St. Clair Shores Police Dept.
27665 Jefferson Ave.
St. Clair Shores MI 48081

FOIA / Subpoena Response Form

FOIA Coordinator-Designee
Operational Support Services
Phone: 586-445-5317

To: **ROBIN ERB** Date: **09/15/25**

RE: **RECORDS**

The following Action has been taken pursuant to your request for a public record:

Your request has been: ■ Granted ■ Denied in Part ☐ Denied

☐ Denied - the Police Dept. finds no documents exist per your request.

Your request will be processed but, Balance Must Be Paid Before copies may be picked up or mailed. See attached Fee Itemization form the amount due and payment should be made payable to the City of St. Clair Shores.

☐ This form constitutes notice that the period for response has been extended by an additional ten (10) business days.

The Public Summary of the City's FOIA Procedures and Guidelines is available free of charge from the website: www.scsmi.net or upon request, it can be mailed/picked up in person.

RECORD/INFORMATION REQUESTED:

Our reason for denial is based on Section 13 of the Freedom of Information Act. The specific reason is as follows:

■ The information requested is of a personal nature, and public disclosure would constitute a clearly unwarranted invasion of an individual's privacy.

■ The requested information constitutes records or information specifically described and exempted from disclosure by statute. (LEIN)

☐ Exempt under MCL 15.243 – Section 13 – ☐ Other:

With the exception of the above redactions(Full Names, Addresses, Phone Numbers, DOBs, Relationships, Medical, LEIN), you are receiving all materials available for this request. There is no labor charge for your item, as the time involved did not meet the minimum requirement under FOIA

This notice is issued in response to your request. Findings must be claimed within 45 days of this notice or the request will be considered abandoned. After the abandoned date has passed, you will be required to submit a new request in order to receive any available findings

RE: RECORDS

Appeal: Under Sec. 10 of the Michigan FOIA, a person receiving written denial of the information requested has the right to submit to the Mayor a written appeal that specifically states the word "appeal" and identifies the reason or reasons for reversal of the denial, or to commence a civil action in circuit court to compel disclosure of the public record within 180 days after a final determination to deny the request. If, in the circuit court action, the court finds that the information withheld by a public body was not exempt from disclosure, the party requesting such information may receive the requested records and, at the court's discretion, reasonable costs.

Sgt. Heather Campbell
Operational Support Services

SAINT CLAIR SHORES PD
27665 JEFFERSON
SAINT CLAIR SHORES MI 48081
586 445-5300

Case Report

Administrative Details:

CR No	Subject
230010568	C3207 - Sudden Death - Accident
Report Date/Time	Occurrence Date/Time
06/03/2023 09:12	06/03/2023 09:03
Location	Call Source
22700 GREATER MACK AVE Apt #: [redacted]	Assoc/Clone
Dispatched Offense	Verified Offense
C3205 Sudden Death - Natural	C3207 Sudden Death - Accident
OIC	OIC Contact Number
Neate, Andrew (SSNEATEA-00246)	
County	City/Twp/Village
50 - Macomb	90 - St Clair Shores
Division	
Patrol	

Action Requested:

[ ] Arrest warrant	[ ] Review only
[ ] Search warrant	[ ] Forfeiture
[ ] Juvenile petition	[ ] Other

Offenses:

[redacted]

IBR Code / IBR Group	Offense File Class	
[redacted]	[redacted]	
Crime Against: PE	Location Type: 09 - Drug Store/Doctors Office/Hospital	Offense Completed: Completed
Domestic Violence: No	Hate/Bias: 00 - None (No Bias)	

Using: A-Alcohol: No C-Computer Equipment: No D-Drugs/Narcotics: No

Weapons: 99 - Unknown

Criminal Activity: N - None/Unknown

[redacted]

IBR Code / IBR Group	Offense File Class	
[redacted]	[redacted]	
Crime Against: PR	Location Type: 09 - Drug Store/Doctors Office/Hospital	Offense Completed: Completed
Domestic Violence: No	Hate/Bias: 00 - None (No Bias)	

Using: A-Alcohol: No C-Computer Equipment: No D-Drugs/Narcotics: No

Criminal Activity: C - Cultivating/Manufacturing/Publishing

C3207 - Sudden Death - Accident [SSMURPHYT (00247)]

IBR Code / IBR Group	Offense File Class	
/		
Crime Against:	Location Type: 88 - Other	Offense Completed: Not Applicable
Domestic Violence: No	Hate/Bias: 00 - None (No Bias)	

Using: A-Alcohol: No C-Computer Equipment: No D-Drugs/Narcotics: No

People:

[redacted] TONI [redacted] [redacted] [SSNEATEA (00246)]

Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
[redacted]	TONI	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Street Address	Apt #	County	Country	Home Phone	Work Phone
[redacted]					

City	State	Zip	Cell Phone	Email
[redacted]	[redacted]	[redacted]		

TRAYLOR, TOLETHA RENAE (A-ARRESTEE) [SSNEATEA (00246)]

Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
TRAYLOR	TOLETHA	RENAE		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Held For	Finger Prints	Photos	Miranda Read	Miranda Waived	Number of Warrants	FBI#

	No	Yes	No	No		

Street Address	Apt #	County	Country	Home Phone	Work Phone
[redacted]					

City	State	Zip	Cell Phone	Email
[redacted]	[redacted]	[redacted]		

Arrest Information

Offenses	Details
[redacted]	Arrest Date/Time: [redacted] Location: Arrest#: Arrest Type: OWI Arrest/BAC: Offense Type: Count: Arresting Officer 1:

MultiClearance	MultiClearance Offense	Armed With
N - Not Applicable		01 - Unarmed

LADEN, TONYA DENISE (A-ARRESTEE) [SSNEATEA (00246)]

Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
LADEN	TONYA	DENISE		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Held For	Finger Prints	Photos	Miranda Read	Miranda Waived	Number of Warrants	FBI#
	No	Yes	No	No		

Street Address	Apt #	County	Country	Home Phone	Work Phone
[redacted]					

City	State	Zip	Cell Phone	Email
[redacted]	[redacted]	[redacted]		

Arrest Information

Offenses	Details
[redacted]	Arrest Date/Time: [redacted] Location: Arrest#: Arrest Type: OWI Arrest/BAC: Offense Type: Count: Arresting Officer 1:

MultiClearance	MultiClearance Offense	Armed With
N - Not Applicable		01 - Unarmed

PICKERING, DAVID [redacted] (V-VICTIM) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		PICKERING	DAVID	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Street Address	Apt #	County	Country	Home Phone	Work Phone
[redacted]					

City	State	Zip	Cell Phone	Email
[redacted]	[redacted]	[redacted]		

Victim Injury

F - Fatal

Victim Offender Relationships

Offender	Type	Relationship
	A-ARRESTEE	
	A-ARRESTEE	
	S-SUSPECT	

[redacted] SCOTT [redacted] (W-WITNESS) [SSMURPHYT (00247)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
	EY	[redacted]	SCOTT	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Street Address	Apt #	County	Country	Home Phone	Work Phone
[redacted]					

City	State	Zip	Cell Phone	Email
[redacted]	[redacted]	[redacted]		

[redacted] MARY (O-OTHER) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	MARY			DR

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Street Address	Apt #	County	Country	Home Phone	Work Phone
[redacted]					

City	State	Zip	Cell Phone	Email
[redacted]	[redacted]	[redacted]		

