The following is supplemental documentation designed to highlight some of our reporting in our "Jailed To Death" investigation.

*NOTE: **Text in bold** is clickable, and will take you to the document referenced.*

Our stories resulted in a new state law requiring that county jailers be enrolled in state-mandated training within 90 days to be fully licensed. Previously, jailers could work for up to a year with a temporary license and no training. We've included **H.B. 4468** and a **letter from State Rep. Garnet Coleman** crediting us with bringing this problem to the attention of lawmakers.

"A free press is essential to our democracy, and WFAA has shown a strong commitment to public service through its stories on for-profit jails in Texas," Coleman wrote. "Their stories on tragic deaths inside jails run by LaSalle Corrections helped bring to light how little training Texas requires for new jailers."

We are also including **a letter from Lance Lowry**, head of the American Federation of State, County and Municipal Employees Local Union 3807, which represents Texas corrections officers, praising our work. "As a criminal justice professional with over 25 years of experience with the Texas criminal justice system I am grateful for Tanya's reporting and understand the impact it will have on reducing Texas jail deaths."

"Jailed To Death" began after we learned of a series of deaths in county jails run by a private, for-profit company called LaSalle Corrections.

Since 2018 (**here is a link to our stories from that year**), our "Jailed To Death" series has told the stories of these eight people. All died in their local county jails run by LaSalle; all were arrested for minor offenses; none were convicted of anything; and all were loved by their families.

Here are their photos:

Ronald Beesley, **Ivan Allen** and **Gregory McElvy** – Johnson County

Morgan Angerbauer, **Michael Sabbie** and **Holly Austin** – Bowie County

Andy DeBusk – Parker County

Paul Plecker – Fannin County

Perhaps our most significant discovery was that jailers can work for a year with virtually no training – the loophole that was closed by the new legislation. We've included the email **documenting how we discovered this**.

We've included the autopsies of **Beesley**, **Angerbauer**, **Sabbie**, and **DeBusk**.

At first glance, their deaths were ruled natural or accidental. But we dug deeper, and a pattern emerged.

Former jailers told us that to boost profits, LaSalle routinely understaffs its jails. That means there are fewer jailers to make the required state-mandated "checks" of inmates to prevent suicide or ill people from going into medical distress.

We've included a transcript of a police interview of Angerbauer's jail nurse where she admits she didn't check on the girl for 12 hours and, in other document, accused the critically young girl of **"acting" sick**.

When Sabbie was booked, jailers knew from **his medical form** he was in bad health. He went into medical distress, and jailers accused him of **"feining [sic] illness** and difficulty breathing" which "disrupted the schedule." After pepper-spraying him – an asthmatic -- they threw him in a cell and left him there, supposedly alive, according to **these use-of-force photos we obtained**.

Jail checks were falsified in Sabbie's case as well. **A jailer admitted** during a deposition that she was trained to "write down your check… before you actually conducted any of those checks" and that the practice **was widespread** at LaSalle.

We wanted to know more about the sergeant over the jail the night Sabbie died. We obtained his employee file and found that he was hired in **February 2014** and got a temporary license, which, again, requires no state training. He still had a temporary license when he promoted in **October 2014**. He didn't get his full state license until **December 2014**. When we showed this to Chairman Coleman he put a provision in his legislation to outlaw promotions for temporary license jailers. It is now state law.

Here's another document we obtained, about a LaSalle facility near Waco, Tx. A jailer told investigators that he was not allowed to leave work "until the log 'looked right,'" which he took to mean "he had to back-fill the times and make it look like he conducted rounds." He told investigators he had to do it or be fired.

We discovered that LaSalle not only encourages its employees to lie about jail checks, one of its supervisors was caught lying to the state about the training it allegedly gave its employees. When the Texas Commission on Law Enforcement investigated the Parker County jail where DeBusk died, they found a lieutenant "**admitted** he had falsely reported training."

For our efforts to promote public safety in the state's county jails, we believe "Jailed To Death" deserves a Headliners Foundation Showcase Award for Enterprise & Innovation.

AN ACT

relating to county jails and community mental health programs in certain counties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Section 511.009(a), Government Code, is amended to read as follows:

(a) The commission shall:

(1) adopt reasonable rules and procedures establishing minimum standards for the construction, equipment, maintenance, and operation of county jails;

(2) adopt reasonable rules and procedures establishing minimum standards for the custody, care, and treatment of prisoners;

(3) adopt reasonable rules establishing minimum standards for the number of jail supervisory personnel and for programs and services to meet the needs of prisoners;

(4) adopt reasonable rules and procedures establishing minimum requirements for programs of rehabilitation, education, and recreation in county jails;

(5) revise, amend, or change rules and procedures if necessary;

(6) provide to local government officials consultation on and technical assistance for county jails;

(7) review and comment on plans for the construction

and major modification or renovation of county jails;

(8) require that the sheriff and commissioners of each county submit to the commission, on a form prescribed by the commission, an annual report on the conditions in each county jail within their jurisdiction, including all information necessary to determine compliance with state law, commission orders, and the rules adopted under this chapter;

(9) review the reports submitted under Subdivision (8) and require commission employees to inspect county jails regularly to ensure compliance with state law, commission orders, and rules and procedures adopted under this chapter;

(10) adopt a classification system to assist sheriffs and judges in determining which defendants are low-risk and consequently suitable participants in a county jail work release program under Article 42.034, Code of Criminal Procedure;

(11) adopt rules relating to requirements for segregation of classes of inmates and to capacities for county jails;

(12) require that the chief jailer of each municipal lockup submit to the commission, on a form prescribed by the commission, an annual report of persons under 17 years of age securely detained in the lockup, including all information necessary to determine compliance with state law concerning secure confinement of children in municipal lockups;

(13) at least annually determine whether each county jail is in compliance with the rules and procedures adopted under this chapter;

(14) require that the sheriff and commissioners court of each county submit to the commission, on a form prescribed by the commission, an annual report of persons under 17 years of age securely detained in the county jail, including all information necessary to determine compliance with state law concerning secure confinement of children in county jails;

(15) schedule announced and unannounced inspections of jails under the commission's jurisdiction using the risk assessment plan established under Section 511.0085 to guide the inspections process;

(16) adopt a policy for gathering and distributing to jails under the commission's jurisdiction information regarding:

(A) common issues concerning jail administration;

(B) examples of successful strategies for maintaining compliance with state law and the rules, standards, and procedures of the commission; and

(C) solutions to operational challenges for jails;

(17) report to the Texas Correctional Office on Offenders with Medical or Mental Impairments on a jail's compliance with Article 16.22, Code of Criminal Procedure;

(18) adopt reasonable rules and procedures establishing minimum requirements for jails to:

(A) determine if a prisoner is pregnant; and

(B) ensure that the jail's health services plan addresses medical and mental health care, including nutritional

requirements, and any special housing or work assignment needs for persons who are confined in the jail and are known or determined to be pregnant;

(19) provide guidelines to sheriffs regarding contracts between a sheriff and another entity for the provision of food services to or the operation of a commissary in a jail under the commission's jurisdiction, including specific provisions regarding conflicts of interest and avoiding the appearance of impropriety;

(20) adopt reasonable rules and procedures establishing minimum standards for prisoner visitation that provide each prisoner at a county jail with a minimum of two in-person, noncontact visitation periods per week of at least 20 minutes duration each;

(21) require the sheriff of each county to:

(A) investigate and verify the veteran status of each prisoner by using data made available from the Veterans Reentry Search Service (VRSS) operated by the United States Department of Veterans Affairs or a similar service; and

(B) use the data described by Paragraph (A) to assist prisoners who are veterans in applying for federal benefits or compensation for which the prisoners may be eligible under a program administered by the United States Department of Veterans Affairs;

(22) adopt reasonable rules and procedures regarding visitation of a prisoner at a county jail by a guardian, as defined by Section 1002.012, Estates Code, that:

(A) allow visitation by a guardian to the same extent as the prisoner's next of kin, including placing the guardian on the prisoner's approved visitors list on the guardian's request and providing the guardian access to the prisoner during a facility's standard visitation hours if the prisoner is otherwise eligible to receive visitors; and

(B) require the guardian to provide the sheriff with letters of guardianship issued as provided by Section 1106.001, Estates Code, before being allowed to visit the prisoner; and

(23) adopt reasonable rules and procedures to ensure the safety of prisoners, including rules and procedures that require a county jail to:

(A) give prisoners the ability to access a mental health professional at the jail or through a telemental health service 24 hours a day or, if a mental health professional is not at the county jail at the time, then require the jail to use all reasonable efforts to arrange for the inmate to have access to a mental health professional within a reasonable time;

(B) give prisoners the ability to access a health professional at the jail or through a telehealth service 24 hours a day or, if a health professional is unavailable at the jail or through a telehealth service, provide for a prisoner to be transported to access a health professional; and

(C) if funding is available under Section 511.019, install automated electronic sensors or cameras to ensure accurate and timely in-person checks of cells or groups of cells

confining at-risk individuals.

SECTION 2. Section 511.011, Government Code, is amended to read as follows:

Sec. 511.011. REPORT ON NONCOMPLIANCE. (a) If the commission finds that a county jail does not comply with state law, including Chapter 89, Health and Safety Code, or the rules, standards, or procedures of the commission, it shall report the noncompliance to the county commissioners and sheriff of the county responsible for the county jail and shall send a copy of the report to the governor.

(b) If a notice of noncompliance is issued to a facility operated by a private entity under Section 351.101 or 361.061, Local Government Code, the compliance status of the facility shall be reviewed at the next meeting of the Commission on Jail Standards.

SECTION 3. Section 511.019(d), Government Code, is amended to read as follows:

(d) The commission by rule may establish a grant program to provide grants to counties to fund capital improvements described by Subsection (c). The commission may only provide a grant to a county for capital improvements to a county jail with a capacity of not more than 288 [~~96~~] prisoners.

SECTION 4. Section 539.002, Government Code, is amended by amending Subsection (b) and adding Subsection (c) to read as follows:

(b) Except as provided by Subsection (c), the [~~The~~] department shall require each entity awarded a grant under this section to:

(1) leverage additional funding or in-kind contributions from private sources in an amount that is at least equal to the amount of the grant awarded under this section;

(2) provide evidence of significant coordination and collaboration between the entity, local mental health authorities, municipalities, local law enforcement agencies, and other community stakeholders in establishing or expanding a community collaborative funded by a grant awarded under this section; and

(3) provide evidence of a local law enforcement policy to divert appropriate persons from jails or other detention facilities to an entity affiliated with a community collaborative for the purpose of providing services to those persons.

(c) The department may award a grant under this chapter to an entity for the purpose of establishing a community mental health program in a county with a population of less than 250,000, if the entity leverages additional funding from private sources in an amount equal to one-quarter of the amount of the grant to be awarded under this section, and the entity otherwise meets the requirements of Subsections (b)(2) and (3).

SECTION 5. Section 1701.310(b), Occupations Code, is amended to read as follows:

(b) A county jailer appointed on a temporary basis who does not satisfactorily complete the preparatory training program before the first anniversary of the date that the person is appointed shall be removed from the position. A county jailer appointed on a temporary basis shall be enrolled in the preparatory training program on or before the 90th day after their temporary

appointment. A temporary appointment may not be renewed[~~, except that not earlier than the first anniversary of the date that a person is removed under this subsection, the sheriff may petition the commission for reinstatement of the person to a temporary appointment~~].

SECTION 6. Section 1701.310, Occupations Code, is amended by adding Subsection (f) to read as follows:

(f) A county jailer appointed on a temporary basis may not be promoted to a supervisory position in a county jail.

SECTION 7. Not later than January 1, 2020, the Commission on Jail Standards shall update rules and procedures as necessary to comply with Section 511.009(a)(23), Government Code, as amended by this Act.

SECTION 8. This Act takes effect September 1, 2019.

STATE of TEXAS
HOUSE of REPRESENTATIVES

GARNET F. COLEMAN
STATE REPRESENTATIVE

June 27, 2019

Dear Judges,

A free press is essential to our democracy, and WFAA has shown a strong commitment to public service through its stories on for-profit jails in Texas.

Their stories on tragic deaths inside jails run by LaSalle Corrections helped bring to light how little training Texas requires for new jailers. Under current law, new hires can work for up to a year under a temporary license, deferring their state training during that period. WFAA showed how this lack of training put people in jeopardy.

As chair of the Texas House Committee on County Affairs, I heard testimony in front of the committee from families who lost loved ones inside LaSalle's jails. What I heard from them, a former LaSalle guard, and law enforcement training experts troubled me. That's why I then demanded that LaSalle Corrections executives come before my committee to answer questions about training, medical care, and safety inside their jails.

As a result of WFAA's reporting, I authored legislation requiring jailers to enroll in training within 90 days of receiving their temporary licenses. Also, after WFAA brought to my attention that LaSalle was allowed to promote guards with temporary licenses to critical supervisory roles, I also outlawed that practice. The legislation becomes effective September 1, 2019.

Sincerely,

Garnet F. Coleman
State Representative--District 147

AFSCME Texas
Correctional Employees

Local 3807

“We Patrol Texas' Toughest Beat”

June 27, 2019

Re: Tanya Eiserer and WFAA's reporting on Texas jail deaths.

Tanya Eiserer's WFAA series 'Jailed to Death' demonstrates upholding journalism standards to the highest level. Tanya's series of reports exposed preventable jail deaths in Texas involving a private jail company that was using a loophole in Texas law allowing the company to hire untrained detention officers and keep them without any training for up to a year.

Thanks to the Tanya's investigative reports, Texas House Bill 2467 was introduced by Representative Bill Zedler and later passed into law as House Bill 4468. The bill helps close the temporary jailer's license loophole in Texas law and now requires Texas county detention officers to enroll in a training academy within the first 90 days of employment. Due to the great reporting by Tanya many deaths will be prevented.

As a criminal justice professional with over 25 years of experience with the Texas criminal justice system I am grateful for Tanya's reporting and understand the impact it will have on reducing Texas jail deaths.

Lance Lowry

AFSCME Local 3807
Texas Correctional Employees


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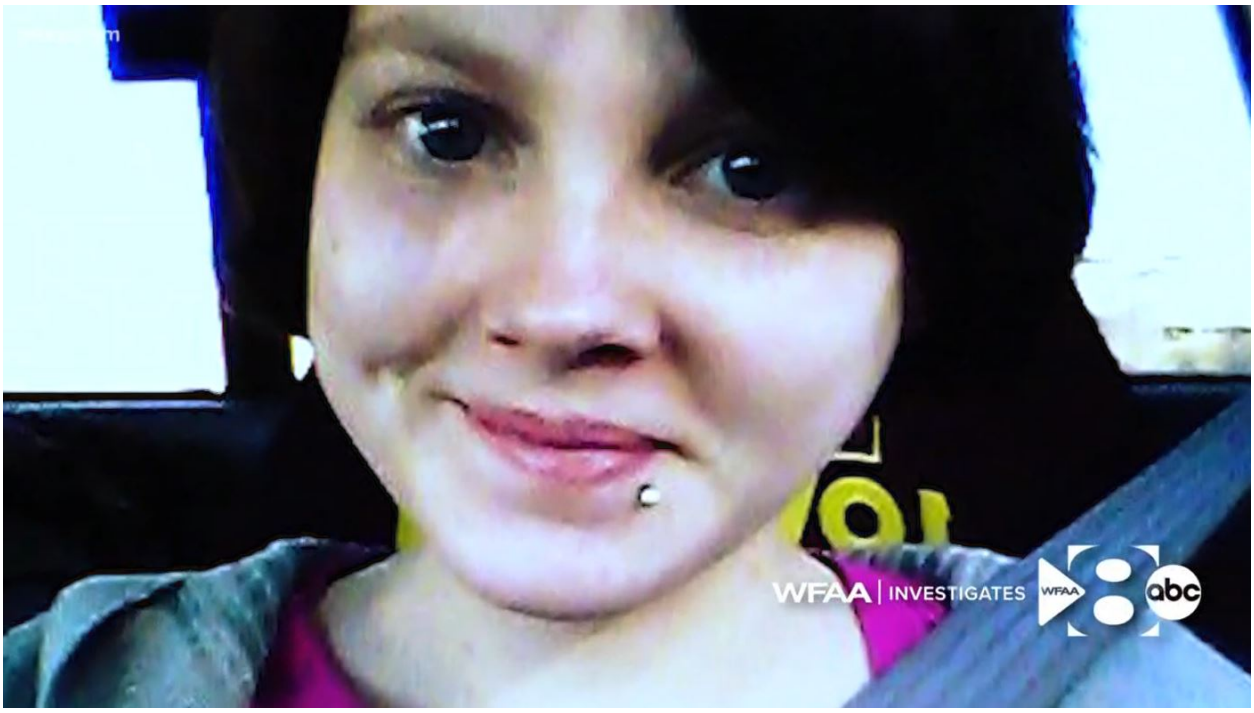
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From: Gretchen Grigsby <Gretchen.Grigsby@tcole.texas.gov>
Sent: Thursday, May 10, 2018 11:48 AM
To: Eiserer, Tanya <teiserer@wfaa.com>
Subject: Re:

External Email – Be Suspicious of Attachments, Links and Requests for Login Information

Without going back into archived legislation, I can tell you the current state of things has been in place since at least 1999.

Gretchen Grigsby

Director, Government Relations

Texas Commission on Law Enforcement

Office: (512) 936-7715

Mobile: (512) 774-2945

Gretchen.Grigsby@TCOLE.Texas.Gov

From: "Eiserer, Tanya" <teiserer@wfaa.com>
Date: Thursday, May 10, 2018 at 11:37 AM
To: Gretchen Grigsby <gretchen.grigsby@tcole.texas.gov>
Subject: RE:

Thanks.

Can you tell me when the state began allowing the temporary licensing of guards? Did the time period that a jailer could hold a temporary license used to be longer or shorter?

My concern here is that there is no training requirement before someone is allowed to be a temporary jailer.

Tanya

From: Gretchen Grigsby [mailto:Gretchen.Grigsby@tcole.texas.gov]
Sent: Thursday, May 10, 2018 9:15 AM
To: Eiserer, Tanya <teiserer@wfaa.com>
Subject: Re:

External Email – Be Suspicious of Attachments, Links and Requests for Login Information

Hi Tanya,

The curriculum for initial licensure for county jailers can be found on our website

Those working under a temporary jailer license have one year, by statute (Occupations Code 1701.310), from the date of their appointment to complete a basic licensing course.

The temporary jailer license is treated as a license; the only part of the process that is delayed is the training itself. All of the other background items must be completed before that jailer can be appointed and go to work. Those requirements can be found on our website.

Please let me know if you have any other questions.

Thanks,

Gretchen Grigsby

Director, Government Relations

Texas Commission on Law Enforcement

Office: (512) 936-7715

Mobile: (512) 774-2945

Gretchen.Grigsby@TCOLE.Texas.Gov

From: "Eiserer, Tanya" <teiserer@wfaa.com>
Date: Wednesday, May 9, 2018 at 2:07 PM
To: Gretchen Grigsby <gretchen.grigsby@tcole.texas.gov>
Subject: <no subject>

Ms. Grigsby:

I'm looking to talk to someone with TCOLE so I can get an understanding of the training requirements and licensing for county jailers.

