OFFICE OF THE SHERIFF
MAHONING COUNTY

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To: Sheriff Greene M-1

From: Commander Antonucci M-5

Date: 09/15/2015

Reference: Suicide of Kevin Burkey, Inmate No.: 8757

I, Commander John Antonucci, was assigned by Sheriff Greene to investigate the suicide of inmate Kevin Burkey.

On August 25, 2015 @ 13:02 hours Kevin Burkey (interchangeably "Mr. Burkey" or "Inmate Burkey") DOB: 09/16/1964 was found unresponsive in his cell with a sheet wound tightly around his neck. Mr. Burkey was pronounced dead at 13:41 hours by the Mahoning County Coroner's Office. According to the official death certificate, Burkey's cause of death was "hanging". A copy of the Official Death Certificate is attached as Exhibit A.

Summary:

The events contained herein are summarized from reports and interviews conducted by Commander Antonucci of the following individuals: Detective Patrick Mondora, Deputy Mary Jane Greene, HMHP Police Sgt. Robert Martin, Deputy Carl Vath, Deputy Nick Argeras, Deputy Tyler L. Peters, HMHP Police Officer Xavier Young and Police Officer Ritchie.

Copies of the actual reports and interviews are attached hereto as Exhibit B.

On Sunday August 23, 2015, Mr. Burkey was brought into the Mahoning County Jail at about 14:55 hours by the HMHP Police Officer Ritchie for criminal charges relating to Theft of Dangerous Drugs, ORC 2913.05 (6) F-4. Officer Ritchie was not the arresting officer, but was the officer who transported Mr. Burkey to the Mahoning County Jail. Upon their arrival, they were met by intake Deputy Mary Jane Greene. Sheriff's Office personnel was given the following documentation from HHMP Police: a copy of an "After Visit Summary" from St. Elizabeth Hospital stating that Mr. Burkey's diagnosis was: Drug Overdose, accidental or unintentional, initial encounter; polysubstance and a Suspect Arrestee Supplement. Copies of these records are attached as Exhibit C.

Upon Mr. Burkey's arrival, Deputy Greene observed that Mr. Burkey was post hospital because he had a large laceration on his head containing stitches. As a result, Deputy Greene contacted jail medical staff to conduct a medical assessment on Mr. Burkey. Mr. Burkey was asked the standard pre-screening questions by Deputy Heather Hunter. At no time did Mr. Burkey indicate that he was suicidal, nor that he had or was having suicidal ideations. Nurse Livingston completed a physical assessment of Mr. Burkey. During intake, Deputy Greene asked HMHP officer Ritchie how Mr. Burkey was injured due to the visible stitches in his head. According to Deputy Greene, Officer Ritchie told her that Mr. Burkey was involved in a motor vehicle accident and was treated at St. Elizabeth Hospital in Youngstown. Officer Ritchie also told Deputy Greene that Mr. Burkey previously overdosed and stole medication from the hospital.

According to Nurse Livingston, there was no documentation indicating Mr. Burkey's mental health was evaluated or that he was a risk to himself or others. Ultimately, Nurse Livingston cleared and accepted Mr. Burkey into the Jail and advised the deputies to house Mr. Burkey in B/C medical housing due to his visible injuries. Inmate Burkey was ultimately assigned to cell C-8 at 16:16 hours and placed on "personal observation" as a result of his head injury. At 19:52 hours, Inmate Burkey's vital signs were checked and medication was administered. According to the jail nurse, Inmate Burkey did not indicate any suicidal ideation at that time. At

00:31 hours, Inmate Burkey's vital signs were checked and no indication was made to the jail nurse that he had suicidal ideations.

On Monday, August 24, 2015, Inmate Burkey was moved from the medical housing unit to L-pod cell L-2 at 11:12 hours. At 13:28 hours, Inmate Burkey was taken out of L-pod for court by Deputy Leipply. At 17:20 hours, Inmate Burkey returned to L-pod from court by Deputy Vath. At 20:13 hours, Inmate Burkey was administered medication from jail Nurse Lester. At that time, Inmate Burkey did not indicate to Nurse Lester he was having issues or intended to hurt himself.