Notes

[redacted] KIARA (O-OTHER) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	Kiara			

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Street Address	Apt #	County	Country	Home Phone	Work Phone
[redacted]					

City	State	Zip	Cell Phone	Email
[redacted]	[redacted]	[redacted]		

Notes

[redacted] KRYSTAL [redacted] (O-OTHER) [redacted] [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	KRYSTAL	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Street Address	Apt #	County	Country	Home Phone	Work Phone
[redacted]					

City	State	Zip	Cell Phone	Email
[redacted]	[redacted]	[redacted]		

Notes

[redacted] GREGORY (O-OTHER) (X-MISCELLANEOUS) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	Gregory			

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Street Address	Apt #	County	Country	Home Phone	Work Phone

City	State	Zip	Cell Phone	Email

Notes

[redacted] ANDRE (O-OTHER) (X-MISCELLANEOUS) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	ANDRE			

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Street Address	Apt #	County	Country	Home Phone	Work Phone

City	State	Zip	Cell Phone	Email

Notes

[redacted] JOSEPH [redacted] (O-OTHER) (I-PERSON INTERVIEW) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	JOSEPH	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Street Address	Apt #	County	Country	Home Phone	Work Phone
[redacted]					

City	State	Zip	Cell Phone	Email
[redacted]		[redacted]		

Notes

[redacted] MICHELLE [redacted] (O-OTHER) (I-PERSON INTERVIEW) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	MICHELLE	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Street Address	Apt #	County	Country	Home Phone	Work Phone
[redacted]					

City	State	Zip	Cell Phone	Email
[redacted]		[redacted]		

Notes

[redacted] SYNIA [redacted] (O-OTHER) (I-PERSON INTERVIEW) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	SYNIA	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Street Address	Apt #	County	Country	Home Phone	Work Phone
[redacted]					

City	State	Zip	Cell Phone	Email
[redacted]		[redacted]		

Notes

[redacted] REGINA (O-OTHER) (I-PERSON INTERVIEW) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	REGINA			

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Street Address	Apt #	County	Country	Home Phone	Work Phone
[redacted]					

City	State	Zip	Cell Phone	Email
[redacted]		[redacted]		

Notes

[redacted] DARLENE [redacted] (O-OTHER) (I-PERSON INTERVIEW) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	DARLENE	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship

Street Address	Apt #	County	Country	Home Phone	Work Phone
[redacted]					

City	State	Zip	Cell Phone	Email
[redacted]		[redacted]		

Notes

[redacted] LATASHA [redacted] (O-OTHER) (I-PERSON INTERVIEW) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	LATASHA	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship
Street Address		Apt #	County	Country	Home Phone	Work Phone
City	State	Zip	Cell Phone	Email		
Notes						

[redacted] GLADYS [redacted] (O-OTHER) (I-PERSON INTERVIEW) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	GLADYS	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship
Street Address		Apt #	County	Country	Home Phone	Work Phone
[redacted]						
City	State	Zip	Cell Phone	Email		
[redacted]	[redacted]	[redacted]				
Notes						

[redacted] PAULYNNE [redacted] (O-OTHER) (I-PERSON INTERVIEW) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	PAULYNNE	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship
Street Address		Apt #	County	Country	Home Phone	Work Phone
[redacted]						
City	State	Zip	Cell Phone	Email		
[redacted]	[redacted]	[redacted]				
Notes						

[redacted] NUEBIBER [redacted] (O-OTHER) (I-PERSON INTERVIEW) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	NUEBIBER	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship
Street Address		Apt #	County	Country	Home Phone	Work Phone
[redacted]						
City	State	Zip	Cell Phone	Email		
[redacted]	[redacted]	[redacted]				
Notes						

[redacted] SHAMIKA [redacted] (O-OTHER) (I-PERSON INTERVIEW) [SSNEATEA (00246)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	SHAMIKA	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship
Street Address		Apt #	County	Country	Home Phone	Work Phone
[redacted]						
City	State	Zip	Cell Phone	Email		
[redacted]	[redacted]	[redacted]				
Notes						

[redacted] CHRISTINE [redacted] (O-OTHER) (X-MISCELLANEOUS) [SSMURPHYT (00247)]

PE:	W.Type:	Last Name	First Name	Middle Name	Suffix	Mr/Mrs/Ms
		[redacted]	CHRISTINE	[redacted]		

Aliases	Driver License#	DL State	DL Country	Personal ID#

DOB (Age)	Sex	Race	Ethnicity	Birth City & State	Birth Country	Country of Citizenship
Street Address		Apt #	County	Country	Home Phone	Work Phone
[redacted]						

City	State	Zip	Cell Phone	Email
[redacted]	[redacted]	[redacted]		

Narrative:

CR No: 230010568-001 Written By: SSMURPHYT (00247) Date: 06/03/2023 02:01 PM

On listed date and time, I, Officer Murphy scout 605, responded to the listed venue regarding a deceased subject. Upon arrival, I spoke with the day shift nurse, Traylor, who stated she checked on David [redacted] at approximately 0800 hours and he was alive. At 0903 hours, Traylor found David unresponsive, and CPR was initiated/continued until 0911 hours when SCSFD arrived on scene and took over. I spoke with SCSFD who advised David had passed and Dr. Nosek [redacted] pronounced the death at 0914 hours.

Upon entering the room, I observed 2 beds separated by a curtain. [redacted] a man (later identified as [redacted] asked me if I wanted to know what happened. I listened as [redacted] told me that between the hours of 0300 and 0315 hours, David spilled a Coke all over himself. A nurse's aide came into the room to change the bedding. David was still on the bed and while changing the sheet, the aid left the room. While the aide was out of the room, David fell off the bed and hit his head. The aide came into the room with a nurse to check David for injuries and [redacted] said David was complaining of pain. I asked [redacted] what words David used to complain of his injuries and [redacted] could not tell me. [redacted] did not see David fall, never observed any injuries, and could not explain exactly how David was complaining of an injury to the head, but stated he knew by the conversation the nurse and aide had (still unable to describe clearly).

I was advised by front staff that the nurse is actually an LPN (licensed practical nurse) named Tanya Laden. Laden contacted Javier [redacted] It is unknown what the conversation was between Laden and [redacted] was, but nobody called for medical assistance to respond to the facility to check David's injuries. I took photos of the room and of David. I observed blood and other unknown fluids on both sides of the bed but did not see any blood on David. I checked the floor near the other bed and found there was blood and other fluids on both sides of that bed as well, so it is unknown if the blood on the side of the bed was David's. I contacted the Macomb County Medical Examiner and spoke with Investigator Brooks. I advised her about the circumstances regarding this death. Brooks contacted an unknown doctor and called back advising she would be responding to my location.

Brooks arrived and we started moving the body. We were able to observe a large knot near his right ear and a contusion on the lower back of his head, which we believed to be recent. Brooks and I spoke with Christine [redacted] who was now at the facility and

advised her of the incident. [redacted] David [redacted] and Daniel [redacted] who were both advised of his passing by Christine. Brooks called for transport and the body was taken to the morgue. The pictures were burned to a disk and placed into the DB bin.

CR No: 230010568-002 Written By: SSNEATEA (00246) Date: 06/05/2023 09:54 AM

6/5/23

On this date, I was assigned and reviewed this case. I viewed the pictures that were taken of the deceased.

I called Scott and left a message for him to call me back.

I called the [redacted] Regency and left a message for him to call me back.

