IN THE CIRCUIT COURT OF THE TWENTIETH JUDICIAL CIRCUIT OF FLORIDA IN AND FOR CHARLOTTE COUNTY, FLORIDA

PRESENTMENT OF THE CHARLOTTE COUNTY GRAND JURY

CONVENED MAY 27, 2015

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REGARDING THE DEATH OF MATTHEW WALKER WHILE IN THE CUSTODY OF THE FLORIDA DEPARTMENT OF CORRECTIONS, CHARLOTTE CORRECTIONAL INSTITUTION

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Legal Advisors to the Grand Jury on behalf of STEPHEN B. RUSSELL, State Attorney, Twentieth Judicial Circuit of Florida in and for Charlotte County:

AMIRA D. FOX
Chief Assistant State Attorney

RICHARD J. MONTECALVO
Assistant State Attorney

SHANNON L. DOOLITY
Assistant State Attorney

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IN THE NAME AND BY THE AUTHORITY OF THE STATE OF FLORIDA

I. GRAND JURY SUMMARY

Matthew Walker, a black male, D.O.B. 8/8/1966, 6'1" height, 250 lbs. weight, D.C. #181642 was an inmate incarcerated at the Charlotte Correctional Institution (CCI), located at 33123 Oil Well Road, Punta Gorda, Charlotte County, Florida. CCI is a prison under the jurisdiction of the Florida Department of Corrections (DOC). The DOC is a statewide agency responsible for the care, custody and safekeeping of those convicted of crimes and sentenced to prison by the Circuit Courts throughout the State of Florida. On April 11, 2014, Mr. Walker died at CCI while in the custody of the DOC. This Grand Jury was asked to investigate the death of Mr. Walker.

At the conclusion of the presentation of evidence, the Grand Jury returned a NO TRUE BILL and voted to make this Presentment.

II. ROLE OF THE GRAND JURY

The Grand Jury system in Florida is governed by Florida Statutes §905 *et. seq.*
A Grand Jury may investigate, report and accuse persons for offenses against the criminal laws.

> [Florida Grand Juries] . . . have a lawful function to investigate possible unlawful actions for all persons, private citizens and public officials alike and to return indictments when warranted, and also have a lawful and proper function to consider actions of public bodies

> and officials in use of public funds and report or present findings and recommendations as to practices, procedures, incompetency, inefficiency, mistakes and misconduct involving public officers and public monies.
>
> *Kelly v. Sturgis,* 453 So.2d 1179 (Fla. 5th DCA 1984)

The purpose of this Grand Jury was to carefully examine the facts and circumstances leading to the death of Matthew Walker on April 11, 2014 while housed at Charlotte Correctional Institution in the care and custody of the Florida Department of Corrections. This Grand Jury convened on May 27, 2015, met for eight (8) days, received testimony and considered evidence from 19 witnesses. This Grand Jury conducted an examination of the policies and procedures of the Florida Department of Corrections and in particular, Charlotte Correctional Institution, and evaluated the conduct of the corrections officers involved on the night of the incident. This Grand Jury has developed recommendations for the DOC regarding its policies and procedures and what we consider to be the numerous and disturbing deficiencies in the behavior of DOC staff leading up to and following Walker's death.

III. DISCUSSION

This Grand Jury evaluated the conduct of the corrections officers involved for potential criminal law violations. Certain corrections officers, including Captain David Thomas, were served with subpoenas to testify and did testify before this Grand Jury. Corrections Sgt. Daniel Lynch, Acting Sgt. Mestely Saintervil, Acting Sgt. Edward Sinor, Lt. Tyler Triplett, and Officer Thomas Weidner were suspected of possible criminal wrongdoing, were not served with subpoenas, and did not testify.

Following the death of Walker, an autopsy on his body was conducted by the Charlotte County Medical Examiner's Office. The cause of death was asphyxia, secondary to laryngeal trauma, secondary to blunt trauma of the head, neck and torso. This Grand Jury took testimony from numerous witnesses, including corrections officers, inmates, the Medical Examiner, an investigator and laboratory analyst from the Florida Department of Law Enforcement (FDLE), and a DOC inspector. Unfortunately, and to the frustration of this Grand Jury, there was a great deal of conflicting testimony regarding who and what was responsible for the injuries suffered by Walker. In addition to the conflicting testimony, there were numerous other issues that prevented this Grand Jury from being able to bring criminal charges against any corrections officers. Such impediments included the poor handling of the crime scene, the evidence, and the initial responses and reactions to the incident by the DOC. These issues will be discussed in further detail later in this Presentment.

A. The Location of the Use of Force Incident

Charlotte Correctional Institution (CCI) is a prison facility under the control of the Florida Department of Corrections. It is located in DOC Region Three and maintains one (1) open bay and six (6) cell housing units. CCI maintains a medical dormitory and a psychiatric dormitory inside of the compound fence. CCI houses inmates of varying custody grades. Prior to 2012, CCI housed only Close Management grade inmates, those who must be maintained within an armed perimeter or under direct, armed supervision when outside of a secure perimeter. The population gender is male only.

E "Echo" Dormitory is located on the west side of the oval-shaped compound. Approach is made from two sidewalks which meet directly in front of the dorm. The sidewalks are separated by a barbed wire fence. The sidewalk which approaches from the northern end of the compound, and at an angle, requires access through a gate immediately in front of E Dorm while the sidewalk approaching from the southern end of the compound, and which approaches straight-on, has no gate access.

