MEMORANDUM

TO: BRAD KING, STATE ATTORNEY
    RIC RIDGWAY, CHIEF ASSISTANT STATE ATTORNEY

FROM: WILLIAM J. CATTO, ASSISTANT STATE ATTORNEY

REF: THE OPERATION OF THE HERNANDO COUNTY JAIL BY CORRECTIONS CORPORATION OF AMERICA

DATE: APRIL 6, 2006

Pursuant to your instructions, I reviewed the results of several investigations conducted by the Hernando County Sheriff’s Department, which involve incidents that occurred at the Hernando County Jail. These incidents are diverse in nature, but all involve the theme of incompetence or negligence on the part of those involved in the jail’s operation. I was asked to determine if there was any evidence of provable criminal acts on the part of jail staff in regard to these incidents, and to determine what corrective actions, if any, were to be taken to reduce the likelihood that these incidents could be repeated in the future. During all relevant periods of time, the Hernando County Jail has been operated by the Corrections Corporation of America (hereafter “CCA”) under a contractual arrangement with Hernando County, and it continues to be so operated to this day. During the relevant period of time the Warden of the jail was Arvil “Butch” Chapman, who had become warden in the summer of 2005.

The jail had recently undergone an expansion which greatly increased its bed space. It is fair to say that the jail had a great deal of difficulty finding and retaining a sufficient quantity of certified correctional officers; as a result they were forced to resort to hiring uncertified officers and attempting to staff the jail with them while they received on the job training and attended the corrections academy program to become certified. This issue has been well documented in the public record and is without question a contributing factor to the problems experienced by the jail. However, there are no criminal statutes proscribing this procedure and it is clear that the CCA administration wishes to move away from it as much as is practicable, as quickly as possible. Since these incidents, CCA has brought in a new warden, Donald Stewart, who has much broader experience in a jail setting and has been given authority to make changes needed to try and reduce the incidents.

The specific incidents I have been asked to review, and have reviewed, are:
1. The suicide of Daniel Warren, and ancillary allegations of criminal activity committed upon Warren by other inmates;
2. The suicide of Geoffrey Conley;
3. The suicide of Truc Tran;
4. The premature release of Daniel Swetokos;
5. The premature transfer of Aaron Hagen to the Department of Corrections;
6. The escape of Matthew Draper;
7. Thefts from inmates by Corrections Officer Jeffrey Hodges;
8. Issues regarding the fingerprinting of inmates for identification databases; and
9. The death by natural causes of John Wells.

I. THE SUICIDE OF DANIEL WARREN AND RELATED ALLEGATIONS

On November 2, 2005, inmate Daniel Warren killed himself by hanging himself with a sheet tied to his cell door. Warren was in a segregation cell, having been placed there by CCA staff earlier that day after having been involved in a fight in which his front tooth had been broken out. An autopsy conducted by the Medical Examiner’s Office ruled that Warren died by hanging, and confirmed the death as a suicide. HCSO investigation # 2005-32675 finds no evidence to the contrary. In the course of the investigation, allegations that Warren may have been sexually battered by another inmate or inmates were made, and these were also investigated, as were the allegations regarding the altercation which resulted in his injuries. I reviewed all three. The finding in the HCSO investigation was that the death was a suicide, and that no improper or negligent actions had occurred on the part of CCA officials that could have prevented the death. I concur with this finding. There was no credible testimony that could have led a reasonable jail official to conclude that Warren was a suicide threat. He was in segregation not because of any likelihood of his harming himself; rather, he was there because of the incident involving the altercation, being separated from other inmates due to this. Unfortunately, inmate suicide does occur in many jails on occasion, and if it occurs without prior threats or actions it can sometimes be difficult to prevent. It is clear that a jail facility must take appropriate safeguards to observe inmates who represent a threat of suicide to prevent it from happening; for inmates who do not represent such a threat more normal supervision is warranted. This type of supervision was provided for Warren, as documented in the reports.

