

Private Corrections Institute, Inc.

July 17, 2008

SENT VIA FAX

The Honorable Patrick Leahy, Chairman
Senate Committee on the Judiciary
United States Senate
224 Dirksen Senate Office Building
Washington, DC 20510

RE: Nomination of Gustavus A. Puryear IV

Dear Chairman Leahy:

In connection with the judicial nomination of Mr. Gustavus A. Puryear, I have previously contacted the Committee concerning the death of Estelle Richardson, a female prisoner who died at a CCA-run jail in Nashville, Tennessee on July 5, 2004.

Mr. Puryear was questioned about Ms. Richardson's death at his Feb. 12 hearing, and issues regarding Ms. Richardson's death were raised in written questions posed to Mr. Puryear by several Committee members, including yourself.

I invite the Committee to compare Mr. Puryear's responses related to Ms. Richardson's death with the attached official report from the Davidson County Sheriff's Office, which, to my knowledge, has not been publicly disclosed until now. The report includes details related to the investigation – such as inconsistencies in the statements of the CCA jail officers involved; the video camera that allegedly “malfunctioned” but was found to be in working condition; the delay in attending to Ms. Richardson; and Ms. Richardson's treatment by the CCA officers who were criminally charged (charges that were later dropped due to uncertainty about when the fatal head injury was inflicted).

Dee Hubbard
President

Alex Friedmann
Vice President

Stephen Rahe
Secretary/Treasurer

Deb Phillips
Director

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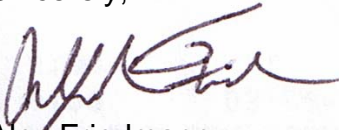
Senator Patrick Leahy
July 17, 2008
Page 2

Notably, Mr. Puryear informed the Committee, in his written response to questions from Senator Russ Feingold, that Ms. Richardson's death could have been attributed to other inmates due to the timing of "other, older head injuries that likely occurred weeks before her death." In support of his statement Mr. Puryear informed the Committee that "... Ms. Richardson was placed in solitary confinement on June 17, or about 18 days prior to her death." However, in direct contradiction to Mr. Puryear's comments, the attached report indicates that Ms. Richardson was "first placed in special needs segregation on April 29, 2004" (Report, p.1) – that is, almost 50 days before the date indicated by Mr. Puryear and 67 days before Ms. Richardson's death, if the report is accurate.

Ms. Richardson's death remains classified as an unsolved homicide. However, that is not how CCA classifies her death. Also attached to this letter is a list of security-related incidents that occurred at CCA facilities from May 17, 2004 through Sept. 5, 2004. This list, which is part of a larger document, was produced by CCA and provided to Florida state officials in support of a contract bid. As indicated by the highlighted line for July 5, 2004 at the Metro-Davidson County Facility (the date and location of Ms. Richardson's death), her death is recorded by CCA as being due to "natural causes."

Thank you for your continued time and attention;

Sincerely,



Alex Friedmann
Vice President, PCI

cc: Senator Arlen Specter, Ranking Member

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DAVIDSON COUNTY SHERIFF'S OFFICE

Daron Hall, *Sheriff*

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Nashville, TN 37201

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MEMORANDUM

TO: Sheriff Daron Hall
Chief Deputy John Ford

FROM: Investigator Chelle Knight *JK*

DATE: August 5, 2005

RE: I/M Richardson*Estelle, OCA/267027—Death in Custody at MDF
Case Number 04-052 MDF

At approximately 0700 hours on July 5, 2004, MDF first shift Captain Eddra Hawkins notified this investigator of the death of I/M Richardson*Estelle, OCA/267067. Hawkins indicated that Richardson had been experiencing "short breathing" and was taken to Southern Hills Hospital at 0604 hours. Hospital staff pronounced her death at 0618 hours.

CCA officials conducted the administrative investigation into the death of Richardson, and the criminal case has thus far been investigated by detectives of the MNPD and the FBI. At the conclusion of the police interviews on the day of Richardson's death, this investigator was instructed to continue involvement with the case in order to liaison with the police department. The information in this report is not intended to outline the complete investigation, but rather, to summarize information that was gathered in the immediate aftermath of the death, often by direct involvement of this investigator. Law enforcement personnel continued to interview witnesses/subjects, administer polygraphs, etc., and although many of the new developments were reported orally to the DCSO administration, they have not been included here to maintain the integrity of the criminal investigation.

Richardson was a thirty-four year old female who had been in custody since March 11, 2004. After being processed into jail, she had been transferred to MDCDF for housing on March 12, 2004, and was first placed in special needs segregation on April 29, 2004. At the time of her death, she was housed in G-unit (segregation). G-unit has one central control center but has been separated into three housing pods connected by interior doors. The segregation females were confined to Pod I, and Richardson was the only inmate assigned to the first cell on the bottom level, #001. That cell is near the back of the left stairway and in the corner next to the program room that was used to house the females isolated for MRSA concerns.