E Dorm is "butterfly" shaped and is divided inside by four (4) quads. Quads 1 and 2 are on the left side of the dorm. Quad 1 is to the front and quad 2 to the rear. Continuing clockwise, quad 3 is located to the rear on the right side and quad 4 to the front on the right side. Essentially, quads 1 and 2 are mirror images of quads 3 and 4. In the center of the quads, a circular shaped sally port area provides access into each quad by separate doors. In the center of the sally port is a raised glass-enclosed Control Room or "bubble" which allows corrections officers to look into the sally port and all four quads. The Control Room serves as master control of all locked doors to the outside of the dormitory, for egress/ingress into each quad, and to open all cell doors within the quads. The sally port connects behind the Control Room but access for each side is controlled by a locked door. The sally port does not connect in the front. There are three doors providing access into the dorm from the outside area at the junction of the sidewalks. A door on the left side of the entrance provides access to the sally port on the quad 1-2 side, a door on the right side provides access to the sally port on the quad 3-4 side, and a center door provides direct access into the Control Room.

Inside quad 4 are two levels of cells numbered 1 to 14, clockwise. Quad 4 is roughly in a triangular shape; the cells are contained on the wall directly opposite the entrance (the back wall) and also on the wall to the right. Bottom tier cells are numbered 101 to 114 and second tier cells are numbered 201 to 214. Cells are identified by their dorm letter (E), followed by the quad number (4), then tier (1 or 2), and then cell number. There are two (2) sets of stairs in each quad. The set closest to the door separating the quad from the sally port rises and connects to the second tier outside of cells E4-212 and E4-213 on the right wall. The other set of stairs rises and connects to the second tier outside of cells E4-201 and E4-202 on the back wall.

The ground tier has open floor space and contains a number of tables for the inmates. There are vacant offices and pay phones along the left wall. The second tier is ringed by a catwalk and connects to the two sets of stairs previously described. There is a railing around the catwalk consisting of three rails parallel to the ground and separated by approximately 18 inches intersected by vertical posts which are affixed to the catwalk flooring. The space between all bars and posts is open. A television is affixed to the catwalk flooring at the triangular junction of the upper tier so that inmates can watch from the ground tier.

The cell doors are opened electronically from the Control Room. They slide along tracks and open to the right or left depending on their location relative to each other. Each door contains a handle which is used to manually pull the door shut. They have windows vertically oriented. There is an open space of approximately 6 inches at the bottom of each door. As each door is on a track, it is possible to see through the very narrow opening created by the track between the door and the wall when the door is shut.

Cells contain two bunks affixed to the wall. Underneath the bottom bunk are two enclosed lockers, side by side, for each inmate. Across from the bunks are two small tables affixed to the wall. There is a toilet just inside the cell door. Each cell has a window on the back wall. The windows have slats similar to a jalousie window but are covered on the inside by plates with holes to allow for air flow.

B. The Use of Force Against Matthew Walker

On April 10, 2014, Walker was housed in cell E4-210. At approximately 10:00 p.m. the corrections officers assigned to E Dorm conducted Master Roster Count, a nightly count while the inmates are locked down. This was completed without incident. "Lights out" in the dorm was at 11:00 p.m. All inmates are supposed to be locked down in their cell although "housemen" may be allowed to remain out of their cell in order to clean and tidy the quad. At some point during the evening of April 10, at least some of the inmates were made aware by a corrections officer that a "spot" inspection of E Dorm was going to be made. This inspection was called different things but what the evidence clearly indicated was that its intention was to ensure that each cell was clean and that personal items were properly put away. Nobody knew at what time this "spot" cell compliance check would be held but the evidence is clear that it occurred after Master Roster Count.

Earlier in the evening, a number of sergeants were ordered to a meeting wherein they were told that cell compliance checks would take place at chosen dormitories on the compound. The inspections would be supervised by Triplett. The inspections were the idea of Thomas, who testified that this was the third or fourth time the checks were being implemented. Thomas was the highest ranking officer on the compound when Walker died on April 11.

A team of six (6) officers, led by Triplett, arrived to E Dorm after "lights out" and around midnight on April 11. There was conflicting evidence presented from among the inmates regarding how many entered the quad, and when. Many of the inmates did not recognize some of the corrections officers nor did they know all of their names. Thomas was not part of the cell compliance team.

Female Corrections Officer #1 (FCO1) came to cell E4-210 where she encountered Walker. She commanded that a cup and a magazine be put away. Neither Walker nor his roommate responded so she ordered the door open from the Control Room. She again commanded the items be put away. She testified that Walker told her "I am not doing shit." She then called down to Triplett to tell him that she had one to lock up for disobeying a verbal order and disrespect. Walker's roommate testified that she was aggressive and cursing and that Walker responded simply that "[T]his is crazy. You are waking me up about a cup. . ." and that this was not "chapter 33" (a reference to Florida Administrative Code Title 33 governing the rules and policies of the Florida Department of Corrections).

Triplett responded to E4-210 with other officers. Testimony conflicted as to who and how many accompanied Triplett. Walker's roommate testified that Triplett ordered Walker up and dressed in order to go to confinement. The roommate was ordered out of the cell and retreated to the first tier before he was later ordered out of the quad and into the sally port. He could still see into E4-210 and could hear commands full of expletives and also see "hands flying everywhere" and punches but had no idea who was hitting whom.

FCO1 saw Triplett and Sinor attempt to place Walker in handcuffs and he refused by bracing and tensing. Saintervil was in the threshold of the cell door with FCO1. Triplett then broke the seal on his department issued OC spray (Oleoresin Capsicum – a chemical compound used in policing) and sprayed it towards Walker in order to gain compliance. As Sinor continued to try to gain control of Walker's arm and as Saintervil now entered the cell, FCO1 testified that she saw Walker knock Triplett against the bunks then saw "everyone" coming out of the cell. Evidence conflicted regarding whether Walker came out of the cell face forward or backwards. Walker's roommate believed the first to lay hands on Walker was Triplett as he was distinguished from the other officers by his white shirt. The others wore brown shirts. He saw Walker "force" his way out of the room hysterical. Walker grabbed onto the railing and continued to ask why he was being hit. Walker's roommate heard no compliance commands from the officers, just expletives.