6/6/23

I called [redacted] Joseph [redacted] Joseph called Tonya Laden into the facility. Tonya is the Midnight Shift LPN that was caring for David when he fell. I went to Regency and met with Joseph, Tonya and [redacted] Michelle [redacted] I went to the room where David died with all three of them so Tonya could explain what happened.

Tonya advised that David spilled soda all over himself in his bed, so [redacted] Toni [redacted] began changing his sheets and giving him a bed bath. Tonya advised she was outside in the hallway at this time and Toni was in the room. Tonya said she heard a thump and Toni came out panicking, saying that David fell off his bed. Tonya entered the room and observed David laying on the floor on his right side. She advised the bed was set approximately 3 ft. high. Tonya asked David if he rolled out of the bed, and he said "yeah". Tonya stated that she specifically asked David if he hit his head, and he said no. She said David did not specifically complain of any pain but noted that David is [redacted] He groaned when they put him back in bed, but Tonya advised this is typical for David to do when he is moved. Tonya stated she physically examined David's head and underneath his hair and she did not observe any obvious injuries or bleeding. Tonya stated she examined the rest of his body and the only injury she observed was a 4-inch scratch on the back of his right shoulder. Tonya said it was bleeding, so she placed a bandage over it. Tonya took David's vital signs, [redacted]

[redacted] Tonya also said she checked David's pupils, and she conducted Neurological Assessments throughout the rest of the morning. Tonya stated those Neurological Assessments [redacted] Tonya noted the lump behind David's right ear/right jawline, stating it has been there for a long time. Joseph showed me an old photograph of David, which confirms the lump was there previously. Tonya stated 911 was not called because David said he did not hit his head, he did not complain of pain or injuries, and [redacted]

Michelle got down on the floor and had Tonya put her in the position that David was found when he fell out of the bed. I took a photograph of this position and added it to the casefile.

Tonya also called [redacted] Javier [redacted] Theoria is a telehealth provider that Regency uses to consult after hours for incidents like this. Tonya advised she communicated the information to Javier via text messaging. I spoke with Javier on the phone. Javier confirmed he was contacted by Regency via text messaging regarding David's fall, although he was not sure who the person that he was communicating with was. Javier confirmed that he was told David rolled out of his bed on to the floor. He was told David denied striking his head and the only reported injury was the scratch to the back of his right shoulder. Javier was told David's vital signs [redacted] Based on this information, Javier advised there would be no need for David to be hospitalized.

Michelle confirmed that with these circumstances, 911 usually would not be called in the situation of a fall. Michelle stated it is preferred that 911 is called if the patient is on an anti-coagulant, and she proceeded to say David [redacted]

I spoke with Scott [redacted] Scott stated he saw Toni walking toward the sink after David spilled the soda on himself. Scott heard a thump and saw Toni run back to check on him. Scott said Toni ran out to get the nurse and they were checking on David. Scott advised the curtain was pulled, shielding his view of David, so he could not actually see what was happening. Scott said he heard one of the staff members ask David if he hit his head. Scott said he did not hear David say anything. Scott claims he thinks David hit his head based on the conversation between Toni and the nurse. I asked him to tell me what was specifically said that made him think this way, but he could not elaborate. He also stated he does not think Tonya was the nurse who was in the room when David fell, saying the Nurse who was there [redacted] Scott said that no one came in to check on David after he fell until he was found deceased. He also said the nurse was complaining to the other employee in the room that she had to take care of 41 patients, and it has always been that way.

Tonya advised it is not true that she was not the nurse who cared for David after he fell. Joseph and Tonya also stated it is not true that no one came in to check on David after his fall.

6/7/23

I spoke with [redacted] Toni [redacted] Toni confirmed that as she was doing her rounds, she observed that David spilled soda all over himself in bed. Toni stated she removed the sheet from the bed using a common technique used by staff that involves the patient remaining in the bed while the sheets are changed. After removing the sheet, Toni started giving David a bed bath to clean him. Toni stated she left David laying down on his right side in the middle of the bed and began walking to the sink. As she walked toward the sink, she had her back toward David. As she reached the foot of Scott's bed, she heard a "boom", and saw David laying on the floor. Toni went and got Tonya, who was a few doors down the hall. They both attended to David, and they both asked David if he hit his head. David responded by saying "no" to both of them. Toni said David did not complain of any pain and the only injury was the scratch on the back of his left shoulder. Toni and Tonya picked David up and put him back on the bed. They remained with him and cleaned the soapy water off of him. Toni stated that they left when David was stabilized around 0400 hours, and she checked on him twice more throughout the rest of the morning at 0515 hours and 0630 hours. Toni advised David said he was fine on both of these occasions. Toni stated Tonya did Neurological Assessments afterward. Toni also said she did not feel 911 needed to be called because David just had a scratch.

Michelle was present during this interview and clarified that the nurses don't need her permission to call 911, which is what Tonya said yesterday. Michelle said based on what she was told about this fall, there was no reason to call 911.

Joseph advised that David [redacted] I attached David's diagnosis sheet to this report.

6/12/2023

I completed a subpoena for David's medical records on the day of his passing along with videos of the outside of Room 229. Judge Oster signed it, and I sent it Joseph in order to produce the results.

6/15/23

I received David's Medical Records and video from the hallway outside Room 229. I copied the Medical Records and videos to a USB and added them to the Casefile. According to the paperwork, David was checked on multiple times after his fall, which was marked on a Neurological Assessment Sheet that was recommended by Javier [redacted] Specifically, the Neurological Assessment requires David's vital signs and pupils to be checked at specific time increments. The sheet was signed by Tonya Laden and each required time slot is completed [redacted] from 0300 to 0645 hours, but the time slots listed after that are left blank. The directions on the sheet indicate the assessment should continue for 48 Hours. [redacted] Reference David's medication sheet for his prescribed medications.

7/6/2023

I have spent several hours reviewing the surveillance videos outside of Room 229A at Regency from 0245 to 0912 on 6/3/23. I have noticed inconsistencies with what was initially reported by Regency staff, what is marked down on the Neurological Assessment and what is actually depicted in the video. The video shows Toni steps out of Room 229A at approx. 0251 hours in an animated state as she speaks with Tonya. Tonya also becomes animated, and they both enter the room at that time. Tonya leaves at 0256 hours and returns with something in her hand at 0257 hours. Between 0301 hours and 0304 hours, Toni exits and returns with materials several times. Tonya exits at 0306, stands at the nurse's station and then walks down the hall. Toni briefly enters Room 229A at 0310 hours and exits. Toni gets her jacket and walks down the hall a short time after. Tanya enters Room 229A at 0315 hours. Tonya leaves Room 229A at approx. 0317 hours and no one enters the room until 0517 hours. At approx. 0517 hours, Toni is seen going in and out of the room until approx. 0519 with trash bags and cans. Toni stated to me in our interview that she asked David how he was at that time and said he was fine. At 0543:39, Tonya enters Room 229A and exits at 0544:01, meaning the total time she was in the room was 22 seconds. On the video, it appears shift change is occurring just prior to 0700 hours. Tonya and the incoming day shift nurse, identified as Toletha Traylor, are observed together at the nurse station for several minutes. It appears no one enters Room 229A until approx. 0827:37, when [redacted] goes in and leaves after 13 seconds. Joseph [redacted] advised this [redacted] is Synia [redacted] Synia is observed at 0845:50 hours entering Room 229A with what

appears to be a food tray. Synia is observed exiting Room 229A at 0846:13 with the food tray still in her hand. She is pointing toward the room, while talking to other employees in the hallway. She appears to be in a hurry and sets down the tray. She begins to hurriedly walk down the hall looking into other rooms, as if she is looking for someone. Toletha exits another patient's room and begins walking towards David's room with Synia. Toletha and Synia enter Room 229A and in the minutes that follow, several more employees enter the room, as if something is wrong. Toletha is seen coming in and out of the room during this time frame. At one point, she is accompanied by [redacted] later identified as Gladys [redacted] and it appears they are holding hands, as if there is something wrong. At approximately 0851 hours, Toletha and another aid exit the room and Toletha is at the computer. She then goes to the desk for several minutes while other employees are in the hallway appearing to conduct business as usual. At approx. 0905 hours, Gladyss is observed pushing a red cart down the hall and into Room 229A. 2 more unknown employees are observed running down the hall to room 229A. In the minutes that follow, several more employees enter the room, some of them with equipment. At 0911 hours, SCSFD arrives on scene and David is pronounced deceased at 0914 hours.