It should be noted that although the MRSA females were housed in segregation, their movement was not restricted like that of the other segregation females. In order to provide the MRSA population with restroom facilities, cell #002 was left unsecured and those females were allowed

to exit the program room as needed to access that cell. Due to the placement of the cells in question, this required that the MRSA females pass directly by Richardson's cell when going to or coming from the bathroom.

Once notified of the death, this investigator contacted MNPd South Precinct Detective Brad Corcoran and he agreed to meet at the MDF facility to review the case. Upon arrival at the facility, MDF third shift Captain John Drake provided the following synopsis of events:

At approximately 0500 hours, an officer had observed Richardson receive her breakfast tray and sit down with it. Then, while the officers, Joshua Schockman and Jeremy Neese, were doing rounds at approximately 0530 hours, they saw Richardson on the floor. A medical emergency was called at 0532 hours. The officers checked her vitals and began CPR. The ambulance arrived within 5-10 minutes and CPR was continued as they exited the facility at 0604 hours.

Lt. Derrick Carlington indicated that Richardson had a history of disruptive behavior and special needs (psych) placement. Drake also pointed out that both Schockman and Neese have "been in training" on the stairs of the cell as both compete in Toughman competitions; Schockman was reportedly a Toughman Champion.

Schockman and Neese were interviewed initially in an effort to further detail the activities of the morning and to ensure that everything related to the death was in order [see statements outlined below]. While waiting to talk to Schockman and Neese, Corcoran reviewed copies from Richardson's medical file that had been provided. Corcoran noted a document that indicated Richardson had refused a medical evaluation on Sunday, July 4, 2004, at 0900 hours, after a Use of Force. Corcoran requested to review the reports related to that Use of Force.

After the initial discussions with Schockman and Neese about the events of the morning, the paperwork was provided concerning the incident of the previous day. Reports indicated that there had been four staff members involved in that incident: Schockman, Neese, Sgt. Keith Hendricks, and C/O William Woods. Indications are that some of the paperwork related to this event was still being completed on the morning of Richardson's death. [Neese confirmed that he filed his report about the 7/4 incident on the morning of July 5, 2004, but it was not clear if it had been before or after her death.]

The paperwork indicated that the Use of Force had occurred less than twenty-four hours before Richardson's death. As a result, Schockman and Hendricks were then asked about the Use of Force incident. As the discussion with Hendricks was ending, Corcoran received a phone call from the Office of the Medical Examiner. Initial information from that office indicated that Richardson had injuries not consistent with a death of natural causes. [These injuries were later confirmed to be: a skull fracture from the back of her head to the left temple, brain hemorrhaging in two places, four broken ribs on her left side, and a lacerated liver. It was the opinion of the Medical Examiner that the injuries had been sustained within the last 24 hours.] Due to this information and some inconsistencies noted between the initial accounts given by Schockman and Hendricks, the focus of the inquiry changed. All interviews were discontinued as Corcoran consulted with his supervisory staff.

At 1103 hours that day, this investigator was notified that the MNPD Homicide Division would handle the case from this point forward. Detective Mike Roland was assigned as the lead detective, and Detective Derry Baltimore assisted. The four officers from the incident of 7/4 were asked to report to the police department for interviews with Roland. Despite a police request, this investigator did not participate in any further questioning with the subject officers to preclude any Garrity concerns.

THE 7/5 INCIDENT: The Death

According to the G-control log:

- 0435 Chow served in Pod 1
- 0450 Chow served in Pod 2
- 0505 Chow served in Pod 3
- 0532 Medical Emergency in Pod 1
- 0534 Floor officers advised me to call 911
- 0536 Nurse Abby, Nurse Michael, Sgt Cornish, Cpt Drake, Lt Carlington into Pod 1
- 0538 Metro calls segregation for causes and symptoms of problem
- 0547 Metro arrives with stretcher and 6 personnel, along with C/O Ashley
- 0555 Metro leaves with I/M Richardson on a stretcher from 01 in Pod 1
- 0600 Medical Emergency cleared
- 0801 Sgt Cornish called, cell 01 is off limits till further notice [Schockman is probable author]
[All entries by C/O Jeffrey Darnell except 0801 hours.]

Officer Statements about the Death [These are summaries based on recollections and notes.]