As the incident spilled out onto the catwalk, FCO1 called for assistance over the radio. Meanwhile, the remaining two officers from the team of six, Female Corrections Officer #2 (FCO2), and a male officer, ran upstairs. They became involved in the melee on the catwalk and were both injured. FCO2 was apparently knocked unconscious for a brief period and the male officer suffered a laceration of his left arm. The circumstances regarding their injuries were the subject of conflicting testimony.

The melee continued on the catwalk, moving away from E4-210 and towards the triangular junction of the upper tier near cells E4-207, 208 and 209. Officer testimony indicated that Walker continued to struggle and refuse physical compliance commands despite being on the ground. At some point, a handcuff was placed on his right wrist and corrections officers testified that Walker refused to give up his left hand. Almost universally, the corrections officers testified to this Grand Jury that Walker was not struck with hands, fists, kicks or by radios. One officer indicated he saw an unknown "white hand" conduct a "hammer strike" (a downward motion with a closed fist) on Walker.

Evidence from the inmates presented a conflicting scenario. What they saw and heard was dependent upon which cell they were housed, whether they went "on the door" and could see through their window or through the narrow space between the cell door and the wall. Inmates watching the incident while huddled against their cell doors were ordered to "get off" the doors by the corrections officers. Some could see inside cell E4-210. Their testimony about what they saw was inconsistent. Some could hear inside the cell and what they heard was conflicting. Some could see the melee as it spilled out onto the catwalk towards E4-207, 208 and 209. Many stated that the officers punched, struck and kicked Walker around the head and torso area. Some indicated that radios were used to administer multiple blows to the head and torso. Testimony was conflicting regarding when certain officers arrived in the quad, which officers were delivering blows to Walker, how many, and where each officer was located while those blows were delivered. Inmates named Triplett, Sinor, Saintervil, Lynch, and Weidner as delivering blows. There was a conflict as to whether Walker was conscious while these blows were struck. There was a conflict in evidence as to what was being said to Walker, whether racial epithets were used, or whether threats of bodily harm to Walker were made.

What is clear is that at some point, near E4-207, 208, 209, Walker was subdued. Having heard the call for help over the radio, Thomas arrived at E Dorm, quad 4. Thomas testified he did not see any officer kick, punch, slap or use radios or flashlights to strike Walker. He ordered FCO2 and the male officer out of the quad because of their injuries and ordered Triplett out because he appeared to be feeling the ill effects of the OC spray. Walker was not cuffed and Thomas ordered the officers to pull up his left side in order to free his left hand. This was done and Walker was cuffed. Walker was lying face down. Blood was evident on the ground near Walker. Thomas saw that a radio was on the floor inside one of the nearby cells and ordered the inmate to kick it out through the approximately 6" opening on the bottom of the cell door. Thomas recovered the radio and gave it back to an officer. He had no recollection of whose radio it was nor did he consider that it might have evidentiary value.

Thomas ordered Walker to stand and he did not. Thomas believed Walker to be "sandbagging" or "dead-weighting", a game inmates play when they don't wish to comply with commands to walk. Thomas believed this to be the case because Walker blinked his eyes at him. Thomas ordered the officers

to do a 4-point carry. This type of carry required an officer on each arm and an officer on each leg. Walker was carried, face down, his hands cuffed behind his back, down the stairs closest to E4-214. Evidence was in conflict as to whether he was 4-point carried down the stairs or whether Walker was being held in an upright position by two officers, with his feet dragging down the stairs. Evidence was also in conflict as to whether Walker was clothed as he was carried down the stairs. He was placed face down on the floor while the door to quad 4 was opened by the Control Room. Walker was again ordered up to walk and he did not. Thomas believed that Walker was, once more, refusing to comply because Walker blinked his eyes at Thomas. There was no verbal response. Thomas did not believe Walker to be in any medical distress and said to Walker: "Whatever game you're playing, you need to get up and walk; my staff is too tired to deal with this." Thomas again ordered the 4-point carry. Numerous witnesses stated they thought Walker was dead at this point. At no time, according to Thomas, did he think this incident was anything beyond a normal use of force and he believed that Walker died due to a heart attack.

Walker was carried outside of E Dorm and placed down in front where the two sidewalks meet. Triplett, who had been ordered out of the dorm by Thomas earlier, returned to this area and started yelling at Walker while he was lying face down on the sidewalk. While evidence differed as to what exactly was said, it was consistent that a voice identified as Triplett was yelling loudly and angrily at Walker. Some testified that he was quoted as saying "Do you know who I am? I will kill you motherfucker!" Inmates testified that there was an incident outside of E Dorm as they could hear the exchange through their windows, especially those along the right wall of quad 4 which ran immediately adjacent to the sidewalk leading to the northern side of the compound. Thomas became so concerned with Triplett's behavior that he had to forcibly restrain Triplett from getting any closer to Walker and ordered him away through the gate and onto the sidewalk that continued towards the northern side of the compound. Thomas also called for a handheld camera to come to the scene.

Walker was picked up and carried down the sidewalk along the southern side of the compound ostensibly to be taken to the Medical Dorm which was half way across and on the north side of the compound. At some point during this carry, Thomas checked on Walker and found that his pupils were not responding. He then called for medical to meet the carry team. The carry team was met on the sidewalk near the Captain's Office by a nurse. At the same time, the handheld camera, ordered by Thomas, arrived. Instead of turning the camera on to record the medical efforts to assist Walker, Thomas decided to forego the camera and begin paperwork documentation of the incident.

Testimony indicated that the nurse checked on Walker, ordered the cuffs off and that he be placed on his back. Medical intervention began at this time. CPR and chest compressions were administered. The nurse and other officers present took turns applying these life-saving techniques. FCO1 indicated

that one of the officers providing medical assistance told her that Walker's head "felt like jello" and that "they must have kicked his ass."

EMS arrived at 12:57 a.m. and immediately assessed and took over the first aid of Walker. Medical assistance ended when a "field termination" was called by a doctor at Bayfront Health, Punta Gorda Hospital. Walker was pronounced dead at 1:20 a.m. The actual time of Walker's death remains unknown.

