PINELLAS COUNTY SHERIFF'S OFFICE
PROFESSIONAL STANDARDS BUREAU
INTER-OFFICE MEMORANDUM

DATE: **OCTOBER 2, 2024**

TO: **DISTRIBUTION**

FROM: **CAPTAIN ROBERT OSTERLAND** RO
Professional Standards Bureau

SUBJECT: **AI-24-007 SHERIFF'S FINDING**

On October 2, 2024, at 0810 hours, Registered Nurse Eileen Long, #57626, was terminated per Sheriff Gualtieri as a result of AI-24-007.

DISTRIBUTION:

Sheriff Bob Gualtieri
Chief Deputy Paul Halle
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RO

PINELLAS COUNTY SHERIFF'S OFFICE
INTER-OFFICE MEMORANDUM

DATE: **OCTOBER 2, 2024**

TO: **REGISTERED NURSE EILEEN LONG, #57626**

FROM: **SHERIFF BOB GUALTIERI**

SUBJECT: **CHARGES RE: AI-24-007**

An investigation has been conducted by the Administrative Investigation Division, Professional Standards Bureau, of the Pinellas County Sheriff's Office. As a result of this investigation, the Administrative Review Board has determined you committed the following violation:

On, but not limited to, January 20, 2024, while on duty in Pinellas County, Florida, you violated the Pinellas County Sheriff's Civil Service Act Laws of Florida, 89-404 as amended by Laws of Florida 08-285, Section 6, Subsection 4, by violating the provisions of law or the rules, regulations, and operating procedures of the Office of the Sheriff.

1. You violated Pinellas County Sheriff's Office General Order 3-1.1, Rule and Regulation 5.4, Duties and Responsibilities.

Synopsis:

On January 20, 2024, while assigned as the registered nurse for housing unit 4H3 at the Pinellas County Jail (PCJ), you were asked by another medical staff member to evaluate an inmate experiencing breathing difficulties and erratic body movements. During your interactions with this inmate, you consistently failed to perform your essential duties and responsibilities as a registered nurse, which included assessing and triaging the inmate's complaints and conditions within your scope of licensure, providing care as the inmate's condition warrants, providing appropriate follow-through when further action is indicated, and documenting efficiently and effectively in the electronic and paper health records.

On January 19, 2024, the day before this incident, you were called to 4H3 to evaluate this same inmate who was complaining of shortness of breath and who was requesting a hospital bed because lying flat made it hard to breathe. You became aware of the inmate's medical history, which included severe chronic conditions like congestive heart failure, hypertension, and insulin-dependent diabetes. On the day of the incident, you re-reviewed the inmate's medical history before responding to the call requesting your assistance.

When you arrived in housing unit 4H3, you observed the inmate sitting in a chair near their bed erratically moving and making moaning sounds. As you walked toward the inmate, you passed the officer's station, leaving some of your medical equipment there. After arriving at

the bedside, you told the inmate that you were going to get their vitals and listen to their lungs. However, you determined that because the inmate continued to moan and move in their seat, they were refusing your care and that they presented safety concerns. Therefore, despite knowing the inmate had serious medical conditions that could cause them to behave erratically and to have profound shortness of breath, you only spent approximately ten seconds interacting with the inmate, failing to make any attempts to speak with them or to gather any additional information about their complaints.

You subsequently turned and walked back to the officer's station, instructing detention staff to bring the inmate over to the station where there was more room to conduct a full assessment and obtain their vitals. Although detention staff informed you that the inmate said they were unable to walk to the officer's station, you suggested they utilize a wheelchair.

While waiting for the inmate to arrive at the officer's station, you watched as detention staff struggled to get the inmate up and into the wheelchair. After several failed attempts by detention staff and another inmate, you asked another member of the medical staff to assist in getting the inmate into the wheelchair and over to the officer's station. Eventually, the inmate was placed into the wheelchair, and detention staff started pushing them toward the officer's station. Seconds later, because of their erratic body movements, the inmate began to slide forward in the wheelchair, subsequently being assisted to the floor by jail staff; you remained at the officer's station.