C/O Joshua Schockman—At approximately 0823 hours that morning, Schockman stated that he had fed chow at approximately 0500 hours. He said he had opened the flap in Richardson's door, she came to the door to get her tray, and she returned to her bunk with it. Schockman indicated that when he had returned for her tray at approximately 0530 hours, she had been lying upright on her bunk, her tray was in her lap, her left arm was hanging down, and her eyes were closed. Schockman stated that Richardson liked to "act out" or pretend to be asleep, but on this occasion, she "didn't look right" and was unresponsive. He went into the cell and felt her arm and her neck and described both as cold. He stated that he had held his fingers up to her nose and determined her breathing to be weak. Schockman stated that he had called a medical emergency and started "assist breathing, two and ten." He said that when the nurse [Michael Ondieki] arrived, he and Ondieki had straightened Richardson out and put her on the floor. Schockman said that when the ambulance arrived, Richardson's eyes were open and it looked as though she had thrown up oatmeal. He finished by saying, "I did everything I could to save her. I thought I saved her life."

C/O Jeremy Neese—Neese stated that he and Schockman had fed chow in Pod I, Pod II, and Pod III, and then took a break so that they too could eat before they returned to Pod I to collect trays. Neese said he went to the top level and Schockman started on the bottom level by cell #001. Neese stated that Schockman had called him to "come look at this." Upon arriving at Richardson's cell, Neese saw her with her head down at her chest and when he touched her, she was "ice cold." He reported that Schockman also touched her and said to call a medical

emergency. As soon as medical arrived, Schockman started breathing for her. Schockman and the male nurse, Mike, moved her from the bunk to the floor, with Schockman pumping and the nurse doing the bag. Approximately 1-½ minutes later, the sergeant [Sgt. Jerome Cornish] arrived and began compressions along with nurse Abby [Abilio Kosoko] who had brought the defibrillator.

At one point in this conversation, Neese had pointed out that the “other inmates were telling us she was acting funny” but that they [correctional officers] had been instructed not to call medical emergencies for epilepsy.

Sgt. Jerome Cornish—Cornish stated that his first impression upon entering Richardson’s cell that morning was that her neck was broken. Cornish stated that the male nurse had checked Richardson’s pulse, and said to call 911. Neese had been approaching the cell at that time, so he had called that request in to master control. Cornish not only indicated that he had arrived earlier than indicated by Neese, he added that he had not seen Schockman performing CPR during the incident; when he arrived, Schockman had “just been standing there.”

Inmate Statements about the Death [These are summaries based on recollections and notes. See audiotapes on file with MNPD for further detail.]

- *Judy Townsend, OCA/111651*, said she called to Richardson every day to wake her up for chow. On this date, Richardson had looked at her and said, “Can you bring it to me?” After Townsend explained that she could not [the door was locked], she saw Richardson get up and get her tray that had been left in the hole in the door. Townsend went to the bathroom and when she passed back by Richardson’s cell, Richardson was lying on the bed with her head on the wall and she was kind of convulsing. Townsend said she called to Schockman and Neese, who were by the exit door leading to pod II, alerting them about Richardson’s condition. Townsend indicated that instead of responding, the officers continued to serve chow to the other two pods, and when they returned 30-45 minutes later, Richardson was in the same position.
- *Angel Halpin, OCA/212243*, said that when she had walked by the cell, it looked like Richardson was having fits and jerking. They told the guards to help Richardson and all the guards said was that they had called the medical staff for her.
- *Linda Hargrove, OCA/181211*, said she was also walking by Richardson’s cell and saw Richardson apparently having a seizure. She said it was 30-45 minutes later before they came to help her.
- *Ruby Champlin, OCA/181656*, said that Richardson had told Townsend she could not breathe. Champlin said Richardson had been shaking. Champlin said she saw Richardson fall back and hit her head on the wall and she was foaming at the mouth. The young blond officer [Neese] and “Shopley” [Schockman] laughed about it. She said “Shopley” had told her it would be best if she just shut her mouth.
- *Wanda Sykes, OCA/151326*, said that at approximately 0115 hours, Townsend and Champlin were calling for the officers who were standing at her door (#004). They told the officers that Richardson needed help because she was foaming at the mouth and could not breathe. The officers said, “well fuck her” and left through the side door.
- *Cameron James, OCA/224010*, said she heard Townsend tell the officers that Richardson was foaming at the mouth and possibly having a seizure. She said that the officer said

words to the effect of, "we can't do nothing. It takes the nurses forever. We'll be back in a minute." James said that it was actually 30-45 minutes before they returned. They went into cell #001 and James heard a nurse say, "there's no pulse."

- *Gwenell McDonald, OCA/134252*, said that she heard one of the "staph girls" hollering to Schockman and Neese that Richardson needed help. One responded, "It'll be a while before the nurse gets here." They left her, and when they came back, she was dead.