C. Activity in the Immediate Aftermath of the Use of Force on Matthew Walker

According to Thomas, despite the death of Walker, he had a compound to run. He contacted the warden and ordered the involved officers into his office and asked them "what the hell happened?" Instead of separating the officers involved in the use of force, Thomas utilized Weidner and Lynch to retrieve Walker's roommate, who, throughout the incident after being ordered to leave the cell, remained either in the quad or in the sally port. The roommate was walked from E Dorm to the Medical Dorm then placed in confinement. This routine and uneventful walk was captured by a handheld video.

Evidence presented from an inmate indicated that Weidner went back to quad 4 upper tier, and recovered his radio – which had somehow come off of his belt and ended up in cell E4-206. The same inmate, who was housed in E4-207, stated that there was a pool of blood the size of a "medium pizza", mucus and phlegm in the area of E4-206, 207. Therefore, according to the evidence presented, two (2) radios that may have been used as weapons were returned to corrections officers involved in the use of force.

Weidner and Lynch were not separated after the incident as evinced by their accompanying Walker's roommate to medical and confinement. Later in the morning, all of the corrections officers involved in the use of force, including injured FCO2 and the male officer with the laceration, both of whom had been transported to the hospital then returned to the compound, were shepherded into the Visitor Park (VP), on the compound, and wrote incident statements. These witnesses were not separated. There was testimony that Triplett admitted that he e-mailed his report to Sinor.

A corrections officer was ordered to E Dorm, quad 4, upper tier to begin a crime scene log. The FDLE arrived around 5:00 a.m. to begin their investigation. Statements were received from the corrections officers throughout April 11, 2014. Second statements from the corrections officers were received beginning 7 to 10 days afterward and continuing until completed.

There was evidence presented from the corrections officers that a group of them met together, after being placed on administrative leave and being told not to discuss the incident, at a convenience store on Tamiami Trail South (US 41) near to the prison a few days after the incident. Most of the corrections officers indicated that the purpose of the meeting was not to speak of the incident but to see how each person was doing, to make sure each person "stay positive" and "stay strong" and whether they

needed legal representation. One corrections officer testified that he was sure the group talked about the incident. The other corrections officers denied speaking of the incident.

IV. FINDINGS & RECOMMENDATIONS

The following areas of deficiencies in DOC policies and procedures, DOC staff behavior, and the DOC's handling of the investigation of Walker's death were found.

A. Cell Compliance Checks After "Lights Out"

Testimony was received from corrections officers and inmates that several weeks prior to this incident a new procedure for cell compliance checks had been implemented. There was varying testimony as to who put this procedure into place. Some correctional officers thought it was put into place by the colonel and the assistant warden. Thomas testified that he was solely responsible for this new procedure; that it was his idea and he instructed that it be done. The new cell compliance check procedure consisted of sergeants going from dorm to dorm and cell to cell after Master Roster Count and after lights out, turning on the lights awakening the inmates in each cell, and checking to see that nothing in the cell was out of place. If something was out of place the corrections officer would command that the inmate put it away. If immediate compliance was not obtained the corrections officer would have the cell door opened by the Control Booth, step in and demand compliance. This procedure precipitated the incident that is the subject of this Presentment. As previously stated, around midnight on April 11, 2014, FCO1 looked into cell E4-210 and demanded that Walker put away a cup and a magazine. When he did not comply she asked that the door be opened and she entered the cell, calling for the assistance of Triplett. The events previously described then ensued concluding with the death of Walker.

Despite a great deal of inconsistent testimony between that of the corrections officers and the inmates, the one thing agreed upon was that the cell compliance checks were a bad idea. The DOC inspector assigned to this case testified that it was not prudent to do these cell compliance checks. Corrections officers stated that it was not a good idea and asking for trouble to awaken a sleeping inmate after lights out for a cell inspection. FCO2 testified that she was absolutely against the compliance checks. "I had already squared away the dorm and felt it was an invasion of their sleep. Who wants to get woken up at 3 or 4 a.m. in the morning to be told a towel is out of place...there was talk amongst the sergeants that this was a ticking time bomb". One officer stated "waking people after lights out makes people agitated." Another officer stated "Anytime you wake people up in middle of the night they are going to be unhappy. You poke a tiger, what do you think is going to happen?"

Thomas, however, stated during his testimony "the compliance checks are a good plan and they are my plan. I am doing them where I am now." This is of great concern as it was felt consistently by

many witnesses and by the members of this Grand Jury that this procedure precipitated the death of Walker. There was no consistency among the corrections officers in enforcement of this procedure. Testimony was received that some corrections officers would not order compliance over something such as a cup or magazine being out of place and others would. One corrections officer would look into a cell and think it was not an issue while another would look in and order that items be put away. In this incident, a corrections officer did look into cell E4-210 and determined it was in compliance. Then FCO1 looked into the cell and ordered the cup and magazine cleaned up. Thomas was asked whether a compliance demand should be made over a cup being out of place and he stated it should not, but that he never articulated this to his staff.

The State of Florida Inmate Handbook for CCI contains the following provision under Housing:

> Housing officers will conduct grooming, housing and bunk inspections Monday thru Friday no later than 8:15 a.m. The housing officer will give an announcement and all inmates will have 5 minutes to prepare for inspections and stand properly dressed and groomed outside of their assigned cells or on the side of their assigned bunk.

There is no other language in the provided handbook regarding cell inspections. This seems inconsistent with the "lights out" cell compliance check procedure implemented by Thomas and may help to explain why inmates indicated they were upset and confused over the procedure.

It was clear from the testimony that cell inspections as explained in the Inmate Handbook were conducted every morning so it is unclear why they would be necessary in the middle of the night. An inmate's testimony indicated that he felt it was solely to harass and aggravate them and done because the corrections officers were bored in the middle of the night. We strongly recommend that these types of cell compliance checks after lights out be discontinued and disallowed.

