Volusia County
FLORIDA

Inter-Office Memorandum

To: **Cynthia Clifford**
Corrections Director

From: **Mark A. Pronovost**
Warden, VCCF

Date: **January 22, 2007**

Re: **After Incident Review Inmate Jack Nelson # 662384**

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1. Chronology of Events:

Inmate Nelson was booked into the Volusia County Branch Jail on December 18, 2006 at 1416 hours on a charge of panhandling with a bond of $100.00. He was processed in the intake area without incident. He was seen by medical staff and a Receiving Screening – Physical was performed indicating he was cleared for open population with a low bunk restriction. Inmate Nelson was moved to Unit One at 2055 hours on this date and housed in 1-C-01.

On December 19, 2006 he was found unresponsive in his assigned cell during the 0800 hours headcount. Staff responded to the cell when other inmates advised the inmate appeared dead. A code white was called and security and medical staff responded. Due to the degree of cyanosis, medical staff determined that life saving measures would be ineffective. They contacted Dr. Rozenblum, who reported to the scene. He pronounced inmate Nelson dead at approximately 0833 hours.

The Volusia County Sheriffs Department was contacted and they conducted an investigation into the death. Staff from the Medical Examiners office arrived and removed the body when the scene investigation was complete.

The Medical Examiner's staff advised that inmate Nelson's death appeared to be from natural causes pending the toxicology report.

2. Procedural & Policy Issues
a.) Remedial Action

In reviewing the attached documentation of this incident I find the following Division Policy and Florida Model Jail Standards (FMJS) violations:

1.) Policy & Procedure 400.18 A 4 (a)
All inmates shall be visually seen every hour from 2300-0500 hours unless involved in an outside work assignment that precludes a personal check. Checks shall be entered in the unit log.

2.) FMJS (11.06) reads in part
All inmates will be visually checked every hour between 11:00 pm and 6:00 am unless involved in an outside program that precludes a personal check. Checks will be entered in the daily log.

3.) The policy and standard were violated by the staff as noted below. Corrective action is recommended, consistent with the seriousness of the conduct lapse and the officer's prior conduct record.

Officer R. Brown at 0200 hours when the round was not conducted

Officer C Coffin at 0001, 0200, 0400 and 0500 hours when the rounds were not conducted.

Officer M. Zemba at the 0001, 0200, 0400 and 0500 hours when the rounds were not conducted.

4.) Although these violations occurred, there is no indication at this time that the policy violations contributed to the Inmate's death, although they may have prevented an earlier discovery.

b. Commendatory Action

1.) The oncoming staff (Charlie Shift) Officers T. Anderson and T. Wininger assumed duties at 0800 hours and began to conduct the 0800 hours headcount. Officer Anderson while counting C-block noticed that Inmate Nelson was not standing at his door. She asked inmates in the block to check in the cell. The inmates reported to her that Inmate Nelson appeared to be dead. Officer Anderson advised Officer Wininger of this and he immediately entered the block to investigate. Officer Wininger entered the cell and checked Inmate Nelson for responsiveness. The results were negative and Officer Wininger checked for a pulse and none was found. He promptly called a Code White and Security and Medical Staff responded. The action taken by these Officers was timely and adheres to Division Policy for this type incident (Code White).

Captain Prince is The Shift Commander for Charlie Shift and was on duty during this incident. He responded to the scene and assumed command of the incident. He ensured policy was followed in reference to an in custody death. He ensured the scene remained secured until the VCSO and the Medical Examiners investigation was complete.

2.) Recommendation for Letters of Recognition

I recommend letters of Recognition for Captain Prince, Officer Anderson and Officer Wininger for their prompt action during this incident. They followed Division policy and conducted themselves professionally.

If you need further information or have any questions about this after incident review, please contact me. Thank you.

C: AD Ford