Additional Concerns

The Timeline of 7/5

Although Schockman maintained that there had been only about 30 minutes that passed between when he saw Richardson take her tray to her bunk and when he returned to find her "not right," indications are that it could have been as much as twice that amount of time. Based on the method of distribution, both Schockman and Neese agreed that cell #001 in Pod I would have been one of the first to receive a tray that morning, and Schockman's timeline had been based on a starting time of 0500 hours. Schockman stated that as soon as they had finished passing trays to all three pods, they had returned to Pod I to begin the retrieval process. Neese, however, indicated that after all three pods had been served trays, he and Schockman had taken a break in order for them to eat as well before they returned to the pods to retrieve the trays. The log entries made by Darnell, assigned that morning to the control room in G-unit, tended to support Neese's version of events and a lengthier passage of time than that indicated by Schockman. Darnell wrote in the log that "chow" had actually been served to Pod I at 0435 hours, and that the medical emergency was called in Pod I at 0532 hours.

When Richardson retrieved her tray

It should be noted that although Schockman stated that he had personally witnessed Richardson retrieve her tray from the door and return to her bunk, inmate accounts did not support this. Both Townsend and Champlin indicated that they regularly made sure that Richardson was awakened to get her tray for breakfast. According to Townsend, the tray had been left at the door by the officer and it was Townsend who awakened Richardson, watched her retrieve her tray, and return to her bunk.

The Response to the Medical Emergency

Several inmate witnesses stated that they told or heard others tell the officers that Richardson needed help or might be having a seizure. Neese confirmed that the inmates had alerted him and Schockman that Richardson was "acting funny" as they left Pod I enroute to distribute meals to the other two pods. By Neese's account, they not only fed the other pods, but also took a break so that they could eat before returning to the cell to find Richardson unresponsive. Neese explained their lack of response by saying that they had been instructed not to call medical emergencies for epilepsy. The inmates also indicated that Schockman had been aware that Richardson was in distress as he had been standing next to Neese at the doorway. Schockman's position on this issue is unknown to this writer.

THE 7/4 INCIDENT: The Use of Force

According to the G-control Log:

- 0701 Richardson, Estelle cell 01 refused to be cuff
0750 Richardson, Estelle jumped up and began to fight as her room was being cleaned and she was being handcuffed (cell searched). [This was by unknown writer although C/O Belmalie Bermudez surmised it looked like the handwriting of Hendricks.]
0800 Late entry. Search cell 01 trash found.
0902 Pill call arrive
0904 I/M Richardson*Estelle from cell 01 refused to be seen by medical.
[All entries by Bermudez except 0750 hours.]

Officer Statements about the Use of Force [These are summaries based on recollections and notes.]

C/O Joshua Schockman—He stated that while Hendricks had been doing rounds in Pod I, Richardson's cell had been trashed and there was stuff on the floor. Schockman said that he told her to come to the flap to cuff up. He said that she asked why she had to get up and she was told that her cell was a mess and it was going to be cleaned. She said, "I can't get up." When asked why, she said, "I don't know, I just can't." Schockman stated that they had gone into her cell to cuff her, and she rolled over, became belligerent, and said that the officers could not come in her cell any time. The sergeant [Hendricks] had his spray pulled. Richardson sat up in her bed, and then began to shake her tray; food was flying as she flailed her fists around. The sergeant sprayed her but it hit her in the shirt and she swung at Hendricks. The sergeant sprayed again, this time making contact in her eye. She grabbed her eye and sat on her bunk. Schockman said, "we put her on the floor." Schockman had her upper body and the other officers had her lower body. Schockman said she was kind of on her side on the floor and she cuffed up. He stated that there had been no strikes at all.

Sgt. Keith Hendricks—Hendricks indicated that he had been on his way out of segregation when Schockman had informed him that Richardson's cell was trashed. Schockman had told Hendricks that he [Schockman] told Richardson to get up but she did not. Hendricks added that Unit Manager Joe Whitlow had been on his way in, so Richardson's cell had to be cleaned. When Hendricks approached the cell, Richardson had been lying on her bunk with her back to the door. Hendricks said he had been knocking, telling her to get up when she said, "I can't get up."

Hendricks said he went to get the video camera from the G-unit control room, but found it not working. He said that he and the other officers then entered the cell, and as they were coming toward her, Richardson jumped up and started swinging food trays at them. Hendricks stated that he had sprayed her in the face with the fogger and she "kinda went down" with her eyes closed trying to wipe them. Hendricks changed to his other can of spray (the stream) while telling her to get on the ground. He sprayed again but stated that the second spray missed or did not do anything; he stated that he did not know where the stream landed. They rolled Richardson over on her stomach and cuffed her, although Hendricks was not sure who had actually applied the cuffs. Hendricks stated that they cleaned the room and Richardson had been compliant after that. Nurse Summer [Shope] came to Richardson's door and Hendricks told Richardson he was going to get medical to look at her. She replied, "What the fuck for? I don't want to see

nobody.” Hendricks stated that Richardson had no visible injuries. He also stated that he had notified Captain Ralph Jackson that Richardson was refusing to clean her cell, but Jackson did not report to the cell at the time of the incident.