B. The Medical Response to the Use of Force Incident

The evidence before the Grand Jury showed that there were at least 11 separate traumas to Walker's body according to the Medical Examiner (ME). At least two (2) of those traumas occurred in the neck area of Walker where his cricoid cartilage was broken and all three sides of his larynx was injured. The ME testified that the traumas Walker sustained to his larynx caused the tissue in that area to swell and in his opinion it was that swelling which resulted in Walker's asphyxiation.

The ME indicated that Walker would have died anywhere from two (2) to fifteen (15) minutes after the trauma. The evidence presented to this Grand Jury revealed that medical personnel at CCI were called for FCO2 and the male officer. Evidence revealed that FCO2 hit her head and was briefly unconscious and that other male officer had a laceration to his arm.

The video evidence showed that the medical personnel came from across CCI towards E Dorm along the sidewalk which traversed the northern side of the compound. They directed their attention to treating FCO2 and the male officer. While the medical personnel was escorting FCO2 and the male officer across CCI to the medical building the evidence presented showed that Walker was unresponsive the entire time and was carried from the area outside cell E4-206, 207, 208 down a catwalk to the staircase; down the staircase to the first floor where Walker was set down; from the bottom of the staircase to the sally port where Walker was set down; from the sally port to outside E dorm where he was set down; and from outside E dorm towards the Captain's Office along the sidewalk spanning the southern side of the compound. Walker was set down several times along the way.

The corrections officers carried Walker along the above described path which was only approximately two-thirds (⅔) of the way to the Medical Dorm before additional medical personnel arrived to assess Walker. Although a gurney was brought to the area of E Dorm, the evidence showed that the gurney was used to transport FCO2 across the compound rather than Walker. Testimony revealed that Triplett stated that Walker did not need a gurney and that, instead, he needed to walk himself to the medical dorm.

Three problems have been identified. First, medical response to inmate injuries has been a problem at CCI according to the evidence. One officer indicated that it can take up to 20 minutes to respond to a medical call for an inmate because charts must first be pulled. Thomas stated that it should only take a few minutes to respond to an inmate injury/illness but at times that period takes longer because "something else" may be going on. Thomas said "It's been a past issue, to be honest with you." CCI has a maximum capacity of 1,291 inmates of all custody grade classifications spread out over seven (7) housing units. E Dorm is on the western end of the compound oval while the Medical Dorm is across the compound on the northern side. Walking through the compound requires the navigation of fences and gates, all controlled by staff. This Grand Jury recommends that the DOC reassess the medical needs of this large and diverse prison, and of all corrections facilities under its jurisdiction, to ensure that there is appropriate staffing for all hours of every day, and that inmates, which society deems to be in the care, custody and control of the state, are given reasonable, timely, and appropriate medical treatment.

The second problem is the lack of readily available medical kits and devices in each dorm. This Grand Jury recommends that all housing dormitories must have reasonably available and functional medical equipment in order to perform cardiopulmonary resuscitation (CPR) and at least one (1) automated external defibrillator (AED) device. The evidence presented indicated that as corrections officers were carrying Walker down the sidewalk towards the center of the compound, medical staff was running from the eastern side of compound with equipment, including CPR equipment and an AED device. At least one corrections officer had to break off from assisting the inmate to run over and assist

medical staff carry these items to the inmate. In this use of force incident, the existence of appropriate medical equipment in each dorm may not have saved Mr. Walker since the corrections officers judged him not to be in need of immediate medical assistance. However, for future inmate medical emergencies, the propriety of requiring medical staff to respond across a large compound weighted down with medical equipment might be avoided if the appropriate equipment is located in each dorm.

The seriousness with which the officers considered Walker's injuries is the third area of concern of this Grand Jury. FCO2 indicated that she was well enough to help herself onto the gurney, spent little time in medical and headed back to the Captain's Office. A gurney was available and was used for a corrections officer who hit her head rather than an inmate who had suffered 11 separate traumas to his body. Evidence was consistent that Walker did not verbally respond to commands after being carried out of quad 4. Thomas said he saw blinking responses until finally he did not. There is no evidence that any of the corrections officers determined that Walker needed immediate medical assistance and no evidence that any corrections officer ordered the medical response team attending to FCO2 and the male officer diverted to Walker despite arriving near E Dorm. This series of unfortunate events calls into question the judgment and training of the officers involved.

This Grand Jury recommends that medical emergencies at CCI, and at all correctional institutions under the jurisdiction of DOC, need to be assessed and prioritized by the medical personnel in all circumstances. While not all use of force incidents are the same, this one occurred while the entirety of CCI was locked down after "lights out." The physical health of Walker was far more important than the need to remove him from the quad in order to maintain peace and protect the officers from possible harm. Given the use of OC spray in a confined space, evidence of blood, the lack of verbal response, and the fact that Walker was subdued and handcuffed on the upper tier, this Grand Jury questions why medical personnel were not immediately called to respond to assist the inmate. At no time did Thomas, the highest ranking officer in charge of the compound and present during the carry, consider this incident anything other than a routine use of force. He presumed Walker was merely "sandbagging or "dead-weighting." Therefore, medical staff was not given the information they needed to make a decision based on an erroneous judgment of the situation. Crucial decisions were made by non-medical corrections officers who mistakenly determined that no medical emergency existed.

C. Preservation of Evidence

This Grand Jury recognizes that there were serious issues raised regarding the preservation of evidence at what were described as crime scenes – areas of CCI which provided items of evidentiary value to the investigation into Walker's death. On April 11, 2014, crime scene technicians from FDLE responded and two (2) primary scenes were processed: first, the area in E Dorm, quad 4, cell E4-210 and the immediate vicinity near E4-210; and second, the sidewalk outside of the Captain's Office where

Walker was pronounced dead. Additionally, the clothing, boots and radios of certain corrections officers involved in the use of force incident were collected. Based upon the totality of the issues presented below, it is the recommendation of this Grand Jury that protocols need to be established and followed to ensure the proper preservation and chain of custody of potential evidence when a crime is committed or after there is a use of force resulting in death or serious bodily injury.