On Tuesday, August 25th, 2015 at 04:44 hours, Inmate Burkey received medication from jail Nurse Puskar. Deputy Peters arrived at 8:00 hours, conducted a head count and was cleared. Upon clearing the head count, L-Pod was off lock down upon request. At 8:50 hours, Deputy Peters was relieved by Deputy Vath to report to the gun range. Deputy Vath stated that Inmate Burkey approached the podium and told him (Deputy Vath) that medical had been checking his blood pressure and "it feels like it is high". Deputy Vath informed Inmate Burkey that he would call medical. Deputy Vath called medical and he was told they would send a nurse up to check on Inmate Burkey. At approximately 09:20 hours, jail Nurse Smith came to Inmate Burkey's pod and checked Inmate Burkey's blood pressure.

At 09:40 hours, Inmate Burkey returned to the deputy's podium and told Deputy Vath that he needed to talk with a psychiatrist because no one knows what he is going through. At no time did Inmate Burkey appear to be in distress or in need of immediate medical attention. As a result, Deputy Vath explained the procedure for requesting a medical visit to Inmate Burkey and provided him with a medical form. Deputy Vath told Inmate Burkey how to fill out the form and where to put it when it was completed. Deputy Peters returned from the firing range at 10:10 hours and Deputy Vath returned to his float position. Because Inmate Burkey did not appear to be in distress or in need of immediate medical attention, Deputy Vath did not tell Deputy Peters that Inmate Burkey told him that he wanted to speak

with a Psychiatrist or that he gave inmate Burkey guidance on filling out a medical request form.

Shortly after Deputy Peters returned from the firing range, Inmate Burkey came to the podium with just a t-shirt on and Deputy Peters ordered him to return to his cell to put on his orange jail shirt. At approximately 10:15 hours, Deputy Peters began to serve lunch trays to all of L-Pod. All inmates came to the food cart to receive their trays. After he passed out the lunch trays, Inmate Burkey complained he was receiving a clear liquid tray and wanted a regular food tray. Deputy Peters told Inmate Burkey that he was receiving a clear liquid tray per the doctor's orders and that Deputy Peters was unable to change his diet without a doctor's authorization.

At 10:45 hours, Nurse Yakopec arrived on station to get inmate Burkey's blood pressure. Deputy Peters called inmate Burkey over to the L-40 door and advised him to set down the tray he was carrying on his way over to the L-40 door. Deputy Peters stood with both the nurse and Inmate Burkey at the L-40 door while she took his blood pressure. Deputy Peters recalls that Inmate Burkey advised the nurse that he had been feeling light headed and woozy and further told Deputy Peters that he felt bad for complaining to him about his clear liquid trays. Deputy Peters observed Nurse Yakopec having a conversation with Inmate Burkey because the blood pressure cuff that Nurse Yakopec had with her was not working and she told Inmate Burkey that she would have to return with the regular arm cuff later in the day.

After Nurse Yakopec left, Deputy Peters observed Inmate Burkey asking other inmates if they were finished with the food on their trays in an attempt to get solid food. At approximately 11:45 hours Deputy Peters ordered L-pod to lock down and all inmates were secured in their cells except for the inmates in charge of cleaning the pod. At approximately 12:00 hours, Deputy Peters secured the inmates in charge of cleaning in their cells and typed in his log. Deputy Peters advised central control to take over L-pod's screen. The numbers used by Deputy Peters at that time were based on head counts conducted earlier in the day. Deputy Peters left L-Pod for his break but failed to conduct a personal visual observation of

each inmate before he left. When he returned to L-Pod at approximately 12:30 hours Deputy Peters went to the Pod microwave to heat his lunch and returned to his desk. Deputy Peters did not conduct a personal visual observation of each inmate when he arrived back at the Pod at 12:30 hours.

