Florida Department of Corrections

Office of the Inspector General

CRIMINAL INVESTIGATION

Case # 16-14837

CASE SUMMARY REPORT

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FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL

CASE SUMMARY REPORT

Case Number: 16-14837

Inspector: Inspector William Miller

Date Assigned or Initiated: 08/04/16

Complaint Against: N/A

Location of Incident – Institution/Facility/Office: Reception and Medical Center- Jacksonville Memorial Hospital

Complainant: Lieutenant Christopher Cobb

Use of Force Number: N/A

PREA Number: N/A

Classification of Incident: [redacted] Natural Death

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 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.

V. PREDICATE

On 07/30/16, Lieutenant Christopher Cobb at the Reception and Medical Center-Jacksonville Memorial Hospital (RMC-JMH) was informed [redacted] that Inmate Brian Challis DC#115118 housed in N3107 North Tower, was pronounced deceased. The primary cause of death [redacted] " This information was reported via the Management Information Notification System (MINS) #716605 on 08/03/16, and assigned to Inspector William Miller as a Criminal Case #16-14837 on 08/04/16.

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 July 30, 2016, at approximately 11:35am, while assigned as the on-call Inspector for District 5, I was contacted by On-Call Inspector Supervisor Yolanda Brown and advised of an Inmate Natural Death [redacted] FDLE was not initially notified because the death was reported as a "Natural/Attended Death".

At approximately 2:20pm, I arrived [redacted] and met with Lieutenant Christopher Cobb. *It should be noted that the delay in responding was due to an inmate death* [redacted] *that occurred approximately 10 minutes earlier.* Lieutenant Cobb informed me that Inmate Challis was housed in N3107 North Tower and had been pronounced deceased [redacted]. Upon arriving at N3107, Officer Brandon Brewer was providing security of Inmate Challis' body and a crime scene log had been initiated. I visually inspected and photographed the entire body of Inmate Challis and no signs of foul play noted. [redacted] observed on the body of Inmate Challis, however there [redacted] was attached to Inmate Challis' [redacted].

I was provided a copy [redacted]. At approximately 2:52pm, I released the body of Inmate Challis and the crime scene to Lieutenant Cobb. Inmate Challis was transferred [redacted] from Lake Correctional Institution on July 16, 2016. Inmate Challis had been housed [redacted] since July 16, 2016 and [redacted]

A review of the notification of death for Inmate Challis revealed that the cause of death pending autopsy was listed [redacted] " Inmate Challis was pronounced deceased [redacted] at 10:46am. Inmate Challis was serving a 40-year sentence for shoot/throw missile building/vehicle. Inmate Challis initial receipt date was December 10, 1998, and his current release date was May 8, 2041.

A review of the Corrections Data Center (CDC) revealed since 2001 Inmate Challis attempted suicide approximately (35) times, [redacted] (17) times, and was ordered [redacted] approximately (45) times.

On January 6, 2017, the final autopsy report for Inmate Challis was received from the Jacksonville Medical Examiner's Office. Associate Medical Examiner Peter Gillespie listed the cause of death as

[redacted] and listed the manner of death as Suicide.

Upon the manner of death being listed as a suicide, The Florida Department of Law Enforcement was contacted. FDLE was provided the facts of the death. After being given the facts of the death, FDLE advised they would not open an investigation in regards to the suicide as it occurred in July of 2016. The investigation was deferred back to the Office of the Inspector General to document the change from “Natural/Attended” to “Suicide”.

VII. CHARGES

N/A

VIII. CONCLUSION

Based on the information gathered during this investigation and the Medical Examiner’s Office findings, it is the recommendation of Inspector William Miller that this investigation be termed as follows:

1. Exceptionally Cleared.

No administrative violations were noted on the part of staff.