Given the times I observed Tonya enter David's Room on the video, it would be impossible for Tonya to complete Neurological Assessments at 0330, 0345, 0415, 0445, 0515, and 0645. It also appears that Toletha did not enter the room to complete the 0745 and 0845 Neurological Assessments, which were blank on the sheet. The only time slot that that corresponds with Tonya entering Room 229A is 0545, when she enters for approx. 22 seconds.

Ofc. T. Murphy's report indicates Toletha last checked on David at around 0800 hours. I reviewed his BWC footage and Toletha says she last saw David alive about an hour and a half ago (time was approx. 0925). The hallway surveillance video does not show Toletha or anyone else enter David's Room from 0544 hours until 0827 hours, indicating Toletha was untruthful to Ofc. T. Murphy on scene.

It should be noted that I am able to distinguish between Room 229A, the room directly to the left of it, and a sitting area directly to the right of it, by using thresholds and molding of the doorways as reference points. I compared these to Ofc. T. Murphy's body camera from when he was on scene in order to determine when employees entered Room 229A, the room to the left and the hallway sitting area to the right. It appears there is some linen and a linen basket in the hallway sitting area, which would explain why some employees spent time there. This area has chairs, so it's possible it could also be used as a break area.

7/7/2023

I drafted a subpoena for Regency Policies/Procedures, disciplinary actions taken against Tonya and Toletha, names, DOB, addresses and phone numbers for employees working on 6/3/23 and any saved communications between Regency and Theoria Health. Judge Oster signed the subpoena, and I served it to Joseph [redacted]

7/24/2023

I received the above requested records from Regency on this date. Tonya and Toletha each signed [redacted] I noticed that both Tonya and Toletha were [redacted] Per his Medical Sheet, David Pickering is [redacted]

In the paperwork I received regarding how falls are managed, I did not see anything that specifically addresses how patients on blood thinners are managed after a fall. I added all the obtained paperwork to a USB listed in the Casefile.

7/25/23

I drafted a subpoena for the communications between Theoria and Regency on 6/3/23 regarding David's fall and subsequent care. Judge Fratarcangeli signed the subpoena, and I served it to the Theoria Medical Legal Department.

7/26/23

On this date, I, along with Det. Peters, interviewed 6 employees from Regency. I also spoke with Joseph about the messages between Regency and Theoria Medical on 6/3/23. Joseph says the

messages only save for 14 days and showed me the app that they use, "Point Click Care". Joseph says he thinks Regency sent just one message to Theoria and one message was sent back from Theoria, which are both synopsizes from Tonya and Javier that I received with David's medical records. Joseph also advised Regency does not have recorded phone calls from their facility.

Interview with Shamika [redacted]

Shamika typically [redacted] Shamika stated that she found out that David passed away, so she went to his room to see if it was true. Shamika stated all she saw when she entered the room was Gladyss and Toletha turning David and it appeared that they were going to start CPR. Shamika stated that Gladyss told her to leave the room, so left. Shamika stated she knew David fell but she did not hear any other information regarding David's treatment after the fall or after he was found unresponsive. Shamika said when she spoke with Regina and Synia in the hallway, they were conversing, wondering how David fell out of the bed. It was well known that David could hardly move in bed. Shamika had no other information to offer.

Interview with Nuebiber [redacted]

Nuebiber is [redacted] and she usually goes by Nicole. Nicole usually [redacted] Nicole advised she does recall the "Code Blue" for David. A "Code Blue" is an emergency response put into place when a patient is found unresponsive. Nicole thinks the Code Blue was called just after 0900 hours. Nicole stated that the Code Blue was called over the PA System that day, so she and another employee went to David's room and [redacted] Nicole had no knowledge of David's fall, and she has no knowledge of what occurred when David was found unresponsive until the code was called. Nicole has not heard anything about David's death since that day, stating she typically [redacted] and does not hear much about what occurs on the second floor. Nicole advised the LPN or RN assigned to a patient who has fallen is responsible for the follow up care of that patient. Nicole said it is protocol to put Neurological Assessments in place, even if a patient says they did not hit their head in an unwitnessed fall. This was based on what she was taught and her experience at Regency. Nicole said Neurological Assessments must be done inside the patient's room and Regency does not have the capability of checking vitals from outside of a patient's room. She advised Neurological Assessments can take 5-10 minutes. Nicole said that a Nurse Assistant can assist the RN or LPN with taking vitals for a Neurological Assessment, but the nurse should be in the room with

them, acting as the responsible party. Nicole was not aware of a delay from when David was found unresponsive until the Code Blue was called.

Interview with Paulynne [redacted]

Paulynne [redacted] Paulynne typically [redacted] Paulynne said she remembers the "Code Blue" for David come over the PA System, just after 0900 hours. Paulynne immediately went to Room 229A when she heard it. Paulynne [redacted] and was working with other nurses during the code for several minutes until SCSFD arrived on scene. Paulynne said Toletha was in charge of David that day and she instructed Toletha to call [redacted] and the doctor. Paulynne went back downstairs after that, but she came back up to check on Toletha later. Paulyanne advised her and Latasha assisted the Medical Examiner when David was examined. Paulyanne advised there was some blood near David's ear when he was moved. Paulyanne does not know if that was from [redacted] or something else. Paulyanne did not hear anything about David's fall, nor did she hear anything about what happened before the Code Blue was called over the PA System. Paulyanne did not know David fell during the night until after he was declared deceased. Paulyanne stated it is protocol to do Neurological Assessments and do a telehealth conference if a patient falls. Paulyanne stated the RN or LPN assigned to that patient's section is responsible for doing these checks. Paulyanne said the nurse assistant should not be doing the Neurological Assessments. Paulyanne did not know of a delay that occurred from when David was found unresponsive until the Code Blue was called. Paulyanne has not heard this being talked about after this occurred.