I'd like to find out, for example, what are the basic minimum standards for training? When a jailer is hired and only has a temporary jailer's license, is there a certain amount of time that they have to work with trainer?

Can someone be hired and work as a jailer and not have the temporary license or is there a lag time on them temporary licenses being issued?

Thanks in advance for your help.
Tanya Eiserer
WFAA-TV
8172283514

JOHNSON COUNTY SHERIFF OFFICE

BOB ALFORD
SHERIFF

Jimmy Johnson, *Chief Deputy*
Tom Craig, *Jail Administrator*

PERSONAL INFORMATION SHEET

PID: 234897
ARREST NO: 126 075796
Name: BEESLEY,RONALD RAY
Alias: BEESLY,RONALD RAY
Alias: BEASLEY,RONALD RAY
Alias: BEESLEY,RAY
Address: 1005 CASA VISTA
RIO VISTA TX76093

DL No: 27090924
State: TX
Type: C
Exp: 05/05/2020
SSN: 455-19-9298

Race: W Ethnic: N Sex: M Age: 46 DOB: 05/05/1969
Place of Birth: TX
Height: 5 08 Weight: 260 Hair: BRO Eyes: BLU
Glasses?: Facial Hair: Y Skin: MED

Scars/Marks:		
	TAT HEAD	Prev Reported
	TAT L ARM	Prev Reported
	TAT CHEST	Prev Reported
	TAT R LEG	Prev Reported
	TAT BACK	Prev Reported
	TAT R ARM	Prev Reported
	TAT L LEG	
	SC BACK	Prev Reported
	SC R THGH	Prev Reported
	TAT L KNEE	Prev Reported
	TAT R KNEE	Prev Reported
	TAT UR ARM	Prev Reported
	TAT FLBODY	
Build:	MEDIUM	

Other Descriptions:

VIOLATION OF PAROLE
Book-In Date: 04/14/2008 Release Date: 04/14/2008
DRIVING WHILE INTOXICATED/OPEN ALCH CONTAINER
Book-In Date: 07/17/2013 Release Date: 07/17/2013
DRIVING WHILE INTOXICATED (W/1 PREV CONV)
Book-In Date: 05/12/2015 Release Date: 05/13/2015
VIOLATION OF PAROLE
Book-In Date: 05/25/2015
DRIVING WHILE INTOXICATED BAC >=0.15/ROS
Book-In Date: 05/25/2015

Office of Chief Medical Examiner
Tarrant County Medical Examiner's District
Tarrant County, Texas
200 Feliks Gwozdz Place, Fort Worth, Texas 76104-4919
(817) 920-5700 FAX (817) 920-5713

AUTOPSY REPORT

Name: Ronald Ray Beesley **CASE NO: 1507900**
Approximate Age: 46 Years **Sex: Male**
Height: 69 Inches **Weight: 235.8 Pounds**

I hereby certify that on the **3rd** day of **June 2015,** beginning at 1120 hours, I, **Susan Roe, M.D.**, pursuant to Statute 49.25 of Texas Criminal Code, performed a complete autopsy on the body of **Ronald Ray Beesley** at the Tarrant County Medical Examiner's District Morgue in Fort Worth, Texas and upon investigation of the essential facts concerning the circumstances of the death and history of the case as known to me, I am of the opinion that the findings, cause and manner of death are as follows:

FINDINGS:

I) Infectious complications of sternal fracture:
   A. Fracture of the body of the sternum with osteomyelitis
   B. Pleural empyema
   C. Focal pneumonia
   D. Culture results:
      1. Sternum fracture swab: Aerobic: Heavy growth of Staphylococcus aureus and Pseudomonas aeruginosa; anaerobic: Moderate growth of Bacteroides fragilis group
      2. Right pleural cavity swab: Aerobic: Heavy growth of Staphylococcus aureus, moderate growth of Citrobacter freundii complex; anaerobic: No anaerobes isolated

II) History of motor vehicle crash 5/12/2015 (motor vehicle – motor vehicle – fixed object collision) (driver)
   A. History of being extricated from vehicle by fire department and evaluated by medics; he refused transport to the hospital

III) Complaints of chest pain and breathing difficulties

IV) Hepatic cirrhosis, chronic active hepatitis and severe steatosis
   A. History of hepatitis C
   B. Splenomegaly

V) Toxicology:
   A. Femoral blood ethanol negative
   B. Aorta blood drug screen positive for ibuprofen

1507900
Ronald Ray Beesley

CAUSE OF DEATH:

I) **INFECTIOUS COMPLICATIONS OF STERNAL FRACTURE DUE TO MOTOR VEHICLE – MOTOR VEHICLE – FIXED OBJECT COLLISION (DRIVER)**
II) **HEPATIC CIRRHOSIS, HEPATITIS C, HEPATIC STEATOSIS**

MANNER OF DEATH: ACCIDENT

COMMENT: This case was presented in Critical Case Review on 6/25/2015. There is consensus with cause of death and manner of death.

Signature

Susan Roe, M.D.
Deputy Medical Examiner

A complete autopsy is carried out at the Tarrant County Medical Examiner's Morgue.

GROSS ANATOMIC DESCRIPTION

I. CLOTHING AND PERSONAL EFFECTS: The body is presented to the Morgue in a blue body bag and a blue sheet and is clad in gray striped pants and white boxers.

II. THERAPEUTIC INTERVENTION: Evidence of medical intervention includes an oral endotracheal tube, four EKG pads, and an intraosseous needle within the left tibia. There is a bandage overlying a needle puncture within the right antecubital fossa.

On the left wrist are two hospital bands. Also on the left wrist is a band that appears to be from a correctional institution. It has the name of the decedent, an arrest number, and what appears to be a booking photograph.

III. EXTERNAL BODY DESCRIPTION: The body is that of a normally-developed, obese Caucasian male adult appearing to be approximately the stated age of 46 years. The body length is 69 inches, and the body weight is 235.8 pounds. The body is cold to touch. Rigor mortis is fully developed within the lower extremities and is partially developed within the upper extremities. Lividity is present posteriorly, is normal in color, and blanches. The hair on the head is very short, and there appears to be male pattern frontal to occipital balding. The remaining hair is largely gray and measures up to 3 mm. The facial hair consists of a gray and brown mustache and a gray and brown, long, goatee-style beard. The remainder of the facial hair is 3-4 mm in length. The body hair distribution is that of a normal male adult.

The head is normocephalic. The face is congested. The eyes when initially viewed are slightly open. The irides are gray, and the pupils are 3 mm in diameter on the right and 5 mm in diameter on the left. The sclerae are slightly icteric. The conjunctivae are without petechiae. The nose is normal in appearance. The septum is intact. The lips are normal in appearance. There are natural teeth within the upper and lower jaws. No oral mucosal trauma is

noted. Coffee ground material is present within the mouth. The ears are normal in appearance.

The neck is somewhat supple and is without masses. The trachea is palpable within the midline. The chest is slightly increased in the anterior to posterior dimension, and the breasts are normal male. The abdomen is moderately protuberant and is obese. There are no palpable masses. The external genitalia is that of a circumcised male adult. The testes are descended bilaterally, and there are no palpable masses. The upper extremities and the lower extremities are equal and symmetric with the appropriate number of digits. The back, buttocks and anal area are unremarkable except as noted below.

There are numerous tattoos on the body. The head is tattooed with tattoos extending onto the neck and largely encircling the neck, extending onto the trunk and covering most areas of the front, sides and back of the trunk. The tattoos over the trunk include designs, faces, women's torsos, an eagle head, and ghost figures that may represent Ku Klux Klan. There are sleeve tattoos covering both arms.

There is a candy cane tattoo over the shaft of the penis extending onto the pubic area.

Over the right knee is a tattoo of a skull with a cowboy hat and confederate flags.

There is a tattoo of a bearded face in addition to another face and designs on the dorsal aspect of the right foot.

Over the left knee is a tattoo of a skull/monster face.

Over the left medial malleolus is a Celtic cross tattoo.

On the dorsal aspect of the left foot is a tattoo of a swastika with a dagger and other designs over the swastika and below this the words "White Separatist".

Over the left buttock is a large tattoo that includes a horse.

Over the right calf is a large tattoo of a skull figure. There are words surrounding this. They appear to be "Rebel til I die".

There are scars on the arms that are difficult to distinguish because of the tattoos. They measure up to 4.5 cm.

There appears to be a scar on the right side of the abdomen that is somewhat curved and is approximately 26 cm in length.

Over the right pretibial area are scars measuring up to 2 cm.

There is a 2 cm purplish discoloration over the left hip.

Over the left anteromedial thigh is a vague purplish discoloration that is 6 cm in size.

There are healing crusted areas over the right calf, measuring up to 1.2 cm.

Over the right lateral iliac area are small abrasions, measuring up to 1.5 cm.

The skin is slightly jaundiced.

IV. INTERNAL EXAMINATION:

1. INTEGUMENT: A Y-shaped thoracoabdominal incision is made, and the organs are examined in-situ and eviscerated in the usual fashion. The subcutaneous fat is normally distributed, moist and bright yellow. The musculature of the chest and abdominal area is of normal color and texture.

2. SEROUS CAVITIES: There is a fracture of the body of the sternum. There is purulent material adjacent to this fracture site on the internal aspect of the sternum. This is overlying the area of the pericardial sac. A swab is obtained from this area, and further examination is done by Dr. Dana Austin. Sections are submitted for histology.

There are fractures of left ribs 3 and 4 anterolaterally, without adjacent hemorrhage. There are approximately 200 cc of green purulent material within the right pleural cavity. The right pleural surface is dull, and there is yellow to green purulent material on the pleural surface. On the visceral pleura, there is a yellowish to greenish purulent material admixed with areas of hemorrhage. Both lungs are somewhat atelectatic. The left pleural cavity has scattered petechial hemorrhages. It is slightly dull in appearance. There is no fluid in the left pleural cavity.

There is no scoliosis, kyphosis, or lordosis present. The left and right hemidiaphragms are in their normal location and appear grossly unremarkable.

The outer surface of the pericardial sac is dull. The inner pericardial sac has a slight yellowish stain. There are approximately 30 cc of yellow fluid within the pericardial sac. There is no free fluid in the abdominal cavity.

The sternum is examined with Dr. Dana Austin, forensic anthropologist. The fracture is at the level of the 3rd rib and is of the body of the sternum. The fracture margins are well rounded, and the fracture appears to have been comminuted. There are pieces of the fractured sternum that are no longer present. Bone appears to have been resorbed from the proximal and distal fracture sites. Sections are submitted for histologic examination, including the adjacent soft tissues and of the bone adjacent to the fracture site.

3. **CARDIOVASCULAR SYSTEM:** The heart weighs 343 grams, and there is no chamber hypertrophy or dilatation. The reference range for body length is 230-458 grams. The left ventricular free wall is 13 mm, and the right is 4 mm. The cardiac valves appear unremarkable. The coronary artery ostia are in their normal anatomic locations. Right dominant circulation is present. Serial sectioning of the coronary arteries shows 60-70% narrowing of the left anterior descending coronary artery and the left circumflex coronary artery by atherosclerotic plaque. There is 30% to 40% narrowing of the right coronary artery by atherosclerotic plaque. The endocardial surface is stained yellow. Sectioning of the myocardium presents no gross evidence of recent or remote ischemic changes. The aortic arch along with the great vessels appears grossly unremarkable.

4. **PULMONARY SYSTEM:** The neck presents an intact hyoid bone as well as thyroid and cricoid cartilages. There is agenesis of the superior horn of the thyroid cartilage on the left. The larynx is comprised of unremarkable vocal cords and folds, appearing widely patent without foreign material, and is lined by a smooth, glistening membrane. The epiglottis is normal. Both the musculature and the vasculature of the anterior neck are unremarkable.

Both lungs are somewhat atelectatic. The right lung weighs 504 grams, and the left lung weighs 439 grams. The pleural surfaces are described above. Both lungs appear moderately congested. No pneumonia is noted on sectioning. Sections are submitted for histologic examination. There are no masses identified. The pulmonary arterial system is intact and grossly unremarkable. There is erythema of the lower tracheobronchial tree.

5. GASTROINTESTINAL SYSTEM: The esophagus is intact with a normal gastroesophageal junction and without erosions or varices. The stomach is also normal without gastritis or ulcers, and the stomach contains 50 cc of green liquid. The duodenum, small bowel and colon are unremarkable. The appendix is present.

The liver weighs 3550 grams and has a smooth, intact capsule. The parenchyma is yellow, and the architecture is markedly distorted by small nodules measuring up to 2-3 mm in size. The liver is markedly fibrotic. No discrete lesions are present. The gallbladder is unremarkable containing approximately 40 cc of thick, greenish bile and no stones.

The pancreas is normally positioned and weighs 353 grams. Cut surfaces are tan and have the usual lobular architecture.

6. GENITOURINARY SYSTEM: The right kidney weighs 191 grams, and the left kidney weighs 163 grams. The external surfaces are smooth. The cortices and medullae are normal. The pelves are of normal size and are lined by gray, glistening mucosa. There are no calculi. Renal arteries and veins are normal.

The ureters are of normal caliber lying in their course within the retroperitoneum and draining into an unremarkable urinary bladder containing no urine.

The prostate is of normal size and shape, and sectioning presents lobular yellow parenchyma. The testes are descended bilaterally and are without palpable masses; they are not removed.

7. HEMATOPOIETIC SYSTEM: The spleen weighs 447 grams, presenting a gray-pink, intact capsule and a soft, dark-red parenchyma. There is no lymphadenopathy. The thymus gland is involuted.

8. ENDOCRINE SYSTEM: The thyroid gland is of normal size and shape, presenting two well-defined lobes with connecting isthmus and a brown cut surface. The adrenal glands are of normal size and shape and on sectioning present no gross pathologic lesions. There is no adrenal hemorrhage. The pituitary is encased within an intact sella turcica and presents no gross pathologic lesions.

9. CENTRAL NERVOUS SYSTEM: A scalp incision, craniotomy and evacuation of the brain are carried out in the usual fashion.

The scalp is intact without contusions or lacerations. The calvarium and basilar skull are intact without bony abnormalities or fractures. The dura is intact and without evidence of epidural or subdural hemorrhage. There is no subarachnoid hemorrhage.

The brain weighs 1329 grams. Cerebral hemispheres present a normal gyral pattern with mild global edema. The brainstem and cerebellum are normal in appearance with no evidence of cerebellar tonsillar notching. The Circle of Willis is patent, presenting no evidence of thrombosis or berry aneurysm. On sectioning of the brain, the ventricular system is symmetrical and contains clear cerebrospinal fluid. There are no space-occupying lesions present. The spinal cord is not examined.

V. MICROSCOPIC EXAMINATION:

Sternum fracture site: Necrotic bone, acute and chronic inflammation, bacterial colonies. Adjacent muscle: Necrosis, acute inflammation, bacteria

Lungs: Fibrin and polymorphonuclear leukocytes on pleural surface, adjacent atelectasis, chronic inflammation. One section with focal pneumonia.

Heart: Scattered hypertrophic myocytes. Two sections of coronary arteries with up to 60-70% narrowing by atherosclerotic plaque.

Liver: Cirrhosis, chronic active hepatitis, severe steatosis

Spleen: Decreased cellularity

Sections of other organs are consistent with the gross impressions.

SPECIMENS AND EVIDENCE COLLECTED

1. 6 cc of vitreous fluid, 13 cc of femoral blood, 13 cc of aortic blood
2. Representative tissues are retained in formalin, 18 cassettes are submitted for histologic examination, and 2 cassettes are submitted for decalcification
3. One blood card
4. Culture swab of the right pleural cavity
5. Culture swab of the sternal fracture

1507900
Ronald Ray Beesley

EDC: 9/3/2015
Dictated: 6/3/2015
Transcribed: 6/4/2015
Completed: 6/26/2015
SR: sad

Forensic Toxicology Results

Office of Chief Medical Examiner
Toxicology Laboratory Service
200 Feliks Gwozdz Place
Fort Worth, Texas 76104

Name: **Ronald Ray Beesley**

Case Number: **1507900**
Toxicology Work Number: **1501640**

Nizam Peerwani, M.D., DABFP
Chief Medical Examiner
Robert Johnson, PH.D., DABFT
Chief Toxicologist

Service Request Number: **003**

Specimen	Drug	Result	Drug Amount	Instrument Used	Performed By
Femoral Blood	Ethanol	NEGATIVE		GC/FID	A. McCALL
AORTA BLOOD	Amphetamine ELISA	NEGATIVE		ELISA	B. LANDRY
AORTA BLOOD	Methamphetamine ELISA	NEGATIVE		ELISA	B. LANDRY
AORTA BLOOD	THC ELISA	NEGATIVE		ELISA	B. LANDRY
AORTA BLOOD	Opiate ELISA	NEGATIVE		ELISA	B. LANDRY
AORTA BLOOD	Cocaine ELISA	NEGATIVE		ELISA	B. LANDRY
AORTA BLOOD	Benzodiazepine ELISA	NEGATIVE		ELISA	B. LANDRY
AORTA BLOOD	Oxycodone ELISA	NEGATIVE		ELISA	B. LANDRY
AORTA BLOOD	IBUPROFEN	POSITIVE		GCMS	A. McCALL
AORTA BLOOD	BASE	NEGATIVE		GCMS	A. McCALL

Approved By: _____

Approved Date: 6/17/15

BOWIE COUNTY SHERIFF OFFIC

BOOKING SHEET

SO# : 233547	Jail Id: J16-004772			Cell: F HOLD
Name : ANGERBAUER , MORGAN		Race: W	DOB: 07/09/95	POB: UNK, XX, TX
AKA :		Sex : F	Hgt: 4 Ft. 8	Eyes: BLU
Phone: 903-244-1392	Marital:	Age :	Wgt: 110	Hair: BLN
Addr : 1305 E 47TH ST			Bld: SM	Comp: LGT
SMT :				
Occup:		Empl:		
DL #:	SSN: 430-89-0962	DPS:		FBI:
Remarks:				
Phone Numbers Called at Booking: 000-000-0000				
Emergency Contact: HOUSER, JENNIFER (MOTHER) 903-244-1392				

WARRANT #	OFFENSE	CO.	BOND & TYPE	FINE	HLD
;	HOLD FOR ARKANSAS-OBST GOV OPERATIONS; HOLD FOR ARKANSAS-HOLD FOR MILLER COUNTY		245.00;		

Arrst Agency: TEXARKANA ARKANSAS POLICE	Arrst Officer: POOLE, JEREMY LEVI		
Arrst Date/Time: 06/28/16 1:35 PM	Arrst Location:		
Defendant Cond.:			
Vehicle Make:	Model:	Color:	Year:
Lic No:	State:	Towed By:	Stored:

Property Sheet

Cash:	Receipt#:	Box #:

QNTY	ITEM DESCRIPTION	LOCAT

I certify that the above is a correct list of items removed from my possession at the time I was placed in jail.

