wing video, and housing logs. Inspector Burge also made arrangements for staff interviews [REDACTED] and security staff.

Inspector Burge took photographs of Inmate Thurwanger and of Inmate Thurwanger's cell (G4-113). Inspector Burge also reviewed the fixed wing video for Dormitory [REDACTED]. Inmate Thurwanger [REDACTED] during a suicide attempt. No foul play was noted as Inmate Thurwanger was housed alone in a confined cell and it initially appeared Security staff conducted security checks in a timely and consistent manner. It was noted [REDACTED] responded in a timely manner. Upon entering Inmate Thurwanger's cell for photographs an inmate request was discovered lying on the bed, which indicated Inmate Thurwanger wanted to remain in confinement due to various threats and a possible "hit," which had been placed on his person. The inmate request was provided to FDLE Special Agent Chase.

Medical Examiner Investigator Andrew Winkler took photographs of Inmate Thurwanger and Inmate Thurwanger's cell then took possession of Inmate Thurwanger's body. Inspector Burge provided [REDACTED] to Investigator Winkler.

The Investigative Report provided by FDLE Special Agent Chase reflected Inmate Thurwanger's cause of death was du [REDACTED] [REDACTED]. FDLE Special Agent Chase noted the Medical Examiner's findings were consistent with FDLE's investigation. FDLE Special Agent Chase recommended her case to be closed without further action and FDLE would not be maintaining any evidence associated with this case.

The autopsy report [REDACTED] for Inmate Thurwanger reflected Dr. Jay M. Radtke concluded Inmate Thurwanger's cause of death [REDACTED] and the manner of death was suicide.

The [REDACTED]
[REDACTED]



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



Investigator's Note: *At the conclusion of the FDLE investigation, Inspector Burge reviewed the fixed wing video from █-dormitory and noted Inmate Thurwanger placed paper over his cell window at approximately 12:40 a.m. Further review noted a fire alarm check was completed at approximately 1:13 a.m.; however, Sergeant Jacob Grantham did not complete a security check, which reflected approximately fifty-five (55) minutes had elapsed since staff last entered the wing. At approximately █ Officer Nicholas Phippen conducted a partial security check, but did not look inside each cell nor address the paper on Inmate Thurwanger's cell window; which reflected approximately one (1) hour and twenty-nine (29) minutes had elapsed since contact was last made with Inmate Thurwanger. At approximately 2:31 a.m., Officer Keshawn Jackson entered the wing and discovered Inmate Thurwanger hanging in his cell; which reflected approximately two (2) hours and thirteen (13) minutes had elapsed since contact was made last with Inmate Thurwanger. A chain of custody was initiated for a copy of the original CD/DVD disc containing the fixed wing video files, and it was secured in evidence.*

Based on the G-dormitory video evidence, Inspector Burge concluded that G-dormitory Housing Sergeant Grantham and Y-dormitory Housing Officer Phippen were in violation of the following:

- Florida Administrative Code (F.A.C.) 33-602.222, Disciplinary Confinement, which states in part, "the following staff members shall be required to officially inspect and tour the disciplinary confinement unit. These visits shall be conducted a minimum of every 30 minutes by a correctional officer, but on an irregular schedule."
- Post Order# 10 (Housing Sergeant/Officer Confinement) which states in part, "the confinement sergeant and officer will conduct frequent security checks/cell front inspections, at least every 30 minutes but on an irregular schedule/varied route."

The administrative issues identified in this investigation will be addressed by Inspector Knight in IG Case #18-15249

VII. CHARGES

There were no charges. Doctor Radtke ruled Inmate Thurwanger's death was a result of suicide.

VIII. CONCLUSION

- **Exceptionally Cleared**