Interview with Gladys [redacted]

Gladys [redacted] Gladys was [redacted] Toletha found Gladys for assistance when David was found unresponsive and both of them went back into his room together. Gladys said Toletha was responsible for David that day. Gladys said a Nurse Assistant went in to feed David and he was unresponsive, so the Nurse Assistant immediately found Toletha. Toletha was in a panic when she came and found Gladys for help. Gladys said she and Toletha spent several minutes with David to confirm that he was unresponsive. I questioned Gladys about when she and Toletha exited David's room after finding him unresponsive, they spent several minutes at the nurse station without anyone else going in to attend to David. Gladys had no explanation for this, saying they did what they needed to do by calling a "Code Blue" and calling 911. I explained that they exit David's room at about 0851 hours and Toletha

gets on the phone at the desk at 0900 hours. A couple people briefly enter the room during that time frame but exit after a short stay, which would indicate they were not giving David [redacted] care. Gladys had no answer for why there was an 8-9 minute gap before anyone was called or why approx. 13 minutes passed before "Code Blue" was called. Gladys did say that sometimes nurses will use the computer to check a DNR status. I asked why 911 would not be called right away to an unresponsive person and Gladys said they will typically check the patient's DNR status first. In this case, Toletha told Gladys that David [redacted]

Gladys stated she was informed by Tonya Laden that David fell out of bed during the night. Gladys did not ask Tonya much about it because it was not her room to be in charge of, but she did ask how David was doing. Tonya told Gladys that David was fine. Gladys said it is protocol to do Neurological Assessment after a patient falls. Gladys said it is not past practice for someone to complete a Neurological Assessment page without actually checking on the patient. I confirmed that the nurse would have to actually be in the room to do these checks. Gladys said the nurses are responsible for doing these checks, not a Nurse Assistant. Gladys has not heard anything about this incident since it happened.

Interview with Latasha [redacted]

Latasha is [redacted] Latasha said on the day of David's death, Toletha was the nurse in charge of him on Day Shift. Latasha stated that on this day, Gladys came to her and asked what to do when someone passed away. Latasha told Gladys you first have to check his code status. Latasha said she looked it up and discovered David was [redacted] Latasha said Toletha was on the phone talking to Michelle, who told Toletha to call a "Code Blue". Toletha then announced a "Code Blue" to the room. Latasha and several other nurses went to the room and [redacted] Toletha said she was first notified by Gladys around 0900 hours. Latasha said she heard David fell out of the bed earlier in the night but did not know anything else about the fall. Latasha said she asked when David was last checked on and Toletha told her that she did her rounds that morning and David was sleeping. Latasha said she put the vital machine on David [redacted] She said his body was cold when the code was started. Latasha did not know who found him. Latasha said she did not hear anything about the time gap between when David was found and when the code was called. Latasha said that it should be protocol for a code to be called when someone is found unresponsive, and someone should remain with the patient while a code is being called. Latasha also said that the DNR status would typically be checked on the computer if the nurse did not know what the status was. She said it should not take more than a minute or 2 to check the DNR status. It appeared to Latasha that Gladys and

Toletha were not sure what to do.

Latasha said it is protocol to do a head-to-toe assessment and call the on-call nurse practitioner via telehealth when someone falls. Latasha said it is protocol to conduct Neurological Assessments for 3 days after a patient falls and the nurse is responsible for doing that. She also said the incoming nurse should be notified about it by the outgoing nurse. Latasha said it is not past practice at Regency for a nurse to not check on the patient but write it in the Neurological Assessment paper that they did check on them. She also confirmed the nurse would have to be in the room with the patient to conduct these assessments. Latasha said [redacted] so she has not heard anything else about David's fall or death. Latasha said she did not know David fell out of bed until after he was deceased. She wondered how he fell out of bed, saying David could not move around much.

Interview with Darlene [redacted]

Darlene has been [redacted] Darlene said she heard that David fell out of bed earlier on the midnight shift and [redacted] was notified about it. Darlene said she also heard that when Synia went to bring him his breakfast tray, she found him not breathing. Latasha said when the Code Blue was called, she went into the room for about a minute and saw them [redacted]. She does not know what happened before that or the timing of it. Darlene did not have more information to offer.

7/31/2023

I received results from Theoria Medical Legal Department for the subpoena I served them. The results show one paragraph written by Javier [redacted] which is a synopsis of his conversation with Regency, which I already had. They were unable to get the word for word messages that were sent between Javier and Regency.

I also downloaded the 911 call regarding this case. Judging by what was said in the call, it appears Regency called 911 and the phone hung up. Dispatch called Regency back at 0902 hours, indicating there was a 911 hangup, and Regency then asked for EMS response for David. I added the Theoria Communications and the 911 call to the Casefile.

8/1/2023

On this date, I interviewed several more members of the regency staff, including a second

interview with Tonya Laden.

Interview with Kendria [redacted]

Kendria [redacted] Kendria was in the hallway with other employees during the time David was found unresponsive and the Code Blue was initiated. Kendria stated that Synia told her she found David unresponsive. Kendria said she saw the nurses in the room [redacted]. Kendria was not present in the room when David was actually found. Synia told Kendria that David fell earlier in the night but that is all she knew about it. Kendria did not know how long it was from when David was found until the Code Blue was called. Kendria said other [redacted] like Synia and Toletha, have said they think David should have been sent to the hospital at the time he actually fell.

Interview with Regina [redacted]

Regina [redacted] Regina was in the hallway when David was found unresponsive, and nurses started working on him. Regina said she did not know anything about when David was found unresponsive or the treatment of him afterward. I told her that she is on video talking to other employees after David was found. Regina stated she does not know what she talked about with other employees. Regina did say Synia found David and she heard Synia go and get his nurse, but she did not remember which nurse it was. She said she later went into David's room and Ofc. Murphy told her to leave. Regina had nothing further to offer.

Interview with Toletha Traylor

Toletha [redacted] Toletha was David's assigned nurse for Day shift on 6/3/2023 and she was the one who spoke with Ofc. Murphy. Toletha advised me [redacted] and this incident was the first time she dealt with a deceased patient. Toletha stated when she came in that day, Tonya told her David and someone else fell that night, but those patients were stable. Toletha stated that she was [redacted] when Synia came and got her, saying David did not look right. Toletha checked on him and discovered David was not breathing, he had no pulse, and he was cold. She believed he was deceased at that time. Toletha then summoned Gladys for assistance, who also checked David. Toletha then checked the computer for his code status, [redacted] and called the "Code Blue" over the PA System. Toletha said it is protocol to check the code status before they start CPR. If the patient is considered a "Full Code", staff is to perform CPR

whether they appear deceased or not. Toletha said it took longer for her to check the status on the computer due to her being [redacted] and unfamiliar with the procedure. I asked Toletha why she wrote on her records that David was found at 0857 hours instead of 0846 hrs, which is when he was actually found, and she said there was a lot going on and she was not sure of the time. I asked Toletha if anyone stayed with David as she and Gladys left his room after he was found unresponsive. Toletha was not sure if someone stayed with him or not. I advised that based on the video, it appeared David was left for several minutes after she and Gladys walked out. Toletha said the patient is not supposed to be left alone when they are found unresponsive.

I asked Toletha to back up and explain what Tonya told her about David's fall and his care going forward. Toletha stated that they typically do Neurological Assessments when someone falls, but she took Tonya's word for it that he was stable. Toletha said Tonya gave her the Neurological Assessment sheet and said she started them. Toletha said she never went into David's room to check on him from when she started her shift until Synia found him unresponsive, even though she told Ofc. Murphy she did at 0800 hours. Toletha said Tonya gave her the Neurological Assessment sheet at shift change. Toletha admitted she did not do the Neurological Assessments at the beginning of the shift, which would have been 0745 and 0845. Toletha said she was [redacted] Toletha told me she should have made her rounds, and she would not be in this position right now.