At approximately 13:00 hours central control advised headcount was clear and that is when Deputy Peters let L-pod off lock down by activating group unlock. As he was typing in his log, inmates were coming out of their cells. At approximately 13:02 hours, an inmate unknown to Deputy Peters approached him and told him that "there was a guy lying down over here". Deputy Peters immediately went over to cell L-2 and discovered inmate Burkey lying on the floor, face up, with a white sheet tied around his neck with the other end of the sheet tied to the stool of his cell desk. Deputy Peters checked Inmate Burkey's right wrist for a pulse and called for medical and float deputies via his portable radio. Deputy Peters then ordered inmates to lockdown and secured the cell doors in L-pod except for cell L-2.

At 13:25 hours Major Jeff Allen, Capt. McGeary, and Detectives Tony Murphy and Pat Mondora arrived in L-Pod to investigate a possible suicide. Four Rural Metro Paramedics along with Deputies Blount and Duzzny were already present and were trying to revive Mr. Burkey. Paramedics and deputies continued life support techniques until Paramedic Tom Allis reviewed the event and techniques used to preserve life with Dr. Arthur Smith from St. Elizabeth Hospital Youngstown. Paramedic Allis was then told by Dr. Smith to discontinue the life support techniques. Once everyone was told to discontinue life support techniques by Dr. Smith, Detective Mondora cleared all personnel from cell L-2. Mr. Burkey was declared dead at 13:41 hours.

Once all personnel were cleared Detectives Mondora and Murphy entered the cell. Detective Mondora began to take photographs of the scene and of Inmate Burkey. While taking photographs, Detective Murphy found copies of several police reports on Inmate Burkey's desk. One report was issued by HMHP Police (HMPD # 15 PDA 032 DATED 8- 23-15) and

related to his theft offense. A second report contained a supplement stating that prior to Inmate Burkey's arrival to the Mahoning County Justice Center on August 23, 2015, he was found by HMHP Police walking on the ledge of the parking deck attempting to commit suicide. This report also indicated that HMHP Police "pink slipped" inmate Burkey and then transported him to The Mahoning County Justice Center.

Thereafter, the sheet used by Mr. Burkey to commit suicide was cut from the desk. Detective Mondora states that they were advised by Deputy Duzzny that he had to cut the sheet with his car keys because Inmate Burkey had wound the sheet so tightly around his neck he was unable to untie it. No suicide note was found and the cell was relatively uncluttered.

Coroner Investigator Theresa Valek ("Investigator Valek") arrived on the scene and was briefed on the events by Detective Mondora. Investigator Valek took photographs and examined Mr. Burkey. No signs of a fight or defensive wounds were noted, though redness was found around his neck. The police report found on Mr. Burkey's table and the bed sheet were taken as evidence and retained by Investigator Valek. Thereafter, a coroner removal crew arrived on the scene and removed the body of Mr. Burkey.

At the request of Detective Mondora, Sgt. Bova reviewed the video from L-Pod. Sgt. Bova notified Detective Mondora that Mr. Burkey was the only one to enter cell L-2 at lockdown and no other activity was noted until Mr. Burkey was discovered by Deputy Peters at about 13:02 hours.

Detectives Mondora and Murphy interviewed several inmates from L-Pod. Inmate Robert Johnson DOB 07/31/1966 was housed in cell L-3 the first cell next to Mr. Burkey. Inmate Johnson said that Inmate Burkey did not seem suicidal nor did he have any problems with other inmates. Inmate Johnson said that he heard some thumps and bumps during lockdown but that is not out of the ordinary.

Inmate James Elliott, DOB 08/23/1989 was housed in cell L-1 which is the first cell to the left of Inmate Burkey's cell. Inmate Elliott stated that

he saw Inmate Burkey go into his cell at lockdown but that he did not hear anything because he (Elliott) was on medication and was asleep.

Inmate James Brown, DOB 08/23/1979 was housed in cell L-15. Inmate Brown stated that during lunch today he heard Inmate Burkey say to Inmate Kocak that he needed to talk to medical.