Prisoner's Signature: A Morgan Angerbauer

Received all the above listed property this 29 day of June, 2016

Booking Officer's Signature: T. Cleghorn 6.28.16 2259

Booking Officer's Name : CLEGHORN, THOMAS | Date/Time: 06/28/16 2259

Medical Examiner
(501) 227-5936

State Crime Laboratory

P.O. Box 8500
3 Natural Resources Drive
Little Rock, Arkansas 72215

Medical Examiner Division

Case No: 2016-015643 / ME-0709-16 **Date of Examination:** July 04, 2016

Name: ANGERBAUER, Morgan Christy-Ruth

Age: 20 Years **Sex:** Female

County: Miller

CONCLUSIONS

CAUSE OF DEATH: Diabetic Ketoacidosis

MANNER OF DEATH: Natural

July 11, 2016

Jennifer Forsyth, M.D., FCAP
Associate Medical Examiner - Pathologist of Record

Frank J. Peretti, M.D.
Associate Medical Examiner - Reviewer

Charles P. Kokes, M.D.
Chief Medical Examiner - Reviewer

EXTERNAL DESCRIPTION:

The body was that of a well-developed, thin, white, adult female. The body was received clad in: red uniform pants, red uniform shirt, and gray underwear. The shirt had previously been cut to accommodate resuscitative efforts. The body measured 60 inches in length and weighed 90 pounds. The body appeared consistent with the stated age of 20 years. The body was cool. Rigor mortis was fully developed. Livor mortis was present on the posterior surfaces of the body, except in areas exposed to pressure. The scalp hair was blond in color and measured approximately 10 cm in maximum length. The irides were unremarkable. The conjunctivae and sclerae showed no petechial hemorrhages or other significant changes. The external ears were normally formed. The bilateral earlobes had previously been pierced; no jewelry was in place. The nasal passages and mouth contained gastric contents. The teeth were natural and in adequate repair. The neck was symmetric and without masses or unusual mobility. The chest was normally developed and generally symmetric. The female breasts were normally developed, generally symmetric, and without palpable masses or other abnormalities. The abdomen was flat. The external genitalia were those of a normally developed adult female. The upper and lower extremities were normally developed and generally symmetric. When first viewed, there were paper bags covering the bilateral hands. The bags were removed to reveal no evidence of injury. The nails were approximately at the level of the fingertips with no traumatic injury. There were tattoos present on the left upper back, right anterior forearm, right hip, and top of the left foot. No needle tracks or wrist scars were present. Examination of the posterior body surfaces revealed a symmetric back and buttocks. The anus was without evidence of injury or abnormality.

EVIDENCE OF MEDICAL ATTENTION:

A palpable medication port was present in the subcutaneous soft tissue of the left upper chest.

EVIDENCE OF OLD INJURY:

On the lateral right knee was a purple contusion measuring 2 x 2 cm. On the lateral left knee were four purple contusions each measuring approximately 1 x 1.5 cm.

EVIDENCE OF RECENT INJURY:

None.

INTERNAL EXAMINATION

The subcutaneous fat layer was diminutive, measuring less than 1 cm. No adhesions or abnormal fluid collections were present in the body cavities. All body organs were present and in normal anatomic position. There was no internal evidence of blunt force or penetrating injury to the thoracoabdominal region.

CARDIOVASCULAR SYSTEM:

Pericardial surfaces were smooth, glistening and transparent. The pericardial sac contained a normal amount of clear, straw-colored pericardial fluid. The heart weighed 205 grams. The heart was of normal size, shape, and configuration. The coronary arteries arose normally, followed the usual course and were widely patent. There was no significant atherosclerosis or evidence of thrombosis. The cardiac valves, papillary muscles and chordae tendineae were unremarkable. The endocardium was unremarkable. The cut surface of the myocardium was red-brown in color and normal in consistency. The atrial and ventricular septa were intact. The aorta and vena cava were unremarkable.

RESPIRATORY SYSTEM:

The right lung weighed 350 grams. The left lung weighed 360 grams. The pleural surfaces were tan-pink, smooth, and glistening. The pulmonary arteries were normally developed, patent, and without evidence of thrombi, emboli, or other gross abnormalities. The upper and lower airways contained scant gastric contents. Hilar lymph nodes were non-prominent. Cut surfaces of both lungs revealed diffuse dark purple-red congestion present throughout the lobes. No focal lesions were present.

NECK:

Examination of neck structures, including strap muscles, thyroid gland, and large vessels, revealed no abnormalities, including hemorrhage. The larynx and hyoid bone were intact. The epiglottis and vocal cords were unremarkable.

ALIMENTARY TRACT:

The tongue was without hemorrhage or other abnormalities. The esophagus was lined by an intact, gray-tan mucosa. The stomach contained scant mucoid fluid and was lined by an intact, gray-tan mucosa. Serosal surfaces of the small and large bowel were intact and unremarkable. The rectum and anus were without evidence of injury or abnormality.

LIVER AND PANCREAS:

The liver weighed 1935 grams and was covered by an intact capsule. Cut surfaces were a uniform tan-brown color and of normal consistency. No focal abnormalities were present. The gallbladder was surgically absent; there were multiple surgical clips present within the gallbladder bed. Periportal lymph nodes were non-prominent. The pancreas weighed 50 grams and displayed a normal lobulated gray-tan appearance. The pancreatic ducts were patent. Peripancreatic lymph nodes were non-prominent.

GENITOURINARY SYSTEM:

The left kidney weighed 105 grams. The right kidney weighed 90 grams. Each was covered by an intact capsule which stripped with ease. Cortical surfaces of the kidneys were brown-red and smooth. Cut surfaces revealed brown-red cortex of normal thickness. A distinct corticomedullary junction was present. The calyces, pelves and ureters were unremarkable. The

urinary bladder contained 250 mL of pale yellow urine and was lined by intact, gray-tan mucosa. The uterus, ovaries, and fallopian tubes were of normal size and conformation. No pregnancy was present.

IMMUNOLOGICAL SYSTEM:

The spleen weighed 50 grams and was covered by an intact capsule. Cut surfaces were red-purple in color with a normal consistency. The white pulp was non-prominent. No focal abnormalities were present. Lymphadenopathy was not identified.

ENDOCRINE SYSTEM:

The pituitary, thyroid, and adrenal glands were free of obvious disease.

MUSCULOSKELETAL SYSTEM:

Skeletal muscle was of uniform beefy-red coloration, with no focal changes present. No gross bone or joint abnormalities were present. The anterior bodies of the cervical, thoracic and lumbar spine were free of hemorrhage and other abnormalities.

CENTRAL NERVOUS SYSTEM:

The scalp was free of hemorrhage and edema. The calvarium and basilar skull were intact. There was no epidural, subdural or subarachnoid hemorrhage present. The brain weighed 1325 grams. The leptomeninges were thin and clear. The cerebral gyri were normally formed and showed no focal lesions. Structures at the base of the brain, including cranial nerves and major blood vessels, were intact and unremarkable. Serial coronal sections of the cerebral hemispheres revealed symmetry between anatomic structures of the left and right sides, with no focal changes present. Cut surfaces of the brainstem and cerebellum were unremarkable.

IDENTIFICATION:

The body was received as identified by the Texarkana Police Department.

EVIDENCE:

Fingerprints and a blood matrix card were retained as evidence.

SPECIMENS:

Specimens retained for ancillary testing included: urine, peripheral blood, heart blood, and vitreous fluid

WITNESSES:

No visitors from outside agencies were present during the examination.

LABORATORY RESULTS

TOXICOLOGY:

Morgan Angerbauer:

Peripheral blood

Volatile

Acetone	0.040 g%	(± 0.004 g%)
Ethanol	not detected	
Isopropanol	0.011 g%	(± 0.001 g%)
Methanol	not detected	

Urine

Volatile

Acetone	0.064 g%	(± 0.006 g%)
Ethanol	not detected	
Isopropanol	< 0.01 g%	
Methanol	not detected	

Immunoassay

Amphetamines	negative
Barbiturates	negative
Benzodiazepines	negative
Cannabinoids	negative
Cocaine Metabolite	negative
Opiates	negative
Oxycodone	negative
PCP	negative

CHEMISTRIES:

Basic Metabolic Panel (vitreous humor):

Sodium (Na)	124.0 mmol/L
Potassium (K)	22.6 mmol/L
Chloride (Cl)	91 mmol/L
Creatinine	1.7 mg/dL
VUN	41 mg/dL
Glucose	813 mg/dL

FINDINGS

I. Well-developed, thin, adult female.
   A. No internal or external evidence of life threatening traumatic injury.

II. Status post cholecystectomy, remote.

III. Status post medication port placement, remote.

IV. Clinical history of diabetes mellitus.
   A. Vitreous glucose 813 mg/dL.
   B. Vitreous electrolyte changes consistent with diabetic ketoacidosis.
   C. Ketones present in urine and peripheral blood.

OPINION:

This 20-year-old female, Morgan Angerbauer, died due to diabetic ketoacidosis.

According to investigative reports provided by the Texarkana Police Department, Ms. Angerbauer was in custody, in a cell alone, when she was found unresponsive. Emergency services were summoned and she was pronounced dead at the scene. Reportedly, Ms. Angerbauer had a medical history significant for diabetes mellitus.

Autopsy revealed a well-developed, thin, adult female with no internal or external evidence of traumatic injury. Analysis of vitreous humor revealed a markedly elevated glucose level and electrolyte abnormalities indicative of diabetic ketoacidosis. Ketones (acetone and isopropanol) were detected in urine and peripheral blood. No ethanol (alcohol) or drugs of abuse were detected.

MANNER OF DEATH: Natural

Custodial Death Report
Filed: 7-18-2016 4:35 pm
PA16312CJ

Agency/Facility Information

Name: Bowie County Sheriff's Dept.
Address: 100 North State Line Ave.
City, Zip: Texarkana, 75501
Phone: 903-798-3149
Director: James W. Prince
Name of Report Filer: Jeffrey K. Neal
Email of Report Filer: jneal@txkusa.org

Identity Of Deceased

Name: Morgan Christy-Ruth Angerbauer
Race/Ethnicity: Anglo
Sex: Female
DOB: 07-09-1995
Age: 20

Date Of Custody (arrest, incarceration)

6-30-2016 10:22 am

Date Of Death

7-1-2016 5:07 am

Where did the event causing the death occur?

Address: 100 North State Line
City: Texarkana
County: Bowie

Has a medical examiner or coroner conducted an evaluation to determine a cause of death?

Yes, results are available

Apparent Manner Of Death:

Natural Causes/Illness
Description: Diabetic Ketoacidosis

Medical Cause Of Death:

Diabetic Ketoacidosis

Was the cause of death the result of a pre-existing medical condition or did the deceased develop the condition after admission?

Pre-existing medical condition

Had the deceased been receiving treatment for the medical condition after admission to your jail's jurisdiction?

Yes

Description: Angerbauer was being given insulin

Type of Custody

Jail - single cell

What were the most serious offenses with which the deceased was (or would have been charged with at the time of death)?

1. Possession of a Controlled Substance
2. Contempt of Court

Status: Filed

Type of Charges

Alcohol/Drug Offense

Did the deceased die from a medical condition or from injuries sustained at the crime/arrest scene?

Not applicable

If injured at the crime/arrest scene, how were these injuries sustained?

Not applicable

Was the deceased under restraint in the time leading up to the death or the events causing the death?

No

At any time during the arrest/incident, did the deceased:

Appear intoxicated (either alcohol or drugs)? - No.
Threaten the officers(s) involved? - No.
Resist being handcuffed or arrested? - No.
Try to escape/flee from custody? - No.
Grab, hit or fight with the officer(s) involved? - No.
Use a weapon to threaten or assault the officer(s)? - No.
Other - No.
Not Applicable - Yes.

What type of weapon(s) caused the death?

Not Applicable

Where did the deceased die?

At law enforcement facility

What was the time and date of the deceased's entry into the law enforcement facility where the death occurred?

6-30-2016 10:22 am

At the time of entry into the facility, did the deceased:

Appear intoxicated (either alcohol or drugs)? - No.
Exhibit any mental health problems? - No.
Exhibit any medical problems? - No.
Not Applicable - Yes.

If death was an accident or homicide, who caused the death?

Not applicable; cause of death was suicide, intoxication or illness/natural causes

If death was an accident, homicide or suicide, what was the means of death?

Not applicable; cause of death was intoxication or illness/natural causes

Summary of How the Death Occurred:

On 07-01-16 around 4:40 am LVN Brittany Johnson went to the medical observation cell of the Bi-State Jail to check on Texarkana Arkansas Police Department Inmate Morgan Angerbauer. LVN Johnson noted that Angerbauer appeared to be sleeping and her breathing was normal. She left to retrieve an Accucheck machine and returned to the medical observation cell a short time later. LVN Johnson attempted several times to get a reading with the Accucheck machine, but kept getting an error message. She then left to get glutose to give Angerbauer. When LVN Johnson returned she was unable to get Angerbauer to swallow the glutose on her own, she helped her. Around 04:55 am Angerbauer began to aspirate. LVN Johnson rolled Angerbauer on her side and noticed her bite through her tongue. She checked Angerbauer for a pulse, but could not find one. 911 was called and an AED machine was hooked up to Angerbauer. CPR was performed on Angerbauer until ambulance personnel arrived. They hooked an EKG machine to Angerbauer and discovered the life saving measures taken had been unsuccessful. The Texarkana Arkansas Police Department conducted the investigation into Angerbauer's death since she was in their custody. Angerbauer was sent off to Little Rock, Arkansas for an autopsy. The results of this autopsy show Angerbauer's manner of death as natural and her cause of death as diabetic ketoacidosis.

Interview with Brittany Johnson

By: Detective Tom Briggs and Detective David Parker

Parker: I know you have already told me, but what was your address?

Johnson: 128 Barkman Creek Road, Hooks, Texas 75561

Parker: What is your name?

Johnson: Brittany, two t's, A-N-Y, Johnson.

Parker: P-N-Y?

Johnson: A-N-Y, yes sir.

Parker: Okay, and Johnson?

Johnson: Yes.

Parker: Okay. Who was the other nurse? Venable?

Johnson: That came in after me?

Parker: No, before you.

Johnson: Before me? It was nurse Venable.

Parker: Okay. You said you did talk to the offender before, what, yesterday afternoon?

Johnson: Yes.

Parker: Okay, did she just tell you that she was ready to go to Medical?

Johnson: Ready to go to medical.

Parker: To medical as in the hospital?

Johnson: To my office.

Parker: Okay. What time was that?

Johnson: About 5:00.

Parker: Okay, so she told you she was ready to go to your office?

Johnson: Yes.

Parker: What was she wanting to go over there for?

Johnson: I'm guessing to get her sugar checked. She didn't tell me why, I am just guessing.

Parker: Okay. So she told you she was ready to go over there?

Johnson: Yes.

Parker: And what did you tell her?

Johnson: I told her no because that is not how it works.

Parker: Okay. I know that you have already said this, but I am just making sure I get everything. Okay, how does it normally work?

Johnson: When we have pill call and Accu-Chek's, they are on a list and if they don't come at that time, they refuse and then we just go on to the next because if we set there and let everybody refuse and then come back later we would never get anything done.

Parker: Right. Yeah.

Johnson: And that sounds kind of hateful.

Parker: And I understand that to a point.

Johnson: Yeah.

Parker: But, how long does it take you to do your pill distribution or whatever it is ya'll do. When you go around at 5:00 I guess you were going around doing your checks. About how long does it take you to get that done?

Johnson: Probably about 5 to 10 minutes.

Parker: Okay, so 5 or 10 minutes for basically all of those in jail to distribute.

Johnson: That is just Seg rounds, not the whole jail.

Parker: Okay. Now, so 5 to 10 minutes for Seg?

Johnson: Yes sir.

Parker: About how much of your day is dedicated to going around and giving medications and things like that to the jail?

Johnson: About 3:00 we start pill passing and I am normally done about 4:20 with pill pass.

Parker: Okay, so about an hour and a half?

Johnson: Yeah.

Parker: Okay. So, let's say 5:00 yesterday she told you, "Hey, I'm ready to go over there", after she had refused at 4:30 and then it takes you about an hour and a half to get everybody else their medications, at what point could it have not....maybe she refused at 4:30 and her body starts....she goes, "You know what? I need that." Is it not common practice to, okay, she refused and now she is saying okay maybe I need to go check it again? If she is willing to get checked at 5:00, but she is told, no, it don't work that way, you refused. So, now she sits for 12 hours and then she is put in a cell by herself, she is screaming and hollering and nobody's checking, nobody's checking, nobody is checking and at 5:00 she is dead, but 12 hours prior to that she said, "Hey, I screwed up and I'm ready, I need my medication." How does that happen?

Johnson: What do you mean? How does that happen? I mean.....

Parker: How is she.... She refused, I understand that.

Johnson: Uh huh.

Parker: She said, "I refuse." Ya'll have how many inmates upstairs? A lot.

Johnson: A 150 something.

Parker: Okay. I understand you can't cater to each and every one.

Johnson: Uh huh.

Parker: Okay, but you get your work done within an hour and a half of handing out medications. How long would it have taken to go, "She refused and I need to check on this girl to make sure that everything is good to go over there and check her blood sugar when she said. "Hey, you know what? I'm ready to go get that checked now."

Johnson: Probably just 5 to 10 minutes. It would have only taken 5 to 10 minutes.

Parker: So, why didn't that happen is what I am getting at? I am not necessarily just blaming, I am not coming at you that way, but I am just....it's a question.

Johnson: Just because ...there was....I mean, she was the nurse didn't see no fit like she didn't have any signs or symptoms of.....

Parker: At that time?

Johnson: Yeah, of going into shock or anything like that.

Parker: But she wasn't checked for 12 or more hours?

Johnson: Uh huh.

Briggs: At what point does insulin become a medical emergency? At what level?

Johnson: You mean like the sugar or?

Briggs: The sugar level.

Johnson: The sugar level? Well, the range is from 70 to 110.

Briggs: So she hasn't been in range since she has been here.

Johnson: Yeah. She was there and that was the only time, but at that point, I don't know if she has ate.

Briggs: Right.

Johnson: The rest of the day or not.

Briggs: And like the question he just asked you, you know, at 5:00 you go by there and she says okay I want to get checked now and you say, no, it don't work that way, we got other stuff we got to take care of. Would that be knowing that she is a diabetic and she is hard to stay in range or don't stay in range, would that be a medical emergency? With her stopping you and saying, "Hey, I am ready to go back there

and see you now" or is it just you got to get your other stuff done and when I can get back to you, I can get back to you.

Johnson: Get back to you. It was not a medical emergency to where I needed to get her out right then and do it.

Briggs: Okay.

Parker: If I was sitting in a cell and I can't take care of myself, I am going to tell somebody and say, "Hey, look, I am ready to go get this checked." I can't check it myself and I am ready to go get this done and then it never. She gets moved to Med Observation because when she told you that was she still over?

Johnson: She was in Med Observation.

Parker: She was in Med Observation when she told you this?

Johnson: Yes.