Toletha told me what she heard about David's fall out of bed. Toletha said she heard Toni was changing David's sheets and he was on the edge of the bed. Toni went to the sink and David fell out of the bed. They put him back in the bed and Toletha was told he seemed fine afterwards. Toletha was told by Tonya that Toni said she had David on his side as Toni changed him and walked to the sink. Toletha clarified her statement of saying that David was on the edge of the bed by saying said she assumed he would be closer to the edge of the bed because he was turned over from his back to his side. Toletha added that obviously she was not there to witness this herself. Toletha also said she was never given the impression that David hit his head.

Interview with Tonya Laden

Tonya [redacted] Tonya repeated the same sequence of events that she previously told me on 6/6/23 about her and Toni's immediate response to David falling and she remained consistent with that part, reiterating that David indicated he did not hit his head when he fell. Tonya does not believe that Toni accidentally rolled David off when she was removing the sheet. Tonya also does not believe Toni purposely pushed him out of the bed.

Tonya did wonder if David was not in the center of the bed and possibly closer to the edge because David could not move very well and did not really roll side to side. She did not think he would have been able to roll from the center of the bed all the way off. Tonya also said it is possible Toni misjudged where he was on the bed or maybe she did not take the proper precautions when she walked away from the bed. Tonya could not be sure because she was not in the room.

I asked Tonya if she spoke with the Nurse Practitioner with Theoria over the telehealth system they use, Point Click Care. Tonya stated there was no ongoing thread regarding David's fall. She said there was one message that she sent Theoria informing them about David's fall and one message sent back to her from Theoria regarding follow up care. These are the messages that I subpoenaed and have copies of in the casefile.

Also, in David's Medical Records is a Neurological Assessment Sheet for 6/3/2023 that showed each time slot completed from 0300 to 0645 hrs. This sheet was signed by Tonya Laden. There is a copy of this sheet in the Casefile.

I questioned Tonya about the Neurological Assessment. Tonya said per protocol, nurses must automatically do Neurological Assessments on a patient that has an unwitnessed fall. David's fall was considered an unwitnessed fall due to Toni having her back turned and not visually seeing the fall. Tonya confirmed that the nurse in charge is responsible for conducting the periodic Neurological Assessment for a patient who has had an unwitnessed fall. Tonya said that the nurse has to be in the room to check vital signs and Regency does not have the capability to check those from outside of the room. She said she has her own device to check vitals which sometimes she uses on patients. I asked Tonya specifically if she conducted every single Neurological Assessment on David and she said, "not all of them". I showed her the sheet that she completed and advised her she filled out that she did all of them. Tonya responded by saying "except for a few of them". I pointed Tonya's signature on the sheet and stated that she signed it, indicating she did all of the Neurological Assessments, but in fact she did not, and she replied "mmhmm". I pointed to the signature, and she confirmed it is hers. I disclosed to Tonya that I observed no one go into David's room on surveillance video from 0317 until 0517, when Toni went in. I asked if Toni would have done a Neurological Assessment and she said no, the nurse is responsible for doing it. I told Tonya that I observed her go into to David's room at 0543 hours for 22 seconds, and asked what she did at that time. Tonya seemed unsure of what she did at that time, saying if she was in there, she would be taking his vital signs. I asked if that would take longer than 22 seconds and she said it could take a couple minutes. She stated that David was sleeping at that time, but she put the pulse oximeter on him, and he woke up a little bit. Tonya

remembered talking to him and then he fell back asleep. She said that was it and that should not take more than 5 minutes. Tonya was sure that David was alive at approx. 0545.

I asked Tonya if she failed to check on him throughout the night, and she said " um, not every hour, no" and I said, "like you were supposed to with this", pointing to the Neurological Assessment sheet, and she replied "yes". Based on my video observations, I told Tonya I know she did not do the 0645 Neurological Check and she said "mmhmm". Based on my video observations, I stated to Tonya that she did the first 2 Neurological Assessments after David fell and then she did not do them the rest of the night. I asked her if this was an accurate statement and she said "yeah".

Tonya confirmed she was [redacted]

Tonya said she relayed to Toletha at shift change that David fell out of the bed, the time it happened, how he fell and that she specifically told her that the Neurological Assessments need to be done and when he was due for the next one. Tonya said she left the Neurological Assessment Sheet on the cart for Toletha.

I asked Tonya if there was anything else she would like to add and she said it is the first time messing up and a life is gone. She said, "why I didn't do it, I couldn't tell you". I clarified that by asking "Why you didn't check on him?" and she shook her head yes. Tonya followed up by saying she was busy working doing other work-related things, and she was not sitting around on her phone doing nothing. Tonya became visibly upset, saying she thinks about this daily because it is her job to care for people.

Given what I observed on the video and Tonya's statements, it appeared she falsified the document by filling out each slot of the of the Neurological Assessment Sheet because it would not be possible for her to do them without entering the room.

Interview with [redacted] Michelle [redacted]

I spoke with Michelle, [redacted] to clarify some things. Michelle said Tonya texted her when David fell out of bed. She showed me the text, which indicated Tonya telling her that David rolled out of bed as the [redacted] was walking to the sink and he obtained a scratch. She sent me a screen shot of the text and I added it to the case file. This was the only text Tonya sent her regarding David. Michelle then received a phone call from Toletha

when David was found unresponsive. She said Toletha was in a panic and Michelle asked if she called code, and Toletha said she was calling code now. Michelle then stated Toletha messed up by not conducting the Neurological Assessments and not doing her rounds. Michelle said Nurses are responsible for doing Neurological Assessments and they have to be in the room to do it. I told Michelle that based on my video and interview with Tonya, Tonya did not go into the room, meaning she could have not completed the Neurological Assessments. I told Michelle that David was found unresponsive at 0846 and Code Blue was called at 0903. Michelle said that time frame it is a little long, but Toletha is [redacted] Michelle confirmed that it is Regency protocol to check DNR status before starting CPR, due to nurses being accused of assault in the past for performing CPR on DNR patients. Michelle said the delay could possibly be due to the nurses trying to determine David's DNR status and Toletha being [redacted] Michelle added that Scott heard David making his usual noises, but she was unsure of an exact time that he stopped.

Interview with Synia [redacted]

I spoke with Synia, who is [redacted] Synia recalled the morning David passed away. Synia said she went in to give David his breakfast and he did not respond. She called his name and touched him. He felt cold and he did not respond. At that time, Synia went and got Toletha to tell her something was wrong. After alerting Toletha, Synia went back into David's room, at which time Scott told Synia he had been quiet for a while. Synia did not know what time David went quiet. It appeared on the video Synia found David unresponsive at approx. 0846. I asked Synia about when she went in David's room at 0827 hrs. Synia said she went in there to give [redacted] his coffee. Synia visually saw David and said he appeared to be sleeping, so she did not get close enough to see if he was actually alive or not. Synia said she did not learn that David fell out of bed earlier in the night until after he was found unresponsive. Synia was not sure of the time frame from when David was found unresponsive until the Code Blue was called, saying she was in another room with the door closed. Synia said when the doors are closed, it is hard to hear the PA System. Synia has not heard of anything else happening and had no further information for me.

8/3/2023

I went to Regency to interview Marlena [redacted] Briana [redacted] and to conduct a secondary interview with Toni [redacted] Joseph advised me Marlena and Toni are refusing to show up. Marlena said she would be there but never showed. Joseph told Toni to be there but has not answered his phone calls since.