1. Proper preservation of evidence at the crime scenes by Department of Corrections staff prior to arrival of Florida Department of Law Enforcement

Immediately upon the discovery that Walker was dead, reasonable and necessary steps should have been taken to preserve the integrity of the evidence at each part of the crime scene. The incident began inside Walker's cell, continued onto the second floor catwalk outside cell E4-210, around the corner and into the area in front of cells E4-206, E4-207 and E4-208. Contact between Walker and the corrections officers continued onto the stairs inside on the right side of quad 4, down those stairs onto the main floor, and to the exit door into the sally port area. Walker was then carried out of the sally port, down the sidewalk to the point of final rest, in front of the building which houses the Captain's Office. Although the exact number is unclear, Walker was placed on the ground in several of these locations.

The act of placing Walker on the ground by corrections officers potentially transferred valuable evidence at each location. Walker and at least one corrections officer was known to be bleeding. Blood was found along many of the locations mentioned above. At least one inmate testified walking through an area of blood thus potentially transferring valuable evidence improperly.

The duty to ensure the integrity of all scenes should fall upon the DOC officer in charge of the facility regardless of time or day. Out of an abundance of caution the officer in charge should have preserved all parts of the crime scenes until FDLE arrived to take over the scenes. In this case Thomas should have ensured that E dorm, quad 4 in its entirety, the 3-4 side of the sally port, the area outside of E Dorm at the junction of the sidewalks, ***and the entire sidewalk*** used to carry Walker up to and including his final resting place was preserved. The failure to properly secure this entire scene allowed for the loss and destruction of potentially vital evidence.

This Grand Jury understands the necessity to ensure the security and safety of the correctional staff and inmates. Preservation of these scenes could have been established by hanging crime scene tape, using barricades or having staff ensure that nobody entered those areas prior to the arrival of FDLE. None of that was done. A DOC officer did sit outside of E4-210 with a log and curtains were erected to protect Walker's body. But there is testimony that corrections officers, involved in the incident, returned to quad 4 and that inmates later walked through areas on the upper tier where items of evidentiary value were present. It is incumbent upon DOC to ensure that its corrections officers are provided a basic understanding of crime scene preservation.

2. *Proper preservation of the integrity of all participants and all witnesses prior to the arrival of Florida Department of Law Enforcement*

As important as securing the potential evidence of the multiple scenes, it was equally important to properly manage any and all potential witnesses until the arrival of investigators from FDLE. The evidence indicates that the corrections officers involved in the use of force were together for hours after the incident. They were in the Captain's Office, some of them moved an inmate together across the compound, and then, ultimately, they were placed in the one room within the Visitation Park (VP) to write out their incident reports. In the VP they were able to sit together, speak with each other and complete basic incident reports about the use of force without being truly separated.

Testimony revealed that there was a superior from the DOC in the VP to ensure that corrections officers did not speak with each other. However other testimony in the record indicates that the officers did, in fact, communicate with each other. Sinor told FDLE investigators that he overheard Saintervil state that Saintervil, had Walker in a choke hold during the use of force. Saintervil denied saying that he had Walker in a choke hold when he provided a statement to FDLE. Remarkably, Triplett told investigators that he had emailed his initial report of the use of force to Sinor at some point during the early morning hours after the incident.

The basic failure to separate witnesses calls into question the veracity of their statements and their overall credibility. This Grand Jury recommends that in any event of use of force involving death or serious bodily injury, all involved DOC staff and witnesses, including inmates, must be immediately separated. The staff involved and the witnesses to the use of force should be placed in separate locations where communication is not possible. No discussion of the event should be permitted and each shall provide a written initial statement per the DOC policy. Each witness should be maintained separately until the arrival of the FDLE. This Grand Jury understands that this may pose a hardship to those responsible for operating the facility. However, this incident is illustrative that most of the corrections officers involved in this use of force were ***not at their assigned posts*** while they were conducting the cell compliance checks. Thomas stated he still had a compound to run and that is why he used Lynch and Weidner to accompany Walker's roommate to medical and confinement. The reality, however, is that the officers were not needed in any particular area in order to maintain a safe and secure environment at the time. If there is a safety concern about isolating staff members in order to preserve the integrity of their testimony then additional staff should be brought in and a procedure should be put into place to facilitate that necessity. Corrections officer housing exists within the grounds of CCI and additional corrections officers were available to respond in order to maintain minimum staffing if that was a real concern.

3. A Suspicion of Tampering with Cell E4-210

This Grand Jury expressed concern about the preservation of cell E4-210. FDLE processed the scenes on April 11, 2014. An FDLE Agent testified that the crime scene inside of cell E4-210 was under the control and jurisdiction of FDLE until it was released to DOC on May 13, 2014. Walker's roommate never returned to cell E4-210 after the incident and it remained vacated of inmates during the entirety of FDLE's control of it. On April 24, 2014, the agent went back to CCI to view cell E4-210. He testified that when he approached cell E4-210 it was taped with crime scene tape and sealed shut. The evidence showed several changes inside of cell E4-210 that the agent is not able to account for. As indicated earlier, there are two (2) foot lockers sitting astride each other and located under the lower bunk. When FDLE crime scene arrived on April 11, the front foot locker, belonging to Walker, was open and the rear locker, belonging to Walker's roommate, was closed and locked. When the agent returned on April 24, the front foot locker was closed and the rear locker was open. The agent testified that FDLE crime scene technicians did not search or process the rear foot locker and he could not account for the discrepancy. Additionally, the agent noted that on his visit of April 24, a laundry bag was in the middle of the floor that was not there on April 11.