While investigating the death of Warren, two ancillary allegations were uncovered. One was the altercation which he had been involved in which led to his being placed in segregation. This was investigated under the above case number and HCSO case number 2006-00373. Investigation revealed that another inmate, Brian Southall, had struck Warren in the mouth earlier on November 2, 2005. This battery was captured on a videotape, which was obtained and made a part of this investigation. It is clear that this battery did happen. When Southall was interviewed, he first attempted to claim that it was self defense. The video shows otherwise, and when confronted with this fact, Southall changed his story to allege that he hit Warren after Warren had attacked another inmate. Two things should be noted. First, when CCA officers brought Southall to Warren for identification following the altercation, he denied that Southall was the one who hit him. Second is that the videotape of the whole incident seems to support Southall’s version of events. In the video, Warren does attack another inmate, and other inmates separate them just prior to Southall striking Warren. In deciding whether to prosecute this case, a major factor is that the complaining witness is deceased and unable to testify. Although the video does show Southall hitting Warren, it also shows Warren hitting the other inmate first. Without an explanation from Warren as to why this occurred, the jury would be left with the image of this
first attack. In addition, Warren's only statement about the incident is that Southall did not do it. Thus I am declining to file charges against Brian Southall in this incident; the issues presented by Warren's death and the evidence we still have make a conviction impossible.

In addition, it was rumored that inmates had sexually assaulted Warren at the jail. This information was unknown until after Warren's death as he did not report it to authorities. As a result, there is no statement from him that this actually happened. HCSO investigated these allegations under case number 2006-00374 as well as the main case above. When the investigation was concluded, the claim rested entirely on the testimony of one inmate, Pietri, who stated that he saw another inmate engaged in what he believed to be sexual activity with Warren from the vantage point of a temporary cot located across from the cell in which the incident was to have occurred. He could not say that he actually saw sexual activity; only that he heard noises and saw the perpetrator on top of Warren. The inmate involved denied such activity. Thus the case rises and falls on the credibility of Pietri and on physical evidence. It is fortunate that authorities became aware of the allegations in time to have the medical examiner look into evidence of sexual assault as part of the autopsy. The autopsy found no evidence of acute trauma to the rectum. Although this does not preclude the possibility of such an assault, it does not provide the physical findings crucial in the absence of victim testimony. Turning to the testimony of Pietri, after he had given his testimony, which is inconclusive, he was given a voice stress exam regarding his allegations. Some of his answers to relevant questions revealed deception. Although these tests are not admissible in court, coupled with the lack of other evidence they create a situation where no prudent prosecutor can conclude that a sexual battery took place, let alone prosecute a person for it. Thus, I am declining to file this allegation as well.

II. THE SUICIDE OF GEOFFREY CONLEY

On January 5, 2006, inmate Geoffrey Conley committed suicide by hanging himself with a bed sheet tied around his cell bunk. The Medical Examiner's Office concluded that Conley died by hanging; no evidence disputes this conclusion. The reason for examination of this situation is to determine whether there was any criminal act involved in the actions of CCA personnel in their handling of the incident, and to review the procedures followed. Conley was in an isolation cell at the time of his death. These cells are occupied by only one inmate. Conley had been under suicide watch in the jail medical unit until December 23, 2005, after which he had been removed because it was felt that he was no longer a suicide threat. He had also received psychiatric treatment and medication at CCA.

Conley was then placed in isolation in one of the pods. It was indicated that Conley was isolated due to having a high bond. The isolation cells are not meant to house inmates on suicide watch; those inmates were placed in medical at the time of this incident. Conley seems to have made an attempt at suicide during his incarceration, as medical forms show that he had scratches/lacerations on his wrists. He had been seen by mental health professionals while at jail, and had been prescribed antidepressants. Documents while he was in suicide watch seem to indicate that he was frequently checked while there. Per jail policy, inmates on suicide watch were to be checked every 15 minutes; they admitted that they did not always follow policy. Conley also had problems with discipline while in jail. He had several write ups and had been
administratively isolated for a time due to destroying property. Nothing in the records indicates that Conley had threatened to kill himself in the time just prior to his death. An inmate told investigators that on his way back from court on 1/5/06, Conley had stated that he wished that the van carrying the inmates would flip, and that officers had heard these statements. When questioned, the officers indicated that they had not. The issue presented here becomes one of how the correctional facility handles inmates with mental health issues. When an inmate is having acute mental health problems or threats of suicide, a different protocol should be observed for their safety. When Conley was in suicide watch, he was observed more carefully to minimize the risk. However, when an inmate appears to be improving, should they be released to regular population, or held in suicide watch for their entire period of incarceration? This is a difficult question. Based upon the evidence presented, I cannot conclude that it was criminal on the part of any member of CCA staff to allow Conley to go back to a more regular environment, albeit an isolation pod.