Inmate Andrew Kocak DOB 05/30/1981 was housed in cell L-23. Inmate Kocak stated that before lockdown Inmate Burkey told him that he needed to talk to someone from mental health. Inmate Kocak stated that Inmate Burkey told him that he could not read or write and asked Kocak to fill out a medical slip for him. Inmate Kocak did so and placed the slip in the medical request box in the Pod. When Detectives Mondora and Murphy asked Inmate Kocak what he wrote on the slip, Kocak replied "I need to see mental health ASAP." Detective Murphy retrieved the medical slip from the box in L-Pod and confirmed that it was written for Mr. Burkey by Inmate Kocak.

Inmate Vincent Moore, DOB 05/15/1981 was housed in cell L-26. Inmate Moore stated that during lunch today, (8/25/2015) he heard Inmate Burkey complaining about being on a liquid diet and said "I tried to kill myself, I shouldn't be on a liquid diet." Inmate Moore did not tell anyone about this comment.

On Wednesday, August 26, 2015 at 8:58 hours, I placed a telephone call to HMHP Police Department to request copies of all reports that they have in relation to Mr. Burkey. I spoke with a dispatcher named Becky who stated that Chief Bonacci was in a meeting and didn't know when he would be available. Becky said that she would have the supervisor on duty call me when he got back to the office. This same day, at approximately 11:45 hours, I received a telephone call from HMHP Police Sergeant Robert Martin. Sgt. Martin told me that he would make copies of all HHMP police reports and would deliver them to me.

At about 12:55 hours on August 26, 2015, Sgt. Martin arrived at the Mahoning County Justice Center where I had a face to face interview with him. Sgt. Martin gave me a packet of reports and stated that Mr. Burkey

was treated at HMHP hospital for an automobile accident. While on site, HMHP police received a telephone call about a possible suicidal subject on top of the St. Elizabeth (Youngstown) Parking Deck at 10:25 hours. Sgt. Martin made contact with the subject who was later identified as Kevin Burkey DOB 09/16/1964. Sgt. Martin said that when Mr. Burkey was located he was shirtless with a large stitched gash on his forehead. Mr. Burkey displayed signs of intoxication as HMHP Officers noted that he had slurred speech, glassy eyes, and was unsteady on his feet.

HMHP Officers then "pink slipped" Mr. Burkey and had him examined by a HMHP Doctor. Ultimately, Sgt. Martin said Mr. Burkey was medically cleared, arrested for theft and other offenses and sent to the Mahoning County Justice Center for booking into the Jail. Sgt. Martin said he was not sure why Mr. Burkey wasn't admitted to the Hospital with the pink slip. Sgt. Martin contacted me by phone at 14:05 hours on August 26, 2015 and informed me that Dr. Holli M.Martinez, D.O was the Doctor who examined Mr. Burkey relative to his "pink slip" and that Jessica Russell was the social worker who worked with him. I was then told by Sgt. Martin that I would need to get a subpoena to obtain any additional information.

I interviewed Deputy Nick Argeras on August 31, 2015.

According to Deputy Argeras, on August 25, 2015 he was assigned to work in the corrections division of the Mahoning County Jail from 7 am to 7pm and was assigned to Q-Pod. Upon his arrival in Q-Pod he completed his first rounds of the day and then met with Deputy Peters at the classroom door. Deputy Argeras spoke with Deputy Peters quickly because Q-Pod was going out to rec. from 8:30 hours to 9:30 hours. At 11:45 hours he advised all inmates that it was time to lockdown. Deputy Argeras searched cell 17 and cell 21 for contraband and after he completed the search he advised the cleaners to lockdown. Deputy Argeras then started to catch up on his daily log and neglected to check with Deputy Peters to see what time they were going to take their breaks. At approximately 12:03, Deputy Agreras left Q-Pod to take his break knowing that Deputy Peters was also on break at this time.

While on break, Deputy Argeras went down to the property room to retrieve books for Inmate Hoyt. After reviewing the books for inmate Hoyt he brought them to booking. Deputy Argeras was advised by Deputy Kephart that the books were inappropriate for inmate viewing. Deputy Argeras returned the books to Inmate Hoyt's property bag. After leaving the property room, he brought his lunch up to U-Pod around 12:53 hours. Deputy Argeras started doing his physical headcount around 13:00 hours.