Interview with Briana

Briana She was involved in the Code Blue that occurred when David passed away. Briana said when she got to his room, She was filling out papers during the code but otherwise was not very involved. Briana said she was working in a separate section on the second floor when the Code Blue was called. She does not know what occurred before they Code Blue or what the time delay was. Briana did not know David fell out of bed earlier until after the Code Blue was over. Briana said she has not heard anything else about this incident Briana does not recall anything being said in the hallway during this incident.

9/13/2023

Interview with Toni

On this date, Toni came in to SCSPD for a secondary interview. I spoke with Toni in the downstairs interview room. I advised her she was free to leave at any time and she is not under arrest. Toni stated that Toni also advised Joseph

Toni stated she felt intimidated, and she thought Tonya should have sent David to the hospital after he fell. She said she told Regency in their original report into this case that she asked Tonya to send him out, but she could not overstep her boundary because she is only

I asked Toni to tell me how David fell out of the bed. Toni stated she was giving him a bed bath due to him spilling soda all over himself. She successfully stripped the sheets, gave him the majority of the bed bath and walked to the sink. Toni said she left David on his back in the center of the bed. In my first interview with her on 6/7/23, Toni said she left David on his right side. This is also inconsistent with Tonya telling Toletha that Toni advised her David was on his side when he fell. Toni said she heard a loud boom when she reached the end of Scott's bed as her back was turned to David.

I asked Toni if she left David near the edge of the bed, and she said no. I asked Toni if she accidentally rolled him out of the bed while removing the sheets and she said no, the sheets

were removed prior to her walking away. I asked if she became frustrated with David and purposely pushed him out of the bed and she said no. After realizing David fell, Toni went and got Tonya. Toni stated she thought Tonya should have been quicker in her response, but the two of them went back in to assess David. Toni confirmed that they assessed him and placed him back in the bed.

Toni advised that she saw Tonya complete the initial Neurological Assessment on David when he fell, but she did not see her go into his room for the rest of the night. She does not believe Tonya completed any further Neurological Assessments on David for the rest of the night. This is contradictory to what Toni told me on 6/7/23.

Toni stated that the Nurse in Charge is responsible for completing the Neurological Assessments at Regency, not a Nurse Assistant. Toni also said Tonya should have called 911 and had David sent to the hospital. This is contradictory to what Toni told me on 6/7/23. Toni said she thinks David was [redacted] so he should have automatically been sent to the hospital after falling. Toni said she asked Tonya to send him to the hospital when she saw the scratch on David's back, but Tonya said no, it is just a skin tear. Toni said she did not want to overstep her boundaries to call 911 herself. Toni expressed concern to Tonya about how loud the fall sounded and the fact that the floors are cement and again asked to have him sent to the hospital, but Tonya did not send him. Toni thinks David would not have died had he been sent to a hospital after falling. Toni also stated that Tonya was angry that David fell, and she complained about being on a double shift and having to care for 42 patients by herself.

Toni also stated that day shift staff members read Tonya's report on David's fall, which they are not supposed to do. Toni said she was told the employees were reading the report out loud after David passed away. Toni said she was told by other staff members that Tonya wrote in her report that [redacted] She was told that Tonya wrote that [redacted] Toni said that none of this happened.

Toni also stated that David is listed as [redacted] Toni advised that although sometimes she sees the patient's chart, called "Kardex", she did not know about the [redacted] so she was unaware a second person was supposed to be in the room. Toni learned after David passed away, that he had a history of [redacted] She also learned from other staff members that David would [redacted] Toni stated because she was not aware that he was a

[redacted] when they conducted their internal investigation. She also said she would not have changed his sheets and given him a bed bath alone had she known this. Toni stated she has heard conflicting stories, with some employees saying he [redacted] while some other employees, including Joseph, said he has not done that in a long time. Toni reiterated she had only [redacted] at the time of David's death, so she wasn't sure what to believe.

I asked Toni if she spoke with David at 0517 when she was changing the trash and she said yes. Toni said David told her he was ok at that time, and he was watching Western shows. I asked Toni to be honest with me and asked if she actually went into David's room and checked on him around 0630-0640. At first, Toni said she did check on him and he was sleeping, so she looked at him and his color looked normal. I confronted her with the fact that the video does not show her going into his room at that time. Toni then said she may not have gone in there around that time, saying she had [redacted] She said she thought she went in his room, but if I saw on video that she did not, then she probably did not.

Toni also mentioned that she got into an argument with Michelle about an order regarding how high David's bed is. Toni felt it should be lower to the ground than what it was.

I was not provided with the report that Tonya wrote that Toni said was inaccurate and read by employees who were not supposed to read it. Based on Toni's claim about David [redacted] I researched the medications listed on his medication sheet. I saw in David's medication sheet that David [redacted]

9/21/23

I drafted a subpoena for David's full care plan and the full internal investigation that Regency did on David's death. Judge Fratarcangeli of the 40th District Court signed the subpoena, and I served it to Joseph at Regency.

9/22/23

On this date, Joseph provided me with a copy of the internal report conducted by [redacted]

[redacted] Michelle [redacted] and a sheet indicating that David is listed [redacted] That sheet also indicated David was [redacted] In the internal report, it is documented that [redacted] Video does not corroborate either one of these times. I added these files to a USB already listed in the case file.

11/3/2023

Dr. Pietrangelo from the Macomb County Medical Examiner provided me with a copy of her Medical Examiner's Report. [redacted]

11/30/23

I served Regency a Subpoena, Signed by Judge Fratarcangeli, to Joseph [redacted] for Toni [redacted] Personnel File and all reports completed by Tonya Laden. I asked Joseph who the initials "TXL" are. He could not be sure, but he said those are initials that are assigned by the computer system to employees. Those initials cannot be altered by the employee once assigned to them. Joseph called [redacted] Erma, to look at these initials. Joseph and Erma believe they are Tonya Laden's initials based on the pattern of use. These initials populate when a nurse checks that they have given medication to a patient. Joseph said nurses are the only ones allowed to give medications, and Nurse Assistants cannot. Joseph also said it is not written in the Regency policy that a patient on a blood thinner automatically should be sent to the hospital. Joseph said it is more of an unwritten rule that it is preferred they are sent to the hospital but some of it depends on the nurse's assessment of the patient at the time of the fall.

Michelle came into the office, and I asked her to clarify what she had said previously. She confirmed it is not a mandatory or written in policy that a patient on a blood thinner be sent to the hospital after a fall. She said they typically go by the advice of the telehealth Nurse Practitioner or Doctor that is consulted at the time of the fall. In this case, the telehealth Nurse Practitioner Javier [redacted] saw no need to hospitalize David based on what Tonya told him over the messaging platform.

12/8/2023

I received Toni's personnel file [redacted]

12/12/2023

I spoke with Michelle and Joseph at Regency. I asked Michelle if Certified Nurse Assistants have access to a patient's chart. Michelle said Certified Nurse Assistants can see the patient's "Kardex", which is the electronic version of the patient's information and care plan, and a sound Nurse Assistant would have checked this prior to giving care to David. Michelle produced a sheet from Regency's Certified Nurse Assistants orientation training. The sheet states that Nurse Assistants should check the patient's Kardex before giving care and before each shift. According to this training, Toni should have known that David [redacted] Joseph said I could have this sheet. Michelle made a copy of it and gave it to me. I scanned it on to the USB in the Casefile.

I recorded this conversation and added it to the USB in the Casefile.