A second issue is presented by the Conley case. This involves the following of policy and proper documentation of actions regarding inmate checks and supervision. Inmates on isolation were to be observed every 30 minutes, per jail policy. Log books obtained by HCSO did not show such documentation. CCA’s independent review of the surveillance tape produced a result that was at odds with the logs. Two detectives reviewed the tape at separate times, to determine whether there was any falsification of documents. Per the reports, and my discussions with Det. Douglas, officers only checked on Conley a few times during the day, apparently in violation of policy. There was a notation of every time Conley was seen at the door to his cell in the video review. Det. Banks’ review of the tapes showed that Conley was actually at the door to his cell on the occasions when CCA personnel has informed the Sheriff’s Department he had been. CCA personnel did not log in individual checks by officers of the isolation cells, even when they were done. My conclusion, along with that of law enforcement, is that there was no falsification of records. The log records were incomplete, devoid of information reference security checks of inmates, including Conley. The CCA investigation, which included a careful review of the tape, correctly documented both the times when officers checked on Conley and the times when he was seen in his cell. This was confirmed by painstaking review of the tapes by detectives. Thus no charges of falsification of records are appropriate. However, it should be pointed out that there are reasons for policies and log books. If a book is supposed to show when an inmate is checked on, it should be expected to do so. Leaving it blank is careless. Similarly, if there is a policy of 30 minute checks for inmates, that policy should be adhered to. I cannot conclude that the failure to follow these caused the suicide of Conley, or that doing them would have prevented it. However, it is clear to me that proper checks and documentation would have removed the questions from everyone’s mind. I recommend that the jail adopt, and strictly adhere to, policies for inmate checks and documentation of same, so that this question will not arise again.

III. THE SUICIDE OF TROUC TRAN

On January 27, 2006, federal pretrial detainee Trouc Tran committed suicide by hanging himself with pieces of cloth inserted and tied through an air vent in his cell. Ligature marks around his neck and the opinion of the medical examiner is consistent with this cause of death. Again the issue for review is the actions taken by CCA staff and whether there was any criminal
activity on the part of anyone involved. Trouc Tran was in a two man cell at the time, which he was ostensibly sharing with another federal detainee, Quang Tran ("Quang" for this report- no relation to Tran). Quang was interviewed by HCSO at length about the incident. Quang was aware for a period of time (about 3 weeks) that Tran was contemplating suicide, but had not informed authorities. Tran wanted to kill himself on the Vietnamese New Year because of the stress of facing a long federal sentence and because the federal authorities had apparently made his fiancee' aware that Tran was cheating on her. Quang said that although Tran waffled about this on occasion, he did believe that Tran was going to kill himself. To that end, Quang determined to move to another cell, so that he would not be present when it happened. Quang moved from cell 211 to cell 218, which was unoccupied at the time. He can be seen moving to cell 218 on the video, along with his mattress. An issue as to this is why this was allowed. Quang did not ever tell jail personnel what was going to happen, and it is clear there was no evidence or information which would have led them to suspect that Tran might kill himself. As an aside, it is not against any law to have such knowledge and not divulge it. Per CCA policy, the inmates in the unit that Tran was in are to be checked every 30 minutes. This was stated by several corrections officers. The CO's on duty at the time of the suicide told law enforcement that they checked the inmates every 20 minutes and logged it in every time. A review by HCSO determined that the inmates were checked only every hour. However, the logs were correctly documented with every time that an actual check was conducted; they correspond to the videotapes. Thus there was no falsification of entries, and the only violations are again of jail policy rather than criminal law. Law enforcement was also involved in investigating how it was that Quang was able to move to another cell. CCA personnel stated that policy does not allow an inmate to change cells on his own; this comes as no surprise. Quang stated that he had requested to be moved, but no documents obtained indicate that this request, or the move, was noted. CCA personnel seemed unaware that Quang had moved, or at best that he was not in his assigned cell.