While he was conducting his headcount, Deputy Argeras heard over the radio that medical assistance was needed in L-Pod. Deputy Argeras ran through the Q-40 door and entered L-Pod to assist. Deputy Argeras approached cell-2 to find an inmate face up with a bed sheet wrapped around his neck and attached to the chair of the cell desk. Deputy Argeras noticed that the inmate's face was blue in color. Deputy Argeras stated that he was in shock because this was the first time he viewed apparent suicide. Deputy Argeras walked back to the podium to make sure Deputy Peters was ok due to the fact that he (Peters) seemed to be in shock also. After responding Deputies and medical staff arrived on L-Pod, Deputy Argeras then returned to Q-Pod and finished his headcount at 13:13 hours.

On September 1, 2015, Detective Mondora was advised by Coroner's Office Investigator Papas that Mr. Burkey's autopsy was complete and the cause of death was hanging.

Following my interviews, I obtained copies of several reports issued by HMHP police officers. Below is summary of those reports.

Report of Officer Xavier Young[1]:

On Sunday, August 23, 2015, HMHP Police received a telephone call in reference to a possible suicidal subject on top of the St. Elizabeth Hospital, Youngstown, Park Ave. Parking Deck at 10:25 hours. HMHP Police Officer Xaiver Young was dispatched at 10:27 hours. He arrived at 10:29 hours and located the subject. Upon Officer Young's arrival, he

[1] The Report of Officer Young was not provided to Mahoning County Sheriff's Department staff when Mr. Burkey was booked. This report was not obtained until after Mr. Burkey's death.

observed a shirtless white male with a large stitched gash on his forehead and displaying signs of intoxication (slurred speech, glassy eyes, unsteady on his feet). As Officer Young approached the subject, later to be identified as Kevin Burkey, he (Burkey) swallowed what appeared to be a white substance in a glass vial. Officer Young then ordered Mr. Burkey to step away from the ledge of the parking deck for his protection and Burkey complied with the order. Officer Young ordered Mr. Burkey to drop the other medication vials in his hands. When they asked Mr. Burkey where he got the medication from he stated that he didn't know.

Officer Young then asked Mr. Burkey why he was on hospital property, and he said that he was in the emergency room and felt that hospital staff wasn't going to help him with his pain so he left. HMHP Police called for an ambulance at 10:33 hours. Rural Metro ambulance arrived on the scene to transport Mr. Burkey from the parking deck to the St. Elizabeth Hospital Emergency Department.

Because the vials of medication found on Mr. Burkey were the property of St. Elizabeth Hospital, HMHP determined that a theft offense occurred at St. Elizabeth Hospital and arrested Mr. Burkey. Following medical treatment and evaluation, Mr. Burkey was then placed on a Police hold and "pink slip" was issued due to his previous suicide attempt. After being medically cleared by HMHP staff, Mr. Burkey was discharged, placed under arrest and transported to the Mahoning County Jail for theft of drugs.

Report of Officer Ritchie:

Officer Ritchie was advised by dispatch that an individual on a "police hold" was being discharged and should be transported to the Mahoning County Justice Center on theft charges for drugs. He and Officers Lucas and Tripi escorted Mr. Burkey to the HMHP police station with his belongings, discharge papers and folder.

Officer Ritchie stated that after filling out a NIBRS (arrest report) he transported Mr. Burkey to the MCSO. Upon arrival at 14:55 hours, Officer

Ritchie entered the sally port and escorted Mr. Burkey into the jail. Officer Ritchie was met by three deputies that accepted Mr. Burkey and began processing him. At this time, he handed over Mr. Burkey's paperwork, including his discharge papers from St. Elizabeth Youngstown. Deputies reviewed the file and proceeded with the intake process.

Deputies then called the nurse down to evaluate Mr. Burkey. The nurse read through the discharge papers and began to ask Mr. Burkey questions about his current state of mind. The nurse asked Mr. Burkey about drug use which he replied "sometimes". She then asked if he felt like hurting himself, and he started to complain about the pain he was in. The nurse then asked Mr. Burkey if he was homicidal, suicidal or wanting to hurt himself. Officer Ritchie acknowledged that while Mr. Burkey answered the questions, he was unable to hear the answer as he was in another room. After the intake process was completed, a deputy advised Officer Ritchie that he could leave.

