Florida Department of Corrections



Office of the Inspector General

CRIMINAL INVESTIGATION INVESTIGATIVE ASSIST CASE # 18-01674





INVESTIGATIVE ASSIST SUMMARY REPORT

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INVESTIGATIVE ASSIS	T SUMMARY REPORT
Case Number:	18-01674
OIG Inspector:	Lead Senior Inspector Johnny Webb Inspector Ryan Muse
Outside Agency:	Florida Department of Law Enforcement
Outside Agency Investigator:	Special Agent Drew Vass
Date Assigned or Initiated:	1-22-2018
Complaint Against:	N/A
Location of Incident – Institution/Facility/Office:	Wakulla Correctional Institution
Complainant:	Inmate Roger Cain, DC# G07872
Outside Agency Case #:	TL-37-0066
Use of Force Number:	N/A
PREA Number:	N/A
Classification of Incident:	Unattended Inmate Death
Confidential Medical Information Included:	<u>X</u> YesNo
Whistle-Blower Investigation:	Yes <u>X</u> No

Chief Inspector General Case Number: N/A

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I. AUTHORITY

The Florida Department of Corrections, Office of the Inspector General, by designation of the Secretary and § 944.31, Florida Statutes, is authorized to conduct any criminal investigation that occurs on property owned or leased by the department or involves matters over which the department has jurisdiction.

The testimony references included in this report are summations of oral or written statements provided to inspectors. Statements contained herein do not necessarily represent complete or certified transcribed testimony, except as noted. Unless specifically indicated otherwise, all interviews with witnesses, complainants, and subjects were audio or video recorded.

II. METHODOLOGY

The investigation reviewed the derivations of the allegation advanced by the complainant. The scope of this investigation does not seek to specifically address tort(s), but violations of criminal statutes. The criterion used to evaluate each contention or allegation was limited to the following standard of analysis:

1. Did the subject's action or behavior violate Florida criminal statutes?

III. ANALYSIS

The standard and analysis in this investigation is predicated with the burden of proving any violation of law, established by probable cause. The evidence considered for analysis is confined to the facts and allegations stated or reasonably implied. The actions or behavior of the subject are presumed to be lawful and in compliance with the applicable Florida law, unless probable cause indicates the contrary.

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IV. DEFINITIONS

Unfounded:

Refers to a disposition of a criminal case for which probable cause does not exist to suggest the suspect's behavior or action occurred nor is an arrest or formal charge being initiated.

Closed by Arrest:

Refers to a disposition of a criminal case for which probable cause exists that an identified subject committed the offense and one for which an arrest or formal prosecution has been initiated.

Exceptionally Cleared:

Refers to a disposition of a criminal case for which probable cause exists that an identified suspect committed the offense, but one for which an arrest or formal charge is not initiated, or in the case of a death investigation, one for which no evidence exists that the death was the result of a crime or neglect.

Open-Inactive:

Refers to a disposition of a criminal case for which a criminal investigation commenced, but where evidence is insufficient to close as unfounded, closed by arrest, or exceptionally cleared.

Investigative Assist Closed

Refers to a disposition of an investigative assist, where the conduct being investigated by the outside agency did not concern allegations against a Department employee, contractor, inmate, offender, or other person either employed or under the supervision of the Department.

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V. PREDICATE:

On January 22, 2018 at 6:18 PM, Inspector Supervisor Ed Rau contacted Lead Senior Inspector Johnny Webb concerning Inmate Roger Cain, DC# G07872 had been pronounced deceased at Wakulla Correctional Institution Annex (*WCI*) in K-Dormitory. The initial cause of death is suspected

This incident was reported to the Office of Inspector General (*OIG*) Intake Unit on January 25, 2018, via the Management Information Notification System (*MINS*) and assigned to Inspector Ryan Muse, as a Criminal Investigative Assist.

VI. SUMMARY OF INVESTIGATIVE FINDINGS

Based on the exhibits, witnesses' testimony, subject officer's statements, and the record as a whole, presented or available to the primary inspector, the following findings of facts were determined:

At approximately 6:18 PM, Inspector Supervisor Rau notified the Florida Department of Law Enforcement (*FDLE*) Watch Desk. At approximately 6:52 PM, FDLE Special Agent Supervisor Tonja Bryant contacted Inspector Webb and advised she would be dispatching two agents. Inspector Webb then contacted Inspector Muse and advised him to report to WCI Annex to assist. At 7:05 PM, Inspectors Webb and Muse contacted FDLE Special Agents William Mickler and Drew Vass. Once briefed, FDLE made the determination they would take lead on the death investigation.

Contact was made with acting Captain Swain, who compiled and provided copies of all; Dormitory Logs, Housing Run Logs, Staff Rosters, Crime Scene Log, Control Room Log, and a copy of the video for K-Dormitory. Captain Swain had already secured the scene, started a log, and initiated the Incident Command Systems (*ICS*) protocols prior to the OIG and FDLE arrival. The video was reviewed showing Inmate Cain sitting on his bunk with two other inmates. All the inmates sitting near Inmate Cain's bed appeared to be smoking a hand rolled cigarette. A few seconds later, all three inmates passed out for approximately 20 minutes; however, Inmate Cain

pronounced Inmate Cain deceased at 5:59 PM. At approximately 9:00 PM, both FDLE and OIG were escorted to K-Dormitory by Warden James Coker to begin their forensic processing of the scene. The processing included; Inmate Cain's body at his final point of rest, his personal belongings, and the area surrounding his body. FDLE photographed, searched and cataloged Inmate Cain, his bed, locker, and the surrounding area.

to Inmate Cain. The cigarette which Inmate Cain was seen on video smoking at the time of his death, was located between two inmate foot lockers. Once the

Vass then interviewed and security staff who were present Inmate Cain. SA Vass completed an investigative demand form and emailed a copy to Inspector Muse.

scene was processed, K-Dormitory was released back to WCI for normal operation. SA Mickler and

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At 11:51 PM, Lee Transport Company took possession of Inmate Cain's body and transported him to the Medical Examiner's Office (*ME*) in Tallahassee. At 12:07 AM, OIG and FDLE departed WCI.

On January 23, 2018, an autopsy was performed on Inmate Cain by Dr. Lisa Flannagan. SA Vass and Inspector Muse were in attendance and Inmate Cain's identity was verified by comparison against his inmate Florida Department of Corrections (<i>FDC</i>) profile sheet. Dr. Flannagan conducted both are external and internal examination of Inmate Cain's body where it was noted,			
On March 19, 2018, Inspector Muse received copy of the completed Autopsy Report (18M-42) Inmate Cain was detailed as a white male, 52 years of age, well developed and nourished. There			
was evidenc			

The Medical Examiner's Final Pathological Diagnoses(s):

- •
-

The Medical Examiner's determined cause(s) of death was due to:

•

On August 20, 2018, SA Vass emailed a copy of FDLE's closed report: TL-37-0066 with their finding mirroring that of the ME's report with a determination of no suspected foul play. Inmate Cain's manner of death is classified as Accidental. FDLE closed their case and no additional investigative activity was deemed necessary, or required. Inspector Muse maintained no further evidence in this case and recommends it be closed.

VII. CHARGES List alleged violations of Florida Law:

1. NONE- Inmate Death (ruled accidental with no suspected foul play).

VIII. CONCLUSION

Based on the information gathered during their investigation, it is the recommendation of FDLE Special Agent Drew Vass the allegation for the unattended inmate death, be termed as follows:

1.) Exceptionally Cleared

Inspector Muse reviewed the investigation completed by FDLE, and administrative issues were not identified.

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