It goes without saying that this is not the proper way for a jail to be run; CCA authorities stated as much to the Sheriff's Department, and to me as well. However, based upon the fact that Quang knew of the situation and did not tell anyone in authority, it does not follow from there that the death would have been prevented had CCA personnel become aware of Quang's move. Again, this is a violation of jail policy and must be dealt with accordingly. Therefore, I conclude that no prosecutable criminal actions occurred with regard to Trouc Tran's death.

IV. THE PREMATURE TRANSFER OF AARON HAGEN

Aaron Hagen entered a plea of guilty to a count of vehicular homicide and was sentenced to 5 years in the Department of Corrections. He was remanded to custody and taken to the Hernando County Jail. Hagen was to remain in the jail until the case of his codefendant was completed; he was to provide testimony in that case as a part of his plea agreement. The orders from Judge Jack Springstead clearly provided that Hagen was not to be sent to prison until after the codefendant's case was done. Whether the order was misread or ignored is unknown. Hagen was taken to the prison reception center contrary to the order. This was learned only after Hagen's mother had contacted counsel and told them of this occurrence. Orders had to be prepared to get Hagen back to the jail, and transport officers had to go and get him, at expense to Hernando County, as a result of this error. CCA's contract monitors withheld a portion of CCA's contract payment due to this error. This type of mistake should not happen; however, it is not
totally unheard of. Hagen was never out of custody and never posed any threat to the citizens as a result of this action. I must conclude that, although there was no crime committed, CCA personnel must carefully review all court orders regarding the disposition of prisoners, requesting clarification when necessary, and prior to taking action. This conclusion also applies to the following incident, which illustrates better what can happen when this process is not adhered to.

V. THE RELEASE AND “RECAPTURE” OF DANIEL SWETOKOS

Daniel Swetokos was a jail inmate facing felony charges. At some point he indicated through counsel that he believed he needed drug treatment. Judge Springstead concurred and sentenced him to probation with the special condition that he be released to the NPI drug treatment program in Ocala. The order specifically states that he is to be released “to NPI program”. Jail personnel, as well as others in the justice system, are familiar with the meaning of such orders. When such an order is entered it means that the inmate is to be held at the jail and not released until a bed is available. When a bed is open, employees of either the treatment facility or the law enforcement agency charged with transporting prisoners actually escorts the inmate to the program. According to HCSO reports, the person who got the order on Swetokos’ case had never heard of the NPI program (it is recently changed to that name from another acronym). Rather than ask, they determined to put the file in the “release” stack. Inexplicably, the file remained there for a couple of days, when a supervisor saw it, and, realizing that the inmate had been ordered “released” two days before, processed it for immediate release. Swetokos was let out of jail that day, I am sure to his surprise, despite the court order that he be held. It seems only fair to point out at this juncture that at no point in this incident did Swetokos do anything wrong; in fact, his responsible behavior prevented this from being a potential disaster. After being released in the afternoon, Swetokos went home, spent the evening, and decided that since he was on probation and out of jail he should report to the local probation office. Swetokos appeared at Probation and Parole when it opened for the day and informed them that he was there and out of jail. Probation authorities immediately realized that this was a mistake and called the jail to inquire why he was not there. At this point the jail realized their mistake and dispatched a team from the jail to take Swetokos back into custody. Swetokos was returned to custody by the jail personnel without incident at the probation office, where he had remained after being told that he should not have been released. Since then his situation has been resolved and he is now on probation.