While on the floor, the inmate continued to exhibit erratic, jerky body movements, including banging their head on the floor; additional detention staff arrived to assist. Only after the shift commander arrived and walked up to the inmate on the floor, did you walk back to the incident. After approximately 45 seconds, you turned and walked back towards the officer's station. During your time at the inmate's side, you made no attempt to speak with them, nor did you attempt to conduct any medical assessment or evaluation of them, citing that the inmate was uncooperative. Based on the initial information you received from the other medical staff member and your direct observations of the inmate's behavior, you determined that the inmate was uncooperative and displaying self-injurious behaviors. Therefore, you placed them on Suicide Risk (SR) status.

Detention staff subsequently secured the inmate in shackles and handcuffs and, after getting them back into the wheelchair, began the process of transferring them to 4H2. As the inmate was being wheeled past you at the officer's station, you made no attempts to speak with or assess them. Despite your knowledge of the inmate's longstanding, serious medical conditions and the potential for these to be aggravated by physical exertion or positioning, you chose not to share this information with detention staff.

You chose to not accompany the inmate as they were relocated to a new housing area. As such, you made no further attempts to assess or evaluate the inmate. Rather, you walked to the nursing office, where you spoke with the registered nurse assigned to 4H2, and to a physician assistant. You told them both about the inmate's erratic behavior, their uncooperative demeanor, and that you tried unsuccessfully to obtain their vitals, but you failed

to mention anything about the inmate's complaint of difficulty breathing and their complicated medical history.

Less than two hours after the inmate was relocated to 4H2, they were found unresponsive in their cell. A Code 99 was initiated, and emergency medical services were summoned. Despite these efforts, the inmate was later pronounced deceased.

In summation, after being requested to assess an inmate who was complaining of shortness of breath and exhibiting bizarre behavior, you failed to conduct any medical assessment to determine the nature of the inmate's problems. Despite being aware of the inmate's significant medical history which could reasonably cause difficulty breathing, you neglected to speak with the inmate to ascertain additional details about their complaints, and you failed to apply basic nursing knowledge about cardiovascular disease to this incident. You had several opportunities to interact with and evaluate the inmate, but instead, you wrongly attributed their issues to a behavioral problem and placed them on SR status.

Although you responded to the Code 99, you failed to recognize the possible relationship between your earlier call to assess the same inmate for shortness of breath. You told no one during the resuscitative efforts that you had been called to see this inmate earlier in the day. Later, while you were documenting your actions and observations in the nursing note, you wrote that during your initial assessment of the inmate, their skin was "warm and dry." However, you never made any physical contact with the inmate. Therefore, because you never touched the inmate's skin, you could not have determined its temperature. By writing in your nursing note that you performed a portion of an assessment that never occurred, you knowingly and intentionally made a false entry into an official record. Additionally, during this investigation, a detention staff member who was in physical contact with the inmate testified that the inmate was "profusely sweating."

During your Administrative Interview, you stated that you "would not have done anything differently," and that you did not believe the inmate was in immediate distress. After your brief initial interaction, you made no further attempts to engage with the inmate, de-escalate the situation, or provide medical care.

During the Administrative Review Board, you reaffirmed that you would not change any of your actions and believed there was no wrongdoing on your part.

The Board determined that you committed this violation.

Disciplinary Points and Recommended Discipline Range:

You were found to be in violation of one (1) Level Five Rules and Regulations violation totaling fifty points. These points, which were affected by no modified points from previous discipline, resulted in fifty (50) progressive discipline points. At this point level, the recommended discipline range is a forty (40) hour suspension to Termination.

Disciplinary action shall be consistent with progressive discipline, for cause in accordance with the provisions of the Pinellas County Civil Service Act.

CAPTAIN ROBERT OSTERLAND
PROFESSIONAL STANDARDS BUREAU
FOR BOB GUALTIERI, SHERIFF

I have received a copy:

Date 10/2/2024

Time 08:10

SIGNATURE

BG:YMT:blb