Hendricks was asked about the area that had been scribbled out in his incident statement. He stated that he was going to write “was restrained” but he had wanted to add that she fell to the ground.

Inmate Statements about the Use of Force [These are summaries based on recollections and notes. See audiotapes on file with MNPd for further detail.]

- *Linda Hargrove, OCA/181211*, said that she heard Richardson screaming “why are y’all doing this to me?” She said that she did not see anyone else in Richardson’s cell but Hendricks, whom she described as a “real asshole.” She heard the sound of mace being sprayed and she could smell it.
- *Joan Brown, OCA/283557*, began by saying that “he kicked her [Richardson] dead in her back and he maced her.” Brown said she had awakened that morning when “Henderson” (big, tall black dude) hit Richardson’s door saying, “Wake your nasty ass up.” Brown said that she could see Richardson on the floor with one arm behind her back and Hendricks had knelt down, with his knee on her back. He left Richardson’s cell and then “stormed in [the MRSA room] and told us all to go back to sleep.”
- *Jackie Wilkerson, OCA/113934*, said that Hendricks beat on the door and said, “Get your nasty ass up.” Wilkerson said that she had been looking through the crack of the door by the hinges and saw Hendricks jerk Richardson up off the bed, pull her to her feet, and throw her on the floor. He maced her and then got on top of her with a knee in her back. Richardson was screaming and crying. Hendricks was mad when he came out of Richardson’s cell and told Wilkerson and I/M Etta Coffelt to sit down and get out of the door. Wilkerson said she does not think medical came, and Richardson was put in cage #3 for a while, at least an hour.
- *Ruby Champlin, OCA/181656*, said that Richardson fell off her bed about 3 days prior to the Use of Force. She had hit her head on the left side and it was bleeding, with a small patch of hair missing. Then, on the morning of 7/4, Champlin said she was coming out of the bathroom [cell #002] when she encountered Hendricks in an “ill mood,” telling her to get in her room and shut the door. The young blond officer [Neese] had been standing at the door at the time. Champlin said she saw Hendricks yank Richardson off the bed and Richardson had hit the floor with a hard hit. Hendricks was on top of Richardson trying to cuff her with his leg on her back. Champlin went on to say that Richardson had not refused medical treatment afterward, but rather, she had been asleep. When she did not get up, Hendricks had said she refused. On the night of 7/4, Richardson had said her chest was hurting.
- *Angel Halpin, OCA/212243*, said that Hendricks had opened Richardson’s cell door and hollered for her to give up her tray. Halpin said she had stood up and could only see Hendricks in the room. She heard Hendricks call Richardson a “nasty bitch.” Richardson was on the floor and Hendricks had been on top of her when he sprayed her in the face.
- *Wanda Sykes, OCA/151326*, said that on Saturday, Hendricks and “Schockley” forced Richardson to take a shower. Richardson was called a nasty, stinking bitch and told to

“wash her ass.” She did not have cuffs on when she was brought out of the cell and taken to cage #3. Schockman punched her in the right side toward her back and Hendricks was standing on her feet. Then, Hendricks put his knee in her back and sprayed her.

- *Cameron James, OCA/224010*, said that Hendricks, Schockman, and Neese went to Richardson’s cell at approximately 0700 hours and told her to cuff up to go to the shower. James heard someone say, “if you don’t, we’re gonna spray you and get you out of this nasty room.” James said that she could hear scuffling and then someone said, “quit dragging her.” James’ view of that corner starts midway on the stairs. She saw the officers dragging Richardson by her arms. When the officers went to take the handcuffs off, Richardson had flinched like she was terrified. One of the officers said, “if you don’t shower and come back out, we’ll spray you again.” Hendricks threw Richardson on the ground and had his knee in her back. One officer was partially blocking James’ view at the time. The officers picked Richardson up and put her in the shower.
- *Medinah Smith, OCA/159058*, said that she did not get to Pod I until about 1900 hours on 7/4. “Schockley” and Neese had been on duty. She stated that she heard Richardson asking for the nurse, saying that she needed help because her head and shoulder were hurting. She had also said something about swelling.
- *Gwenell McDonald, OCA/134252*, said that she saw Hendricks, Schockman, and Neese rushing up under the stairs. She heard scuffling but no talking except Hendricks saying “get your ass to the door and cuff up.” When they brought Richardson out, Bermudez came into the unit and took her to cage #3. The officers took Richardson straight to the shower, and brought her back out to uncuff her. Richardson had been terrified and shaking. Hendricks told her, “Every time I have to come in here for you, this is what I’m gonna do to you.” Richardson had been abnormally quiet.
- *Lavonia Johnson, OCA/208858*, said that around breakfast time on 7/4, she heard Richardson making comments like, “you’re hurting me,” “stop, stop,” and “oh, oh.” Recognizing Hendricks’s voice, Johnson heard him say “get on the ground” and later “every time your room ain’t clean, we’re gonna spray you.” Hendricks and Schockman pulled her out and drug her to the shower where she stayed for approximately 40 minutes. They came back and told her to get out and get dressed. When she did not, Hendricks went in, grabbed the mace, and told her “when I get back, if you’re not ready, I’m gonna spray you again.”