Despite the obvious appearance that entry was made into cell E4-210 without the permission of FDLE, Thomas denied that anyone went into the cell before the crime scene was released from FDLE jurisdiction. A DOC Inspector indicated that if a DOC employee needed to get into cell E4-210 the request would have been made through him, or another inspector, to FDLE. This inspector denied that any requests were made to him. The FDLE Agent did not grant anyone permission to enter or manipulate cell E4-210.

The Grand Jury recommends that entrance to crime scenes on the grounds of a correctional facility under the jurisdiction of DOC should be on camera and recorded to ensure that there is not tampering with the crime scene. If the entrance to a crime scene is not covered by an existing camera, a temporary camera should be set up to record the entrance to the crime scene to guarantee that unauthorized persons do not enter the scene. Any agreement that DOC enters into with an agency vested with authority to investigate criminal activity, an in custody death or a use of force incident on a property under the jurisdiction of DOC must include provisions for the use of cameras to document and maintain the integrity of such scenes.

4. A Lack of Preservation of DNA Evidence and Chain of Custody Problems

It was clear from the evidence presented by the FDLE Biology Section Lab Analyst that he was not able to articulate from the chain of custody paperwork he received from which location one of the radios was collected. In order to link the testimony regarding the DNA results the analyst had to testify to the serial number of the radio. The FDLE Agent was then required to testify that on April 10, Triplett had

that radio assigned to him. The agent further explained that the particular radio assigned to Triplett when he started his shift on April 10 had been reassigned to a different corrections officer during the morning of April 11. This second corrections officer had absolutely nothing to do with the use of force incident. It was only after that second corrections officer received the radio that it was then collected for evidentiary purposes. This is of particular concern to the Grand Jury since there was evidence presented that Triplett was beating Walker with a radio. Furthermore, the radio collected from Lynch had a DNA mixture of at least two (2) contributors with the major contributor being that of Matthew Walker.

This Grand Jury was troubled regarding the process utilized by corrections officers to check out equipment at the start of their shift. The evidence showed that a DOC employee would fill out a log showing that equipment was given to the corrections officers at the beginning of their shift. Upon receipt, the corrections officers were not required to sign the log acknowledging that they received the equipment. It is the recommendation of this Grand Jury to require the corrections officers to sign the log indicating acknowledgement of receipt. This will ensure accuracy of the log, require accountability for the equipment, and confirm chain of custody for investigation purposes should the need arise.

Fingernail clippings were collected from Walker. The results from the right hand fingernail clippings revealed a mixture of DNA. The analyst was able to explain that the major foreign contributor to that DNA mixture was identified as Sinor's.

The FDLE Biology Lab Analyst further testified about the results from four (4) sets of boots collected from corrections officers and tested for the existence of DNA. All of the boots tested were swabbed on the toe and heel portions of the boot since it was alleged in the investigation that there was stomping and kicking of Walker. The results for every toe of every boot tested revealed that there was such a complexity of DNA on the swabbed toe areas of each boot tested that the analyst could not identify the source of nor interpret any of the DNA results.

Results of the heel swabs for three (3) sets of the boots tested elicited a similar conclusion from the witness: there was so much DNA that he could not reasonably interpret the results in order to determine a source. The fourth set of boots tested, belonging to Saintervil, required a different conclusion. Curiously, results of that the left boot heel swab had ***no DNA*** and the right boot heel swab had such a ***limited amount*** of DNA that the analyst could not interpret the results in order to determine the source of the DNA. The witness could not tell the Grand Jury why there was no or very limited DNA on the heel swabs of those boots. He did opine on several possible explanations: intentional cleaning, walking through a puddle, or the friction involved when the boots are taken off. It is of particular concern to the Grand Jury that one (1) set of boots that were in the same environment as the other three (3) sets of boots would have such dramatically different DNA results especially given the testimony that the clothing, boots and radio were not collected until hours after the incident. While one is left to wonder why such a

result could be so incongruous, this is yet another example of a failure by DOC to recognize the importance of preserving evidence relevant to this use of force and in custody death incident.

5. Lack of Cameras/Videos

The evidence revealed that there were not any working cameras in E Dorm on April 11, 2014. By current rules and policies, cameras are only required in the Close Management Dormitories and Mental Health Dormitories. Prior to 2012, CCI was solely a Close Management facility and ***all*** dormitories were required, pursuant to the rules and policies of DOC, to have cameras. After the custody grade status changed and CCI converted to an "Open Population" facility, cameras were no longer required in every dormitory and when the equipment broke down, they were not always maintained. The only working dormitory cameras on the compound at the time of the incident were the cameras required by rule.

There were several working cameras monitoring the outside compound that were working on April 11, 2014. FDLE was provided with video from two (2) different camera angles recording the sidewalk that runs on the northern end of the campus and approaches E Dorm from an angle, passing in front of A Dorm, Medical and G Dorm. Those recordings show a few corrections officers running towards E Dorm and then, a short time later, medical staff and a gurney heading to E Dorm. The recordings also show seven (7) people returning from the area of E Dorm and heading towards medical.

When asked if there were any other available cameras or angles, the FDLE agent testified that the video footage described above was all that was given. The DOC Inspector was also questioned about which cameras were working on April 11, 2014. He indicated that there was a camera on the corner of the canteen building facing southerly which may have also contained images of the sidewalk on the southern end of the compound and which terminates directly in front of E Dorm. No footage from this camera was provided or preserved. The location and orientation of this camera on the canteen building as described by the inspector should have captured Walker being carried from E Dorm towards the Captain's Office. It is of great concern to this Grand Jury that this video footage was not provided to FDLE.

The DOC Inspector also testified that he reviewed some of the camera footage from April 11, 2014 but that he was not in charge of copying any of that video for FDLE. The DOC Inspector specified that a different inspector copied the footage onto discs for FDLE.