Conclusion:

Based upon the information provided to Mahoning County Sheriff's Office personnel at the time Mr. Burkey was presented at intake, he was properly screened and placed in the appropriate pod. Mr. Burkey did not indicate that he was a danger to himself or others or that he was suicidal or had suicidal ideations. Jail personnel were not informed, at intake, of the events taking place at HMHP earlier that day. In fact, Jail personnel did not discover these events until after Mr. Burkey committed suicide. For these reasons, it is the opinion of this investigator that Jail policies and procedures were followed and that Mr. Burkey was properly classified at intake.

M-5

Commander John Antonucci
Internal Affairs

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To: Sheriff Greene M-1

From: Commander John Antonucci M-5

Date: 09/15/15

Reference: Deputy Nicholas Argeras

I, Commander John Antonucci, was asked to investigate allegations that Deputy Nicholas Argeras ("Deputy Argeras") violated the policies or procedures of the Mahoning County Sheriff's Office during his shift on August 25, 2015 when he left his post without getting properly relieved.

On August 31, 2015, I had a face to face interview with Deputy Argeras along with his union rep. John Tkach. On August 25, 2015, Deputy Argeras was working the Mahoning County Jail from 7 am to 7pm and assigned to Q-Pod. At 11:45 hours, he advised all inmates that it was time to lockdown. Deputy Argeras then searched cells 17 and 21 for contraband. After completing the search, he advised the cleaners to lockdown. Deputy Argeras said he left Q-Pod at 12:03 hours for his break. Deputy Argeras admitted that he did not check with L-Pod Deputy Peters to see which Deputy was going to go on break first and which Deputy was going to stay in the housing units. Deputy Argeras further admitted that he went on break at the same time as Deputy Peters.

Applicable Policies and Procedures:

1. Directive # 53.6.3 addresses Inmate Supervision and Surveillance and provides, in part:

   Deputies will not leave their posts unless properly relieved.

2. 13.1.1 Code of Conduct Rule # 37 D # 4 Violation of Any MCSO Directive, General Order or Issued Order.

As a result of my investigation, I believe Deputy Argeras violated Directive #53.6.3 and 13.1.1 Code of Conduct Rule # 37 D # 4 Violation of Any MCSO Directive, General Order or Issued Order.

By his own admission, Deputy Argeras said he left his post for break without being properly relieved. He acknowledged that he went on break without first checking with Deputy Peters to determine whether Peters would be on break during the same time.

Deputy Nicholas Argeras will be issued an Adverse Behavior Report for the above violations.

Commander John Antonucci
Internal Affairs

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To: Sheriff Greene M-1

From: Commander John Antonucci M-5

Date: 09/22/15

Reference: Deputy Tyler Peters

I, Commander John Antonucci, was asked to investigate allegations that Deputy Tyler Peters ("Deputy Peters") violated the policies or procedures of the Mahoning County Sheriff's Office during his shift on August 25, 2015 when he failed to make an actual visual/physical headcount (personal observation check) of inmates housed in his pod. I was also asked to investigate allegations that Deputy Peters violated the policies and/or procedures of the Mahoning County Sheriff's Office when he failed to provide an accurate headcount to booking on the same date and if procedures were followed to be properly relieved while he went on break.

On Tuesday September 8, 2015, I had a face to face interview with Deputy Peters along with his Union Representative Charles Choate. During our interview Mr. Choate waived the reading of Deputy Peters' Garrity Rights. Following my interview, I ordered Deputy Peters to provide a written statement. The following is a summary of Deputy Peters' written statement.

When Deputy Peters arrived to L-Pod on Tuesday August 25, 2015 he picked up his clipboard and inmate eye check bunk assignment sheet and proceeded to do his initial round. All inmates were accounted for and in their assigned cells at this time. At 08:00 hours, the head count was cleared and L-Pod was taken off "lock down" upon request. At 08:50 hours, Deputy Peters was ordered to report to the gun range. He was relieved by Deputy Carl Vath ("Deputy Vath"). Deputy Peters returned from the gun range, at which time, Deputy Vath left the pod.