Swetokos complains that CCA personnel violated his rights by arresting him. I disagree with this contention. It is my opinion that jail personnel have the right to recapture an inmate who is improperly released. Law enforcement authorities would also have this right; however, since there was no “escape” from custody, the jail can simply take him back. I am declining to file any criminal actions against jail personnel for recapturing Swetokos on that basis. There was no evidence of excessive force on the part of jail officials, nor evidence of any resistance or improper behavior on the part of Swetokos. As to the actions which led to his improvident release, my conclusions above are even more applicable. The jail, and the citizens, were very fortunate that they released this particular inmate instead of some of the others who may not have been inclined to act as responsibly as Swetokos. Orders must be understood clearly and completely before they are acted upon.
VI. ISSUES REGARDING THE FINGERPRINTING OF INMATES

One of the functions that occurs at the jail is that all inmates are fingerprinted. With the advent of technology there is a process that allows the inmates to be fingerprinted and scanned into a database which is kept by the Florida Department of Law Enforcement ("FDLE"). In most jurisdictions, this process is carried out by law enforcement (most county jails are part of the county sheriff’s office). Since CCA runs the Hernando County Jail they were in charge of doing the fingerprinting. This is not required; law enforcement can keep this function even in privately run jails, as they do in the CCA-administered Citrus County Jail (and as they now are doing in Hernando County). In August of 2005 FDLE contacted the Hernando County Sheriff’s Department and informed them that CCA had failed to submit arrest prints and information on over 700 people. Sheriff’s officials met with CCA staff and determined that there were numerous problems contributing to the backlog. The construction crew doing the jail expansion had cut the line leading to the machine, rendering it inoperable. It was also determined that even if operable, the jail staff was unaware of how to properly use the machine to begin with. By December 2005 Hernando County was 67th out of 67 Florida counties in submission of fingerprints. Part of the reason was that the broken cable had been spliced at the jail but was not working; another problem was that the jail staff was unaware that the scanning process had two parts; they were only completing the first part. FDLE asserted that they had attempted to help but their assistance was mostly to no avail in resolving the problem. A plan was implemented to get the backlog cleared up and it was done in December 2005 and January 2006. The issues involved with catching up the backlog caused the Sheriff to decide that he felt it was in the best interest of the citizens for his agency to take over the fingerprinting. CCA agreed to pay for this, and as of today the Sheriff’s Department is performing this function. Again no crimes have occurred, and this agency agrees with all of the others that allowing this type of backlog to occur was capable of creating a public safety issue and should have been handled differently, and sooner, by CCA.

VII. THEFTS FROM INMATES BY CORRECTIONS OFFICER HODGES

A number of inmates reported that a particular corrections officer, Jeffrey Hodges, was stealing funds from them when he booked them into the jail following their arrest. Hodges was a booking officer, and part of the booking process involves cataloguing each item of property an inmate has in his or her possession and placing it in safekeeping until the inmate is released or transferred. Hodges was falsifying the amount of money in an inmate’s possession on the documents, and taking advantage of the inmate’s concerns about having been just arrested to get them to sign the false documents. Hodges would then keep part of the money. When released from jail, the inmates would find that they had less money than they thought. Several complained, and HCSO began an investigation. The booking area has video surveillance; however, you cannot see everything the officer is doing during the booking process. Law enforcement confronted Hodges and he confessed to stealing money from these inmates. He has been prosecuted by this office for the thefts in an independent prosecution, and has pleaded guilty and been sentenced. CCA fired him immediately upon becoming aware that the allegations had substance. It is difficult to see where the administration could have found out about this earlier, and there is no indication that inmates had complained to CCA. A better booking area and
process would reduce the likelihood of this ever happening again; the new Warden, Don Stewart, wishes to implement this change to streamline the facility and make it safer.