Additional Concerns

The Incident Reports

As indicated, Neese admitted that he completed his report on July 5, 2004, not the day/shift of the incident. It is not clear if the written statements of the other officers had been completed prior to Corcoran’s request, or if they had been completed in response to his request. Each of the reports lacked detail on some points and the information provided in the interviews was at times inconsistent with the reports. For instance, Neese’s written statement never mentioned Richardson swinging at Hendricks [as indicated by Schockman and Hendricks] or Hendricks spraying her in response [as indicated by Hendricks and Wood], and the report seemed to indicate that Neese simply rolled Richardson over at Hendricks’ command and handcuffed her.

Schockman’s report indicated that it was Hendricks who made Schockman aware of the mess in Richardson’s cell, not the reverse as told in interviews. In his report, Schockman covered all of

the events in the cell with the sentence, "I then assisted in restraining her after she refused to cuff up and attacked Sgt. Hendricks." There was again no mention of Richardson being sprayed or any other details provided. Hendricks's written statement only mentioned one spray and indicated that Richardson then "fell to the floor and was restrained." There was no information on who applied the restraints. Wood, in his report, wrote that Richardson was "flailing her arms at the officers. Sgt. Hendricks sprayed I/M Richardson who was then restrained." Wood went on to write that he then relieved Bermudez in the control room, even though in his interviews, he has since stated that Richardson had not been restrained when he left the cell.

None of the incident statements provided any indication that the events that morning may have lasted up to two hours. It should also be noted that the incident statement packet [synopsis of the overall incident] that is compiled by the shift captain was not completed until July 5, 2004, at 1500 hours, 32 hours after the Use of Force incident, and several hours after Richardson's death.

The Medical Evaluation

According to CCA policy, any Use of Force involving an inmate should result in a medical evaluation of those involved. In this case, a logbook entry indicated that the first trouble with Richardson began that morning as early as 0701 hours. It is not clear from the reports exactly what time the officers entered the cell, but the log indicated that she had "jumped up" at 0750 hours. However, according to the medical documentation, it was more than an hour after that when Richardson reportedly refused to be seen at 0900 hours.

C/O Hirsil, assigned to medical that morning, indicated that Hendricks had come to the clinic at approximately 0840 hours, looked around, and then left. When interviewed by a detective on July 6, 2004, nurse Summer Shope stated that Hendricks had come by the clinic in the interim and asked her to bring a form to see someone when she came to the unit to do pill call. Shope had arrived in the unit to do pill call at approximately 0900 hours, and there is not agreement among the witnesses whether Richardson actually refused the medical evaluation. The purpose of having the inmate evaluated after a Use of Force is to ensure and document that there were no injuries. The timeliness of the offered evaluation in this case seems to be at odds with the intent of the policy.

The Video Camera

Hendricks wrote in his incident statement that he went to get the video camera but it did not work. However, when the camera was tested during the investigation, it was confirmed that the cover was broken, but Detective Baltimore was able to make a recording using the camera. There was no mention in the report of Hendricks attempting to get another camera, although MDF officials indicated that another camera should have been available nearby in the long hall. According to Assistant Warden Steve Garner, Hendricks had explained that he and the other officers had entered the cell without the camera due to medical concerns, i.e., Richardson's claim that she was not able to get up. Thus, indications are that Hendricks portrayed the incident to Garner as an immediate use of force instead of planned. However, in his own incident statement, Hendricks contradicted that by writing that they went in "so we could clean her cell". It was also clear from Hendricks' report that Richardson had already said she could not get up when he first went to get the camera. Thus, if there had been a medical concern that overrode the need for a camera, the entry into the cell would have been made prior to the attempt to retrieve the camera.

There was nothing to indicate that her medical condition had worsened between the time that she said she could not get up and the time that Hendricks returned from trying to get a camera.

Authorization to enter the cell

According to Lt. Derrick Carlington, Hendricks was required to have authorization from his supervisor to enter Richardson's cell. Hendricks stated that he had called Captain Ralph Jackson and was given that authorization. Jackson, on the other hand, told the detectives that Hendricks had called after the fact at 0750 hours on July 4, 2004, and told him that they had gone into Richardson's cell. As noted, Jackson's paperwork and recap of the 7/4 incident was obviously not completed until after Richardson had already died the next day.

The Surveillance Camera

Acting Unit Manager Joe Whitlow stated that he had changed the tape for G-unit's surveillance camera on Friday (7/2) morning. On the weekends, the sergeant on-duty in the unit is responsible for changing the tape. When Whitlow came in on Sunday (7/4) at approximately 0802 hours, soon after the incident, he noticed that Hendricks had not changed the tape on Saturday. Thus, the recorder had not been running when the Use of Force incident occurred prior to Whitlow's arrival Sunday morning. It should also be noted that on the tapes that were available, there is limited sight within the pod, showing only 8 of the 22 cells and part of one of the three shower areas. Furthermore, of those available, there was no time/date stamp on the recordings to confirm the time period they would have shown.

Administrative concerns about Schockman

Whitlow, when interviewed on July 12, 2004, discussed his recent assignment to the position, and indicated that he wanted to speak "off the record." He stated that he had had concerns prior to Richardson's death that Schockman was overzealous in his dealings with inmates. As a result, Whitlow had thought that Schockman probably needed to be reassigned out of segregation and off of the Special Operations Response Team. Whitlow indicated that he had been getting ready to address the matter, and had already spoken to Hendricks, Program Manager Tina England, and SORT Commander Bryan Williams about his concerns. Whitlow stated that he did not want to make his concerns part of the record because he "doesn't want to be in the middle."

In a subsequent conversation, Williams confirmed that he and Whitlow had discussed these concerns about Schockman on Wednesday or Thursday of the week prior to the death [6/30-7/1]. In fact, Williams added that he had been on vacation the week of 7/5, but that he had been called by "the administration" on that Monday [the date of the death] and asked if he and Whitlow had a discussion about Schockman and if anything had been documented. Indications are that nothing had been documented, and despite the discussions before the death and on the date of the death, Whitlow was the first person to mention these concerns to the detectives a full week later.

Indications are that the statements given by the subject officers have evolved during the course of the investigation, at times contradicting or elaborating upon the statements of the other officers, the written reports, and in some cases, their own initial statements. At a minimum, it

appears that these two incidents (the use of force on 7/4 and the medical emergency on 7/5) represent failures to adhere to some basic correctional procedures. For instance:

- ◆ Ensuring the use of a video camera during planned uses of force
- ◆ Promptly providing medical care after a use of force
- ◆ Preparing clear and concise incident reports to document an incident
- ◆ Responding to medical emergencies in a timely manner
- ◆ Ensuring continual video recording in high-risk areas

In addition to these oversights, administrative concerns and complaints leveled by other inmates in the aftermath of the death were forwarded to officials at MDF for handling.

On November 11, 2004, this investigator was called to testify before a federal grand jury concerning the death of Richardson. However, on August 4, 2005, notification was made that the case would most likely be handled in the state criminal courts. Further developments are unknown as of the date of this writing.

cc: Mike Roland, MNPD

Bay County Jail - Annex	09/05/04	Four maximum security inmates took hostages on the medical floor of the main jail. After a 12 hour standoff with the Sheriff's Office hostage negotiators, the BCSO SWAT team opened fire, injuring a CCA nurse. The nurse was hospitalized for injuries sustained during this incident.
Gadsden Correctional Facility	09/04/04	Inmate died of natural causes.
Florence Correctional Center	09/03/04	Inmate died of natural causes.
Hardeman County Correctional Facility	08/26/04	Staff member arrested and charged with Introduction of Contraband into a Penal Facility after bringing in 4.7 ounces of marijuana for an inmate.
Wheeler Correctional Facility	08/25/04	John Williams a Vocational Instructed was arrested at the facility by the DEA on a drug raid which occurred at his residence.
Central Arizona Detention Center	08/24/04	Inmate died of natural causes.
Metro-Davidson County Detention Facility	08/19/04	Inmate on inmate assault which required admission to hospital.
Elizabeth Detention Center	08/19/04	Inmate claimed to the medical dept that he wanted to harm himself. His cell was searched by officers and broken glass was found. It was recommended by medical that he be sent to Elizabeth General Hospital for evaluation.
Central Arizona Detention Center	08/14/04	Fighting/10 or more. No hospital admission required.
Bradshaw State Jail	08/11/04	Disturbance between 17 black and white offenders over an unpaid debt. No serious injuries, no damage to property.
Willacy State Jail	08/10/04	Offender slipped and fell down. Treated at hospital and released.
Florence Correctional Center	08/08/04	Several inmates began fighting in pool, inflammatory agents used to regain control. No hospital admission required.
Hardeman County Correctional Facility	08/07/04	An inmate escaped by cutting through perimeter fences from the recreation yard using wire cutters he had obtained from a vocational classroom. The cutters were not detected as missing prior to the escape because the inmate had replaced them with an exact replica that had been made of wood. The inmate was recaptured on 8/8/2004 at the county landfill approximately 25 hours after his escape.
Willacy State Jail	08/02/04	Racial disturbance. No hospital admission required.
Central Arizona Detention Center	07/31/04	Inmate on inmate assault which required admission to hospital.
Silverdale Facilities	07/29/04	Correctional Officer was arrested on the facility for possession of marijuana, marijuana pipe.
Central Arizona Detention Center	07/29/04	Fighting/10 or more inmates.
Florence Correctional Center	07/25/04	Inmate died from accidental drug overdose.
Delta Correctional Facility	07/25/04	Contract Employee was arrested for introduction of contraband into a correctional facility.
Tallahatchie County Correctional Facility	07/21/04	Inmates on new rec. yard, kick the chains until the locks broke. 30 inmates exit the rec. cages and went out on the big yard. There were no inmates hospitalized and there was minor property damage.
Crowley County Correctional Facility	07/20/04	Several hundred inmates exited the living units and began to gather in one mass group with several smaller groups spaced out across the yard. Staff attempted to disperse the groupings with a show of officer presence, as well as verbal directives; however, the groups refused and began making threats toward staff. Inmates began throwing rocks at staff and windows as well as using the weight equipment to access buildings and control rooms. Several fires were set and extensive property damage occurred. A combination of CCA SORT and DOC SORT were able to regain control of the facility. No staff injuries occurred; one inmate incurred severe injuries and was later released from the hospital.
Elroy Detention Center	07/19/04	Fighting/10 or more inmates.
Wheeler Correctional Facility	07/12/04	Inmate on inmate assault which required admission to hospital.
Silverdale Facilities	07/07/04	Inmate on inmate assault which required admission to hospital.
Metro-Davidson County Detention Facility	07/05/04	3 correctional officers arrested for bringing approx. 3 ounces of Marijuana
Delta Correctional Facility	07/04/04	Officer was arrested at the facility for aggravated domestic assault by the east ridge police.
Lake City Correctional Facility	07/02/04	Inmate died of natural causes.
Hernando County Jail	07/02/04	Inmate on inmate assault which resulted in admission to hospital.
David L. Moss Criminal Justice Center	07/02/04	Inmate attempted suicide by overdose, treated and released from hospital.
Hardeman County Correctional Facility	07/01/04	Instructor arrested and charged with Introduction of Contraband into a Penal Facility after bringing in 15.6 ounces of marijuana and .8 grams of cocaine.
Correctional Treatment Facility	06/24/04	Inmate on inmate assault which required admission to hospital.
Winn Correctional Center	06/23/04	Correctional Officer was found to have concealed on his person a small plastic bag containing a green leafy substance that appeared to be marijuana. Sheriff's Office was notified and C/O was arrested at the facility for introduction of contraband.
Liberty County Jail	06/23/04	Offenders were fighting and one offender was kept in hospital for observation and returned to the unit the next day.
McRae Correctional Facility	06/22/04	Three inmates escaped from the secure confines of the facility.
Bradshaw State Jail	06/20/04	Phone Strike - inmates placed on lockdown for precautionary measures.
Willacy State Jail	06/15/04	Inmate on inmate assault which required admission to hospital.
Correctional Treatment Facility	06/09/04	Inmate on inmate assault which required admission to hospital.
Central Arizona Detention Center	06/07/04	Inmate escaped at night by climbing over the fence in the early port, captured the next day
McRae Correctional Facility	06/06/04	Fighting/10 or more which required admission to hospital.
Marion County Jail II	06/05/04	Inmate on inmate assault which required admission to hospital.
Bartlett State Jail	06/05/04	Inmate escaped from the second floor counselor's office, captured 07-June-04 by Marion County Sheriff's Dept.
Bent County Correctional Facility	05/29/04	Group disturbance involving 10 offenders.
Willacy State Jail	05/24/04	Inmate on inmate assault which required admission to hospital.
California City Correctional Center	05/24/04	Inmate on inmate assault which required admission to hospital.
Bay County Jail - Annex	05/17/04	Inmate died of natural causes.