Parker: So, like I said, I am not trying to come at you and throw this all on you, I'm not, but I am just trying to get the questions answered because we are putting together a puzzle here. Okay. What is your daily....after you do pills...after you go around and do your checks...what are you doing because you work 12 hours.

Johnson: Uh huh.

Parker: Are you, I mean, slammed packed for 12 hours? You are regimenting this is what you are doing?

Johnson: Most of the time I am usually done about mid-night.

Parker: Okay, so from mid-night until 4:00 or let's say mid-night to 2:00, okay? What are you occupied with between there last night?

Johnson: Last night?

Parker: Uh huh.

Johnson: Setting up for morning pill pass because that is at 3:00. I go in and try to set it up just in case something happens and there was a use of force around 3:00 or something that we had to deal with and other than that I was just in my office cleaning and all that.

Parker: Okay, so basically, I mean, there was time that you could have went back and checked right?

Johnson: Yes.

Parker: Okay.

Briggs: I know it seems like we are kind of jumping around and asking questions, but I want to make sure that I get everything clarified here and now. I noticed that while talking to you earlier, you were in the cell and you say that when you went in by the time....when you went in there and accessed the situation to the time you called 10:10 could have been about 15 minutes.

Johnson: Uh huh.

Briggs: At what point, did you know that this is a medical emergency and this is above my head.

Johnson: When we laid her back and she started aspirating. That is when.

Briggs: So that would have been how many minutes into it?

Johnson: Probably like 11 or 12 minutes.

Briggs: Okay, that is when you knew this is going and this is going quick.

Johnson: Yeah.

Parker: How equipped are ya'll up there to handle lifesaving stuff on diabetes. You got glucose up there, you got...Normally if somebody has to be administered glucose, do ya'll just give it to them and tell them you know, "Your good to go, go back to your cell?" or do they go to a doctor to get checked out further?

Johnson: No, like we, like depending on if they can chew they will chew a tablet and if they can't chew they will squirt stuff in their mouth. That is what I had to do, squirt some sugar in her mouth.

Parker: Right.

Johnson: But we do that. We don't really have the capabilities to send people to the hospital unless it is like dire need.

Briggs: So if you would have requested that she go to the hospital would they have been able to take her last night?

Johnson: It would have taken some time because I would have had to call TAPD and anyway.....

Briggs: Okay, so that would have been a process.

Johnson: Yeah.

Parker: It would have taken awhile?

Johnson: Yeah.

Parker: Okay.

Briggs: Not this morning, but the previous morning when you did your diabetic stuff, was she in Med Observation then or was she still in regular GP?

Johnson: She was in general.

Briggs: She was in regular general population?

Johnson: Yeah.

Briggs: You went through there and she was as you said, she was dramatic then and everything was.

Johnson: Yes, she came to my office. Yeah, she was very very dramatic.

Briggs: Okay, and she came to your office and she let you check her blood sugar?

Johnson: Yes.

Briggs: Okay, but between that day and this day, she gets moved to Med Observation and while she is in there this is when all of this goes down?

Johnson: Uh huh.

Briggs: Do you know how many people normally work on a shift up there? Officers rather?

Johnson: Let's see. Normally around seven, I believe.

Briggs: Okay.

Parker: That is a normal occurrence or that's on a good day?

Johnson: That is on a good day.

Briggs: When the MT's got there do you know what all they did as far as lifesaving measures?

Johnson: I was doing CPR at that point and then they put an EKG on her and when they told me to stop they ran a strip and at that point the strip determined that she was no longer with us and they looked at her pupils as well and her pupils were not reacting so at that point I think 5:07, I think is when they called it.

Briggs: Okay. Is there any questions you have for us or anything?

Johnson: No, just.....

Briggs: On the nurses that work up there, all of ya'll are LVN's or LPN's, but do ya'll work for an RN or is there anybody that is.....

Johnson: Yes, our supervisor is an RN.

Briggs: Okay.

Johnson: Ms. Lynch.

Briggs: She works at the other side?

Johnson: The Annex.

Briggs: Okay.

Parker: Now, do ya'll normally....Is she there? Do ya'll have other nurses or anything over there?

Johnson: Yes, at the Annex, yes.

Parker: Is there just one over there too?

Johnson: There are some part-time people that come over there sometimes, but normally it is just one nurse.

Parker: Okay. Are ya'll supposed to call her if anything gets like this or what is ya'll's protocol for that?

Johnson: Umm, I really don't know, but if we have a chance we can call if we need help, but I was in the full swing of stuff to where I didn't have the time to grab the phone and call anybody.

Parker: Okay. Do ya'll have, I know, because most places have policies and everything...where does it say like you are working on her... is there a certain thing that says, hey, at this point, get somebody else to help or you know, you are allowed to work on a patient for so long before you call for EMT's. Is there anything like that that you know of?

Johnson: Not that I know of, no.

Briggs: But you did continue until the EMT's got there?

Johnson: Yes.

Parker: I'm good if you are.

Briggs: I am going to make sure we got everything out of the way that we need from her and we will be ready to rock n roll. (Briggs leaves the room)

Parker: Have you talked to Ms. Lynch at all?

Johnson: Yea, I called her this morning because we have to notify her if somebody passes away.

Parker: Right.

Johnson: I called her this morning.

Parker: Okay. What did she have to say, anything?

Johnson: She just was asking if I was okay and what went on and I told her.

Parker: Right. How well do you know Cleghorne?

Johnson: Just a co-worker.

Parker: Okay. Is he is pretty knowledgeable on medical stuff or?

Johnson: Yeah.

Parker: Okay, so if anybody was to help you he would probably be the one to.

Johnson: Yes. Yes.

Parker: Does he help with stuff like that on a routine basis?

Johnson: Yeah, he has helped me with a couple of other patient's that have gone like gotten hurt, not gone down, but gotten hurt on the shift.

Parker: Okay. Tell us the details on the equipment?

Johnson: Like the AAD?

Parker: No, like the sugar test. What do they call that? Because you said it was getting errors and stuff.

Johnson: Yes.

Parker: I mean, is this pretty reliable or is it?

Johnson: Yeah, like all other times I have checked people's sugars, it just feels like in a bad situation nothing works.

Parker: Kind of like Murphy's Law?

Johnson: Yeah.

Parker: When it's going crazy everything goes bad.

Johnson: Everything goes crazy.

Parker: Yeah. I understand. I kind of jumped down a rabbit trail earlier on the whole sugar level thing that....is that normally? I mean, when the sugar is off though do they kind of act out more or how does...I know at some point they are just going to crash.

Johnson: Yeah.

Parker: But is there like multiple stages where it is like they are way up here and then all of a sudden they just go or how does that normally work?

Johnson: It just depends on the body type.

Parker: Okay.

Johnson: Of course.

Parker: And she is what? 80 pounds?

Johnson: Yeah.

Parker: She is a little bitty girl. It wouldn't take her long for her sugar level to drop would it?

Johnson: No.

Parker: Like I said, I don't think she weighed, I think her ribs were like that, I mean....

Johnson: Yeah, she was super small.

Parker: On the Med Observation how often are they supposed to check those?

Johnson: MCO's?

Parker: Yeah.

Johnson: Medical wise it is 30 and if they are on suicide it is 15. It is like 30 minutes.

Parker: Okay, this girl was just medical?

Johnson: Yes, just medical.

Parker: Are they supposed to check everything?

Johnson: Yes.

Parker: How are they supposed to check? Is it eyes on, hands on? Is it go by and just see them move or just go by and peak and make sure they are still breathing? How does that normally work?

Johnson: You are supposed to look, peak and if they have been in the same position for like two checks, then have them move or kick something to show that they are.

Parker: Okay. Then if somebody was like watching the camera's, okay, she was laying in there on a slab, uh, periodically when she would flip around, I mean, she was very sporadic on her movement and stuff, do they normally, I mean...that is just what they are looking for. If they are not in the same position they go on about their business?

Johnson: Uh huh. If they see that they are breathing and in a different position they usually go about their business.

Parker: What all do they normally go in the Med Observation cells for? I mean, they are supposed to have a medical condition that is requiring more treatment or?

Johnson: Sometimes. Sometimes it is just another place to put Seg people that they don't have any place to put them in Seg they will put them in Med Ob cell.

Parker: So, if I am a guard and I am supposed to do my check every 30 minutes and I go by and I peak in and they are laying down on the slab there and then so I mark that one, she is good. I go back 30 more minutes later and she is still in the same position, am I required to check then or is it more than two consecutive checks I would knock on the window to make them move?

Johnson: I am not too sure. I do not know what the CO's really have....

Parker: Okay, so but basically what I am getting at is if I see them laying there and I peak in the window and go okay, yeah, they are there and then I come back around basically an hour and I am going, oh, they haven't moved so now I'm going to knock and check, if they are in a medical cell is that, I mean, 30 minutes without, you know, aid, that is a long time. I am just trying to figure out if that is normal.

Johnson: Yeah. What I have learned with up there is that there is a lot of people that play possum. A lot of people play possum.

Parker: So have we made rules to cater to the people that play possum or what is going on with that? Is it that after so much normalcy it is just....they are playing possum?

Johnson: Yeah.

Parker: Okay.

Briggs: What does t.i.d. stand for?

Johnson: Three times a day.

Briggs: Alright, this right here. I want to show this to you to make sure it is right. This was a fax sent off right? On the 29th after she got seen to clear for medical observation and she was supposed to get that by Venable right?

Johnson: Uh huh.

Briggs: It said that she was not seen since November 2015 at the doctor I guess and that will be her medical release form so they can send something back?

Johnson: Yes.

Briggs: And this is what they sent back?

Johnson: Yes.

Briggs: All forms were number 1 of 1, 2 of 2 and 3 of 3 forms.

Johnson: Yes.

Briggs: Would ya'll work off of this form since this is the last thing that they sent back?

Johnson: No, because it was 11/20.

Briggs: This was the last thing sent from her doctors that they last seen her and this is what she was last prescribed. Ya'll don't necessarily go by that?

Johnson: No, because it has to be a certain period. I believe with life ___(24:01), I think it is within a three month period they have to be at the doctor because it can change so drastically.

Briggs: So since this was the last time she was seen? No matter that it was almost a year ago? Ya'll would go with your regular protocol?

Johnson: Yes, we would just go with our regular protocol.

Briggs: Gottcha. I don't want to overlook nothing and I noticed she had some stuff in here about bipolar, drug use and things like that there that are documented. I know that she told the people she hadn't done drugs in two days when she got here and that it had been at least two days, so. I wonder why is there a reason that the staff upstairs said she never made it to the pod.

Parker: Yeah, they said she was never in General pod.

Briggs: They said she was in holding to straight over to the Medical Observation. This was the 28th when she came in and she was normal behavior. This is something she would have let them know right? That she was bipolar?

Johnson: Yeah, that was the pre-book officer.

Briggs: But she would have let them know that not?

Johnson: Yes.

Briggs: Okay.

Parker: How much training have ya'll had since you have been up there?

Johnson: Training like how?

Parker: How to deal with situations in the jail by yourself?

Johnson: We have had to do like, let's see, one was the other week. We have got to do two or three, like we will come in and before we even hit the shift we do training.

Parker: Good.

Johnson: And then we just did one here recently.

Parker: So do we normally do....when I say we I'm talking about LaSalle or whoever up there...do we normally do medical treatment based off of what they tell us?

Johnson: We confirm everything with the doctor.

Parker: Which doctor?

Johnson: Whichever doctor they say. Like if they said, they went to Wadley or whatever, we would fax off to Wadley to see what they said.

Parker: Okay and then we would wait for them to send it back? How quick do they normally respond?

Johnson: I couldn't tell you because it is usually the day shift that they respond.

Briggs: This one came from East Texas Broyhill Clinic.

Parker: When was that one?

Briggs: 6/30/16 is when it came through a fax.

Johnson: And then they were like faxed the 29th todays?

Briggs: Yeah. So 11:15 to a little over a day actually 24 hours before getting it back.

Parker: Yeah.

Briggs: But, you say since it is not in a three month time frame from seeing the doctor then you got to use your regular protocol to administer medication.

Johnson: Yes.

Briggs: Gottcha. The phone numbers and stuff you gave us (903) 949-0222?

Johnson: Yes.

Briggs: That's a good phone number?

Johnson: Yes.

Briggs: Okay. I don't know if ya'll work shift work or? You got to work again tonight?

Johnson: No.

Briggs: You off? You working with that crew or something?

Johnson: Yes. I work with that crew so I am off.

Briggs: For the next few days or whatever it is?

Johnson: Yeah.

Briggs: So this is a good phone number to get in contact with you if we need you to answer any questions or anything like that?

Johnson: Yes.

Briggs: Okay, let me make sure I can get you going and we will take care of that.

Parker: The protocol is three times a day right?

Johnson: Yes sir.

Parker: Alright. So basically we are relying on sending a fax over requesting the information to get back in a timely fashion, but until then.

Johnson: We are running on protocol.

Parker: So we could be giving the wrong medications or at wrong times?

Johnson: Well, if you think about it that way, but it's, we are providing, let's see, we are providing medical where needed. Like, it could be wrong because that is not what she is taking or what people are taking in the real world, but we are over here trying to help prevent from any disasters or like trying to keep them alive by using our protocol until the other medicine comes in and then we are like okay and then we confirm it with our doctor and make sure he is okay with that.

Parker: Okay, but if hers and this is hypothetical, okay?

Johnson: Uh huh.

Parker: If hers is once a day, okay? Maybe she gets insulin once a day and then she comes in and we haven't heard from a doctor, so we are going to give her morning, lunch, supper and now she is getting three times a day.

Johnson: Uh huh.

Parker: Is that not a problem at all? I have never used insulin, I don't know.

Johnson: No, because her sugar was so high and we were trying to control it that that wouldn't be an issue.

Parker: Okay.

Johnson: And even if the doctor sent back that it was one time a day and we were checking her sugar and it was still running high we would talk to our doctor and our doctor would try to work out something better with her health.

Parker: So if somebody's sugar is high, what do you normally do?

Johnson: If it is registered high we give 15 units of regular insulin. We have a scale, like I think it is 0 to 150, we don't give anything and 151 to 200 we give two units and it goes like that, but once it gets over 450 or something, you give 15 units. I think that is the top. So when it registers high you give 15 units.

Parker: Okay, so what do we do if it is low? I am trying to get educated.

Johnson: No, no. If it's low then we give glucose. I mean, we have orange juice, but we don't really have access to orange juice up there. We give them a glucose tablet or if it is real low to where they can't really chew on anything, then the Glutose which is the gel.

Parker: Did she take that at all? I mean was she actually ingesting it? Because I was kind of told that she was spitting a lot of it back out.

Johnson: Yeah, she was spitting a lot of it back out. Like I would put it in there and she closed her mouth and I was like, no, you need to open and at that point we were manually trying to get it down her just so that cus that is what I was figuring was happening is her sugar dropped and I was trying to get her sugar up.

Parker: Okay, so, this is again, if her sugar is high because it hadn't been checked, if her sugar is high and it was in the ranges of way high and then we put glucose down her to where basically that is going to throw it back up there again right?

Johnson: Uh huh.

Parker: Okay, what would happen if we, say her sugar is high and she has got another issue, you know, something else is making her to where she is not responding, she has already got high sugar and then we cram glucose down, what is that going to do?

Johnson: Just make it higher.

Parker: Make it higher?

Johnson: Yeah.

Parker: At what point is too high? Say if I drink a whole lot of...I drink sweet tea like it is water...and my sugar gets way up here and I am off the charts high, what is that going to do to my body?

Johnson: You will start shutting down. You will start....

Parker: Could I die from it?

Johnson: Like if it is continued, I mean, we all were kids. You know, we all did sugar crazy, you know, so but it is just a continuous and if your body is not making enough insulin yourself then you know it could...

Parker: Okay. So, too much sugar for an 80 pound woman...cus, I know it would take a whole lot for me, but for an 80 pound girl, we cram in...because glucose is basically...

Johnson: Straight sugar.

Parker: Yeah, just straight, you know, straight running sugar.

Johnson: Uh huh.

Parker: We shove that down her. Is going to blow her off the charts?

Johnson: It is going to bring it up. Like, say, if it is was, say it was like 20 or whatever, it is going to bring it up to about 120ish depending on...

Parker: Okay, but what I am trying to figure out for me to wrap my mind around it is if it was already high because we haven't checked her in over 12 hours...if she was already high blood sugar and we poured unregulated basically sugar down her throat and all of a sudden her body gets all of this sugar and glucose in there...could that make her shut down like that? Could that make her aspirate?

Johnson: No.

Parker: You are the medical person. I am not. That is what I am.

Johnson: No.

Parker: Okay.

Briggs: Well, we got good numbers and everything and if we need to ask you anymore questions we can call you?

Parker: Yes.

Briggs: We will get a hold of you. Just go get some rest. Are you going back upstairs or are you headed out the door?

Parker: I am headed out the door.

housed prior to being placed in med-op 2 and I showed her a jail document which had the victim being housed in Q-pod and she stated that this was correct. Johnson was asked by Det. Parker what she meant by being placed in med-op for being verbal. Johnson stated that she was told by nurse Venable that she was placed in med-op for being loud and verbal about what she "was going to do" and "not going to do", so she was placed in med-op so she could be monitored.

Johnson was asked what their staff's procedures were on insulin patients and how often they were given their meds? Johnson stated that it depends on if they were insulin dependent or how severe their condition was on the type of doses they would get. She advised that regular insulin dependent offenders are seen (TID) which is three times a day, and on severe cases they are seen four times a day. She stated that Angerbauer did not have severe status so she was seen three times a day before each meal. I asked Johnson if this practice or procedure was prescribed from her doctor or if it was the practice of the jail? Johnson advised me that this was their (the jail's) protocol. She also advised that they have to fax off a request for the current medical information to the offenders doctor and wait on a response to the request.

I asked Johnson what their procedure is on a medication refusal? She stated that it depends on if their blood sugar level comes down or not. She then advised me that their protocol stated that they are to get a signed document from the offender with any life threatening illnesses. Diabetes is life threatening if not managed and treated. She also stated that if the offender refuses to sign the document then there is to be two witnesses there to verify that the offender refused medical treatment. I asked Johnson where I could obtain that document from and she stated that if there was one it would be in the jail.

I asked Johnson about the blood sugar reading on the medical documentation chart for this offender which showed one reading to be a 487. I then showed her where it just said "HI" and asked her what the difference was or why there was not a numerical reading. She said normally when the word "HI" is displayed then the machine did not register which means the blood sugar is above 500, and that their meter did not read over 500. Det. Parker asked Johnson what the staff normally did when the reading is super high like that and she replied that "they would give 15 units of insulin and wait 2 hours and check it again." She then stated that they would re-evaluate and give more meds as needed and continued this every two hours until the elevated blood sugar level came down.

I clarified with Johnson that offender Angerbauer had not received any insulin medication since 0530 hours on 06/30/2016, and she stated this was correct.