VIII. THE ESCAPE OF MATTHEW DRAPER

On February 10, 2006, Matthew Draper, an inmate in the jail who was working as a trustee, escaped from the jail through an unlocked door left open by a guard during the removal of trash. Draper had stacked chairs which were sitting outside and used them to scale a relatively low wall onto the roof. From there he walked to a place where there was no fence and jumped to freedom. During his brief period of freedom Draper committed several crimes; these crimes are being prosecuted independently by this office and the charges are all currently pending. My inquiry was into whether there was any criminal culpability on the part of CCA personnel, and what lessons could be learned from the incident.

Draper’s escape was captured by surveillance video, as was the trash detail which resulted in the door being left open. Draper also spoke freely about his escape with detectives. He happened to notice that the officer left the door open, and just walked outside to see whether an escape chance presented itself. The chairs being out there was that chance. He stacked the chairs and climbed up, effecting the escape. Draper told detectives that the officer who left the door open did so strictly by accident; she was not a part of his escape. Most interestingly, Draper told investigators that he felt that there were plenty of escape opportunities available at the jail, as doors were left open on occasion, locked doors were opened by jail personnel without confirming who was going through them. He went as far as to say that he believed that he could have escaped by walking out the front door of the jail. Law enforcement questioned the guard who left the door open. She told them that she did not intend to help Draper, who she barely knew, escape, but left the door open by accident. She passed a voice stress test on these issues. Detectives concluded that she did not intentionally assist Draper in any way, and I find no reason to disagree with their conclusions. I also can find no evidence sufficient to charge her with any crime relating to leaving the door open; all of the evidence leaves the conclusion that it was a mistake, better handled by the jail through the employer-employee relationship. However, the issues presented by this incident show why this type of simple negligence must be prevented. I cannot see any way that senior staff at CCA could have been aware of this particular incident in time to stop it before it was too late. But Draper describes a pattern of unlocked doors and locked doors too easily opened. Why were chairs allowed to be sitting outside waiting for an opportunity like this to present itself? Why was there no fence around the area where Draper jumped off the roof? For most of these questions there are no answers; however, they must be corrected and it is in the public interest to be assured that they will be corrected. My conversation with the new Warden, Don Stewart, focused on many of these issues and his plans for correction of these problems. This discussion will be described in more detail later in this memo, but he did indicate to me specifically that the fence was not present because it had been removed by County employees for aesthetic reasons; in all fairness, they likely did not think that the doors to the area near the roof would be left open with chairs sitting out there for climbing. Training is also an issue here, the officer in question was relatively new and was uncertified. Training has come up frequently in these incidents; it is clear that a lack of experienced people has contributed greatly to the problems. This also needs to be rectified for the protection of the inmates jail personnel,
and the public.

IX. THE DEATH OF JOHN WELLS

John Wells was incarcerated in the Hernando County Jail on felony charges when he developed an infection that spread into his brain, ultimately causing his death. Wells was first incarcerated on December 21, 2005, and records do not show any medical requests until January 1, 2006, when Wells requested to go to sick call for the first time. Wells was placed on sick call and was given Tylenol for fever. This did not improve his condition, so the following day Wells was taken to Brooksville Regional Hospital. They diagnosed Wells with sinusitis, treated and released him back to CCA. When Wells did not improve, and began acting disoriented, CCA staff had him taken to Spring Hill Regional Hospital, where tests were performed and the infection was actually diagnosed. Wells was admitted to the hospital at that time, and his condition deteriorated until he was removed from life support and died on January 27, 2006. Attending physicians failed to notify the Medical Examiner’s Office as is required when an inmate dies, although technically Wells’ custody status changed on January 10, 2006, when the State dropped the charges against him due to his medical condition. The Medical Examiner’s Office became aware of the situation when a funeral home contacted them regarding cremation of the body. They took custody of the body and notified HCSO, which also began to look into the matter. An autopsy was performed and the cause of death was the infection, which the Medical Examiner, Dr. Cogswell, told law enforcement was unfortunately common. Other than anecdotal information from inmates, no evidence that CCA staff failed to respond to Wells’ complaints has been uncovered. Allegations have been made to the effect that Wells cried for days from headaches, but he never made a sick call request until January 1. When CCA staff brought him to Brooksville Regional, they felt that he was not sick enough to be admitted and sent him back to CCA. Evidence establishes that it was CCA staff that noted the problems Wells was having later that day, and they who ultimately took the steps needed to get him admitted to Spring Hill Regional. It cannot be shown in this case that CCA staff was even negligent at all, let alone to the level of proof required to sustain criminal charges. No inmates have been named or have offered to come forward on any of these matters, except on condition that they receive favorable treatment regarding their legal issues.

