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

DATE: **DECEMBER 10, 2025**

TO: **DISTRIBUTION**

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

SUBJECT: **SHERIFF'S FINDING**

Per Sheriff Gualtieri, Licensed Practical Nurse (LPN) Juliana Newsome, #60648, will receive the following as a result of AI 25-015:

1. Forty (40) hour Suspension to be served on:

   December 17, 2025 (11.5 hours), December 18, 2025 (11.5 hours), December 28, 2025 (11.5 hours), and January 7, 2026 (5.5 hours).

DISTRIBUTION:
Sheriff Bob Gualtieri
Chief Deputy Dave Danzig
Assistant Chief Deputy Paul Carey
Assistant Chief Deputy Dennis Komar
Colonel Dennis Garvey Sr.
Major Deanna Carey
Major Greg Danzig
Major Joe Gerretz
Major Alyson Henry
Major Jon Tobeck
Director Jennifer Crockett
Director Susan Krause
Director Tom Lancto
Director Jason Malpass
Dorector Kristi Wong
Shannon Lockheart, General Counsel
Payroll
Purchasing-Uniform Supply
LPN Juliana Newsome

RO/blb

PINELLAS COUNTY SHERIFF'S OFFICE
OFFICE OF THE SHERIFF
INTER-OFFICE MEMORANDUM

DATE: **DECEMBER 5, 2025**

TO: **LICENSED PRACTICAL NURSE JULIANA NEWSOME, #60648**

FROM: **SHERIFF BOB GUALTIERI**

SUBJECT: **CHARGES RE: AI 25-015**

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 that you committed the following violation.

On, but not limited to, July 16, 2025, 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 July 16, 2025, you were working in the jail as a licensed practical nurse (LPN), assigned to South Division Medication Cart 2. The assignment covered medication distribution for Delta Wing and the Upper/Lower Gulf Wings, as well as medical response upon request from detention staff or other medical personnel.

   Your responsibilities included maintaining patient safety and comfort, escalating care to a registered nurse (RN) or higher-level clinician when required, providing treatment according to protocol, and completing timely, accurate, and legible documentation in the electronic or paper medical record. As a licensed clinician, you were also required to fully and legibly document health histories, assessments, treatments, and outcomes.

   At approximately 1903 hours, you responded to Echo Wing at the request of detention staff for an inmate who had just attempted suicide by hanging. When you arrived, the inmate was awake, alert, and responsive, with visible ligature marks around her neck. Although the inmate had just tried to hang herself and there were visible injuries to her neck, your sole interactions with her were limited to conducting a mental health check that lasted less than 30 seconds.

Despite a significant mechanism of injury and observable trauma, you failed to assess airway patency, breathing rate/quality, heart rate, cervical spine stability, or vital signs.

You did not recognize the significance of the medical event or the potential for the inmate's medical condition to deteriorate rapidly. You failed to elevate the incident to a higher-level clinician or initiate a medical emergency (Code 99). Instead, you left the inmate with non-medical detention staff and asked another LPN, in passing, to obtain the inmate's vital signs on your behalf. At 1910 hours, you contacted a licensed clinical social worker (LCSW) for a mental-health evaluation of the inmate. The LCSW evaluated the inmate at 1915 hours and placed her on Suicide Risk 2 status. You then resumed your daily medication distribution.

You failed to promptly notify any medical provider or your clinical supervisor about the suicide attempt. During your Administrative Interview, you testified that you spoke with an RN in the North Division and believed this was adequate notification. The RN you spoke with did not notify a medical provider or a nursing supervisor; neither became aware of the incident until hours later.

At 2247 hours, you entered a progress note stating, "...Notified nursing supervisor." Although your note indicated that you had notified the supervisor, she did not learn about the incident until approximately 2309 hours, 22 minutes after the note was entered, when you told her in person.

Once informed, the clinical supervisor ordered immediate notification of the medical provider. You contacted an Advanced Practice Registered Nurse (APRN) at 2330 hours. The APRN responded, evaluated the inmate, and ordered ambulance transport to the hospital. By failing to notify a provider earlier, you delayed the inmate's medical assessment by approximately 4.5 hours after the attempted suicide.

At 2333 hours, you entered a late-entry note stating, "Late Entry: For note on 7/16/25 @ 1900 notified [the APRN]. No new orders at this time." The note created a false clinical timeline and inaccurately documented that the APRN was contacted at 1900 hours and that she issued no medical orders. You contacted the APRN at 2330 hours at your supervisor's direction.

At 0015 hours (July 17, 2025), you were instructed by a supervisor to enter an additional late-entry note to clarify the time you actually notified the APRN. However, this note was poorly written and lacked the necessary information; the medical record remained clinically inaccurate and unclear.

Throughout the entirety of this event, your clinical judgement and your actions/inactions indicated that you failed to recognize the inmate's suicide attempt by hanging as a true medical emergency, requiring prompt assessment, stabilization, and management. Additionally, your documentation created an inaccurate clinical timeline, misrepresented supervisory notification, and obscured the delay in care.

The Administrative Review 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 Rule and Regulation violation totaling fifty (50) 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 from 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.

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COLONEL DENNIS GARVEY SR.
DEPARTMENT OF DETENTION & CORRECTIONS
FOR BOB GUALTIERI, SHERIFF

I have received a copy:

Date 12/9/25

Time 1555

60648

SIGNATURE