Johnson said that shortly after 4:00am on 07/01/2016 she entered medical observation cell #2 to hand out meds. Johnson said that Sgt. Lindsey let her into the cell. Johnson said when she entered the cell that Angerbauer was breathing but she was non responsive to any of her questions. She stated that she asked Angerbauer to roll over so she could stick her finger for the purpose of checking her blood sugar level but she would not rollover. She said that she advised Angerbauer to stop playing because the night before she was very audible and dramatic and that she knew how she was acting. She stated that she then sat the offender up so she could stick her finger, but could not get the monitor to work. She advised that she had Officer Cleghorn go and get some more supplies for the machine and it still did not work. I then asked Johnson what she meant by the machine did not work and if it meant the reading was too high or it was just not working. She then advised me that the machine was reading "error" which means there was something wrong with the test strip or not enough blood. She stated that she tried to get more blood on the strip and that the "error" reading was because she did not eat and her sugar had dropped. She stated that she was trying to check it again and get her some sugar and after the 6th or 7th time of attempting to check her blood sugar and the machine reading "error" she just went and got some glucose (sugar) and gave it to her to see if she could get her to respond. I asked Johnson that if during this process of her attempting to check her blood sugar 6 or 7 times, was the offender able to sit up on her own and was she still responsive. She replied that she was breathing and she did have a pulse. She advised me that they did have to support the victim to help her sit up. She stated that Officer Brown was holding her up at one point then Officer Cleghorn took over.

Johnson stated that she was continuously trying to talk with Angerbauer, but she would not speak with them or say anything. She did state that Angerbauer was trying to pull her arms away from her. I

Medical Examiner
(501) 227-5936

State Crime Laboratory

P.O. Box 8500
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Little Rock, Arkansas 72215

Medical Examiner Division

Case No:	2015-015384 / ME-0719-15	**Date of Examination:**	July 23, 2015		
Name:	SABBIE, Michael T				
Age:	35 Years	**Race:**	Black	**Sex:**	Male
County:	Miller				

CONCLUSIONS

CAUSE OF DEATH: Hypertensive Arteriosclerotic Cardiovascular Disease

MANNER OF DEATH: Natural

September 11, 2015

Adam F. Craig, M.D.
Associate Medical Examiner - Pathologist of Record

Frank J. Peretti, M.D.
Associate Medical Examiner - Reviewer

Charles P. Kokes, M.D.
Chief Medical Examiner - Reviewer

EXTERNAL DESCRIPTION:

The body was that of a well-developed, well-nourished, obese, black male, received clad in a pair of red pants. Taped over both hands were brown paper bags. The body weighed 152 kg (334 pounds), had a length of 196 cm (77 inches), and appeared consistent with the reported age of 35 years. The body was cool. Rigor was present and equal in all extremities. Lividity was faint red-purple and fixed on the posterior surface of the body, except in areas exposed to pressure. The scalp hair was black, curly, and short. The decedent wore a thin mustache and had a goatee, with facial stubble in the remaining beard areas. The irides were unremarkable and the pupils were equal at 4 mm in diameter. The corneae were clouded. The conjunctivae and sclerae had congestive changes without petechiae or icterus. The external nares and lips were unremarkable. The teeth of the lower alveolar ridge were natural and in good condition. The upper alveolar ridge had many teeth absent, and the ones remaining were natural and in poor condition. The auricles of the ears were unremarkable and the external auditory canals were dry. Examination of the neck revealed no evidence of injury. The chest was unremarkable, with no external evidence of injury of the ribs or sternum. The abdomen was obese, with no acute injuries noted. The external genitalia were those of a normal adult male, without injuries. The upper and lower extremities were well developed and symmetric, without edema or loss of digits. On the arms were tattoos. No apparent needle tracks or wrist scars were noted. The spine appeared to be intact by external examination. The anus was patent. The posterior surface of the body was symmetric.

EVIDENCE OF MEDICAL ATTENTION:

On the chest were two attached defibrillator pads. On the chest and abdomen were four attached heart monitor pads.

EVIDENCE OF OLD INJURY:

Scattered across the anterior aspect of the abdomen were multiple, minute, healing and well-healed scars. Within an area of the ventral aspect of the right forearm were multiple, irregular, well-healed scars. On the ventral radial aspect of the left forearm was a 0.5 cm, white, eschar formation.

EVIDENCE OF RECENT INJURY:

On the right posterolateral lower aspect of the back was a 4 cm, elongated, faint, discontinuous, purple-blue contusion, with irregular red-brown abrasion. Reflection of the scalp revealed an approximately 11 cm area of galeal contusion, located at the right posterior aspect of the scalp. No associated skull fracture, bleeding around the brain, or cerebral contusion was identified. Close examination of the forearms revealed no abrasions, contusions, or handcuff imprints.

INTERNAL EXAMINATION:

The subcutaneous fat layer of the abdomen measured up to 8 cm. No adhesions or abnormal collections of fluid were present in the pleural or peritoneal cavities. Petechiae were not present on the thoracic organs. All body organs were present in their normal anatomic positions.

CARDIOVASCULAR SYSTEM:

The pericardial and epicardial surfaces were smooth, glistening, and unremarkable. The pericardial sac contained a normal amount of serous fluid and was without adhesions. The 815 g heart was markedly enlarged in size, with a normal shape and configuration. The coronary arteries arose normally, followed the usual distribution, and had mild to moderate atherosclerotic changes. All of the atherosclerotic plaques in the coronary arteries were crescent-shaped on cross section of the arteries. Maximum luminal narrowing in the coronary arteries were 40% in the left anterior descending, 20% in the right, and 10% in the left circumflex. None of the coronary arteries had evidence of thrombosis. Examination of the chambers and valves revealed a normal size-position relationship, with normal endocardial surfaces, chordae tendineae, papillary muscles, and valve leaflets. The myocardium of the ventricles was dark red-brown, with increased thickness of the left ventricular free wall and the interventricular septum. In the myocardium were three dark red discolorations, none of which measured greater than 0.7 cm, and were located in the lateral aspect of the left ventricle near the apex of the heart, in the posterolateral aspect of the left ventricle near its mid aspect, and in the endocardial region of the anterior aspect of the intraventricular septum near the base of the heart. The atrial and ventricular septa were intact. The aorta and its major branches arose normally, followed the usual course, and were widely patent, free of significant atherosclerosis and other abnormality. The vena cava and its major tributaries returned to the heart in the usual distribution and were free of thrombi.

RESPIRATORY SYSTEM:

The 865 g right and 760 g left lungs had smooth, glistening pleural surfaces. The pulmonary arteries were normally developed and patent, without thrombus or embolus. In the larynx and trachea was mild froth deposition on the luminal surfaces. The airways were otherwise clear of debris and foreign material, and had mucosal surfaces that were smooth and of normal coloration. The pulmonary parenchyma had prominent dark red-purple, mottled, dependent congestion, and diffuse edema. No specific focal lesions were noted.

NECK:

Examination of the soft tissues of the neck, including strap muscles, thyroid gland, and large vessels, revealed no abnormalities or hemorrhage. The hyoid bone and larynx were intact. The epiglottis and vocal cords were unremarkable.

ALIMENTARY TRACT:

The tongue was without evidence of recent injury. The esophagus was lined by gray-white, smooth mucosa. The gastric mucosa was arranged in the usual rugal folds, and the lumen contained approximately 50 mL of brown fluid. The small and large intestines were unremarkable and the colon contained formed stool. The rectum and anus were unremarkable. The appendix was present.

LIVER AND PANCREAS:

The 2380 g liver had a smooth, glistening, intact capsule, covering red-brown, firm parenchyma, with a nutmeg pattern of passive congestion to the cut surfaces of the parenchyma. No focal lesions were noted. The edges were sharp. The gallbladder contained a scant amount of green bile. The mucosa was velvety and unremarkable. The extrahepatic biliary tree was patent, without evidence of calculi. The 205 g pancreas was gray-tan, firm, and lobulated, with patent ducts.

GENITOURINARY SYSTEM:

The 175 g right and 195 g left kidneys had thin renal capsules that stripped with ease from the underlying, roughly-granular, slightly-mottled, moderately-firm cortical surfaces. The red-brown cortices were sharply delineated from the red-purple medullary pyramids. The calyces, pelves, and ureters were unremarkable. The urinary bladder contained approximately 200 mL of yellow urine. The mucosa was gray-tan and smooth. The prostate and testes were unremarkable.

IMMUNOLOGICAL SYSTEM:

The thymus was identified and composed of fat. The 240 g spleen had a smooth, intact capsule covering red-purple, moderately-firm parenchyma, with slightly prominent white pulp. No accessory spleen was identified. Regional lymph nodes were not enlarged.

ENDOCRINE SYSTEM:

The pituitary, pineal, thyroid, and adrenal glands were free of obvious disease.

MUSCULOSKELETAL SYSTEM:

Muscles were red-brown and had normal development. No bone or joint abnormalities were noted. The cervical, thoracic, and lumbar spine showed no obvious fractures or other abnormalities.

CENTRAL NERVOUS SYSTEM:

The scalp had findings as previously described. The calvarium and base of the skull showed no fractures. The dura mater and falx cerebri were intact. There was no epidural, subdural, or subarachnoid hemorrhage present. The leptomeninges were thin, delicate, and clear. The 1445 g brain had symmetric cerebral hemispheres, with typical gyri and sulci for the decedent's age. The cranial nerves were intact. The circle of Willis and related blood vessels were normal in caliber and distribution. Sections through the cerebral hemispheres, brainstem, and cerebellum revealed no focal lesions or herniation. The spinal cord was not examined.

HISTOLOGY:

Heart and vessels: Six sections of left ventricle and interventricular septum had vascular congestion and frequent hypertrophied myocytes with enlarged nuclei. Three of the sections contained the areas of red seen grossly, which consisted of areas of dense fibrosis containing prominent neovascularization. The other sections had extensive areas of mild to moderate, perivascular and interstitial fibrosis. No evidence of acute ischemia or significant inflammation was identified.

Lung: Five sections of lung had vascular congestion and numerous, scattered alveolar macrophages with dark brown cytoplasmic pigment. Occasional multinucleated giant cells with similar brown cytoplasmic pigment were also present in the alveoli. Iron stains of the sections revealed the brown pigment to be positive for iron, which was consistent with hemosiderin. No significant inflammation was identified.

Liver: A section of liver had prominent congestion of sinusoids, and mild chronic inflammatory cell infiltration of the portal triads, with no significant steatosis.

Pancreas: A section of pancreas had diffuse loss of hematoxylin staining and cellular details, consistent with autolysis. The glandular parenchyma had mild adipose tissue infiltration. No significant inflammation or fibrosis was identified.

Spleen: A section of spleen had congestion of the red pulp and vessels, and infrequent germinal centers of the white pulp.

Kidney: A section of kidney had vascular congestion, occasional small subcapsular cortical foci of interstitial fibrosis with associated mild to moderate chronic inflammatory cell infiltration and globally-sclerotic glomeruli, and mild variable intimal thickening of artery walls.

Brain: A section of cerebrum from the region of the hippocampus had vascular congestion, with no significant inflammation or evidence of ischemia.

Pituitary gland: A section of pituitary gland had vascular congestion. Both anterior and posterior lobes of gland were present in the section. A vessel adjacent to the gland had an intimal layer of dense fibrous atherosclerosis, with less than 50% narrowing of the lumen.

Pineal gland: A section of pineal gland had vascular congestion with a typical glandular configuration of cells and a few corpora arenacea.

RADIOLOGY:

No radiographs were prepared prior to autopsy.

IDENTIFICATION:

The body was received as identified by the Texarkana Police Department.

EVIDENCE:

Evidence collected and retained consisted of a blood matrix card for DNA, fingerprints, palm prints, and pulled head and pubic hairs. The bags from the hands and the clothing were returned to the investigating agency.

SPECIMENS:

Specimens collected for toxicology consisted of peripheral blood, urine, and vitreous humor.

PHOTOGRAPHS:

Standard photographs of the body, along with photographs of the injuries and the heart muscle, were prepared.

WITNESSES:

No visitors from outside agencies were present during the autopsy.

LABORATORY RESULTS

TOXICOLOGY:

Michael Sabbie:
Peripheral blood

Volatiles assay	
Acetone	< 0.01 g%
Ethanol	not detected
Isopropanol	not detected
Methanol	not detected
Immunoassay	
Propoxyphene	Negative
Oxycodone	Negative
Opiates	Negative
Methamphetamines	Negative
Methadone	Negative
Cocaine	Negative
Cannabinoids	Negative
Benzodiazepines	Negative

FINDINGS

I. Hypertensive arteriosclerotic cardiovascular disease:
   A. Cardiomegaly (heart 815 g), with left ventricular hypertrophy.
   B. Multifocal coronary artery atherosclerosis:
      1. Left anterior descending coronary artery: 40% maximum luminal narrowing.
      2. Right coronary artery: 20% maximum luminal narrowing.
      3. Left circumflex coronary artery: 10% maximum luminal narrowing.
   C. Foci of left ventricular myocardial fibrosis with neovascularization (total of three, no greater than 0.7 cm).
   D. Left ventricular myocardial fibrosis, extensive, mild to moderate (microscopic).
   E. Arteriolonephrosclerosis.
   F. Pulmonary congestion and edema.
   G. Passive congestion of liver (nutmeg pattern of parenchyma).
   H. Evidence of past episode(s) of congestive heart failure (numerous hemosiderin-laden alveolar macrophages in lungs).

II. Abraded contusion of back; galeal contusion of scalp.

OPINION:

This 35-year-old, black male, Michael Sabbie, died of hypertensive arteriosclerotic cardiovascular disease.

The agencies responsible for investigation of this death were the Texarkana Police Department and the Miller County Coroner's Office, who reported that the decedent had been arrested on July 19, 2015. He was transported to the bi-state jail, which is on the state line between Arkansas and Texas. Two days later, on July 21, 2015, at 4:15 PM, the decedent was transported from the booking desk to a jail cell, when he began refusing to cooperate with jail staff. Jail staff gained control of the decedent through physical force by bringing him to the ground and then using a burst of pepper spray. The decedent was restrained with handcuffs, checked out by the nurse, and then taken to the showers to rinse off the pepper spray. While in the showers, the decedent sat or fell down, and then was picked up. He was placed in a single jail cell. While attempting to serve the decedent breakfast the next morning on July 22, 2015, the decedent was found to be expired. He was pronounced dead at the scene by the Miller County Coroner. It was reported that the decedent complained of shortness of breath (SOB) both before and after the physical altercation on July 21, 2015.

An autopsy revealed a well-developed, well-nourished, obese, black male, who had a small abraded contusion (scraped bruise) on the right side of his back. Reflection of his scalp revealed a contusion on the right backside of his head. There was no skull fracture or damage to the brain identified in association with the scalp contusion. Internal examination of the body revealed a markedly enlarged heart at 815 g, which is often the result of long-term hypertension (high blood pressure). There was mild to moderate coronary artery disease. Sectioning the heart muscle revealed three areas of red discoloration within the heart muscle, which microscopically revealed areas of dense fibrosis with numerous blood vessels, which gave them the red color. These areas were consistent with old heart muscle damage. Additional mild to moderate fibrosis was present throughout the heart sections. The kidneys had a granular surface, consistent with a diagnosis of arteriolonephrosclerosis, which is also the result of long-term hypertension. The lungs had edema and congestion. Sectioning the liver revealed a pattern consistent with passive congestion. No other significant gross or microscopic findings are identified. A test of the blood for volatiles was negative for alcohol, but did show a trace amount of acetone, which may have been produced endogenously. A drugs-of-abuse screen of the blood was negative.

The autopsy revealed severe heart disease with evidence of at least two prior episodes of heart muscle damage, indicated by various ages of fibrosis in the heart, and one or more past episodes of congestive heart failure. These findings, along with the report that the decedent had shortness of breath prior to the altercation, and that the decedent did not expire during the altercation, suggests that the altercation played a minimal role in the decedent's death, and may not have contributed at all to his death. Due to this, the altercation was not considered as contributing to the cause of death, and therefore, the manner of death was classified as natural.

MANNER OF DEATH: Natural

11/01/2013

Bowie County Correctional Center

INTAKE SCREENING FORM

Admission Date: 7-19-15 **Admission Time:** 2036 **AM/PM**

NAME/AKA: Sabbie, Michael DOB: 11-15-79 Male: B Female: —

ID NUMBER: 175838 Social Security#: _____ Religion: _____

VITAL SIGNS: Temp: 97.5 Pulse: 60 BP: 166/99 Resp: 12 HT: 6'1" WT: 305 Pain 0 O2 98%

ALLERGIES: **OCCUPATION:** _____

Medications/Reactions: Deny

Foods/Reactions: Deny

Other/Reactions: Deny

Have you ever had chickenpox or been vaccinated for varicella? (YES) NO **If yes, when** CH

MEDICAL HISTORY: Deny

PREVIOUS HOSPITALIZATIONS: Deny

CHRONIC MEDICAL CONDITIONS (circle all that apply)

(Asthma) Arthritis (Diabetes) insulin GI Disease Headaches Heart Disease Kidney Disease Lung Disease

Hep A Hep B Hep C HIV (HTN) Seizures Smoker Other: _____

CHRONIC CONDITIONS/ADDITIONAL INFORMATION: _____

SKIN CONDITIONS (boils, sores, rashes): Deny

DIET: Diabetic **MEDICAL RESTRICTIONS:** _____

MEDICATIONS (include route, dose, and time): Dr. Rush

PPD HISTORY: Date of Last PPD: Jan 2014 Results: 0mm

Date of Chest X-Ray Results (if PPD Positive): — Results: —

Treatment for ~~positive~~ PPD (include medications, route, dose, time): —

Date of treatment (if PPD Positive): —

DENTAL ISSUES: Broken teeth

SUBSTANCE ABUSE HISTORY

Do you use drugs or drink alcohol? YES (NO)

How much do you use in a day? 0

How much do you use in a week? 0

When was the last time you drank alcohol? 0

When was the last time you used drugs? 0

INFORMAL RESOLUTION APPROPIATE: Y (N)

BI-STATE JAIL Case No.: _____

INFRACTION REPORT- MINOR AND MAJOR INFRACTIONS

THIS FORM IS NOT NEEDED IF THE OFFICER'S RESPONSE TO THE BEHAVIOR IS LIMITED TO A VERBAL OR WRITTEN REPRIMAND ONLY.

DATE AND TIME OF INCIDENT: 07-21-2015 1015

INMATE NAME: Sabbie, Michael Todd SO#: 175838

OFFENSE TITLE, LEVEL, AND CODE: Creating a disturbance, Level 2 Code 23.0

PLACED IN PRE-HEARING DETENTION? [ ] YES [ ] NO. IF YES, TIME/DATE OF PLACEMENT IN PHD: /

DETAILS OF INCIDENT IS OFFENDER A WORKER? Y (N) JOB TITLE: N/A

DATE: 07-21-2015 TIME: 1015 LOCATION: B. POD Cell 2

DESCRIBE WHAT HAPPENED. BE SPECIFIC AND DETAILED. IF DESCRIBING MORE THAN ONE INFRACTION, INDICATE WHAT INFRACTION IS DESCRIBED IN EACH PART OF THE INCIDENT DESCRIPTION. USE EXTRA SHEETS, IF NECESSARY:

On the date and time listed above, and at B pod 2 cell, offender Sabbie, Michael Todd, 175838 did create a disturbance, namely by feining illness and difficulty breathing. When taken to the Bi State nurses' station, Nurse Venable, Tiffany performed an evaluation and found no signs of illness. This event disrupted the schedule of Dr. Montoya, delayed dinner chow proceedings, book-in and processing procedures for approximately thirty minutes and diverted the attention of the shift supervisor, Lieutenant Johnson, Nathaniel.