At approximately 11:45 hours, Deputy Peters ordered L-pod to lock down and all inmates were secured in their cells except for the inmates in charge of cleaning the pod. At approximately 12:00 hours, Deputy Peters secured the inmates in charge of cleaning in their cells and says he typed in his log. Deputy Peters advised central control to take

over L-pod's screen. Deputy Peters left L-Pod for his break but failed to conduct an actual visual/physical headcount aka "personal visual observation" of each inmate before he left. When he returned to L-Pod at approximately 12:30 hours Deputy Peters went to the Pod microwave to heat his lunch and returned to his desk. Deputy Peters did not conduct an actual visual/physical headcount of each inmate when he arrived back at the Pod at 12:30 hours. The inmate count used by Deputy Peters and given to booking for a mid-day head count were based on head counts conducted earlier in the day, not from doing a personal observation check.

Deputy Peters' written report corroborates the answers he gave during my face to face interview with him on Tuesday September 8, 2015 @ 09:58 hours. At this time, Deputy Peters was asked the following questions:

Q: (Antonucci) When you left did you do a headcount prior to lunch?

A: (Peters) As in Round?

Q: (Antonucci) Yes.

A: (Peters) No.

Q: (Antonucci) Did you make a round when you returned to the pod?

A: (Peters) No.

Q: (Antonucci) When you talk about the headcount clears did you take the numbers you already had or did you do an actual physical headcount?

A: (Peters) I took the numbers I already had.

On Wednesday, September 16, 2015 I had a telephone interview with Deputy Nick Blount ("Deputy Blount"). Deputy Blount was the booking Deputy on Tuesday August 25, 2015. The Booking Deputy, according to Deputy Blount, is responsible for maintaining the jail headcount. On August 25, 2015, he received the mid-day headcount from Deputy Tyler Peters. Deputy Blount did not know whether the numbers provided by Deputy Peters were based upon an actual visual/physical headcount conducted immediately prior or were provided from a head count conducted from observations made earlier that day.

Applicable Policies and Procedures:

1. Directive # 53.6.3 addresses Inmate Supervision and Surveillance and provides, in part:

Personal observation checks of inmates shall be conducted every sixty minutes on an irregular schedule, at least every sixty minutes. Observation checks shall be conducted at varying times and shall be documented after completion by the staff person performing the check. This will ensure their state of well-being, i.e. they are alive, free from injury or assault and that their needs are being tended to.

During intermittent surveillance, personal observation checks will increase to twice and hour. These checks will be conducted on an irregular schedule. Observation will include a visual inspection of each individual cell and/or housing unit and the area immediately surrounding the unit in order to ensure safety, security and good order in the facility.

2. 13.1.1 Code of Conduct Rule # 37 D # 4 Violation of Any MCSO Directive, General Order or Issued Order.

3. 13.1.1 Code of Conduct Rule # 5 Dishonesty.

4. Directive # 53.6.3 addresses Inmate Supervision and Surveillance and provides, in part:

Deputies will not leave their posts unless properly relieved.

As a result of my investigation, I believe Deputy Peters violated Directive #53.6.3 13.1.1 Code of Conduct Rule # 5 Dishonesty and 13.1.1 Code of Conduct Rule # 37 D # 4 Violation of Any MCSO Directive, General Order or Issued Order.

By his own admission, Deputy Peters said he not only failed to conduct personal visual observations of his pod inmates on August 25, 2015 in accordance with Directive #56.6.3, he also acknowledged that he submitted to booking a mid-day head count which was not obtained from an actual physical headcount. Deputy Peters further acknowledged that he left his post for break without being properly relieved. Deputy Peters should have worked out a staggered break schedule with Deputy Nick Argeras, who was working Q-Pod that day, prior to leaving his post at L-Pod.

Deputy Tyler Peters will be issued an Adverse Behavior Report for the above violations.

Commander John Antonucci