Florida Department of Corrections

Office of the Inspector General

CRIMINAL INVESTIGATION

Case # 17-06960

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 8
VIII. CONCLUSION 8

FLORIDA DEPARTMENT OF CORRECTIONS
OFFICE OF THE INSPECTOR GENERAL

CASE SUMMARY REPORT

Case Number: 17-06960

Inspector: Inspector Randall Merritt

Date Assigned or Initiated: 04-25-2017

Complaint Against: N/A

Location of Incident – Institution/Facility/Office: 207 Reception and Medical Center

Complainant: Inmate James Couch DC# C00461

Use of Force Number: N/A

PREA Number: N/A

Classification of Incident: ███ Accidental 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 April 22 2017, Correctional Officer Joshua Lynn submitted an Incident Report that indicated Inmate James Couch DC# C00461 was pronounced deceased by [REDACTED] at 4:25 PM. Inmate Couch was housed at the [REDACTED]. The cause of death was noted as [REDACTED]. The manner of death was Natural. This incident was reported in Management Information Notation System (MINS) 0000772666. This Death Investigation 17-06960 was assigned to Inspector Randall Merritt on April 25, 2017.

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 22, 2017, at approximately 5:00 PM, District 5 On-Call Inspector Randall Merritt with the Office of Inspector General was contacted by On-Call Supervisor Katouree Jackson who requested a response to the [REDACTED] The response was in reference to the reported [REDACTED] natural death of Inmate James Couch.

Upon arrival at [REDACTED] Inspector Merritt proceeded to [REDACTED] where Inmate Couch's body was observed. A visual identification and inspection was completed on the body and photographs were taken. According to records, Inmate Couch arrived at [REDACTED] on April 21, 2017. He was under the [REDACTED]. Inmate Couch was pronounced deceased by [REDACTED] [REDACTED] at 4:25 PM, on April 22, 2017.

Pending final autopsy results, the cause of death was noted as [REDACTED] [REDACTED] The manner of death was listed as Natural. No evidence of foul play was observed. Note: a [REDACTED] was noted in records. [REDACTED] was secured by Officer Ashley Matthews. This Incident did not meet the criteria for Florida Department of Law Enforcement (FDLE) notification per Memorandum of Understanding (MOU).

On April 22, 2017, Inspector Merritt took photos of the body and scene. On May 2, 2017, the photos were attached in IGIIS.

On August 10, 2017, Inspector Randall Merritt submitted an electronic request to the Duval County Medical Examiner's Office in Jacksonville. The request was for the autopsy results for deceased Inmate James Couch DC# C00461.

On August 10, 2017, Inspector Merritt received the Findings from the Medical Examiner's (ME) Office in Jacksonville, on Inmate James Couch DC# C00461. Associate Medical Examiner Peter Gillespie listed the manner of death for Inmate McRae as Accidental. The cause of death was listed as [REDACTED] [REDACTED] [REDACTED] Contributory causes were [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] [REDACTED] No evidence of foul play was noted.

Note: Inspector Merritt contacted the ME office in regards to the findings. They advised that the ██████████ were requested but never received from the Reception and Medical Center █████ records section. Therefore, they were unable to establish when the ████████████ occurred. That was the reason for the manner of death being listed as an accident.

On August 16, 2017, Inspector Merritt contacted the Florida Department of Law Enforcement (FDLE) at the request of OIG District 5 Supervisor David Allen. Contact was made with FDLE Special Agent Supervisor (SAS) Matt Walsh. The contact was in regards to the Medical Examiner's (ME) findings on the death of Inmate Couch.

SAS Walsh indicated that the DOC / OIG could handle the ██████████ review of the incident. He also advised that FDLE would not provide a response. Inspector Merritt followed the phone contact with an email to SAS Walsh.

Note: the Department of Corrections and Florida Department of Law Enforcement have a Memorandum of Understanding which requires contact when an incident occurs that results in an unattended or accidental death of an inmate.

On August 16, 2017, Inspector Merritt contacted the Department of Corrections / Inactive Records section to request a review of Inmate Couch's ██████████ On the same date, Inactive Records Section forwarded my request to the Mortality Coordinator at the Reception and Medical Center (RMC).

On August 29, 2017, after no response, Inspector Merritt contacted the Mortality Coordinator's Office for a status on the original request. On the same date, Inspector Merritt received the ██████████ of Inmate Couch by email.

The records revealed that Inmate Couch was ██████████ at Gulf CI and transferred to █████ ████████████████████████████████ on March 24, 2017. The ███████████████ on March 25, 2017. The original incident was reported on August 24, 2017 in Incident Report 17-109-537 that indicated Inmate Couch ████████████████████ after a self-inflicted fall. He was ultimately transported to ████████████████████████████ were the ██████ was completed.

Note: Inspector Merritt previously contacted the Medical Examiner's Office (Duval County) in regards to the findings. They advised that the ██████████ were requested but never received from the Reception and Medical Center █████ records section. Therefore, they were unable to establish when the ████████████ occurred. That was the reason for the manner of death being listed as an accident. On August 30, 2017, follow up contact was made with the MEO. They advised that the records review would not change the manner of death therefore they did not need a copy of the ██████████.

Based on the investigation, the Medical Examiner's (ME) findings ruled the manner of death as accidental due to the descendant's [REDACTED] At the time of the findings the ME did not have access to the historical [REDACTED] The investigation revealed that Inmate Couch [REDACTED] following a self-inflicted fall. He was transferred to an [REDACTED] for a [REDACTED] The incident and [REDACTED] took place approximately one month before his death. The cause of death was [REDACTED] Contributory causes were [REDACTED] No suspected foul play was noted. Inmate Couch accidentally fell while under his own control.

VII. CHARGES

List alleged violations of Florida Law:

N/A

VIII. CONCLUSION

Based on the findings of this Investigation and the Medical Examiner, it is the recommendation of Inspector Randall Merritt for this Accidental Death case to be termed as follows:

"Exceptionally Cleared"