WITNESSES TO INCIDENT: [LIST ALL WITNESSES UNLESS LARGE GROUP OF PERSONS WITNESSED INCIDENT]

CO's Palmer; Boozer; Brown; Lieteanant Johnson, and Nurse Venable, Dr. Montoya

DESCRIBE ANY PERSONAL INJURIES, NOTING FOR EACH PERSON LIST WHETHER THEY RECEIVED [X] OR DID NOT RECEIVE [ ] MEDICAL ATTENTION: Evaluated by Nurse, no injuries, No illness

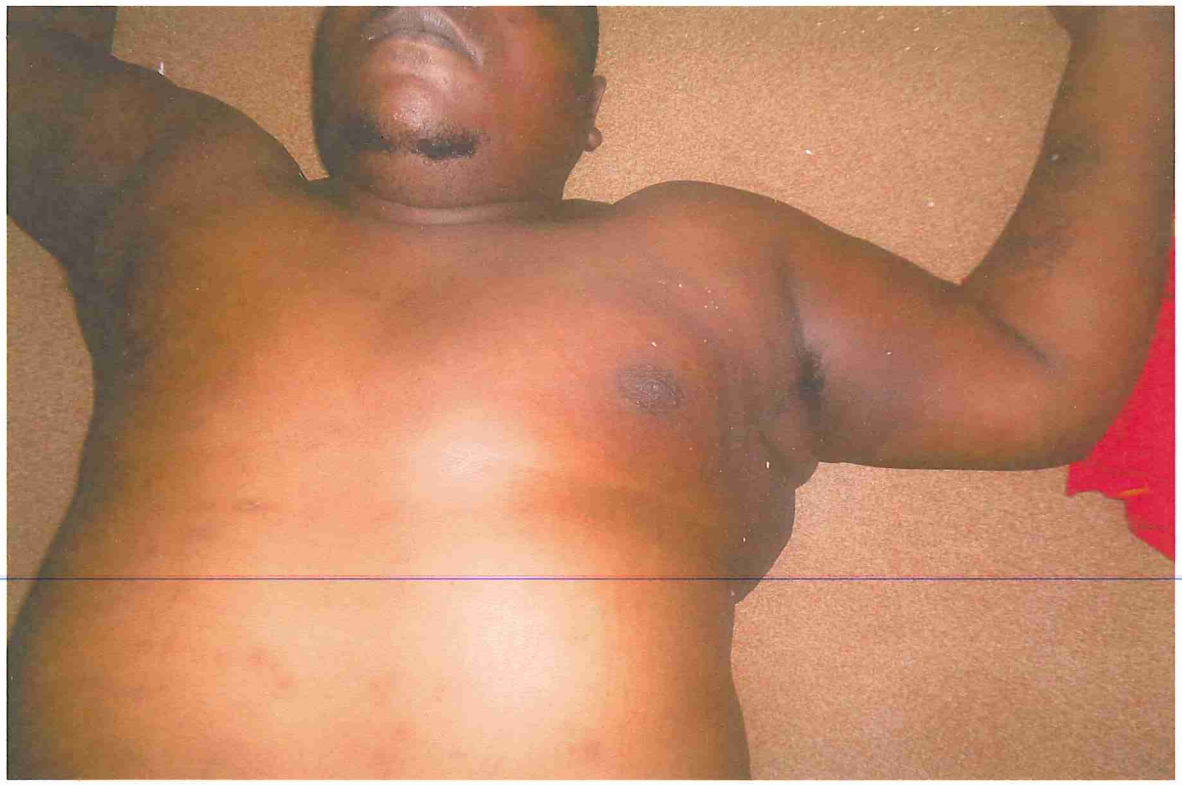
DESCRIBE ANY PROPERTY DAMAGE: No property damage

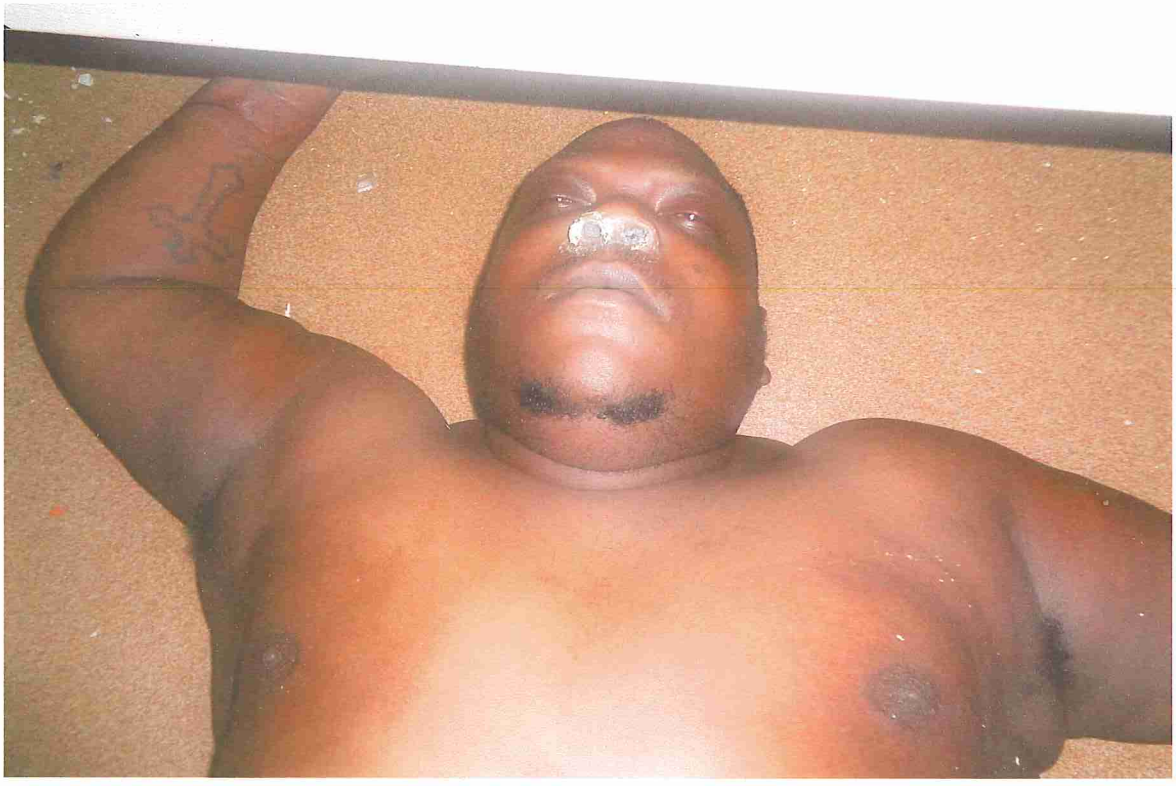
S. Palmer		07-21-2015
REPORTING OFFICER'S PRINTED NAME	REPORTING OFFICER'S SIGNATURE	DATE
APPROVING SUPERVISOR'S PRINTED NAME	APPROVING SUPERVISOR'S SIGNATURE	DATE
GRADING OFFICIAL'S PRINTED NAME	GRADING OFFICIAL'S SIGNATURE	DATE

THIS DISCIPLINARY CASE IS GRADED AS A: [ ] MINOR [ ] MAJOR Informally resolved by: _____

[ ] I BELIEVE THIS INFRACTION(S) WAS COMMITTED IN A WAY THAT [ ] SERIOUSLY ENDANGERED PERSONS OR PROPERTYAND/OR [ ] CREATED A SERIOUS RISK TO THE SECURITY OF THE INSTITUTION AND THEREFORE RECOMMEND THE INFRACTION(S) BE ENHANCED AND TREATED AS MEDIUM/MAJOR INFRACTIONS. ADD ADDITIONAL DETAIL AS DEEMED NECESSARY TO SUPPORT THIS RECOMMENDATION: _____

7/21/15 TAPD Offender Michael SABBie # 175838





U.S. District Court, Eastern District of Texas
No. 5:17-cv-0113-RWS-CMC
Exhibit. No. 47

UOF 150721-BIS 4

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Q All right. And are those your initials off to the right?
A Yes, sir.
Q Is that your handwriting?
A Yes, sir.
Q And are those Sergeant Jordan's initials next to yours?
A Yes, sir.
Q Now, this document, which you initialed and which Sergeant Jordan initialed, suggests that you did get all 40 hours of training, but that was not the case, was it?
A No, it wasn't.
Q Did Sergeant Jordan ask you to sign off on this knowing that he didn't give you all the training?
A We actually signed off on those during the preservice. I -- the only thing I went back and done on the 8th was put the date -- sign my name and date. All of this was done on the day -- the last day of preservice.
Q And was that the case with all of the --
A Yes.
Q -- employees?
A Everyone that went through that preservice class.

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Q Okay. And that was -- we kind of spoke at the -- the same time, so I just want to make sure we have a clear record.
Was -- was it the case with all the employees in the preservice class that their new-employee on-the-job training was signed and initialed as if it had already been done before it had even started?
A Yes.
Q Besides Sergeant Jordan, do you know any others at LaSalle, in a supervisory or higher-up role, that knew about that practice?
A No, sir.
Q Okay.
As of July 21, 2015, do you believe LaSalle provided you with adequate training to work in Zone 2?
A No, sir.
Q If LaSalle had provided you with proper training, do you believe you would have avoided some of the wrongdoing you committed on the night shift that began on July 21, 2015?
A Yes, sir.
Q You're no longer working for LaSalle, correct?
A Correct.

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Q As I understand it from your personnel file, your last day of employment was July 27, 2015. Does that sound right?
A Yes, sir.
Q You were fired, correct?
A Correct.
Q And your official termination date was July 28th, 2015?
A Yes, sir.
Q Were you fired because you filled out your 30-minute checks at the start of your shift and because you didn't end up doing all the checks that you wrote down?
A Yes, sir.
Q Do you know who a day-shift officer named Robert Derrick is?
A I don't know him.
Q Okay. He was working Zone 2 just before you, and I'm wondering if you're aware that, like you, he wrote down all his 30-minute checks at the beginning of his shift and that he didn't do the checks that he wrote down.
A No, I didn't know that before today.
Q And before today, were you aware that, unlike you, he didn't get fired?

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A I know I was the only one that was terminated.
Q Do you feel like you were made to be a scapegoat for Michael Sabbie's death?
A I know I was made to be a scapegoat.
Q Let me ask you this: Given that we have two employees, and Officer Derrick before you, who both did the exact same thing -- both of you wrote down these 30-minute checks at the beginning of your shift, before actually doing them, and then ultimately didn't actually do the checks on the times that you wrote them down or missed many of them altogether -- I'm wondering if it was just you and Derrick and that was it, or was it your belief, from your observations, that this was widespread practice at the jail?
A It was. That's -- I mean, you know, not to throw anyone under the bus, but since I'm being honest, that's -- my first night of training, that's the first thing we did, was fill out all of the checks in the book except for the counts.
Q And so if I understand your testimony, you were literally trained to write down your check -- the times you were doing your 30-minute checks before you actually conducted any of those checks. Is that correct?
A Yes, sir.

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Q And to leave those checks there even if you didn't do the checks.
A Yes, sir.
Q And that -- if I understand your earlier testimony, you said that that was a widespread practice at the jail.
A Yes, sir.
Q Do you think your termination was fair?
A No.
Q Can you give me all the reasons, besides what we've already discussed, that leads you to believe that?
A Well, when I was called into the office the day I was terminated, on the 28th -- I'm not sure what the warden's name -- I can't remember his name, but --
Q Bob Page?
A Page.
And he -- he called me -- well, I went into the office after speaking briefly with Major Nelson, and I already, you know, knew what it was going to lead to; however, like I said, I didn't know anyone else had done that and, you know, that -- marking times and not completing the checks and prefilling out the paper. I didn't know that had taken place, but --
Q You didn't know that had taken place that night?

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A No -- right, that night.
And Warden Page, I remember him telling me, basically, "Well, you're not" -- "you're not an important asset anyhow, so we're going to go ahead and let you go, since you've only been here for a month anyways."
Q And --
A So, you know, I just -- he was -- I don't feel that he, himself, was the slightest bit, you know, concerned with the situation, only just to get me out the picture.
Q Did you get the very clear impression from him that he knew full well that other employees were doing this exact same thing?
MR. MILLER: Objection, form.
A I don't really know, but -- it's just -- I don't know. I didn't know what to think. All I knew was I was jobless and I had three kids, you know, so...
Q (BY MR. HEIPT) So what did you do next, in terms of your employment history, after you were --
A I sat at home and cried for two weeks, first off, about not having a job. I just knew that nothing else would go up from there. And then I, you know -- I said I might as well put my license, you know, license back to use, and I applied for a job in Ashdown,

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Arkansas, and started working the next day.
Q Where in Arkansas?
A Ashdown. S-H -- no, Ash, A-S-H-D-O-W-N.
Q Ashdown, okay.
And how long did you work there?
A Two weeks shy of two years.
Q So somewhere in the neighborhood June or July of 2017?
A August 2017.
Q August 2017.
And then what did you do after that -- oh, wait, why did you leave that job?
A School.
Q Okay. And that's Texarkana College?
A Yes, sir.
Q And have you had any other jobs, or have you been a full-time student since then?
A I've worked. I've -- yeah. I worked there, and I came to Texarkana and I worked at a local nursing home and -- while I was going to school still. And I went and worked at Road Runner for nine months --
Q Road Runner --
A -- seven months, maybe.
Q Road Runner Sports?
A No. Road Runner is a convenience store.

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Q Oh. In Seattle, we have a running store called Road Runner.
A Oh, okay.
Q And how far into your college are you now?
A This semester completes my prerequisites, and January starts my program.
Q Okay. What program is that?
A Nursing program, LVN.
Q All right. Again, congratulations.
A Thanks.
Q All right. So let's go back to LaSalle.
A Uh-huh.
Q Back in July, you're working full-time, correct?
A Yes, sir.
Q And you were working the night shift?
A Yes, sir.
Q Which is 7:00 p.m. to 7:00 a.m.?
A Yes, sir.
Q And were you working the A card or the B card or both?
A I don't know which -- I can't remember which one was my assigned card, but I did work on the opposite card for overtime a few times.
Q Okay. I'd like to try and determine which

LASALLE CORRECTIONS

Employee Information Sheet

Last Name:	First Name	MI	Status [Part-Time / Full Time]
HOPKINS	DANIEL	L	FULL-TIME

Employment Date	Unit/Facility
02/24/2014	BOWIE COUNTY/ BI STATE

If the employee separates employment, the training record shall be placed in an inactive file on the facility where the employee terminated. The file should be retained as per the policy on records retention. If an employee transfers to another facility, the record shall be forwarded to that facility. If the employee is re-hired, the record will be re-activated and training brought current.

Subject	Date	Documented/verified by: (print name, initial)
Secure Facilities Division Pre-Service (40 Hours)	02/24/2014	N. Jordan N.J.
Secure Facilities Division On The Job Training/ Practical (40 Hours)	03/03/2014	N. Jordan N.J.
F-5-R Sent to TCLEOSE (currently certified Officers only) (if Applicable)		
Temporary License Requested (if Applicable)	02/24/2014	N. Jordan N.J.
Temporary License Received (if Applicable)		
Attended State Certification Course (96 hours) (if applicable)	11/12/2014	N. Jordan N.J.
Passed State Licensing Test	12/05/2014	N. Jordan N.J.
Received State Permanent License	12/05/2014 5/29/14	N. Jordan N.J.
Weapons Qualified		N. Jordan N.J.
Chemical Agents Qualified		
Annual In-Service Training Year (2nd year)		
Annual In-Service Training (3rd year)		
Other _____		
Other _____		
Other _____		
Termination Date with F-5 documentation		

Kim Vickers
Executive Director

TEXAS COMMISSION ON LAW ENFORCEMENT

2/25/2014

JAMES W. PRINCE
BOWIE CO. SHERIFF'S OFFICE
100 NORTH STATELINE BOX 18
TEXARKANA, TX 75501

REF: DANIEL L. HOPKINS - 426527
Jailer - Temporary Jailer License
Date of appointment: 2/24/2014

Dear Administrator:

The Commission has received an employment report (L-1) for the licensee referenced above. The Commission's records have been updated to note the licensee's current employment. This acknowledgement must be maintained in your agency's personnel files and must be available to Commission staff upon request.

Please be advised that this Temporary Jailer License EXPIRES one (1) year from the date of initial appointment, and

WILL EXPIRE ON: 02/24/2015

Upon separation from the agency, upon expiration, or if the licensee fails to successfully complete the jailer training course and pass the licensing examination by the expiration date of the Temporary Jailer License, the agency administrator of designee must submit to the Commission an F-5 form (Report of Separation of Licensee).

Chief Kim Vickers
Executive Director

Texas Commission On Law Enforcement

6330 E. HIGHWAY 290, SUITE 200, AUSTIN, Texas 78723
(512) 936-7700

2/25/2014

BOWIE CO. SHERIFF'S OFFICE
100 NORTH STATELINE BOX 18
TEXARKANA, TX 75501

To Department Administrator:

Based upon the application submitted by the BOWIE CO. SHERIFF'S OFFICE, this Temporary Jailer License is being issued to DANIEL L. HOPKINS.

TYPE	P ID	ISSUE DATE	EXPIRATION DATE
Temporary Jailer License			
DANIEL L. HOPKINS	**426527**	**02/24/2014**	**02/24/2015**

This acknowledgement is to be maintained in the personnel file of DANIEL L. HOPKINS and made available for inspection by Commission personnel upon request.

Chief Kim Vickers
Executive Director

Good luck on your law enforcement career in Texas. Please give us a call whenever we may be of assistance.

Texas Commission on Law Enforcement
Officer Standards and Education
Issues

DANIEL L. HOPKINS
Temporary Jailer License
Issue Date: **02/24/2014**
Expiration Date: **02/24/2015**
P ID: 426527

Issue Authority Chap. 1701, Texas Occupations Code.