X. THE NEW ADMINISTRATION AT THE HERNANDO COUNTY JAIL

In response to some of the issues raised in this inquiry, CCA has appointed a new Warden for the facility. Don Stewart has many years of experience in corrections, at both the jail and prison levels. I spoke to Stewart about the issues involved in the inquiry and what his plans were to better the situation at the jail. He wishes to establish a stabilization unit for inmates who are suicide risks, with open cells and officers assigned directly to the pods for constant supervision. He has instituted a suicide watch where inmates are constantly observed if on the watch. Stewart believes it is crucial to try and find out which inmates may become suicidal before they actually attempt to kill themselves, and wishes to retain more mental health personnel to try and ferret them out. CCA is getting an electronic watch system which requires officers to wave a wand to a sensor every time they check a cell; this will create an automatic log to show whether the
required checks are being made in a timely manner. Late checks will be recorded in a different color on the printouts so they may be easily observed by supervisors and corrective action taken. More security cameras are being ordered and installed as well. If these programs are instituted, it is likely that the opportunity for inmate suicides will decrease, and time will be the judge of how well the programs are implemented and enforced.

Stewart feels that no area of the jail should not be fenced on the outside, and his plan is to put appropriate fencing completely around all jail buildings. This would certainly prevent many escape chances from coming to fruition. Draper would not have been able to get out of custody as easily under this plan. It is his belief that training issues are creating a lot of the problems experienced in this report. Getting more certified personnel is crucial to the operation; this is especially true in light of the jail's increased capacity, and training is going to be an important focus under his administration. Stewart also wishes to completely revamp and streamline the booking and property areas so that less commotion occurs there. Inmates to be released will eventually be let out through a completely different exit door than inmates being processed in. A property room will be located in a strategic position so that there will be separate windows for inmates booking in and those being released. The Sheriff's Department will have personnel at the jail to handle the booking prints; they are already in place. Also, more attorney conference space is being developed, with more privacy.

Whether these improvements are implemented and how well they work can only be determined by the passage of some time. Perhaps some progress is being made; the recent attempted suicide of the same Matthew Draper is on point. He was unsuccessful in his attempt; perhaps the new program is working. It should also be noted that some of these issues are hazards that are faced in all jails; inmates do kill themselves and do occasionally escape. The key is having the appropriate safeguards in place to minimize them, and conducting a careful policy review when incidents do happen. If these new programs are implemented, the result should be a lessening of such incidents in the future.

Although I have found no evidence of criminal activity, except as noted above, there is the question of negligence or incompetence in the operation of the jail. On March 8, 2006, State Attorney Brad King and I met with the Hernando County Grand Jury to review the issue. They share the concerns of most about the operation of the jail. However, they also realize that the new management should be given an opportunity to implement the changes they propose. Accordingly, they decided to delay any action on their part.
XI. CONCLUSION AND RECOMMENDATION

I recommend that we continue to monitor the situation and do a follow up in July, before the end of the current Grand Jury's term. We will then be able to advise the Grand Jury if further action is appropriate.

Respectfully Submitted,

William J. Capo
Assistant State Attorney
Florida Bar No. 337838
CORRECTION

On Page 7 of my Memorandum regarding the operation of the Hernando County Jail, there is an error that needs to be corrected. I inadvertently stated that Sheriff's Office personnel were out at the jail performing the fingerprinting function. This is not the case; they are awaiting the funding needed to take over the process, although they have been approved to take over this function. CCA personnel are doing the fingerprinting at the present time. I apologize for any misunderstanding.

Respectfully Submitted,

William J. Catto
Assistant State Attorney