The Grand Jury recommends that neither the DOC nor its Office of Inspector General should determine which video evidence is preserved or provided to FDLE. So long as FDLE is tasked with investigating crimes, use of force involving death or serious bodily injury, or in custody death incidents at CCI, it should have open and free access to the camera system there at any time. FDLE should be able to log on to the camera system remotely to retrieve footage from those cameras at any time. Recorded video footage from the cameras at CCI should be maintained for a minimum of 90 days. When there is a use of

force involving death or serious bodily injury, the DOC should maintain video footage for a minimum period of five (5) years.

There was not a handheld video camera present before FCO1 ordered cell door E4-210 open or when Triplett went into the cell although such cameras are available at CCI. This is particularly troublesome since the fixed cameras in E Dorm were not functional. Important visual documentation does not exist. It was clear from the evidence that Walker was upset and that FCO1 intended for him to be placed in confinement when she called down to Triplett. The Grand Jury recommends that when DOC staff intends to enter a cell to deal with a disgruntled, upset or irate inmate, video documentation should be made. Such video documentation should, at a minimum, be covered by fixed cameras in the dorm. Additionally, a handheld camera should be present if more than one DOC staff member intends on entering a cell with an already disgruntled, upset or irate inmate. Alternatively, the DOC could provide body cameras which are signed out by and utilized by staff during their shift.

This Grand Jury also received testimony that a handheld camera was called for by Thomas since there was a use of force incident. The handheld camera was retrieved and brought to Walker's location outside the Captain's Office. By the time that the handheld camera arrived the medical staff was on scene. Thomas began to write out a statement he intended to read on camera to document the use of force but before Thomas could go on camera CPR was started on Walker. The handheld camera was never turned on to document the scene outside of the Captain's Office, nor any of the other scenes previously described in this Presentment. This is extremely puzzling and suspicious since a handheld camera was used shortly thereafter to document the unremarkable transfer of Walker's roommate to confinement. This Grand Jury further recommends that each dormitory on the compound contains a working handheld camera to be utilized as mentioned above.

6 General Recommendations

This Grand Jury recommends that every applicant for the position of corrections officer should undergo rigorous psychological testing before being hired by the Department of Corrections. Additionally, ongoing testing should be conducted as necessary and should be required after a corrections officer is involved in a use of force incident involving death or serious bodily injury. Finally, drug testing should be mandatory after a corrections officer is involved in a use of force incident involving death or serious bodily injury.

V. CONCLUSION

The death of Matthew Walker was tragic, senseless and avoidable. This Grand Jury has endeavored to make positive recommendations to assist the Department of Corrections to avoid these types of incidents in the future.

In light of the actions and decisions made by the individuals named in this Presentment, this Grand Jury requests that the Department of Corrections revisit their employment status and continued fitness to serve the citizens of the State of Florida.

DISTRIBUTION REQUEST

The Grand Jury requests that this Presentment be furnished to the following:

The Honorable Rick Scott, Governor
Office of the Governor
State of Florida
The Capitol
400 South Monroe Street
Tallahassee, Florida 32399-0001

The Honorable Pam Bondi
Attorney General of Florida
Office of the Attorney General
State of Florida
The Capitol PL-01
Tallahassee, Florida 32399-1050

The Honorable Julie L. Jones, Secretary,
Florida Department of Corrections
501 South Calhoun Street
Tallahassee, Florida 32399-2500

The Honorable Andy Gardiner
President of the Senate
409 Capitol
404 South Monroe Street
Tallahassee, Florida 32399

The Honorable Steve Crisafulli
Speaker of the House of Representatives
420 Capitol
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable Larry Ahern
405 HOB
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable Danny Burgess
1301 Capitol
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable Lizbeth Benacquisto
326 SOB
404 South Monroe Street
Tallahassee, Florida 32399

The Honorable Nancy Detert
416 SOB
404 South Monroe Street
Tallahassee, Florida 32399

The Honorable Rob Bradley
208 SOB
404 South Monroe Street
Tallahassee, Florida 32399

The Honorable Eric Eisnaugle
1301 Capitol
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable Greg Evers
308 SOB
404 South Monroe Street
Tallahassee, Florida 32399

The Honorable Anitere Flores
413 SOB
404 South Monroe Street
Tallahassee, Florida 32399

The Honorable Bill Galvano
330 SOB
404 South Monroe Street
Tallahassee, Florida 32399

The Honorable Arthenia Joyner
200 SOB
404 South Monroe Street
Tallahassee, Florida 32399

The Honorable Chris Latvala
1101 Capitol
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable Kionne McGhee
1401 Capitol
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable Larry Metz
222 Capitol
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable Mike Miller
1101 Capitol
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable Joe Negron
412 SOB
404 South Monroe Street
Tallahassee, Florida 32399

The Honorable Kathleen Peters
400 HOB
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable Sharon Pritchett
1302 Capitol
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable Kenneth Roberson
214 HOB
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable José Rodríguez
1302 Capitol
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable Darryl Rouson
212 Capitol
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable Ross Spano
1102 Capitol
402 South Monroe Street
Tallahassee, Florida 32399

The Honorable Darren Soto
220 SOB
404 South Monroe Street
Tallahassee, Florida 32399

The Honorable Carlos Trujillo
417 HOB
402 South Monroe Street
Tallahassee, Florida 32399

CERTIFICATION OF PRESENTMENT

The Grand Jury respectfully submits this Presentment this, the 16 day of June, 2015.

FOREPERSON OF THE GRAND JURY

We, Amira D. Fox, Chief Assistant State Attorney and Richard J. Montecalvo, Assistant State Attorney and Shannon L. Doolity, Assistant State Attorney as authorized and required by law, have advised the Grand Jury returning this Presentment.

AMIRA D. FOX
Chief Assistant State Attorney

RICHARD J. MONTECALVO
Assistant State Attorney

SHANNON L. DOOLITY
Assistant State Attorney