I drafted a subpoena for Regency's Employee Handbook, which has rules that Toni and Tonya [redacted] Judge Fratarcangeli signed the subpoena, and I served it to Joseph.

12/19/2023

I received the Employee Handbook and a Certification of Records from Joseph, which states the records he provided to me are true, accurate and from their original source.

I reviewed the Employee Handbook. The specific [redacted] is listed in Category II, Work Rule #37 which states " Employees may not disregard resident care plans including but not limited to repositioning, transfers and/or lifting a resident. The specific [redacted] is listed in Category I, Work Rule #5 which states" Employees shall satisfactorily perform jobs, duties, and responsibilities in an appropriate manner". The specific [redacted] is listed in Category I, Work Rule #5 which states "Employees shall satisfactorily perform jobs, duties, and responsibilities in an appropriate manner." I tagged the Handbook as Evidence and entered it

into the Casefile.

12/20/23

I ran LEIN/CCH on Tonya, Toni and Toletha. [redacted]

I forwarded each CCH/LEIN/SOS to the Macomb County Prosecutors Office along with Warrant Requests for review for the following:

Tonya Laden- [redacted]

Toletha Traylor- [redacted]

Toni [redacted]

Evidence gathered in this case including documents, voice recordings, 911 calls and Regency Hallway video was downloaded to 1 USB and subsequently uploaded to Evidence.com. The BWC Interviews that were conducted with the employees was saved in a Case in the Motorola system. These interviews will be added to a USB and evidence.com at a later date due to the large volume of the files and amount of time it will take to upload them.

CR No: 230010568-003 Written By: SSNEATEA (00246) Date: 01/01/2024 10:46 AM

12/20/23

On this date, I met with the Macomb County Prosecutor's Office about the details of this case. I was advised to complete further investigation.

12/21/23

On this date, I received the autopsy photographs and the report from the Medical Examiner Investigator, Kiara Brooks. I added these documents to the USB in the Casefile.

12/28/23

I completed two subpoenas, 1 for the Medical Records of Scott [redacted], and another for David's previous Medical Progress Notes from Regency. Judge Fratarcangeli signed both subpoenas and I served them to Joseph at Regency.

I also spoke with Toletha Traylor on the phone. Toletha advised me that Tonya gave her the Neurological Assessment Sheet at the Nurses Cart at shift change. Toletha is sure that all of the slots were filled in through the 0645-time slot when she received it from Tonya. Toletha said she could not remember where she put the sheet after David passed away, but she believes Michelle ended up with it and put it in his file. I recorded this conversation and added it to the USB in the Casefile.

1/2/24

I spoke with Scott [redacted] on this date over the phone. Scott stated he was [redacted]

Scott stated he recalls the night David fell and died very well. He proceeded to give me an account of the incident that was consistent with how he described it a few days after it occurred. The only detail Scott was confused about was that he thinks the midnight nurse was not Tonya, but a nurse [redacted] I explained to Scott that [redacted] Gladys, was in the room when David was found deceased, [redacted] and maybe that's who he got Tonya mixed up with.

Scott maintained that no one came in to check on David until they served breakfast. He did not see Toni come in to change the trash nor did he see Tonya come in for 22 seconds. Scott said he did not hear David make any noises from the time Tonya and Toni put him back in bed after

0300 hours until he was found deceased.

Based on my conversations with him, Scott appears to be cognitively sharp at this time. I recorded this conversation along with 2 short follow up conversations with Scott in which he provided me with contact phone numbers for Andre [redacted] Greg [redacted] I added the recordings to the USB in the Casefile.

I spoke with Andre [redacted] about [redacted] Scott. Andre stated he [redacted] Andre stated he is not [redacted] and he is in the process of arranging [redacted] Andre stated since he is [redacted] he has contact with Scott several times a week when he checks in [redacted] Andre stated he is probably the person who Scott has the most contact with currently, advising that Scott [redacted] Andre stated he believes Scott is [redacted] Andre said he has never noticed Scott having any [redacted] Andre said he has no reason to believe Scott [redacted] or that he makes things up. [redacted]

I recorded the majority of my conversation with Andre but missed the beginning of it. I added the recording to the USB in the Casefile.

1/9/2024

I spoke with Gregory [redacted] who confirmed he is [redacted] and lives [redacted] Gregory stated he communicates with Scott mostly via text messages on a fairly consistent basis and via phone call on occasion. Gregory stated Scott had [redacted] Gregory was aware of [redacted] Gregory stated he has no reason to believe that Scott is frequently confused, [redacted] I recorded this conversation and added it to the Casefile.

1/11/24

I went to Regency and received Scott's medical records [redacted] I spoke with Joseph

and asked if the nurses document their rounds at the start of each shift and he said there is no documentation for rounds. I spoke with Michelle and asked how the Neurological Assessment Sheet was entered into David's records. Michelle advised the sheet was at the nurse's station when she came in on the day of David's death. It was completed in the manner in which it appears in the Casefile, with the slots completed up until 0645 and signed by Tonya. Michelle said she put it in her office and added to David's records.

I reviewed Scott's records. [redacted]

I reviewed several hundred more pages of Scott's medical records and [redacted]

On this date, I also received David's Medical Records dating back 1 year from his death.

I added both David's and Scott's records to the Casefile.

1/16/2024

I spoke with [redacted] Krystal [redacted] over the phone. I reminded her that Scott was there [redacted] Krystal also said she recalls [redacted] Krystal said it is possible [redacted] Krystal also said she did not recall [redacted]

I called [redacted] Judy [redacted] who did not answer.

1/17/2024

I submitted a Warrant Request on Tonya Laden [redacted] I uploaded the Warrant Request, Police Report and Tonya's CCH/SOS via Karpel.

I submitted a Warrant Request on Toletha Traylor [redacted] I uploaded the Warrant Request, Police Report and Toletha's CCH/SOS via Karpel.

I uploaded all evidence I obtained to evidence.com.

CR No: 230010568-004 Written By: SSNEATEA (00246) Date: 01/17/2024 11:28 AM

1/17/2024

On this date, I added Medical Examiner Personnel to the People Section of this report.

CR No: 230010568-005 Written By: SSNEATEA (00246) Date: 01/30/2024 10:19 AM

1/30/2024

APA Debruin authorized 1 Count of Medical Records-Intentionally Placing False Information on Chart-HCP against Tonya Laden and 1 Count of Lying to a Peace Officer against Toletha Traylor. I signed both Authorizations and swore to them in front of Judge Oster of the 40th District Court.

CR No: 230010568-007 Written By: SSAYANP (00229) Date: 01/31/2024 10:26 AM

Toletha Traylor came into the police department for court ordered prints. She was printed and released.

CR No: 230010568-008 Written By: SSAYANP (00229) Date: 02/01/2024 02:55 PM

Tonya Laden came into the police station for court ordered prints. She was printed and released. Livescan failed to send a return in a timely manner, therefore no DNA was taken at this time. Tonya was advised she may be ordered to come back in for DNA.

CR No: 230010568-009 Written By: SSNEATEA (00246) Date: 10/10/2024 10:00 AM

On 6/3/2024, Tonya Laden pled guilty to one count of Falsification of Medical records. On 7/29/2024, Tonya Laden was sentenced to 2 years' Probation with fines and costs and prohibited from working in health care while on probation.

On 10/10/2024, Toletha Traylor pled guilty to one count of Lying to a Police Officer, with sentencing scheduled for 12/3/24.