Card Removal Directions:

1. Turn letter over to remove card.
2. Push left side of card towards you from back.
3. Slowly pull card away with clear film and press film over card

LASALLE SOUTHWEST CORRECTIONS

PERSONNEL STATUS/CHANGE REPORT

- [x] Bowie County
- [ ] Burnet County
- [ ] Jefferson County
- [ ] Johnson County
- [ ] SWC Corporate

REASON FOR ACTION

☐ NEW HIRE ☐ REHIRE ☑ SALARY CHANGE ☐ TERMINATION ☐ ADDRESS CHANGE ☑ JOB TITLE CHANGE ☐ Other

EMPLOYEE INFORMATION - Please Print

LAST NAME (Name on SS Card)	FIRST NAME	MI	SOCIAL SECURITY NUMBER
Hopkins	Daniel	L	REDACTED

ADDRESS	CITY	ST	ZIP
REDACTED	Hooks	Tx	75561

BIRTH DATE	HIRE DATE	FIRST DAY WORKED	PHONE NUMBER(S)
REDACTED	2-24-14	2-24-14	REDACTED

NEW HIRE INFORMATION

☐ New Hire ☐ Re-Hire	☐ Full Time ☐ Part Time Hours per week:	JOB TITLE	PAY RATE: $ (PER HOUR) $ (PER PAY PERIOD)

GENDER	CHECK ONE	RACE		
☐ Male ☐ Female	☐ Hispanic ☐ Not Hispanic	☐ White ☐ Black or African American	☐ Native Hawaiian ☐ Asian	☐ American Indian ☐ Two or More Races

MARITAL STATUS
☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated

EMERGENCY NOTIFICATION (Please list two names)

NAME	ADDRESS
PHONE	RELATIONSHIP
NAME	ADDRESS
PHONE	RELATIONSHIP

TERMINATION

TERMINATION ☐ INVOLUNTARY ☐ VOLUNTARY RESIGNATION	REASON FOR TERMINATION	
LAST DAY WORKED	TERMINATION DATE	NOTES

EMPLOYEE STATUS CHANGE

NEW PAY RATE	EFFECTIVE DATE (Must be first day of pay period)	CHANGE IN WORK STATUS TO:
33,500.00	10-26-14 - Sergeant	☐ Full-Time ☐ Part-Time

NEW ADDRESS	CITY	ST	ZIP

NEW NAME	REASON	EFFECTIVE DATE

NEW MARITAL STATUS	REASON	EFFECTIVE DATE

SIGNATURES

EMPLOYEE	Date	SUPERVISOR	Date
Daniel Hopkins	10-22-14		
WARDEN	Date	Pay increases/changes must be made at the beginning of a pay period for the current pay period. No retroactive increases/ch...	
[signature]	10/22/14		

Rev 1/17/11

Kim Vickers
Executive Director

TEXAS COMMISSION ON LAW ENFORCEMENT

12/6/2014

JAMES W. PRINCE
BOWIE CO. SHERIFF'S OFFICE
100 NORTH STATELINE BOX 18
TEXARKANA, TX 75501

REF: DANIEL L. HOPKINS - 426527
Jailer - Jailer License
Date of appointment: 12/5/2014

Dear Administrator:

The Commission's records have been updated to note the licensee referenced above has successfully completed the jailer training course and passed the licensing examination. This acknowledgement must be maintained in your agency's personnel files and must be available to Commission staff upon request.

Chief Kim Vickers
Executive Director

Texas Commission On Law Enforcement

6330 E. HIGHWAY 290, SUITE 200, AUSTIN, Texas 78723
(512) 936-7700

12/6/2014

BOWIE CO. SHERIFF'S OFFICE
100 NORTH STATELINE BOX 18
TEXARKANA, TX 75501

To Department Administrator:

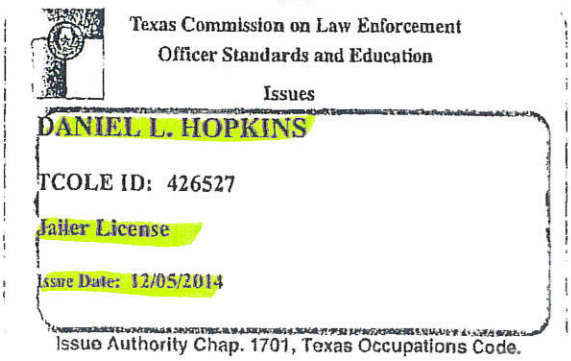
Based upon the application submitted by the BOWIE CO. SHERIFF'S OFFICE, DANIEL L. HOPKINS is hereby issued the following:

TYPE	P ID	ISSUE DATE
Jailer License		
DANIEL L. HOPKINS	**426527**	**12/05/2014**

This acknowledgement is to be maintained in the personnel file of DANIEL L. HOPKINS and made available for inspection by Commission personnel upon request.

Chief Kim Vickers
Executive Director

Good luck on your law enforcement career in Texas. Please give us a call whenever we may be of assistance.



Card Removal Directions:

1. Turn letter over to remove card.
2. Push left side of card towards you from back.
3. Slowly pull card away with cl film and press film over card

Booking Sheet

Parker County Sheriff's Office

SO NUMBER	DATE BOOKED	JAIL ID NUMBER	PAGE
96-25166	12/23/2016	1241416	1

CURRENT CELL	CUSTODY STATUS	OF
HOLDING C	F. PRETRIAL FELONS (DO NOT INCLUDE PAROLE VIOLATORS, ETC.)	2

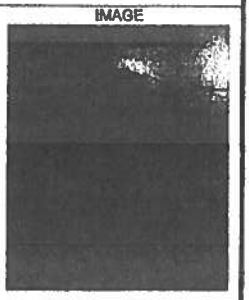
IDENTIFICATION

NAME	PID	SID	JAIL ID / BOOKING NUMBER
DEBUSK, JESSE ANDREW	519403;	05633544	1241416

ALIAS NAME(S): DEBUSK, ANDY; DEBUSK, JESSE; DEBUSK, JESSE A; DEBUSK, JESSE ANDRE; DEBUSK, JESSE H

FBI: 844249MB3

IMAGE



RACE	SEX	ETHNICITY	DATE OF BIRTH	AGE	DL / ID NO.
W	MALE	NON HISPANIC	07/24/1978	38	TX-04092604

HEIGHT	WEIGHT	HAIR	EYES	BUILD	COMPLEXION	SOCIAL SECURITY NO.
6 FT. 1	280	BRO	BLU	LG	MED	458-91-8635

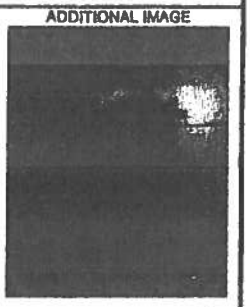
SCARS, MARKS, TATTOOS, AMPUTATIONS: TATTOO ON ABDOMEN; TATTOO ON LEG, LEFT, NONSPECIFIC; TATTOO ON LEG, RIGHT, NONSPECIFIC; TATTOO ON WRIST, RIGHT

ADDRESS	PHONE	PLACE OF BIRTH
108 MEANDERING WAY WEATHERFORD TX 76086	817-374-3043	FT WORTH, TX UNITED STATES

EMER

EMERGENCY CONTACT NAME	EMERGENCY CONTACT ADDRESS & PHONE	PHONE NUMBER(S) CALLED AT BOOKING:
ASHLEY BOARDLY	698 SPRINGWAY CREEK PKWY WEATHERFORD,TX 76087 817-597-7101	817-374-3043 REFUSED2ND
RELATIONSHIP: SISTER		

ADDITIONAL IMAGE



ARREST

ARRESTING AGENCY	ARRESTING OFFICER	ARREST DATE	ARREST TIME	ARREST LOCATION
PARKER COUNTY SHERIFF'S OFFICE	1539, KILGORE, J	12/23/2016	2:53 PM	JPS HOSPITAL FT WORTH, TX

VEHICLE MAKE	MODEL	LICENSE NO.	STATE	VEHICLE TOWED BY	VEHICLE STORED AT

PROPERTY

PROPERTY BOX	INITIAL DEPOSIT AMT.	CURRENT BALANCE
	$.00	$.00

QTY	ITEM DESCRIPTION	LOCATION	BIN/BOX
1	$500.00 DROPPED	Property	
1	BLK WALLET	Property	
1	PR BLK SHOES	Property	
1	BLK CAP	Property	

◄ END OF LIST ►

I certify that this is a correct list of items removed from my possession at the time I was placed in jail.

X _____
Prisoner's Signature

DATE RECEIVED: 12 23 16

Woods, Rita

THUMB PRINT

CHARGES

HOLD REASON	WARRANT / REFERENCE NO.	OFFENSE	ISSUING AUTHORITY	BONDING STATUS	BOND AMOUNT	BOND TYPE	FINE	DISP
LOCAL WARRANT	CR16-0691	BI/ATTEMPT TO COMMIT BURGLARY OF HABITATION	415TH DISTRICT COURT					

Office of Chief Medical Examiner
Tarrant County Medical Examiner's District
Tarrant County, Texas
200 Feliks Gwozdz Place, Fort Worth, Texas 76104-4919
(817) 920-5700 FAX (817) 920-5713

AUTOPSY REPORT

Name: Jesse Andrew Debusk | **CASE NO: 1619245**
Approximate Age: 38 Years | **Sex: Male**
Height: 72 Inches | **Weight: 198.3 Pounds**

I hereby certify that on the **25th** day of **December 2016**, beginning at **0850** hours, I, **Tasha Z. Greenberg, M.D.**, pursuant to Statute 49.25 of Texas Criminal Code, performed a complete autopsy on the body of **Jesse Andrew Debusk** at the Tarrant County Medical Examiner's District Morgue in Fort Worth, Texas and upon investigation of the essential facts concerning the circumstances of the death and history of the case as known to me, I am of the opinion that the findings, cause and manner of death are as follows:

FINDINGS:

I) Investigative findings:

A. Booked into Parker County jail on 12/23/16 at 2:58 pm for outstanding warrants; police had been called for a bleeding white male subject running through the backyards in a neighborhood; he had sustained a dog bite prior to arrest
B. He was arrested and taken to JPS for treatment for the bite; he told deputies that he had been using methamphetamine and hadn't slept for > 24 hours
C. He was noted to be cooperative and coherent, however dozed off frequently and appeared to be talking to people who weren't present
D. On 12/24/16, at approximately 6:30 pm, he became upset that he had not bonded out and became involved in an altercation with jailers in a holding cell; there was a physical struggle with him on the ground and multiple jailers trying to restrain him; at some point he was sprayed with OC spray
E. He was moved out of the holding cell into the hallway, where he was standing against the wall while they attempt to cuff him; his statements included "I can't breathe, help"
F. He slid down wall to the ground where he continued to struggle with the guards while they attempted to restrain him with handcuffs and leg restraints; he stated "I can't breathe", and there were sounds of gagging and vomiting
G. Once wrist and leg restraints were in place, he was carried in a prone position down the hall to a violent cell; he continued to state " I can't

breathe, help please", and there were sounds of heavy breathing

H. Once in the violent cell, he was placed face down, still breathing heavily and gagging, saying "I can't breathe"; he continued to struggle
I. Multiple officers held him down to attempt to remove the restraints (including one knee on right mid back, one knee and hands on left back, other on back and legs); he was vomiting, stated "please get off me"
J. Guards change – two on back, two on legs; still struggling, says "I'm gonna die", gagging and vomiting
K. At this time, one officer noted that his color had changed, but someone commented that he was breathing; at around this time, he appears to stop struggling
L. Once the cuffs were removed, he is noted to spit and move his head; all officers exited the cell; at that time, he was face down with his head down off of a small step with a pile of emesis beneath his face
M. A few minutes later, it was noted that he was in the same position; entry was made into the cell, and he was turned over; he was not breathing and CPR was begun
N. Camcorder recorded altercation and subsequent events:
    1) 6:32 pm carried into cell
    2) 6:36 pm door shut to cell
    3) 6:41 pm noted to be not breathing
O. 911 called at 6:44 pm; at patient's side at 6:50 pm
P. He was noted to be asystolic, unconscious and unresponsive, with no respiratory effort, pupils fixed and non-reactive with a GCS of 3
Q. Transported to hospital by EMS where pronounced at 7:27 pm on 12/24/16
R. Medical history of hypertension, Hepatitis C, alcoholism and acute pancreatitis, opioid dependency with withdrawal as well as head injury approximately one month prior where was reportedly struck with a hammer

II) Examination findings:

A. Abrasions of forehead and chin
B. Scattered contusions and abrasions of extremities
C. Contusions of wrists, consistent with handcuffs
D. Sutured lesion of dorsal left hand, consistent with reported dog bite
E. Cardiomegaly (705.5 gms)
    1) Left ventricular hypertrophy
    2) Coronary atherosclerosis:
        a.60% stenosis, left anterior descending
        b.75% stenosis, first diagonal branch
F. Aspiration of gastric contents
G. Pulmonary congestion and edema

H. Hepatic congestion
I. Left renal scars
J. Bladder calculus
K. Healing cortical contusion, inferior right temporo-occipital lobe

III) Toxicology (femoral blood):
A. Methamphetamine: 1663 ng/mL
B. Amphetamine: 112 ng/mL
C. Benzoylecgonine: 32 ng/mL

IV) Urine: positive for morphine, amphetamine, benzoylecgonine, methamphetamine and lidocaine

CAUSE OF DEATH:	**I. METHAMPHETAMINE INTOXICATION AND HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR DISEASE ASSOCIATED WITH PHYSICAL STRUGGLE DURING APPLICATION OF RESTRAINT II.RECENT COCAINE USE**

MANNER OF DEATH: UNDETERMINED

COMMENT: This case represents a death that occurred in jail on 12/24/2016. The circumstances are that the decedent was involved in a physical struggle with jailers while on Methamphetamine with sleep deprivation. Restraint involved the use of OC spray in a confined space, as well as physical restraint with multiple jailers on top of him in a prone position, as well as the application of mechanical restraint including handcuffs and leg restraints. During a prolonged period of agitation, struggle and restraint, he complained repeatedly that he could not breathe and vomited. When the restraints were removed and he was left alone in a cell, he was noted on video to be barely moving. After a few minutes, it was noted that he was unresponsive, cardiopulmonary resuscitation was performed but it was unsuccessful. Autopsy findings included the presence of Methamphetamine and Amphetamine in the blood and a metabolite of cocaine in the urine. His heart was enlarged with a thickened left ventricle and focally severe blockage of his coronary arteries by atherosclerosis. There was also food present in the upper and lower airways. There were superficial external injuries including abrasions of the forehead and chin, scattered abrasions and contusions of the extremities, and evidence of handcuffs and leg restraints at the wrists and ankles. There was also evidence of remote head injury with a healing contusion of the right temporo-occipital lobe of the brain. However, there was no acute evidence of injury of the structures of the neck, of the head and brain or the thoracic and abdominal viscera.

The issues to consider in this case include the inmate's underlying cardiac pathology, stimulant use, asphyxia, physical struggle and restraint.

The decedent had significant cardiac pathology with a markedly enlarged heart and blockage of the coronary arteries. Sudden cardiac death in the absence of any additional complicating factors is known to occur with cardiomegaly or an enlarged heart >550 gms, with significant coronary atherosclerosis >75%, during or after hyperactivity with severe physical stress or in hearts primed by epinephrine, also seen during severe physical stress or a physical struggle as was seen in this case.

Methamphetamine is a CNS stimulant drug with a potential lethal level of 600 ng/mL. In this case, the level was greater than 1600 ng/mL after over 24 hours of incarceration. Cardiotoxic effects of Methamphetamine are known to occur, including tachycardia and hypertension, in particular in the presence of underlying cardiac pathology, and combined with the CNS effects can lead to sudden death.

Asphyxia must be considered as well, which in this case is multifactorial. First, there is food present in the airways, a potential cause of choking and asphyxia. Second, OC spray was used in a confined environment, which is a known airway irritant, and the inmate continued to complain of difficulty breathing. Lastly, there were prolonged periods of prone restraint with compression of the torso and extremities, potentially contributing to a reduced respiratory capacity or ability to breathe.

The prolonged physical struggle that ensued contributed to an elevated epinephrine (adrenaline) level consistent with the so called fight-or-flight response. It stimulates the sympathetic nervous system and has direct effects on the heart, including increasing the rate and force of contraction leading to increased cardiac output and blood pressure. In someone with underlying cardiac pathology, these effects can be amplified and create the potential for a fatal arrhythmia and sudden death.

Individuals have been known to die during intense periods of excitement, with or without a struggle, even in the absence of underlying cardiac pathology, known as excited delirium, most commonly associated with psychiatric disorders or the use of stimulant or psychoactive drugs.

In summary, this is a complex case of the death of an inmate involving underlying significant cardiac issues, use of stimulant drugs, a physical struggle and the use of chemical and physical restraint. The cause of death is multifactorial and therefore, the manner of death is best certified as Undetermined.

1619245
Jesse Andrew Debusk

This case was presented at Critical Case Review on February 8, 2017.

Signature

Tasha Z. Greenberg, M.D.
Deputy Medical Examiner

A complete autopsy is carried out at the Tarrant County Medical Examiner's Morgue.

GROSS ANATOMIC DESCRIPTION

I. CLOTHING AND PERSONAL EFFECTS:

The body is presented to the Morgue in a white sheet with hospital gown, and clad in white boxers.

II. THERAPEUTIC INTERVENTION:

Evidence of terminal medical intervention includes an oral endotracheal tube, cervical collar, electrocardiogram leads, pacer pads, blood pressure cuff on right arm, pulse oximeter on right index finger, left nasogastric tube, intravascular catheters in the right and left index finger with attached IV bag, Foley catheter, and a dry abrasion on the mid chest.

There is a plastic bag over the left hand that is wrapped in gauze, secured by tape. Beneath this is an apparent 1 inch injury with three sutures present.

III. EXTERNAL BODY DESCRIPTION:

The body is that of a normally developed adult white male weighing 198.3 pounds, measuring 72 inches in height, and appearing compatible with the stated age of 38 years. The body is cold following refrigeration. Rigor mortis is well-developed in the small and large muscles. Livor mortis is red-purple, posterior dependent with contact pallor, and blanches with pressure. Preservation is good with no decomposition changes. Body hair distribution is that of a normal adult male.

The head is normocephalic and atraumatic. The head hair is dark brown and short, 2 inches on top and shorter on the sides. Facial hair consists of mustache and beard stubble. The eyes when initially viewed are closed. The corneae are slightly cloudy. The irides are blue, and there is no arcus senilis. The pupils measure 4 mm on the right and 4 mm on the left. The conjunctivae are pink. The sclerae are nonicteric. No petechial hemorrhages are identified. The nasal skeleton and septum are intact. The ears are unremarkable; the left earlobe is

pierced. The lips are atraumatic. The teeth are natural and in good repair. There is blood-tinged fluid in the external nares and scant gastric contents in the oral cavity.

The neck shows no external evidence of injury. The trachea is midline. The chest is symmetric with normal male breasts. The abdomen is flat with no fluid wave or palpable masses. The hair on the torso is partially shaved with stubble present. The external genitalia are that of a normal circumcised male with descended testes; the perineum and anus are unremarkable. The back and buttocks are symmetric.

The extremities are normally developed and symmetric with no deformities or fractures. The fingernails are slightly soiled. The legs show no edema or venous stasis changes. The toenails are irregular and soiled.

IV. IDENTIFYING MARKS:

Scars:

There is an irregular healing scar on the left forehead, approximately 2 inches overall. There are scattered scars on the extremities.

Tattoos:

Right neck	-	name "Kr..."
Left neck	-	design
Right chest	-	swastika in square
Right forearm	-	Lesley
Right wrist	-	flames, maltese cross
Left arm	-	sleeve containing faces, skull, demon, x in circle, FORSAKE
Right leg	-	tower, Amnesty, three sticks of dynamite 00:03
Left leg	-	heart, Ashley, Peyton, Diane
Right foot	-	double lightning bolts, toe tag "Fuck Life"

V. EVIDENCE OF INJURY:

The upper edge of the left forehead scar is bleeding slightly where it has been abraded. There is a 1 x ¾ inch abrasion on the inferior chin.

On the right lateral chest there is a ½ inch contusion. On the left upper chest there is a 2 x ½ inch area of linear parallel discontinuous scabs and two contusions, 1 inch and 1/3 inch. On the left lateral chest is a ½ inch contusion. Three 1/8 inch scabs are on the lower abdomen above the pubis. A 1/8 inch linear abrasion is on the left anterior hip. There is a 4 inch obliquely oriented linear abrasion with lateral 1 inch contusion on the right mid back.

On the anterior right arm there are a few small contusions ranging from ¼ to ½ inch. There is a vertically oriented linear abrasion on the anteromedial right wrist, 2 inches in length by 1/8 in width. In addition, there is a horizontally oriented parallel linear contusion on the anterior right wrist and wrapped around the lateral aspect of the wrist, consistent with a handcuff. Additional small healing abrasions are on the dorsal right and left hand, including the fingers, as well as multiple contusions ranging from 1/3 to ¾ inch. An irregular 2 inch contusion is on the dorsal left wrist. An injury on the left hand that has been medically sutured is described above under Evidence of Therapy.

A 2 inch x 1/16 inch linear abrasion is on the upper posteromedial left thigh. Two linear abrasions, ½ and 2 inches in length, are on the left medial calf. There are contusions ranging from1/4 to 2 inches on the right medial knee, superior left knee, anterior legs, posterior right ankle and lateral left ankle. There are also multiple fresh and healing abrasions ranging from 1/16 inch to 2 inches in greatest dimension, most linear, on the knees and anterior legs, as well as the lateral left ankle.

Upon reflection of the scalp, there is a ½ inch subscalpular right frontal hemorrhage. On the inferior surface of the brain, there is a healing brown-golden contusion on the inferior right temporal/occipital lobe, 1 cm in dimension.

VI. INTERNAL EXAMINATION:

BODY CAVITIES:

A Y-shaped thoracoabdominal incision is made; the organs are examined in situ and eviscerated in the usual fashion. The subcutaneous fat of the abdomen measures 3/4 inch in thickness. The musculature of the chest and abdominal area is unremarkable.

The chest wall displays fractures anteriorly of the left ribs #2 and 3 and the right ribs #2-5 consistent with resuscitation efforts. There is anterior mediastinal hemorrhage as well. The serous body cavity membranes are smooth and glistening with no adhesions or effusions. The pericardium shows a normal amount of serous fluid. The vertebral column shows no scoliosis or kyphosis. The left and right hemidiaphragms are in their normal location and appear grossly unremarkable. The pelvis is intact.

NECK:

The neck presents an intact hyoid bone as well as thyroid and cricoid cartilages. The larynx is comprised of unremarkable vocal cords and folds with no erythema or edema, and contains a large piece of food near the epiglottis and multiple smaller pieces of food throughout the remainder of the larynx. The epiglottis shows no edema, trauma or pathologic lesions. There is no hemorrhage of the anterior musculature of the neck. The vasculature of the anterior neck is unremarkable. The trachea and cervical spine are in the midline presenting no traumatic injuries or pathologic lesions.

CARDIOVASCULAR SYSTEM:

The heart is enlarged and weighs 705.5 gms. There is normal epicardial fat. The coronary artery ostia are in the normal anatomical location. The coronary arteries show focal atherosclerosis. There is 60% stenosis of the left anterior descending, 75% of the first diagonal branch and 30-40% of the right. There is a right dominant circulation. The endocardium is smooth. The myocardium is red-brown and mottled, with subendocardial erythema, but no definitive evidence of acute or remote infarction. There is concentric left ventricular hypertrophy; the free wall of the left ventricle is 2.0 cm in thickness, the interventricular septum 2.0 cm, and the right ventricle 0.5 cm. The tricuspid, pulmonic, mitral and aortic valves are unremarkable. The aorta is unremarkable.

RESPIRATORY SYSTEM:

The tracheobronchial tree contains aspirated gastric contents throughout and is lined by smooth, glistening mucosa. The right lung weighs 700 gms and the left 718 gms. The pleural surfaces of the lungs are smooth and glistening with moderate anthracosis. On sectioning, the lungs are congested and edematous; aspirated gastric contents are visible peripherally. There are no cysts, abnormal

masses or other discrete lesions identified. The pulmonary arterial system is unremarkable without thromboemboli or atherosclerosis.

GASTROINTESTINAL SYSTEM:

The esophagus is intact, lined by smooth glistening mucosa with distal vertical erosions involving the gastroesophageal junction. The stomach shows normal rugal folds without gastritis or ulcers, and contains 200 mL of partially digested food particles; no capsules or tablets are identified. The small and large bowel appear grossly unremarkable. The appendix is present and is unremarkable.

The pancreas has a yellow lobulated cut surface without hemorrhage, calcification, fat necrosis, pseudocysts or masses.

HEPATOBILIARY SYSTEM:

The liver weighs 2218 gms and has a red-brown, smooth, glistening surface. On sectioning, the hepatic parenchyma is red-brown with nutmeg congestion. The gallbladder is unremarkable containing 6 mL of yellow-green bile and no calculi. The mucosa is red-green and velvety. The extrahepatic biliary system is patent.

RETICULOENDOTHELIAL (HEMATOPOIETIC) SYSTEM:

The spleen weighs 318 gms with a gray smooth capsule. On sectioning, the parenchyma is reddish-brown and soft with prominent white pulp. Examination of the identified lymph nodes reveals no lymphadenopathy. The examined bone marrow is red and firm without lesions. The thymus gland is involuted, appropriate for age.

GENITOURINARY SYSTEM:

The right and left kidneys weigh 238.5 gms and 202.5 gms, respectively. The capsules strip with ease, and the cortical surfaces are smooth with retained fetal lobulations, however there are multiple pitted scars on the left. On sectioning, the cortex is of normal thickness, with a well-defined corticomedullary junction and unremarkable medullae. The pelves and calyces are of normal size and lined by gray glistening mucosa. There are no calculi. The renal arteries and veins are normal. The ureters are of normal caliber in the retroperitoneum; there is a 2 mm brown calculus obstructing the right ureteral orifice at the bladder. The

otherwise unremarkable urinary bladder contains 200 mL of urine and a small 2 mm brown calculus. The prostate gland and seminal vesicles are unremarkable. The testes are not removed.

ENDOCRINE SYSTEM:

The thyroid gland is of normal size and shape with a red-brown cut surface and no lesions. The adrenal glands have yellow cortices of normal thickness and the medullae show no lesions or hemorrhage. The pituitary gland is of normal size with no gross pathologic lesions.

HEAD AND CENTRAL NERVOUS SYSTEM:

A scalp incision, craniotomy and removal of the brain are performed in the usual fashion. There are no scalp lesions or injuries. The calvarium is intact without bony abnormalities or fractures. The dura is intact and unremarkable. On stripping of the dura, the base of the skull is intact with no fractures.

The brain weighs 1698.5 gms and has translucent leptomeninges. The cerebral hemispheres have a normal gyral pattern with no edema. The brainstem and cerebellar hemispheres are externally unremarkable. The Circle of Willis is patent with no atherosclerosis or aneurysms. The cranial nerves are intact. Coronal sectioning of the cerebrum shows a symmetric ventricular system without hydrocephalus, containing clear cerebrospinal fluid. There are no space occupying lesions present. Sagittal sections of the cerebellum and horizontal sections of the brainstem are unremarkable. The spinal cord is not examined.

VII. HISTOLOGY:

Heart - hypertrophic myocytes, small vessel sclerosis, coronary artery with moderate to severe atherosclerosis
Lungs- aggregates of pigmented alveolar macrophages, patchy anthracosis, congestion, aspirated foreign material in airways
Brain - healing contusion with hematoidin, rarefaction, chronic inflammation and vascular proliferation
Liver - congestion, focal parenchymal inflammation, portal inflammation increased portal fibrosis with focal bridging
Aorta - mild atherosclerosis, basophilic degeneration of media

Pancreas - interstitial giant cells containing fat-like vacuoles, fine calcifications
Kidney - numerous sclerotic glomeruli, arteriolar sclerosis
Larynx - minimal submucosal chronic inflammation
Epiglottis - mild submucosal chronic inflammation
Bladder - chronic inflammation
Esophagus - submucosal congestion, focal erosion with bacteria
Spleen, thyroid - unremarkable

SPECIMENS AND EVIDENCE COLLECTED

1. 15 mL of heart blood, 15 mL of femoral blood, 15 mL of urine and 4 mL of vitreous
2. Representative tissue sections in formalin for possible further examination
3. Blood card
4. Representative photographs
5. Tissue in cassettes for histology (12)
6. Fingerprints and palmprints
7. Forensic evidence:
   a) Blood card
   b) Pulled scalp hair

EDC: 3/25/2017
Transcribed: 12/25/2016
Completed: 3/2/2017
TZG: tzg

Forensic Toxicology Results

Office of Chief Medical Examiner
Toxicology Laboratory Service
200 Feliks Gwozdz Place
Fort Worth, Texas 76104

Name: Jesse Andrew Debusk

Case Number: 1619245
Toxicology Work Number: 1604436

Nizam Peerwani, M.D., DABFP
Chief Medical Examiner
Robert Johnson, PH.D., DABFT
Chief Toxicologist

Service Request Number: 001

Specimen	Drug	Result	Drug Amount	Instrument Used	Performed By
Femoral Blood	Ethanol	NEGATIVE		GC/FID	K. SCOTT
URINE	Amphetamine ELISA	POSITIVE		ELISA	B. LANDRY
URINE	Methamphetamine ELISA	POSITIVE		ELISA	B. LANDRY
URINE	THC ELISA	NEGATIVE		ELISA	B. LANDRY
URINE	Opiate ELISA	POSITIVE		ELISA	B. LANDRY
URINE	Cocaine ELISA	POSITIVE		ELISA	B. LANDRY
URINE	Benzodiazepine ELISA	NEGATIVE		ELISA	B. LANDRY
URINE	Oxycodone ELISA	NEGATIVE		ELISA	B. LANDRY
URINE	ACID	NEGATIVE		GCMS	C. WHEELER
URINE	LIDOCAINE	POSITIVE		GCMS	C. WHEELER
FEMORAL BLOOD	METHAMPHETAMINE	POSITIVE	1663 ng/mL	LCMS	L. HAZARD
URINE	METHAMPHETAMINE	POSITIVE		LCMS	L. HAZARD
FEMORAL BLOOD	BENZOYLECGONINE	POSITIVE	32 ng/mL	LCMS	L. HAZARD
URINE	BENZOYLECGONINE	POSITIVE		LCMS	L. HAZARD
FEMORAL BLOOD	AMPHETAMINE	POSITIVE	112 ng/mL	LCMS	L. HAZARD
URINE	AMPHETAMINE	POSITIVE		LCMS	L. HAZARD
FEMORAL BLOOD	MORPHINE	NEGATIVE		LCMS	L. HAZARD
URINE	MORPHINE	POSITIVE		LCMS	L. HAZARD

Approved By: _____

Approved Date: 1/18/17

TARRANT COUNTY MEDICAL EXAMINER'S DISTRICT
SERVING TARRANT, PARKER, JOHNSON & DENTON COUNTIES
Investigator's Report

CASE #: 1619245 Parker TYPE: Jurisdiction IDENTITY: Identified

NIZAM PEERWANI, M.D.
CHIEF MEDICAL EXAMINER

MICHAEL FLOYD
CHIEF FORENSIC DEATH INVESTIGATOR

DECEASED: Jesse Andrew Debusk
ADDRESS: 108 Meandering Way, Weatherford, Texas 76086
AGE: 38 BIRTH DATE: 7/24/1978 MARITAL STATUS: Single
PHONE: RACE OR COLOR: White SEX: M
HEIGHT: WEIGHT:
SSN: MANNER OF DRESS: hospital gown
OCCUPATION:
PLACE OF EMPLOYMENT:

DATE OF DEATH: 12/24/2016 TIME OF DEATH: 19:27
PLACE OF DEATH DESCRIPTION: Hospital
ADDRESS OF DEATH: 713 E Anderson St, Weatherford, Texas 76086
HOSPITALIZED: Yes
ADMIT DATE: 12/24/2016 ADMIT TIME: 19:10
ENVIRONMENT CONDITION: Controlled
CHARACTERISTIC OF PREMISES: emergency room

DATE/TIME M.E. NOTIFIED: 12/24/2016 20:08
ARRIVED: 12/24/2016 20:34
REPORTING PERSON: Ranger T Bradford
REPORTING AGENCY: Texas Ranger Service
ADDRESS: Not entered
PHONE:
PRONOUNCED DEAD BY: Dr Babu Subrahmanyam
PRONOUNCING AGENCY: Weatherford Regional Hospital
LAST TREATED BY:

DATE/TIME OF OCCURRENCE: 12/24/2016 19:00
INJURY AT WORK: N0
PLACE OF OCCURRENCE: County Jail
LOCATION: 209 Hogle St, Weatherford, Texas 76086
TRAUMA RELATED: No

IDENTIFIED BY: Bryan Wright
IDENTIFICATION TYPE: Visual
DATE/TIME OF IDENTIFICATION: 12/24/2016 -Time: 22:01
IDENTIFICATION STATUS: Positive ID
COMMENTS:
ADDRESS:
PHONE:

NEXT OF KIN NOTIFICATION DATE/TIME: 12/24/2016 21:30
NOTIFIED BY: Bryan Wright
NOTIFYING AGENCY: PCME
NEXT OF KIN NAME: Diane Wallace
RELATIONSHIP: Mother
COMMENTS:
ADDRESS: 1125 Briarwood, Weatherford, 76087 Texas
PHONE: (817)596-8645

TARRANT COUNTY MEDICAL EXAMINER'S DISTRICT
SERVING TARRANT, PARKER, JOHNSON & DENTON COUNTIES
Investigator's Report

CASE #: 1619245 Parker TYPE: Jurisdiction IDENTITY: Identified

NIZAM PEERWANI, M.D.
CHIEF MEDICAL EXAMINER

MICHAEL FLOYD
CHIEF FORENSIC DEATH INVESTIGATOR

BODY TO: TCME
FUNERAL HOME: Galbreaith Pickard FH

CONVEYANCE: Accucare

NAME OF RELEASING AUTHORITY:

RELATIONSHIP:

DISPOSITION OF PROPERTY: none

MEDICAL INVESTIGATOR:
Bryan Wright

of Corrio Washington will remain with the case file. The PSR (Personal Service Record) for Corrio Washington, which he initialed with the correct hours he attended the listed training courses will also remain with the case file.
****

On Friday September 15, 2017 Sergeant Stan Roper and I traveled back to Austin.

****
After reviewing statements obtained in this investigation it clear that numerous false training hours were reported to the Texas Commission on Law Enforcement between 2015 and 2017 by former Lieutenant Atlee Walters, a former LaSalle Corrections employee, who was appointed by the Parker County Sheriff's Office. Former Lieutenant Walters reported the false training to the Texas Commission on Law Enforcement through Weatherford College Law Enforcement Academy. The majority of the false training was not required by the Texas Commission on Law Enforcement as a requirement for Jailer Licensure. A Jailer licensee is required to take Cultural Diversity training in every 48 month training cycle.

During this investigation former LaSalle Lieutenant Atlee Walters admitted he had falsely reported training to the Texas Commission on Law Enforcement between 2015 and 2017 and he has permanently surrendered his jailer license to the Texas Commission on Law Enforcement.

The investigation revealed during the time period of 2015 through 2017 there were two different LaSalle Corrections Head Administrators overseeing the Parker County Sheriff's Office Jail, Warden Ron King and Warden William Gray. During that time period the investigation revealed a lack of over site in training by both Warden William Gray and Warden Ron King. Both admitted there was a lack of over site by them, concerning the training of their LaSalle Corrections employee's at the Parker County Jail. Both admitted that they had placed their trust in the training coordinator, Atlee Walters to see that the jailer training was properly done and reported. Warden Gray and Warden King admitted they should have monitored the training closer.

The Texas Commission on Law Enforcement, after considering facts and circumstances surrounding this investigation will pursue administrative actions regarding the false reporting of training by former Lieutenant Atlee Walters.

Recommendations:

Atlee Walters- Voluntary self- surrendered his jailer license for permanent surrender on 09/12/2017 and is permanently barred by the Texas Commission on Law Enforcement to receive a peace officer, jailer or tele-communicator license issued by the State of Texas.

Warden William Gray- Warning Letter regarding the responsibilities as Head Administrator (Designee), title 37 Texas Administrative Code §211.29

Warden Ron King- Warning Letter regarding the responsibilities as Head Administrator (Designee), title 37 Texas Administrative Code §211.29

The false training will be removed or adjusted on the jailer's personal service record.

A copy of this case will be provided to the Parker County District Attorney's Office for review due to the pending Parker County Sheriff's Office investigation.

not a towel covering the window of cell N503.

3.5 Interview with Lechler continued:

Lechler stated this shift was extremely shorthanded, so he was pulled from his area of responsibility, and tasked to conduct other duties throughout the detention center. Lechler stated he informed his supervisor, Sergeant Pless, that he needed assistance because he was running behind on his visual inmate checks. Lechler stated Sergeant Pless never provided assistance.

3.6 Interview with Lechler concluded:

Lechler finally made it back to 500 Wing at shift change at approximately 6:00 PM and the last entry made on the visual check log was 1620 hours. Lechler stated Sergeant Pless told him he was not allowed to leave work until the log "looked right." Lechler stated this meant he had to back-fill the times and make it look like he conducted rounds. Lechler knew what he did was wrong and illegal, but he did it out of fear of losing his job. Though he was instructed to do so, Lechler admitted he knowingly falsified a government document. This interview with Lechler ended, and Lechler left.

3.7 This investigation will continue.

Activity Location

Originating Invest #: 2016I-TRF-50005223

Location Name:
Street:
City:
Zip Code:
County:
State: Texas
Country: US - United States of America (USA)
Mile Mark:
Location Description:

Personnel

Originating Invest #: 2016I-TRF-50005223

Name: Robert P Pena - RP10773
Type: Lead Investigator
ID #: 10773
Agency/Service: Texas Dept of Public Safety
Assign Date: 07/27/2016
End Date:
Division: Texas Rangers
Region/Company: F
Distict:
Area:
Email: patrick.pena@dps.texas.gov
Phone:
Address:
Supervisor: JAMIE DOWNS - JD10382

Name: Detective Kimberly King
Type:
ID #:
Agency/Service: McLennan County Sheriff's Office
Assign Date: 11/15/2016
End Date:
Division:
Region/Company: